

On the Origin of **SPEOCCUPANCIES**

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Charles Darwin never mentioned post-acute care in his treatise on evolutionary biology, but the theory of Natural Selection is evident throughout the skilled nursing industry.

A generation ago, SNFs were on the precipice of an epigenetic shift that would carry them beyond “subacute” care. They would offer managed care organizations a cost-effective alternative to hospitalizations. Facilities were renamed; more “D/B/As” were filed in 2001 than in all previous years combined. “Nursing Homes” became “Health & Rehabilitation Centers.” SNFs would create and lead Integrated Delivery Systems to the promised land known as “Healthcare Reform.” Alas, it seems that nature, not to mention insurance companies, has rules. A comparative search on Google Trends distills the essence of public perception. No matter how far the SNF model of care evolves, people see only nursing homes.



One issue that has plagued the SNF image may finally be phased out. High-capacity rooms (i.e., “Triples & Quads”) are officially on the “Endangered Species List.” They’ve been waning since shortly after scientists located the massive Chicxulub Crater at the tip of Mexico’s Yucatán Peninsula (ground-zero for the mass dinosaur extinction). The slow [decline of SNF occupancy](#) has made them unnecessary in many markets, and the giant COVID meteor that slammed Earth this year highlights the wisdom of total eradication.

There is no official count of national Triples & Quads, but healthcare is a local business. To borrow terminology from the International Union for Conservation of Nature, they are “Extinct in the Wild” in several habitats but of “Least Concern” in many others. Nevertheless, fossil records show them being excised from existence by the Natural Selection of legislation and public opinion.



There are subtle but significant economic reasons why capacity reduction is beneficial to the healthcare ecosystem, but as with any environmental disruption, there are consequences to consider.

First, we examine how the “climate change” of healthcare reform has impacted Skilled Nursing Facility occupancy in recent years, keeping in mind that common capacity reports express market occupancy as a “simple average” of “total residents” to “total beds” per year. We refer to this measure as “Nominal Occupancy,” and it’s as dangerous as an invasive species.

Year	SNFs	Beds	Census	Nominal Occupancy
2013	15,534	1,694,759	1,359,645	80.2%
2019	15,061	1,591,948	1,246,709	78.3%

Data represents Medicare certified SNF beds, courtesy of Kaiser Family Foundation

In “Nominal” terms, SNF occupancy fell 1.9 points (2.4%) from 2013 – 2019, end of story. But as a post-acute care conservationist (“Consultavationist”???), I’m more concerned with the species’ health than reclaiming lost habitat; we should not trend occupancy without the context of bed count declines.

The industry “lost” over 100,000 beds from 2013 - 2019, so the Nominal Occupancy drop does not reveal the whole story. The far more insightful utilization benchmark is “Relative Occupancy,” a common-sense measure we developed that, in this example, places all 2019 residents into the total complement of 2013 beds. This calculation reveals a more hostile environment.

Market demand deteriorated more severely than the Nominal rate of 2.4% suggests. When bed inventory is considered, we see that the Relative Occupancy decline was more than triple the Nominal Occupancy decrease: 8.3% (6.6 percentage points).

Year	SNFs	Beds	Average Census	Relative Occupancy
2013	15,534	1,694,759		73.6%
2019	15,061		1,246,709	

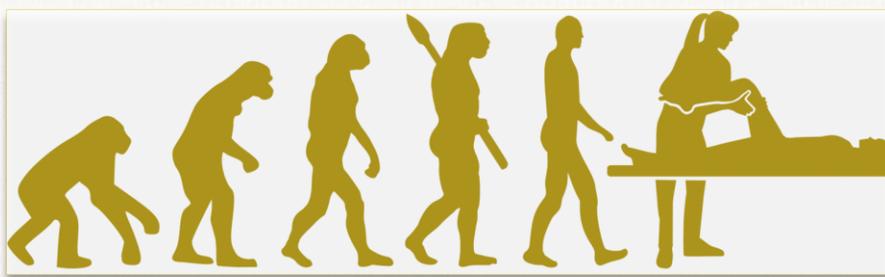
Census is the oxygen of our SNF environment; Relative Occupancy models the future’s air quality.

Nominal	Relative	Outlook	Explanation
-1.5%	> -4.0%	Negative	Utilization decreasing faster than beds closing; census should decline
1.9%	= 1.9%	Neutral	Market is in equilibrium
-3.1%	< 5.5%	Opportunity	Utilization growing faster than new beds; census should improve



Survival of the SNFittest

I've watched enough National Geographic specials to know that nature can be cruel, and here's where it gets visceral for SNFs. Occupied or not, a licensed bed carries intrinsic value. In fact, there's a cottage industry for trading/brokering beds by arbitraging local supply & demand imbalances within a state. So why would an operator willingly surrender a licensed bed? It may seem blasphemous, but there are good reasons to consider it. The most compelling consideration, at least for providers in half the nation, is reimbursement.



While many Medicaid payment systems have evolved into “price-based” or managed rate structures, the cost report remains a fundamental rate setting instrument throughout the country. In basic terms, “cost-based reimbursement” is simple division: Specific expenses (numerator) are divided by Patient days (denominator). For example, assume indirect operating expenses are reimbursed at reasonable costs in the following scenarios:

- A. 100 bed SNF, 100% occupied, \$1,000,000 of fixed, allowable annual expenses.
 $\$1,000,000 / 36,500 \text{ days} = \27.40 toward the rate.
- B. 100 bed SNF, 50% occupied, \$1,000,000 of fixed, allowable annual expenses.
 $\$1,000,000 / (36,500 \times 50\%) = \58.80 toward the rate.

Why does Facility B receive twice the rate for being half full? After all, it may be struggling due to substandard care or inefficiency. Medicaid systems avoid rewarding inefficiency by setting “ceilings” on allowable costs, and then by “imputing” occupancy for the rate equation. To impute is to set a “floor” on the percent of certified bed capacity (typically ~ use an 85%) floor. Back to Facility B:

- B. 100 bed SNF, 50% occupied, \$1,000,000 of annual expenses. 85% occupancy floor.
 $\$1,000,000 / (36,500 \times 85\%) = \32.23 toward the rate.
\$PPD remains \$58.80, but Facility B is “penalized” \$26.57 PPD by the low occupancy.



The key here is basing the denominator on available days using certified beds. If Facility B has 20 Triples and 5 Quads, converting to doubles effectively eliminates 30 beds from inventory. In addition, Isolation protocols and consumer demands require providers to maintain private rooms, thus Facility B converts 10 doubles to single occupancy. Our putative 100-bed facility is now effectively scaled down to 60 beds!

The problem is that Skilled Nursing Facilities cannot be scaled down in this manner – fixed costs are simply too high. Facility B maintains all the overhead of a 100-bed provider; yet for cost-based calculations, the closest it can get to full capacity is 60%. The operator will forever be burdened by the imputed occupancy penalty... unless beds are decertified.



This may be COVID’s legacy, a new species introduced into the post-acute care biome; it therefore needs a name. In keeping with all the “Ps” that 2020 produced (PPP, PPE, PRF), we introduce PPC to the provider lexicon: Post-Pandemic Capacity.

PPC is going to sneak up on us if not addressed prior to filing 2020 cost reports, but the issue extends beyond state Medicaid departments. “Per bed” pricing contracts such as software, insurance, “hotel functions,” and even rent carry an almost literal “hidden bed tax.” For those looking to invest in skilled nursing, we recommend avoiding the “Price per Bed” benchmark; we prefer to qualify value at “Price per PPC Bed.”

Stakeholders are pondering what the post-COVID world holds for Skilled Nursing. While it may be too early to tell, PPC is already impacting operators and investors. However, PPC should not become our version of the Chicxulub Crater. I remain optimistic that this rightsizing will ultimately strengthen the provider community, and SNFs will be best prepared to survive the next mass-extinction event.

This is a pivotal time in SNF evolution.

Charles Darwin would be fascinated.

