Investment Thesis Report: Skilled Nursing Facilities

April 2025

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Background

The concept of skilled nursing facilities ("SNFs") emerged in response to the growing need for short-term care in the United States, particularly after World War II. Before the mid-20th century, elderly and disabled individuals who required medical support were often cared for by family members or placed in charitable almshouses, which provided minimal medical oversight and often suffered from overcrowding and poor conditions (Grabowski, 2022). The transformation of long-term care began with the Hill-Burton Act of 1946, a landmark law that provided federal funding for hospital and healthcare facility construction. Although its primary goal was to expand acute hospital care, an amendment in 1954 allocated resources specifically for nonprofit SNFs, leading to a significant increase in the number of facilities capable of delivering skilled nursing care (National Research Council, 1986).

With the passage of Medicare and Medicaid in 1965, the U.S. government formalized funding for SNFs, establishing federal standards for participation. This further accelerated the development of skilled nursing care as an essential component of post-acute care. As hospital stays became shorter due to cost-control measures and medical advancements, the demand for intermediate care settings surged. SNFs became a critical part of the continuum of care, providing rehabilitation, skilled nursing, and therapy services to patients recovering from surgery, strokes, and other serious conditions (MedPAC, 2024).

However, the quality and regulation of these facilities remained inconsistent until the Omnibus Budget Reconciliation Act (OBRA) of 1987, which introduced sweeping reforms to improve the quality of care in SNFs. OBRA mandated uniform standards for resident assessment, care planning, and patient rights, ensuring that residents received high-quality,

dignified care (National Research Council, 1986). This law set the foundation for modern SNF regulations, reinforcing the government's role in overseeing long-term care quality. As of 2025, there are approximately 15,000 skilled nursing facilities (SNFs) operating in the United States, providing care to about 1.4 million Americans annually. The industry has experienced a significant shift toward for-profit ownership over the past few decades. In 2000, approximately 65% of nursing homes were for-profit entities; by 2017, this figure had increased to 70%, reflecting a trend toward privatization and consolidation within the sector (Tuck School of Business, 2023).

Internationally, long-term care models differ notably from those in the U.S. In the Netherlands, long-term care has been integrated into the universal healthcare system since 1968. The Dutch system includes mandatory public insurance programs that cover both institutional settings and home-based care, with taxpayers contributing nearly 10% of their income toward premiums. Out-of-pocket expenses for institutional care are relatively low, averaging about 7% of the total cost (KFF Health News, 2023). In Japan, the government has implemented a comprehensive long-term care insurance program to address the needs of its aging population. This system emphasizes home-based services and community support, aiming to reduce reliance on institutional care. In 2020, Japan allocated approximately 2% of its gross domestic product to long-term care, which was 67% more than the United States spent in the same year (KFF Health News, 2023). In contrast, the United Kingdom, particularly England, operates a model closer to that of the United States. Long-term care is not fully covered by the National Health Service (NHS) and is primarily means-tested. Individuals with assets above a certain threshold must pay for their own care, which has led to increasing reliance on private care providers and significant financial burden for many families. About 84% of care home beds in England are provided by

the independent (for-profit and nonprofit) sector, and concerns over quality, staffing, and sustainability are common, mirroring many of the challenges faced by SNFs in the U.S. (The King's Fund, 2023).

Introduction

A SNF is a healthcare institution that delivers medically necessary skilled nursing care and rehabilitation services to patients following a qualifying hospital stay (Centers for Medicare & Medicaid Services [CMS], 2024). These facilities primarily provide short-term, intensive care for individuals recovering from illness, injury, or surgery, typically after being hospitalized for at least three consecutive days, in accordance with the Two-Midnight Rule. Medicare covers up to 100 days of SNF care per spell of illness for eligible beneficiaries, with full coverage for the first 20 days. From day 21 through day 100, patients are responsible for daily copayments, which in 2024 were set at $204 per day (CMS, 2024). As of 2025, there are approximately 15,000 SNFs operating in the United States. Of these, roughly 70% are for-profit, 24% are non-profit, and the remaining 6% are government-owned (KFF, 2025). Each year, about 1.4 million Americans receive care in these facilities, with Medicare beneficiaries comprising the majority of residents. Around 65 million people are enrolled in Medicare, and 79 million in Medicaid, programs that together serve as primary payers for SNF services (Medicare Advocacy, 2024; Medicaid.gov, 2024).

SNFs are required to meet staffing and operational standards set by Medicare, including the presence of a registered nurse (RN) on-site for at least eight hours per day and licensed nursing staff available 24/7 (Centers for Medicare & Medicaid Services [CMS], 2024). Core services offered include occupational therapy (OT), physical therapy (PT), and speech-language pathology (SLP), all tailored to individual recovery plans. While SNFs must comply with Medicare's regulatory framework, they are not obligated to accept Medicaid, which can limit access for lower-income patients (Medicare Payment Advisory Commission [MedPAC], 2024).

However, approximately 96% of SNFs are dually certified to provide both Medicare and Medicaid services (MedPAC, 2024). Medicaid is the primary payer for long-term care in SNFs, covering about 56% of nursing home residents nationwide (Axios, 2025). Despite this, Medicaid reimbursement rates often fall short of covering the full cost of care, averaging about 82% of actual expenses (LeadingAge, 2024).

Private equity (PE) investment in the SNF sector has grown significantly over the past decade, with many large for-profit chains backed by PE firms. As of 2025, the top 10 PE-backed SNF chains include Genesis HealthCare, The Ensign Group, Life Care Centers of America, Consulate Health Care, SavaSeniorCare, Prestige Care, CommuniCare Health Services, Saber Healthcare, Trilogy Health Services, and Greystone Healthcare. A recent notable transaction is the 2024 acquisition of Trilogy Health Services by Welltower and Integra Healthcare Partners, which valued the chain at approximately $1.5 billion, reflecting continued investor interest in consolidating and scaling operations across the fragmented SNF market.

Affected Parties

Owners perspective

From the corporate owners and operators of SNFs perspective, the primary focus is on maintaining profitability while ensuring compliance with strict healthcare regulations. They must navigate financial pressures caused by rising operational costs, including staff wages, facility maintenance, and regulatory requirements. Reimbursement models, particularly from Medicare and Medicaid, dictate much of their revenue, making policy changes a critical concern. Additionally, staffing shortages pose a major challenge, as hiring and retaining skilled nurses is

both costly and competitive. Poor facility ratings or compliance violations can lead to financial strain, as lower ratings reduce patient admissions and increase scrutiny from government agencies. Owners must also manage legal risks, as lawsuits related to neglect, abuse, or poor care quality are common in the industry. In fact, nursing home bed sore cases alone account for an estimated 17,000 lawsuits annually in the U.S. (Lawsuit Information Center, n.d.). A national survey of attorneys revealed that in 2001, law firms were involved in over 8,200 claims against nursing homes, with more than half occurring in Florida and Texas (Stevenson & Studdert, 2003).

Research indicates that for-profit nursing homes are more susceptible to litigation compared to non-profit facilities. A study analyzing data from 2,378 nursing homes across 45 states found that for-profit status, larger facility size, and a higher number of care deficiencies were associated with increased lawsuit filings (Stevenson et al., 2005). Conversely, higher staffing levels of certified nursing assistants (CNAs) and registered nurses (RNs), as well as membership in multistate chains, were linked to fewer lawsuits. The financial implications of litigation are significant. The average settlement for nursing home neglect cases is approximately $406,000, with some cases resulting in awards exceeding $1 million (Sokolove Law, n.d.). These costs, coupled with reputational damage, can severely impact a facility's financial stability. As a result, owners are increasingly investing in risk management strategies, including enhanced staff training, compliance programs, and quality improvement initiatives, to mitigate potential legal exposures.

Health Insurance Perspective

For health insurance providers, cost containment is a top priority. Insurers aim to reduce the length of SNF stays, encourage alternative care options such as home healthcare, and enforce strict pre authorization policies to manage expenses. Many insurers are shifting toward value-based payment models, linking reimbursement rates to quality metrics such as hospital readmission rates and patient satisfaction scores. Fraud prevention is another major concern, as some SNFs engage in overbilling or providing unnecessary services. However, insurers also face their own set of challenges, including the high cost of skilled nursing care and regulatory limitations on reimbursement structures. Balancing cost efficiency with member satisfaction is often difficult, as patients and families advocate for longer, higher-quality care while insurers push for financial sustainability.

Members' Perspective

From the members' (patients and families) perspective, access to quality, affordable care is the most pressing issue. Many patients struggle with out-of-pocket costs, particularly when Medicaid coverage is unavailable or private insurance offers limited SNF benefits. Families also prioritize continuity of care, seeking smooth transitions between hospitals, SNFs, and home health services to prevent gaps in treatment. Transparency and accountability are essential, as families want clear communication regarding treatment plans, costs, and facility performance. However, they face significant challenges, including limited choices due to financial or insurance constraints and concerns about staffing shortages that may lead to neglect or subpar care. The emotional and psychological toll of placing a loved one in an SNF adds another layer of difficulty, often leading to stress, guilt, and anxiety about the quality of care.

Payment Models

Fee-for-Service vs. Patient-Driven Payment Driven Model

The Medicare Fee-for-Service (FFS) program reimburses healthcare providers, including physicians, hospitals, and SNFs, based on statutorily established payment systems (CMS, 2024). Under FFS, healthcare providers bill Medicare directly for each service provided, rather than receiving a predetermined bundled payment. While this model allows patients the flexibility to choose medical providers who participate in Medicare and agree to reduce their charges, it is often associated with higher overall healthcare spending. The structure incentivizes higher service utilization, as providers are reimbursed per procedure, leading to increased costs for Medicare and, indirectly, for patients through higher premiums and copayments (MedPAC, 2024).

Given these inefficiencies, there has been a shift toward alternative payment models, such as the Patient-Driven Payment Model (PDPM), to better align incentives with patient needs. The PDPM, implemented in October 2019, replaced the previous Resource Utilization Group "RUG-IV" system to reform how Medicare reimburses SNFs (CMS, 2024). Unlike RUG-IV, which incentivized high therapy minutes by tying payments to the volume of therapy provided, PDPM shifts the focus to patient characteristics and clinical needs. The model classifies residents into case-mix groups based on diagnoses, functional status, and comorbidities to determine reimbursement rates (MedPAC, 2024). Studies have shown that PDPM has led to a reduction in therapy minutes without negatively affecting short-term health outcomes, with patients receiving about 13% fewer therapy minutes post-implementation (Prusynski et al., 2022). By December 2020, the Centers for Medicare & Medicaid Services (CMS) estimated a 30% reduction in

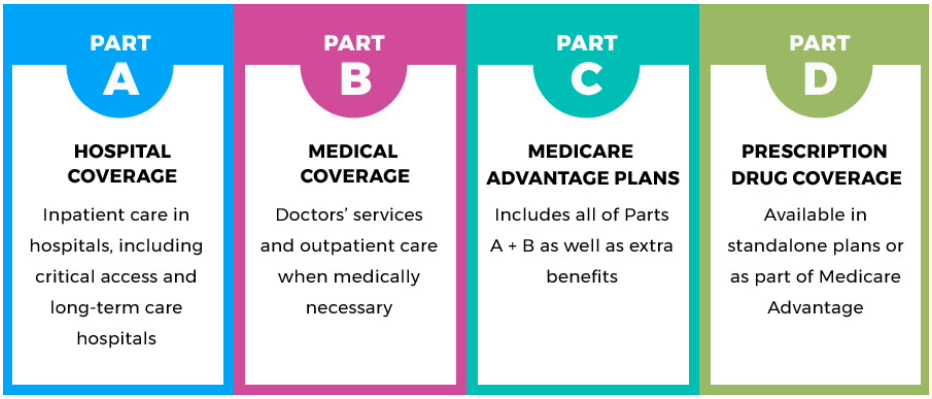
therapy minutes (CMS, 2021). SNFs responded with both immediate and gradual reductions in therapy staffing, averaging a decline of 80 therapy staffing minutes over the average patient stay (McGarry et al., 2023). Despite these reductions, the likelihood of rehospitalization and functional scores at discharge remained unchanged (Prusynski et al., 2022). However, a study in the Journal of the American Medical Directors Association reported significant improvements in quality measures related to patient outcomes in SNFs following PDPM implementation (Xu et al., 2023). While PDPM's focus on patient-centered care shows promise, the long-term impacts on patient outcomes and the balance between cost-efficiency and optimal care require continued evaluation.

Medicare Advantage

In recent years, there has been a growing shift towards Medicare Advantage ("MA"), an alternative to the standard Medicare program. Medicare Advantage, also known as Medicare Part C, is offered by private insurance companies that are approved by the CMS. These plans provide the same coverage as Original Medicare (Part A and Part B) but often include additional benefits such as vision, dental, hearing, and wellness programs. In some cases, Medicare Advantage plans may also include prescription drug coverage (Part D). One of the key differences between Original Medicare and MA is that the latter typically operates through managed care models like Health Maintenance Organizations (HMOs) or Preferred Provider Organizations (PPOs). MA plans often require beneficiaries to use a network of healthcare providers and may have restrictions on out-of-network care, though they can provide lower out-of-pocket costs, depending on the plan structure.

Figure 1

Chart showing the different parts within Medicare



From Group Plans Inc., 2024.

One of the most significant advantages of MA is its potential for cost savings. By limiting access to a network of healthcare providers and implementing care coordination efforts, MA plans aim to reduce unnecessary hospital admissions, manage chronic conditions more efficiently, and prevent costly complications. These plans also operate with a fixed premium, which can make budgeting easier for beneficiaries, and the premiums for many MA plans may be lower than those under traditional Medicare, especially when factoring in out-of-pocket costs. Additionally, MA plans often include an out-of-pocket maximum, providing beneficiaries with greater financial protection against high healthcare costs.

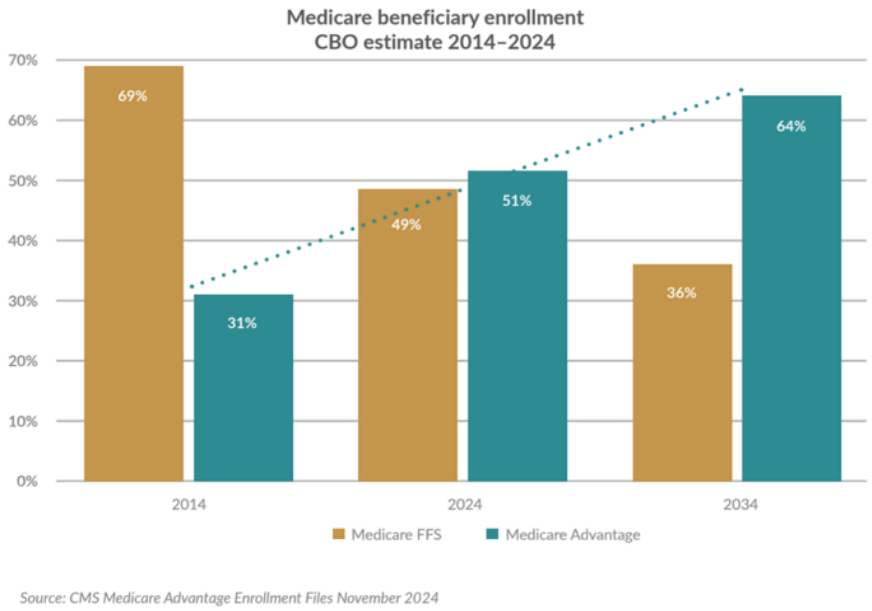
MA plans are reimbursed on a capitated basis, meaning that CMS pays the private insurer a fixed amount per enrollee each month, regardless of how many services are used. This differs from the Medicare FFS program, where providers are paid for each individual service provided. Because of this, MA plans have an incentive to focus on preventative care and care coordination, seeking to reduce the overall costs by avoiding expensive interventions through early detection

and management. Despite these advantages, some criticisms of MA exist. Critics argue that while these plans can save money for both the CMS and beneficiaries, they may limit beneficiaries' access to care due to restrictive networks or prior authorization requirements. Additionally, some MA plans have been criticized for offering limited coverage in certain areas or for the denial of services deemed unnecessary by the insurer. Moreover, as MA plans rely on private insurers, there is concern over the complexity of comparing plans and the ability of some beneficiaries to navigate the system, particularly those with limited resources or healthcare literacy (Braun et al., 2018).

MA is rapidly becoming the dominant choice for senior healthcare, with projections indicating that by 2030, nearly 64% of the senior population will be enrolled in these plans. In 2014, 69% of Medicare beneficiaries were enrolled in the traditional Medicare FFS system, while 31% were covered by MA plans. However, by 2024, the landscape had dramatically shifted. According to a report, 49% of Medicare beneficiaries were enrolled in FFS, while 51% were enrolled in MA plans, reflecting a significant transformation in the way healthcare is delivered to seniors (National Council on Aging [NCOA], 2023).

Figure 2

Shift in Medicare Enrollment: Traditional Medicare vs. Medicare Advantage Plans (2014-2024)

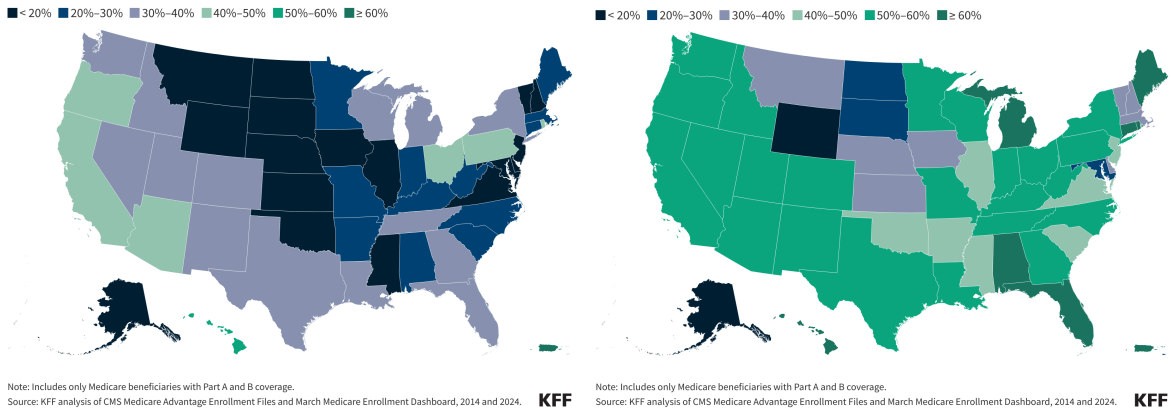


From Centers for Medicare & Medicaid Services, 2024.

Between 2014 and 2024, there has been a significant nationwide increase in MA enrollment across nearly all U.S. states. In 2014, most states had less than 40% of beneficiaries enrolled in MA plans, with several states, particularly in the Midwest and Mountain West, showing enrollment rates under 30%. By 2024, the landscape had shifted dramatically, with the majority of states reaching enrollment levels of 50% or more, and several, including Florida, California, and Michigan, surpassing 60%. This growth has been especially prominent in Southern, Western, and Northeastern states. However, a few states remain low adopters of MA, most notably Alaska, which continues to have less than 20% enrollment, and Wyoming and North Dakota, which fall into the 20–30% range. These outliers suggest persistent structural, political or geographic barriers to MA adoption. Overall, the trend indicates a strong and widespread move toward Medicare Advantage, with only a handful of states lagging behind.

Figure 3

Medicare Enrollment Trends in 2024



From Kaiser Family Foundation, 2024.

This shift in enrollment underscores the growing popularity of Medicare Advantage plans. As the MA market continues to expand, insurers have been capitalizing on this trend. The 2024 data below illustrates that a few major players dominate this market, with UnitedHealthcare leading the way, followed by Humana and BCBS:

Figure 4

Market Share of Medicare Advantage Insurance Plans (2024)

Insurer	Market Share	Number of Beneficiaries (MA)
United Healthcare	29%	9.4 million
Humana	18%	6.0 million
BCBS plans	14%	4.6 million
CVS Health	12%	4.1 million
Kaiser Permanente	6%	1.9 million
Centene	3%	1.1 million
Cigna	2%	0.6 million
Other Insurers	16%	5.1 million

From Kaiser Family Foundation, 2024.

However, while MA plans offer comprehensive coverage, they come with concerns over transparency and accountability. Issues related to access to care, plan restrictions, and unexpected out-of-pocket costs are growing points of contention. In response, the CMS has begun implementing auditing techniques to improve transparency within these plans. These efforts are intended to ensure that beneficiaries receive the care promised under their plans and that insurers maintain proper oversight (NCOA, 2023). As Medicare Advantage becomes the standard for senior healthcare, the implications for healthcare providers, insurers, and beneficiaries are significant.

Factoring in MA, for SNF owners, this plan presents lower reimbursement rates, stricter authorization processes, and shorter covered stays compared to traditional Medicare. These financial pressures, combined with staffing shortages and regulatory compliance, make it difficult for SNFs to remain profitable. Although some facilities actively contract with MA plans for a steady flow of patients, they must navigate delayed payments, complex administrative requirements, and performance-based incentives that tie reimbursement to quality metrics. From the insurer's perspective, MA is designed to control costs by limiting SNF admissions, encouraging home health alternatives, and enforcing preauthorization. While this model reduces unnecessary stays and promotes value-based care, it often leads to conflicts with SNFs over coverage decisions and reimbursement disputes. Additionally, patient dissatisfaction due to denied stays or early discharges can create retention issues for insurers. For patients and families, MA can mean restricted access to SNF care, unexpected coverage denials, and financial strain if longer stays are needed. Unlike traditional Medicare's relatively straightforward coverage, MA plans vary widely, requiring pre approvals that may override physician recommendations. While

some members benefit from expanded home health services and care coordination, others face stress and uncertainty when SNF coverage is limited.

Regulations

SNFs are regulated through several CMS initiatives aimed at promoting high-quality, patient-centered care. The Skilled Nursing Facility Quality Reporting Program (SNF QRP) requires facilities to report standardized clinical quality measures—such as fall rates, pressure ulcers, and rehospitalization data—using tools like the Minimum Data Set (MDS) and claims-based metrics. Non-compliance leads to a 2% reduction in Medicare reimbursements. Complementing this, the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program ties Medicare payments directly to a facility's performance in reducing 30-day hospital readmissions. Introduced under the Protecting Access to Medicare Act of 2014 and implemented in FY 2019, the program withholds 2% of Medicare Part A payments to all SNFs and redistributes those funds based on each facility's performance score. Facilities are evaluated on either their improvement over time or their achievement relative to national benchmarks, with higher-performing SNFs receiving incentive payments.

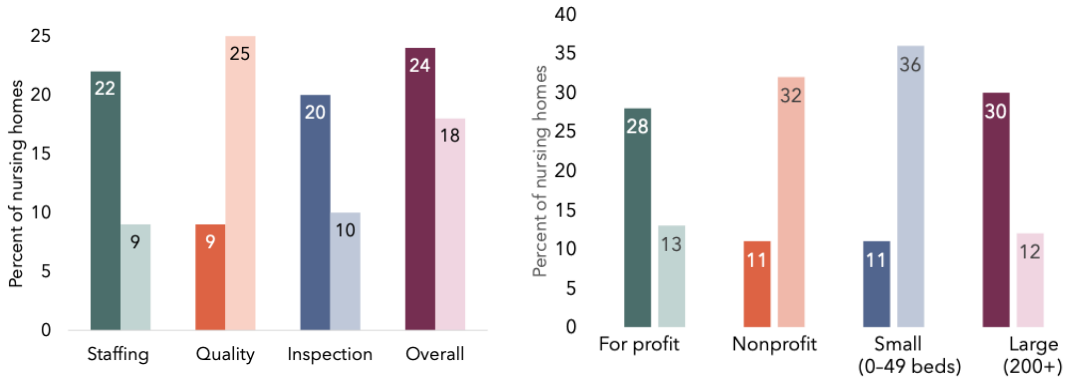
The SNF VBP program uses the SNF 30-Day All-Cause Readmission Measure (SNFRM) as its core quality metric, which assesses the rate of unplanned hospital readmissions within 30 days of discharge from an SNF. This system encourages providers to improve care transitions, enhance discharge planning, and reduce preventable hospitalizations. Starting in FY 2027, CMS plans to expand the program to include additional quality measures such as healthcare-associated

infections and patient functional outcomes, aligning SNF reimbursement more closely with value-based care principles.

Furthermore, the IMPACT Act of 2014 supports these efforts by mandating standardized data collection across post-acute care settings. SNFs must report consistent information on patient function, medical conditions, cognitive abilities, and social risk factors—enabling comparisons across providers and improving continuity of care. In addition, SNFs are evaluated through the CMS Five-Star Quality Rating System, which publicly scores facilities based on health inspections, staffing ratios, and quality outcomes. Collectively, these regulatory mechanisms aim to shift the industry from volume-based to value-based care, incentivizing better patient outcomes and greater transparency.

Figure 5

Distribution of 1-Star and 5-Star Ratings Among Nursing Homes (April 2025)



From MedPAC (2025).

These graphs illustrate the distribution of 1-star and 5-star ratings among nursing homes (including SNFs), broken down by domain (left) and by ownership and size (right). The darker bars represent the percentage of facilities receiving 1-star ratings, while the lighter bars indicate

those receiving 5-star ratings. In examining the domain-based ratings, it is evident that most areas are skewed toward lower performance. For instance, 22% of nursing homes received a 1-star rating in staffing compared to just 9% receiving a 5-star. Similarly, inspection and overall categories show a greater proportion of 1-star facilities (20% and 24%, respectively) than 5-star (10% and 18%). The only exception is the quality domain, where 25% of homes received a 5-star rating compared to 10% with just 1-star, suggesting that while many facilities struggle with staffing and compliance, some still maintain strong inspection outcomes.

Looking at the right-hand graph, which categorizes facilities by ownership type and size, stark contrasts emerge. For-profit facilities are more likely to receive low ratings, with 28% falling into the 1-star category and only 13% achieving a 5-star rating. In contrast, nonprofit nursing homes perform much better, with only 11% receiving a 1-star and a notable 32% earning a 5-star rating. A similar pattern is evident when comparing facility sizes. Smaller facilities (0–49 beds) demonstrate significantly stronger performance, with 36% achieving 5 stars and only 11% receiving 1 star. Meanwhile, larger facilities (200+ beds) tend to underperform, with 30% rated 1-star and just 12% reaching the highest rating. Overall, the data highlight that nonprofit and smaller facilities are more likely to provide high-quality care, while for-profit and larger homes are disproportionately represented among the lowest-rated providers.

Alternatives to SNFs

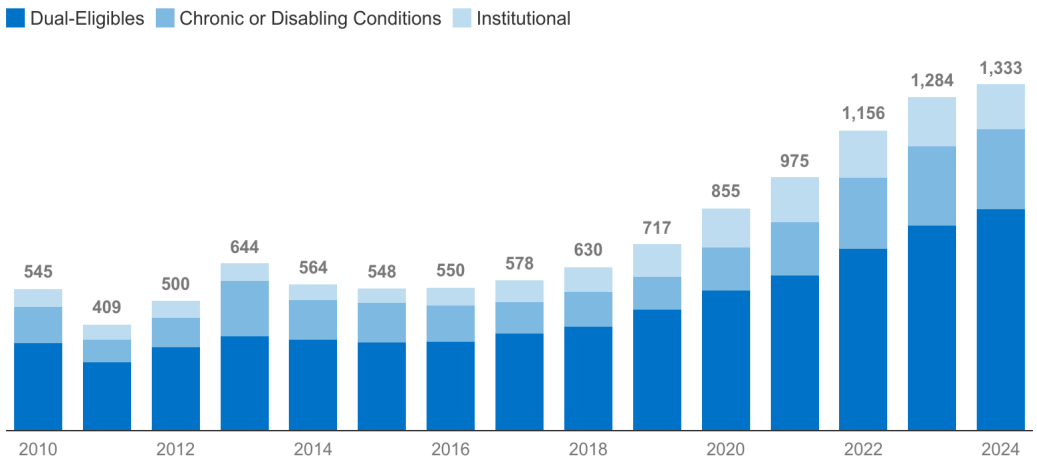
I-SNPs

Institutional Special Needs Plans (I-SNPs) are a type of Medicare Advantage plan specifically designed for individuals who reside in long-term care settings, such as SNFs or

nursing homes, or for those receiving institutional-equivalent care at home (Centers for Medicare & Medicaid Services [CMS], n.d.). These plans emerged as a more targeted solution to manage the complex medical needs of frail, chronically ill patients, with the concept gaining significant traction during the COVID-19 pandemic when the importance of coordinated, facility-based care became more evident (CMS, n.d.). As shown in the graph below, the need for more Special Needs Plans (including I-SNPs in light blue) has nearly doubled since 2019:

Figure 6

Growth in Special Needs Plans (SNPs) Enrollment (2019-2024)



From Jacobson et al. (2023).

To qualify for an I-SNP, a physician must certify that the individual requires an institutional level of care, and the individual must have lived in a qualifying facility for at least 90 consecutive days (CMS, n.d.). Despite their benefits, I-SNPs remain underutilized: while the program can accommodate between 3 to 4 million people, only about 500,000 are currently enrolled (Lambert, 2023). Historically, UnitedHealthcare played a dominant role in this space, but the market is expanding with new players and service providers. The back-end of I-SNPs is

managed like any other insurance product, but some companies, such as Optum SNP Solutions, offer end-to-end services to nursing homes and care facilities that want to implement or participate in I-SNPs (Lambert, 2023). These plans offer an opportunity for more proactive, integrated care, yet many facilities still have not adopted them widely.

Swing beds

Swing beds are hospital-based beds that can be used interchangeably for either acute care or post-acute skilled nursing facility (SNF)-level care, depending on patient needs. This designation, primarily used in rural hospitals and critical access hospitals (CAHs), allows facilities to maximize bed utilization and offer skilled nursing care without requiring a dedicated SNF unit. Medicare Part A covers swing bed services similarly to SNF care, provided the patient meets the same eligibility criteria, including a three-day inpatient hospital stay before transfer (CMS, 2024). Swing beds offer continuity of care in rural communities where dedicated SNF facilities may be unavailable, reducing the need for long-distance transfers. However, reimbursement rates for swing bed care are often higher than those for freestanding SNFs, raising concerns about cost inefficiencies within Medicare's payment structure (MedPAC, 2024). Specifically, Medicare reimburses CAHs at 101% of their reasonable costs for swing bed services. A 2020 audit by the Office of Inspector General (OIG) found that the average daily reimbursement for skilled nursing services in a swing bed was $1,845.69, significantly higher than the average SNF per diem rate of approximately $400 (OIG, 2024). This discrepancy has led to calls for aligning swing bed payments more closely with SNF rates.

Unlike Medicare, Medicaid generally does not reimburse for swing bed services in CAHs. Most states do not include swing beds as Medicaid-certified nursing facility beds, which

means that CAHs must typically rely on Medicare or private payers to cover swing bed stays. In some cases, Medicaid patients may be transferred to traditional SNFs if long-term care is needed, as CAHs often cannot bill Medicaid for extended post-acute stays. This limitation can create challenges for continuity of care in rural areas, particularly for low-income patients who rely on Medicaid coverage (National Rural Health Association, 2023).

At Home Care

The SNF market is experiencing a significant transition, with an increasing number of patients and families opting for home-based care over institutional settings. This shift is driven by several factors, including patient preference for aging in place, advancements in telehealth and remote monitoring, and cost efficiencies associated with at-home care models. Additionally, Medicare Advantage plans are increasingly incentivizing care in lower-cost settings, accelerating the move away from traditional SNF utilization (Kaiser Health News, 2022). As a result, SNFs are facing pressure to adapt by enhancing post-acute care coordination, integrating with home health providers, or repositioning their services for higher-acuity patients who require intensive, facility-based care.

Current Trends & Problem Identification

Problem Identification

Rising patient acuity, uneven occupancy rates, and increased pressure to innovate without clear avenues for new revenue creation remain critical issues in the SNF market. Many SNFs are focused on maintaining financial solvency amid staffing shortages, regulatory hurdles, and declining reimbursements, rather than embracing innovation and value-based care opportunities.

Occupancy rates, long considered a core indicator of SNF financial health, have shown signs of recovery but remain below pre-pandemic levels. As of October 2024, the median national SNF occupancy rate was 84%, with the top quartile of facilities exceeding 92% occupancy, while the bottom quartile remained at or below 71% (Medicare Payment Advisory Commission [MedPAC], 2025). This variability underscores the challenges of applying uniform policy or investment strategies across a fragmented national market.

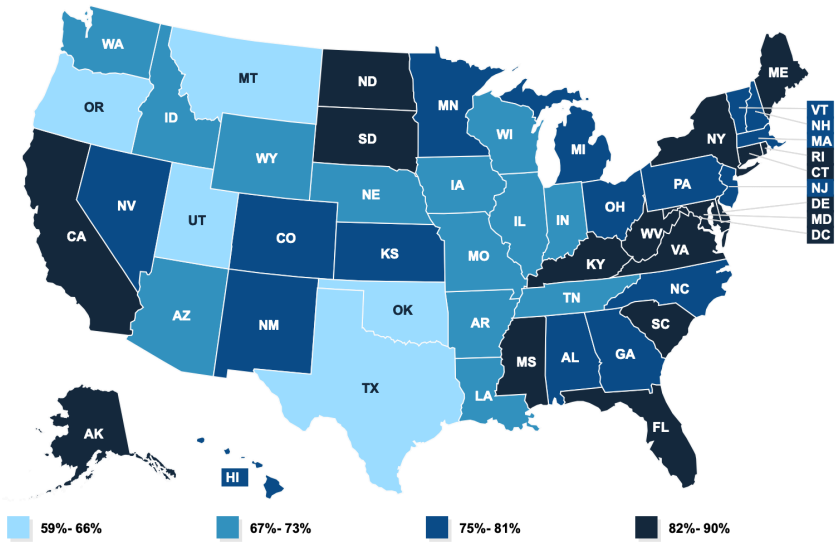
Several structural and systemic factors contribute to persistently low occupancy rates. First, the COVID-19 pandemic accelerated discharges and discouraged admissions due to infection risks, leading families and hospitals to pursue home-based or alternative post-acute options like hospice, personal care homes, and hospital-at-home programs. Second, many hospitals, SNFs' primary referral source, are retaining patients longer or bypassing SNFs entirely, particularly when dealing with high-acuity or complex cases that might require more robust infrastructure or staffing than many SNFs can offer (MedPAC, 2025). Additionally, perceived and actual quality concerns, driven by staffing shortages, media coverage, and CMS quality ratings, have made families more hesitant to choose institutional care.

Demographic and behavioral shifts are also shaping demand. The rise in aging-in-place preferences, supported by Medicare Advantage plans and Medicaid Home and Community-Based Services (HCBS) waivers, is redirecting funding and patients away from institutional settings. This is especially impactful in states with well-developed HCBS networks, where patients who would have entered SNFs a decade ago are now receiving comparable care at home. At the same time, SNFs face fixed operating costs, making it difficult to scale down during periods of underutilization.

The result is a system where occupancy has yet to rebound fully to pre-pandemic levels, and many facilities operate below the 85%–90% benchmark typically needed for long-term profitability. In some markets, persistent under-occupancy is driving closures, mergers, and private equity divestitures, while in others, high-acuity specialization or diversification into transitional care is helping facilities regain volume.

Figure 7

Skilled Nursing Facility Occupancy Rates by State



From Kaiser Family Foundation (2024).

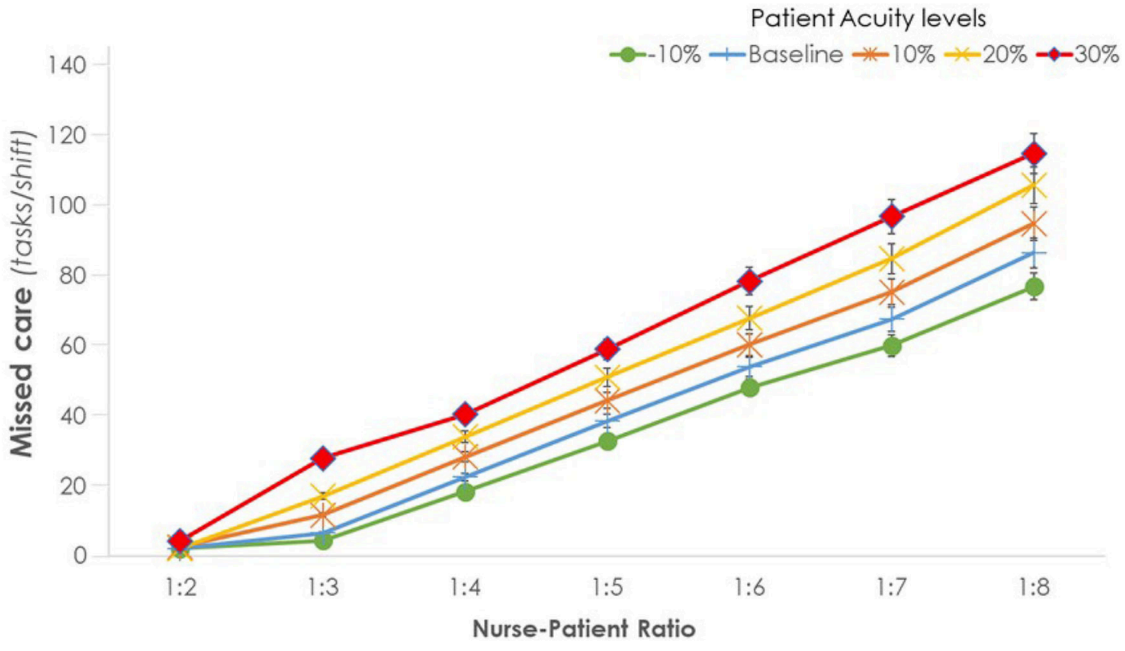
In response to these pressures, there has been increased consolidation in the market. Publicly traded companies in the space like The Ensign Group (ENSG) have been actively acquiring facilities, with multiple acquisitions across various states in recent years. According to CEO Barry Port, the strategy centers on scaling up operations while investing in high-acuity care models that align with Medicare Advantage opportunities (The Ensign Group, 2025). These

acquisitions reflect a broader trend of institutional investors and large providers betting on value-based care and vertical integration in the SNF space.

Besides this, there is the paradox related to the growing division between high-acuity and low-acuity patients. High-acuity patients, who require intensive clinical care and complex care coordination, present greater revenue potential but also higher costs and operational strain. In contrast, low-acuity patients are increasingly being diverted to home and community-based care settings, leaving SNFs to manage more medically complex populations without proportionate increases in reimbursement or staff support.

Figure 8

Mean Numbers of Missed Care Tasks per Shift as a Function of Nurse-Patient Ratio and Patient Acuity Level



From Dorr, H., & Dent, E. B. (2020).

Research underscores the significant relationship between nurse-to-patient ratios and the quality of care delivered. This study reveals that when nurse staffing levels are insufficient, there is a notable increase in the amount of missed care, which includes vital tasks such as patient comfort, communication, and care planning. These omissions occur because nurses are unable to attend to all the needs of their patients within the limited time available. This directly impacts the overall quality of care and patient satisfaction, as patients may feel that their concerns and needs are not adequately addressed. The authors argue that improving nurse staffing could reduce the incidence of missed care and, consequently, enhance both patient outcomes and their perceptions of care (Qureshi, Purdy, & Neumann, 2020). However, for SNFs, increasing staffing levels also presents a financial challenge, as labor is one of their highest expenses. Hiring more personnel could tighten already thin operating margins, making it difficult for facilities to balance high-quality care with financial sustainability.

Current Trends

Expansion of Institutional-Level Care in Lower-Cost Settings

In 2025, the healthcare system is accelerating the shift of institutional-level care out of hospitals and into lower-cost environments such as SNFs, home health, and community-based care. As Medicare and Medicaid tighten reimbursement rates, SNFs are adapting by caring for more complex patients who would have traditionally remained hospitalized longer. Based on conversations with professionals in the SNF space, innovations in remote monitoring, care coordination platforms, and home-based care models are making it feasible to manage higher acuity patients outside the hospital. This shift not only saves money but also aligns with patient preferences for aging in place. Consequently, SNFs are playing a more central role in post-acute

care, serving as a critical cost containment vehicle. While this trend improves overall system efficiency, it also places pressure on facilities to invest in staff training, digital infrastructure, and interdisciplinary care teams. As such, operational adaptability and clinical innovation are now essential traits for successful providers. With the backing of new CMS waivers, this trend is expected to accelerate over the next few years. Payers, too, are aligning reimbursement policies to support lower-cost alternatives with comparable patient outcomes.

Workforce Challenges and Staffing Innovation

The skilled nursing industry continues to grapple with critical staffing shortages in 2025, a challenge amplified by burnout, aging healthcare workers, and increased care demands. Operators are responding by adopting hybrid staffing models, leveraging virtual nursing solutions, and investing in workforce development programs. Many facilities are now partnering with community colleges and vocational schools to build talent pipelines. At the same time, regulatory bodies are pressuring providers to meet minimum staffing standards, pushing some under-resourced facilities toward consolidation or closure. Technology is beginning to bridge gaps, with real-time patient monitoring, predictive analytics, and AI-assisted documentation which are helping reduce the workload on clinical staff. However, smaller SNFs are struggling to keep pace with these investments. The labor crisis remains one of the most significant barriers to expansion and quality improvement in the sector.

Increasing Influence of Prior Authorization and Payer Oversight

In the past year, insurance carriers have significantly tightened oversight on SNFs utilization through expanded use of prior authorization protocols and post-acute care reviews. The increased involvement of payers in determining the medical necessity and appropriate length

of SNF stays has led to growing friction with healthcare providers. This heightened scrutiny is partly in response to concerns about cost containment and fraud prevention in the post-acute space. While intended to curb unnecessary services, these controls have introduced delays in care transitions and increased administrative burdens for SNFs. Facilities now require robust utilization review teams to navigate the approval processes and avoid revenue loss. As a result, SNFs are developing stronger partnerships with payers and investing in predictive analytics to anticipate authorization outcomes, with some operators even hiring former insurance case managers to streamline approvals.

Value-Based Care and Risk-Sharing Models Become the Norm

As of 2025, the shift from fee-for-service to value-based care is no longer a trend, it's the industry standard. Medicare Advantage plans, Accountable Care Organizations (ACOs), and other payers are pushing SNFs into risk-sharing arrangements that reward improved outcomes, patient satisfaction, and reduced rehospitalizations. This new normal is forcing SNFs to invest in robust care management systems, quality reporting tools, and patient engagement strategies. Providers who fail to adapt risk exclusion from preferred networks, limited referral flow, or lower reimbursement rates. Conversely, those who excel in quality metrics are seeing financial bonuses and increased patient volume. The rise of I-SNPs has further tied reimbursement to performance, creating both opportunity and pressure. Value-based models also demand tighter integration with hospitals and primary care providers, encouraging a more collaborative ecosystem.

Note: This information is based on discussions with professionals in the SNF space.

Potential Investment Areas

Current Landscape

The skilled nursing facility (SNF) software market is increasingly defined by a few dominant players, most notably PointClickCare (PCC) and WellSky, which together hold a substantial share of the electronic health record (EHR) and workflow management systems used across the industry. As of 2024, the global long-term care (LTC) software market, which includes SNF-focused platforms, is valued at approximately $5.13 billion and is projected to grow at a compound annual growth rate (CAGR) of 8.02% through 2030, driven by an aging population and the growing complexity of patient care needs (Grand View Research, 2024).

PointClickCare offers a cloud-based EHR solution tailored for post-acute and long-term care providers. Its suite includes tools for clinical documentation, financial management, care transitions, compliance, and population health. The company has strategically expanded its footprint through acquisitions, including QuickMAR (an electronic medication administration record platform), Audacious Inquiry (a connected care and interoperability firm), and Patient Pattern (a care management solution designed to support value-based care initiatives) (Healthcare IT Today, 2023; McKnight's Senior Living, 2019; PointClickCare, 2022).

Similarly, WellSky has built a comprehensive platform serving SNFs, home health, hospice, and rehabilitation providers. The company offers integrated EHR, analytics, and care coordination tools and has made strategic moves to deepen its presence in the SNF space. In 2023, WellSky acquired Experience Care, a technology firm specializing in long-term care software, to enhance functionality for SNF operators (WellSky, 2023). WellSky has also

partnered with Google Cloud to develop AI-powered tools designed to address major sector challenges, such as staffing shortages and workflow inefficiencies (Skilled Nursing News, 2024). Despite their market leadership, both PCC and WellSky have faced criticism for slow innovation, particularly in the area of artificial intelligence (AI). Until recently, their platforms offered limited AI integration, reducing their ability to support the dynamic needs of SNFs facing rising patient acuity, labor shortages, and tightening regulatory oversight (Modern Healthcare, 2023; Skilled Nursing News, 2023).

Other notable competitors in the space include MatrixCare (owned by ResMed), which delivers EHR and workflow tools across various post-acute settings, and Netsmart Technologies, whose myUnity platform offers a unified clinical and financial system for long-term care providers. While these firms have smaller market shares compared to PCC and WellSky, they continue to gain ground through interoperability improvements and modular solutions that cater to specific operational needs (Enlyft, n.d.).

AI can dramatically improve SNF operations across multiple domains. Predictive analytics powered by machine learning can forecast hospital readmissions, patient deterioration, and staffing needs, allowing facilities to proactively intervene and allocate resources more effectively. Natural language processing can automate documentation and reduce time spent on electronic charting, freeing up clinicians for direct care. AI-driven scheduling and resource optimization tools can improve staff deployment, reduce overtime costs, and align shifts with patient acuity levels. Additionally, compliance and quality tracking can be enhanced through AI systems that monitor for documentation gaps, flag anomalies, and generate real-time alerts for regulatory requirements.

From a financial perspective, these efficiencies directly translate into a stronger return on investment. By reducing avoidable readmissions, SNFs avoid costly penalties and maintain eligibility for value-based reimbursement programs. Automation lowers administrative overhead and minimizes errors that can lead to denied claims or fines. Enhanced staff utilization reduces reliance on expensive agency labor while improving care quality. Collectively, these benefits can push ROI well beyond the 5x threshold required by most SNFs to justify new technology adoption, instead of a 3x. Three solutions will be contemplated in this report.

Addressing SNFs Critical Pain Points

One of the most effective ways to move the needle in SNFs is to focus on software solutions that address the core challenges in day-to-day operations. By zeroing in on pain points such as inefficient care coordination, ever-evolving compliance demands, or workforce management bottlenecks, SNF owners and investors can deploy SaaS tools that don't just fill gaps but truly transform care delivery. When these solutions align with operational needs, they drive tangible improvements: smoother workflows, better patient outcomes, and an optimal financial performance. In an industry where every efficiency matters, finding the right technology can be the key differentiator between staying ahead or falling behind.

Patient Acquisition & Referral Network Management

In SNFs, securing a consistent flow of referrals from hospitals is critical. This ecosystem operates in a "winner takes all" fashion, where top-rated facilities with stronger CMS scores and better outcomes tend to monopolize referrals. Investing in platforms that help SNFs manage and enhance their referral networks is vital. These tools can track referral patterns, hospital discharge trends, and even automate outreach to referring physicians or discharge planners. Data

transparency across these networks could give SNFs a strategic edge, particularly when tools include features like CRM integrations, real-time hospital census data, or even competitor benchmarking. The ultimate goal is to make SNFs more visible and attractive in the eyes of hospitals seeking reliable post-acute partners. The following is a good example:

pac iQ Powered by DIRECT SUPPLY	In October 2024, Direct Supply acquired PAC-IQ, a health tech startup focused on automating referral management for SNFs. The acquisition enhances Direct Supply's capabilities in streamlining care transitions and supports value-based post-acute workflows	Pac-IQ is a healthcare tech company that uses AI to simplify and automate post-acute care referrals. Its platform, Referral-IQ, reduces administrative burden and improves care coordination for providers

Billing, Revenue Cycle Management & Predictive Payment Models

Billing complexity in SNFs is notoriously high, given the mix of Medicare, Medicaid, private payers, and value-based care arrangements. Traditional revenue cycle management (RCM) tools are not always optimized for SNFs, especially under the PDPM model. There's a growing need for platforms that go beyond claim submission and denial management to include predictive cash flow tools, payment automation, and compliance risk alerts. Emerging fintech tools for "buy now, pay later" healthcare services, deferred payment plans, or income-based financing could also create significant patient-side value, especially for long-term residents who may exceed Medicare day thresholds. Predictive reimbursement forecasting would allow administrators to better manage staffing and care delivery around expected revenue.

Waterlily	The company raised a $7M Seed round in January 2025. Investors include: Genworth Financial, Great North Ventures, Edward Jones Ventures & Nationwide Ventures	Waterlily is an AI-powered platform that helps families plan for future long-term care needs. It predicts when care might be needed, estimates costs, and shows how savings or insurance can cover them

Staffing & Workforce Optimization

SNFs face one of the most acute labor shortages in healthcare. High turnover, shift coverage inefficiencies, and burnout contribute to inconsistent care quality and increased costs. Investment opportunities lie in intelligent workforce platforms that combine scheduling optimization, real-time labor cost tracking, and staff well-being analytics. Recruitment automation platforms tailored to SNFs can also address persistent hiring gaps. Some solutions now incorporate personality or culture fit analysis, and others enable real-time bidding for open shifts among part-time staff, maximizing labor flexibility.

In-House Health	In May 2024, In-House Health raised $4 million in seed funding led by NEA and Trail Mix Ventures, bringing its total investment to $5.4 million	A scheduling platform built for skilled nursing facilities, using census and acuity forecasts to automate precise staffing. It aligns shift assignments with PPD and labor cost targets while incorporating staff preferences to boost retention. The platform helps SNFs reduce agency reliance and streamline workforce operation

Telehealth, Remote Patient Monitoring (RPM), & Post-Discharge Continuity

Telehealth and RPM have seen rapid adoption, but SNFs still lag behind in leveraging these tools effectively. Platforms that allow for continuous monitoring of patients, both during their SNF stay and post-discharge, can prevent readmissions and improve transitions of care. These solutions may also support hospital-at-home alternatives, especially for low-acuity patients. Technology that extends beyond episodic virtual visits to ongoing biometric data tracking (like heart rate, O2 saturation, or fall risk sensors) could transform chronic condition management in SNFs. Additionally, SNF-tailored post-discharge platforms help maintain continuity of care and track patient outcomes over time, enhancing CMS star ratings.

Tembo.Health	The company's latest round secured venture funding from Primetime Partners, B Capital Group, and Headwater Ventures, though the date of the investment was not disclosed	Tembo Health connects residents with board-certified specialists in areas like psychiatry, cardiology, and neurology. The platform aims to reduce hospitalizations and improve care quality through accessible, on-demand virtual consultations

Regulatory Compliance & Reporting

Regulatory burden is one of the biggest challenges SNFs face. Between CMS documentation requirements, quality metrics reporting, and state-specific regulations, the compliance load is massive. While solutions that directly target these regulations might be helpful, investing in solutions that help increase ratings such as reducing the Length of Stay (LOS) or the readmission rate is critical for SNFs given how tightly connected their revenues and ratings are.

SafelyYou	In January 2025, the company secured $43 million in Series C funding, with Touring Capital leading the investment round.	Their primary product is an AI-powered fall detection system that uses cameras to monitor residents in real-time and alert caregivers if a fall occurs. This technology helps to reduce LOS (metric used in the Prospective Payment System for Medicare reimbursement in SNFs)

At Home Care

The vision for post-acute care at home is compelling: a model that brings recovery to the patient, rather than the other way around. Home health care offers numerous advantages over SNFs, particularly in terms of patient comfort, autonomy, and cost-effectiveness. According to a 2024 industry report, the home health market, defined as short-term, physician-directed nursing and/or therapy provided in a Medicare beneficiary's place of residence, was valued at over $94.9 billion in 2023. This substantial market size reflects the strong and growing demand for care delivered in the home. Moreover, the market is expected to grow at a compound annual growth rate (CAGR) of 7.2% or more from 2023 to 2029, highlighting the increasing shift toward home-based care (Harris Williams, 2024). A confluence of factors is driving momentum for home-based post-acute care. First, patient preferences have shifted, particularly among older adults and individuals with chronic conditions who overwhelmingly prefer to recover at home when given the choice. This preference is grounded not just in convenience but in better outcomes: home recovery has been associated with lower rates of infection, improved mental well-being, and faster return to daily life.

Second, hospitals and health systems are under intense pressure to optimize bed capacity and reduce readmissions. Many are operating near full capacity, with nurse shortages and staff burnout exacerbating these constraints. Transitioning appropriate patients to at-home settings can relieve some of this strain while still ensuring continuity of care. For facilities that rely on value-based payment models, preventing avoidable complications and ensuring smooth care transitions is critical, making at-home care strategic lever for both clinical and financial performance.

Third, technological advancements have removed many of the barriers that once made home-based care infeasible. Remote patient monitoring tools now allow clinicians to track vital signs, medication adherence, and symptom progression in real time. Telehealth platforms enable virtual consultations and specialist check-ins. Mobile care teams can deliver everything from wound care to physical therapy. Collectively, these innovations make it possible to deliver complex care with the same rigor and safety as traditional settings, without the institutional overhead.

FCA's Investments related to the SNFs space

SAFERIDE	**Transportation** FCA participated in a Seed round in July 2017	A tech-enabled platform that provides non-emergency medical transportation by connecting patients to care through a secure network of transport providers. It works with payers and providers to reduce missed appointments and improve health outcomes. In the post-acute space, SafeRide ensures smooth care transitions from hospitals to SNFs or home, helping prevent rehospitalizations
PEAK MOBILE VASCULAR ACCESS	**Vascular Access** FCA led a Series A round in January 2025	Provides mobile, on-site vascular access services, specializing in the placement of PICC lines, midlines, and peripheral IVs by certified clinicians. Their services reduce delays in treatment and hospital stays by bringing timely vascular access directly to patients. In the post-acute market, Peak supports skilled nursing facilities and home health agencies by improving care efficiency and reducing the need for hospital transfers
aidin	**Patient Referral Management** FCA led a Series A round in October 2022	A care coordination platform that streamlines patient transitions by helping hospitals and health systems manage post-acute referrals through a transparent, data-driven marketplace. It enables providers to make informed decisions based on outcomes, availability, and patient preferences. In the post-acute market, Aidin improves discharge planning and placement into SNFs, rehab, or home health, enhancing care continuity and reducing readmissions
spiras HEALTH helping you BREATHE better	**Home-based Care** FCA led a Series A round in December 2018	Delivers nurse practitioner-led, in-home care for patients with complex chronic conditions like COPD, CHF, and diabetes. Utilizing a longitudinal care model, they combine in-person visits, telehealth, remote monitoring, and digital communication to proactively manage health and reduce hospitalizations. In the post-acute market, Spiras supports transitions from hospital to home or skilled nursing facilities by addressing social determinants of health and ensuring continuity of care, ultimately improving outcomes and lowering costs

How could AI be used in the future?

Given the rapid advances in artificial intelligence, inevitably sooner or later software selling into the SNF market will have to adopt this technology fully. Given the strength of AI, a solution could be created to cover all of the workflow of a SNF, instead of just targeting one step. This would be an all-in-one software solution designed to optimize every stage of the Skilled Nursing Facility (SNF) workflow by integrating agentic AI and automation across admission, care planning, ongoing treatment, compliance, discharge, and follow-up. The system would begin by streamlining the admission and intake process through automated patient referral triage, real-time insurance eligibility verification, and pre-populated digital admission forms. It would also include voice-to-text capabilities for consent documentation, reducing manual data entry and improving accuracy.

Upon a patient's admission, the platform would use AI to generate initial assessments by analyzing electronic health records and diagnostic data. It would dynamically build care plans that adapt in real time to changes in patient condition. Predictive models would assess risks such as falls or infections, while natural language processing tools would summarize clinical notes for more efficient care team communication. During daily care, the system would support real-time monitoring through wearable integrations and automate therapy tracking. It could also enhance emotional and behavioral oversight by flagging signs of patient distress, prompting proactive staff engagement. Importantly, this system would be designed to integrate seamlessly with existing platforms like PointClickCare and WellSky. Rather than replacing them, it would function as an intelligent, AI-driven overlay, reading and writing data in real time through secure, HIPAA-compliant APIs and FHIR or HL7 protocols. For example, it could extract EHR data from PointClickCare to generate risk scores or care plan suggestions, and then push

finalized summaries or documentation back into the system to maintain continuity. Staff would be able to interact with the platform directly within their current workflows, through browser extensions or embedded modules, avoiding disruption. Routine actions like submitting a progress note or scheduling a discharge in WellSky could trigger backend automations, such as preparing referral packets or initiating post-discharge monitoring.

Billing and compliance would also be fully integrated. An AI-powered coding assistant would optimize PDPM submissions and identify potential claim errors before they're filed. The platform would classify all required documentation according to CMS standards and offer a live compliance dashboard to ensure ongoing audit readiness. At the point of discharge, the system would score patient readiness, coordinate transitions to follow-on care providers, and generate complete transfer packets, automatically streamlining this critical process. After discharge, the system would continue to support patients with remote monitoring capabilities and conversational AI tools such as follow-up SMS or calls and chatbots for a certain amount of time. Predictive alerts could notify care teams of early signs of patient decline, helping reduce readmissions. The technical architecture behind this platform would be modular, cloud-native, and built on a microservices infrastructure with an AI orchestration layer at its core. Each workflow, including intake, risk scoring, billing, care planning, would operate as a standalone service, managed by a centralized workflow orchestrator capable of sequencing actions based on real-time triggers and user behavior. This orchestrator would interface with external systems like PointClickCare and WellSky through secure API gateways, handling data routing, transformation, and compliance enforcement. The AI stack would include a foundation model layer (e.g., LLMs for documentation, NLU for chatbot), a rule-based engine for compliance

workflows, and fine-tuned machine learning models trained on SNF-specific outcomes and patient trends, which could even be trained by geography, SNF brand, etc.

Data would flow securely through an event-driven architecture, where updates (like a new admission or a flagged fall risk) would generate events consumed by downstream services like automating actions, updating dashboards, or prompting human intervention. The system would also include a unified data lakehouse architecture to support real-time analytics, historical benchmarking, and regulatory reporting, all while maintaining strict access control and audit trails.

Moving forward

Many SNFs operate within a scarcity mindset, prioritizing financial survival amid staffing shortages, regulatory hurdles, and declining reimbursements, rather than shifting to an abundance mindset that embraces innovation opportunities. Despite their financial and operational struggles, SNFs will not disappear. The aging population, often referred to as the "Silver Tsunami," is the key factor, with the 65+ demographic expected to nearly double by 2050 and the 85+ group, the cohort most likely to require long-term care, set to quadruple (U.S. Census Bureau, 2020). This demographic shift ensures SNFs will remain a critical component of the healthcare ecosystem, particularly for high-acuity patients, and therefore, will have to keep up to date with new innovations.

While demographic trends ensure SNFs' long-term relevance, their path forward is anything but uniform. Factors such as geography, payor mix, regulatory variation, and staffing dynamics make this sector highly fragmented and nuanced. Consequently, broad software

platforms like PointClickCare or WellSky, while dominant in market share, may struggle to drive deep, lasting impact in the long term. Their generalist approaches often fail to account for the highly localized and operationally unique needs of SNFs. What works in a large, urban facility in California may be wholly ineffective in a rural Midwest setting with different reimbursement structures and workforce availability. Looking ahead, a hybrid strategy that blends three core approaches will be key to unlocking real value: (1) selling vertical-specific software solutions that address the unique challenges of different SNF types; (2) capturing share in the rapidly expanding at-home care market; and (3) investing in an intelligent, comprehensive AI-driven platform that can act agentically across settings, streamlining workflows, adapting to local complexities, and delivering actionable insights in real time. This level of targeted, adaptive innovation will define the next generation of leaders in post-acute care

FCA Venture Partners is a venture capital firm investing in early-stage healthcare technology and technology-enabled healthcare services companies that improve patient care, reduce costs, and increase efficiency. FCA manages over $250M and invests across the Series Seed to Series B stages. Our firm brings portfolio companies valuable healthcare insights, connections, and board-level experience to accelerate growth and build disruptive and sustainable businesses. Based in Nashville, the epicenter of healthcare innovation, with a strategic network in Charlotte and Winston-Salem, NC, our team has a decades-long track record including more than 60 investments in the rapidly changing healthcare industry.

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