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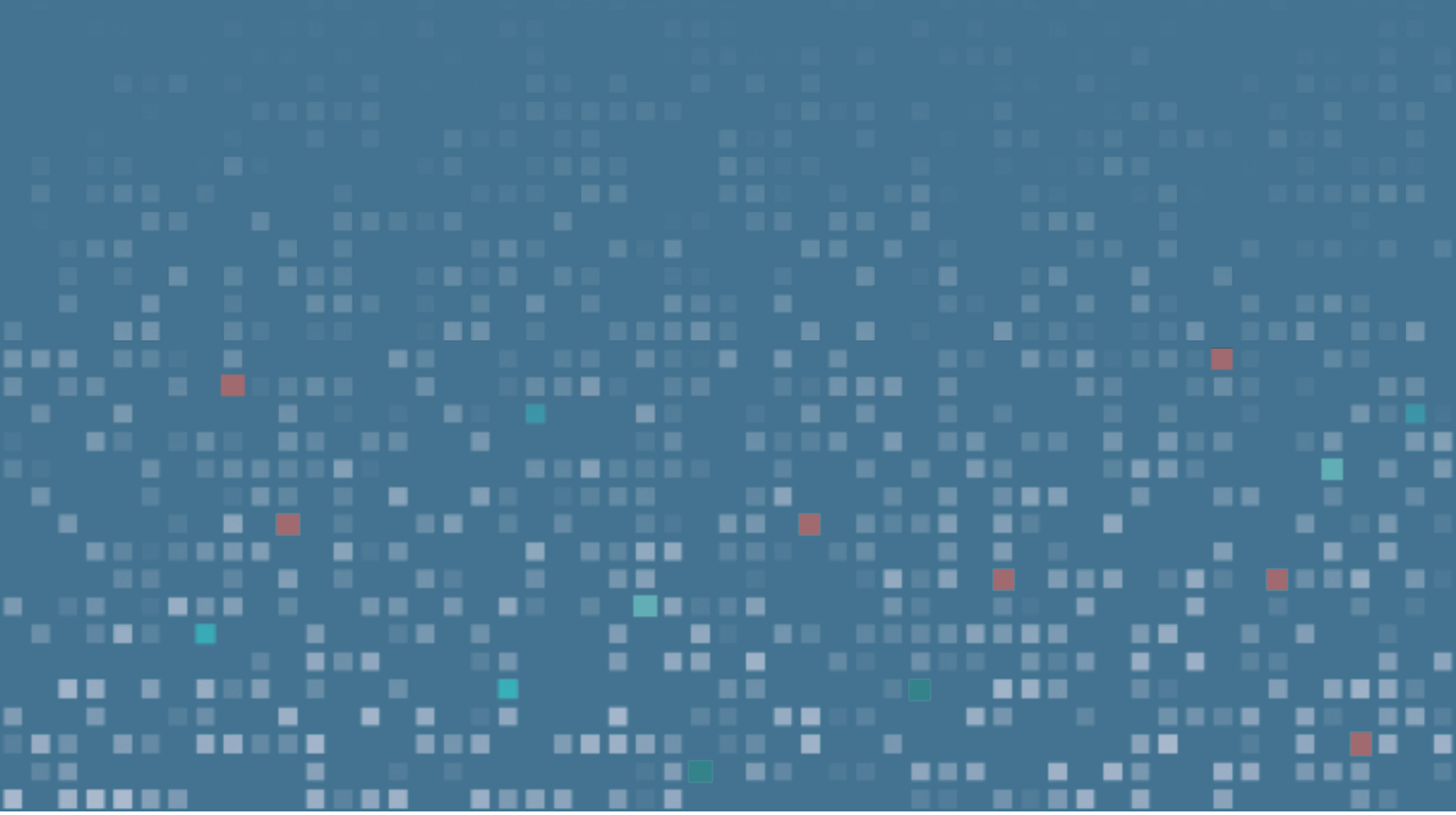
Access to Capital in the Nursing Home Industry: *A Resource on the Role of Policy and Implications for the Future*



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EXECUTIVE SUMMARY

The COVID-19 pandemic reminded policymakers of the weaknesses in the United States' long-term care system, including its workforce challenges, financing mechanisms, and dependence on nursing homes[1] as the primary infrastructure and **only guaranteed site of care for Medicaid beneficiaries who need long-term services and supports (LTSS)**. The policy response has been to temporarily increase federal funding for Medicaid home-based care, propose mandatory staffing levels in nursing homes, and further tighten nursing home regulation. Furthermore, policymakers and researchers are increasingly calling attention to the need for nursing home regulation that would more clearly identify the owners and operators in an industry that largely relies on public funds for revenue. Unfortunately, these proposals fail to address the root cause of problems they are trying to solve.

The nursing home industry has, since its inception, been a partnership between private and public entities intended to provide a public good. Private investment has historically provided the capital to build nursing homes, while state and federal governments have offered daily operational support via reimbursement mechanisms, which are bound by significant regulation regarding how these payments are used.

This public system, once intended to attract private capital and enterprise to develop infrastructure to care for the poor and frail elderly, has not evolved to meet the increasing needs of a rapidly aging America in conjunction with practical budget constraints. Over its first 30 years (from the late 1960s to late 1990s), this private and public partnership created an infrastructure of 17,000 nursing homes serving 1.6 million Americans (1997 data).[i] Since then, the industry has weathered nursing home payment policy changes across two largely uncoordinated government programs (Medicare and Medicaid) that have historically accounted for almost all of nursing home revenue. These dynamics have produced an increasingly dysfunctional and unpredictable reimbursement system, which has negative implications for the nursing home operator's continued role in the nation's post-acute care continuum:

- Inconsistent and uncoordinated payment policy across Medicare and Medicaid has contributed to inefficient care delivery that is at odds with positive outcomes and often inconsistent with what patients and residents need and want.
- Generally, low Medicaid reimbursement has limited the amount of resources nursing home operators have to attract, fairly pay, and retain employees, particularly in roles of front-line caregivers who help patients toilet, dress, and take medications. A dedicated, well-trained staff is required to help residents live and die with dignity. In many geographies across the United States, healthcare facilities such as nursing homes are the leading employer[2] and are often the only option for long-term care, especially in rural counties.
- Reimbursement policy across all payers has inhibited access to capital that values investment in clinical operations and technological innovation, while retaining features designed to attract real estate capital. This has created an industry in which capital is targeted toward new builds, rather than improvements and innovation.

1 For purposes of this collective work, the term nursing homes refers to long-term care facilities that manage a post-acute patient as well as a long-stay resident population through the varying internal influences of owners, operators, and investors. The term "skilled nursing facility" refers to facilities certified by Centers for Medicare & Medicaid Services (CMS), while other facilities may be certified by the state only. For simplicity, this work collectively refers to these settings as "nursing homes."

2 On average, the health sector constitutes 14% of total employment in rural communities, with rural hospitals typically being one of the largest employers in the area.

This paper is intended to assist policymakers in understanding the nursing home environment and the policy events that have shaped this landscape. In doing so, this resource will demonstrate the link between **payment and regulatory policy** and **access to capital that begets investment in infrastructure and operational innovation**. By evaluating the impacts from past decision making, policymakers can address underlying *issues* affecting the industry, rather than the *symptoms*.

Part 1 of this paper (also presented visually via a separate databook) provides a snapshot of the current nursing home environment, including data on residents/patients, staffing, reimbursement methods, infrastructure, and quality. With so many of the nation's nursing homes now assessing financial viability, it is clear that funding remains one of the most important issues of the industry's many challenges. These funding considerations affect and interact with the nursing home operator's ability to offer high-quality care to residents, attract and retain staff, and modernize infrastructure.

Part 2 of this paper evaluates the history of policymaking impacts (intended and unintended) on nursing homes. Over the last three decades, nursing home operators have had to adapt to shifting reimbursement models originating from a patchwork of policy reforms. In response, nursing home owners and operators have sought refuge in a range of sources to finance their companies, from obtaining debt to partnering with equity investors. A review of landmark policy decisions demonstrates how policy reforms have impacted the cost and availability of capital within the nursing home sector. The shift from cost-plus to Medicare prospective payment, and subsequently a value-based reimbursement environment, along with growth in lower-reimbursed Medicare Advantage volume, together have over time reduced the commitment of federal and state governments to cover nursing home costs making it more difficult for operators to obtain affordable private capital to fund long-term investments. Instead of investing in technology platforms and initiatives to improve staffing ratios, the challenging reimbursement environment has incentivized private investors to allocate resources toward improving the operator's financial profile in ways that are not accruing to patients and residents. The repercussions of policymaking and resulting nursing home financing choices are visible through unsatisfactory quality and outcomes in the industry today, suggesting it is critical that policymakers better understand nursing home capital market dynamics.

To that end, **Part 3 of this paper explains the capital markets landscape, with a specific focus on the types of debt and equity structures accessible to nursing home operators,** and the benefits and drawbacks of these sources. To reform the nursing home industry in any meaningful way, there must be functional relationships between the two key funding sources for nursing home operators: government entities (via reimbursement) and private capital providers (debt lenders and equity investors).

Part 4 of this paper promotes opportunities for policymakers as they seek to improve nursing home patient and resident experiences. Policy proposals that do not consider the array of public and private funding sources, as well as the underlying policy decisions that led to the prevalence of some sources, run the risk of exacerbating deep-rooted issues in the nursing home sector. Key to this is a recognition that:

- **Government-backed financing and traditional commercial bank loans provide the vast majority of capital deployed in the nursing home sector.** The primary source of real estate debt for nursing homes is government-backed debt through the United States Department of Housing and Urban Development (HUD) Section 232 Federal Housing Administration (FHA) Insurance for Nursing Homes (collectively herein, HUD or HUD financing). Commercial loans from local and regional banking institutions are also used to finance both real estate and operations. Although they are the most common forms of nursing home debt financing, these loan structures have some shortcomings, or at least opportunities to better serve

the operational side of the nursing home business. For example, commercial bank loans may not be readily accessible to nursing homes serving large numbers of Medicaid residents, due to low Medicaid reimbursement rates that are insufficient to support both operations and debt service requirements. Financing under the HUD program, which has a long history of offering low-rate, long-term loans to operators, is at best neutral in incentivizing operational innovation in the industry.

- **Private equity[3] firms own a minority share (between five and ten percent) of nursing homes.**[ii,iii] Private equity firms comprise just one aspect of equity financing sources; other prevalent private capital sources include real estate investment trusts (REITs) and joint ventures with other companies. Together these sources have emerged to address the gaps in the traditional debt financing structures described above. The portion of financing that occurs via these private sources is small[4] (and decreasing),[iv] though policy reform has often been at odds with these entities given a history that includes extractive, rather than additive, effects. Owners, operators, and investors should be held responsible for how they utilize public funds within the nursing home setting, however, there also exists some room for education regarding how policy choices affect the role that private capital plays in the industry.

- **Government entities, including Medicare Advantage plans via Medicare funding, impact a significant portion of a nursing home's revenue base but are also influential in other aspects of a nursing home's financial viability.** Repeated changes to reimbursement policy make nursing home operators' revenue unpredictable. This regulatory risk increases the cost and availability of long-term capital accessible to nursing home operators. As Medicare Advantage becomes the primary payer for Medicare beneficiaries, the problem of predictability (or, "stroke of the pen risk") will be compounded by lower reimbursement from these private plans. Today, Medicare Advantage rates are just under 80 percent of Medicare fee-for-service (FFS) rates.[v] This loss in revenue – and dissolution of what was primarily a publicly-run federal and state payment system, with federal funds covering shortfalls in state reimbursement – has severe consequences for the nursing home industry; operators are being challenged to fund daily operations on a lower revenue base and private investors are increasingly dissuaded from entering an industry in which revenue is contracting. These trends forebode the demise of many nursing homes. A tighter market may be beneficial in some geographic areas, but in many rural counties across the United States, nursing homes are a leading employer and also the only viable option for long-term care at this moment.

- **Reimbursement policies have led to cross-subsidization across federal and state payers.** As state rates have progressively deteriorated (or become a smaller portion of total reimbursement), operators have struggled to figure out how to stem financial losses from serving a largely Medicaid population. The responsibility to fund operators increasingly fell to private capital, who entered upon the premise of an opportunity to enhance revenue (via increasing the share of higher-paying short-stay patients) and/or reduce costs through economies of scale via the aggregation of smaller facilities and ancillary services. Unfortunately, in many instances these initiatives have fueled poorer quality and disproportionately affected minority populations; lower-tiered nursing homes tend to possess a larger minority census as well as a higher Medicaid payer-mix.[vi]

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3 Private equity is a form of financing through which a group of investors provide capital in exchange for equity or ownership in a public or private company. As a result of this investment, private equity investors may engage in the management and direction of the company, in an effort to increase the company's value. Private equity encompasses a vast array of firms, ranging from small single individual or family-run offices to large, global firms. Please see Part 3.

4 Similar to the minority share owned by private equity, research shows that REITs owned approximately 12% of all skilled nursing assets in 2021.

Key Opportunities for Improvement

Policy solutions targeted toward nursing homes often address industry symptoms rather than underlying regulatory problems. Coupled with an increasingly medically complex nursing home population, these well-intended policy approaches have placed pressure on nursing home operators to secure financial support in the form of private capital funding. Underlying problems and key areas of policy opportunity include the following (see Part 4 for more detail):

- Without question, staffing levels pose the biggest challenge to operators and policymakers. Staffing levels are highly correlated with nursing home quality. Operators complain about the lack of reimbursement to attract and retain care staff and policymakers argue staffing levels are inadequate for patient care. The Biden administration recently proposed **federal nursing home staffing mandates**. However, given wide ranges in Medicaid reimbursement across states and a declining ability to cross-subsidize with Medicare, the most effective policy may be to tie higher staffing levels with payments that can adequately cover increased costs and offer transparency related to how operators deploy the funding. New policy can also institute measures that better utilize the existing labor pool and/or improve labor supply and staff retention. Longer-term policy solutions can support educational institutions and prospective students to promote a steady flow of individuals into long-term care professions.
- Lack of **industry innovation** is rooted in policy decisions and funding approaches that have left nursing home operators behind, and as mentioned above, incentivize new builds rather than improvements and innovation. Policy solutions may consider incentives to attract private investment to modernize not just the underlying real estate, but also the operating model.
- **Regulation is too often a blunt instrument that has unintended consequences.** Effective policymaking incorporates an investor mindset and can articulate how proposals will affect industry economics on a macro and micro level. This may include the potential for market disruptions (for example, changes in ownership) as well as increased costs to operators. Measures that lead to increased accountability and oversight, such as the Department of Health and Human Services (HHS) implementing timely reporting of data including corporate structure and flow of funds, may be an important first step toward culling the industry of low-quality operators. However, operators that uphold these standards should be granted meaningful financial upside, whether through greater revenue predictability (in terms of reimbursement) or flexibility of funds, which together can support access to private capital markets at sustainable rates.
- **Misaligned public and private capital sources** produce policy decisions that fail to incorporate capital market dynamics, which can lead to policymaking focused on a small percentage of the industry and can unintentionally sever access to capital. The acceleration of Medicare Advantage as the primary Medicare payer is an important dynamic for policymakers to consider. Private plans on average pay significantly less than Medicare FFS (due to both lower per diem rates and shorter lengths of stay), which may dispel private investment at the same moment that policy-driven reform in staffing and innovation is increasing costs, meaning operators are losing revenue as well as private capital-infused funds required to support these initiatives in the long-term. Despite its complexity, policymakers must avail themselves of expertise in capital markets in order to most strategically deploy federal reimbursement and set regulations to achieve desired outcomes.

This work is intended to support policymakers in their approaches to nursing home reform and is accompanied by a visual databook that offers a look into the patients and residents, staff, reimbursement models, infrastructure, and quality measures that in large part comprise the workings of the nursing home industry.

PART 1.
THE CURRENT NURSING HOME ENVIRONMENT

Please see the accompanying databook for further detail on the state of the nursing home industry, as described by key characteristics and constituents.

Key Points:

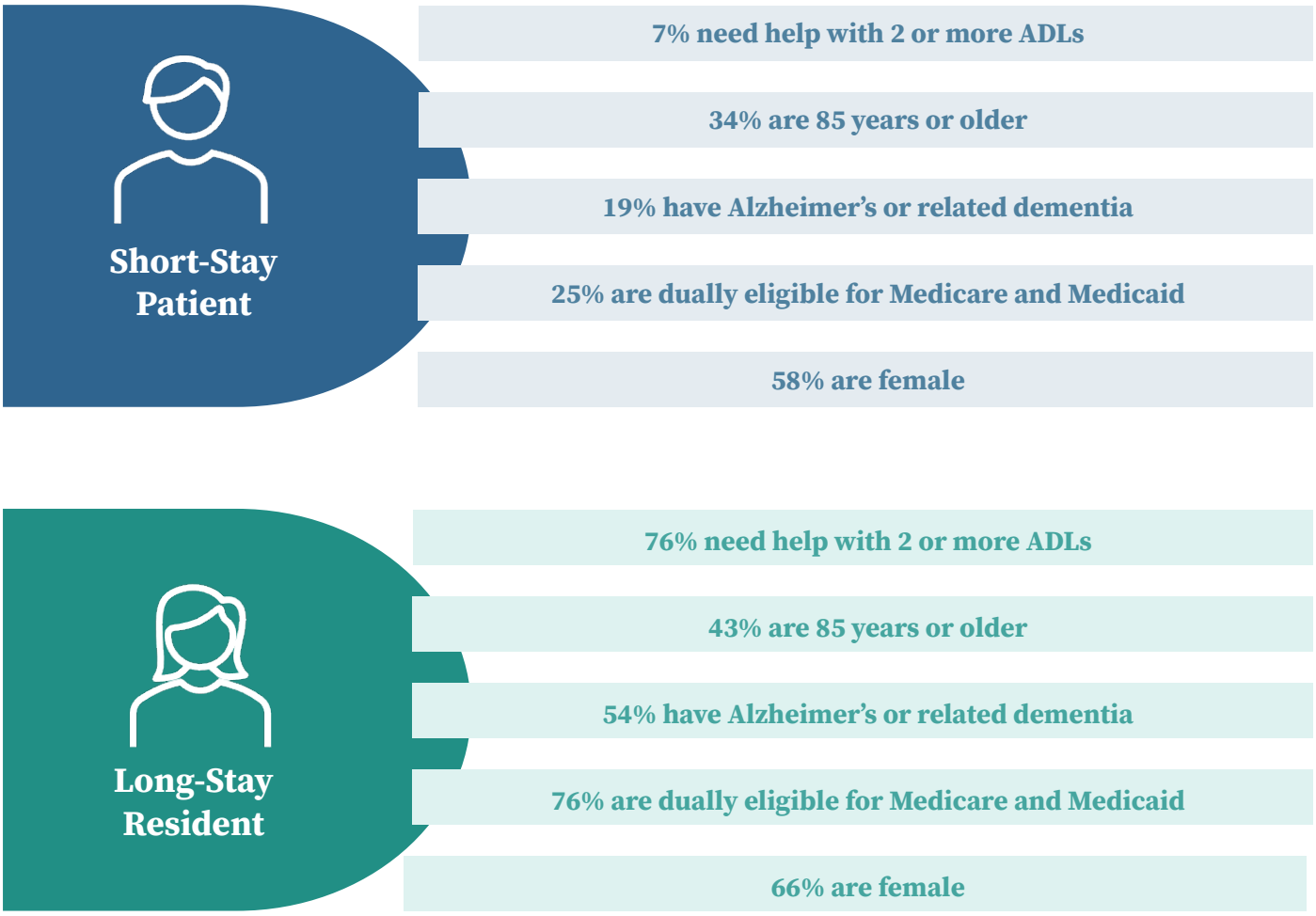
- Women comprise the majority of nursing home staff, and they are likely to be Black, Latinx, and/or born outside the United States
- Nursing homes experience high rates of staff turnover, reflecting a lack of career advancement opportunities, desire to relocate, and compensation challenges
- Imbalances in nursing home reimbursement by payer result in cross-subsidization, with Medicare, Medicaid, managed care sources, and private pay as the key payers
- Nursing home infrastructure is outdated as a consequence of policy decisions that have bolstered other provider types but left nursing homes behind

Today's nursing home industry can be characterized by aging, for-profit entities, with a mostly female staff serving a disproportionately minority and Medicaid resident population whose care is subsidized by Medicare payments for post-acute rehabilitative patients.

Residents and Patients

In 2020, United States nursing home operators cared for 1.3 million individuals, or 2.4 percent of Americans aged 65 and older.[5,vii] Nursing home operators serve the needs of both the post-acute patient population who require recovery and rehabilitation after a hospital stay ("short-stay"), as well as long-term residents who require significant help with activities of daily living (ADLs) such as bathing, eating and dressing ("long-stay") (Figure 1). Short-stay patients may return to the community or convert to a long-stay resident.

Figure 1. Key Differences Between Nursing Home Short-stay Patients and Long-stay Residents



Source: ATI analysis of 2019 Medicare Current Beneficiary Survey. Long-stay residents have been at a facility for over 100 days. Short-stay residents have been at a facility for under 100 days and may be living in the community at time of assessment.

5 Data are for nursing facility residents in certified nursing facilities surveyed in the United States.

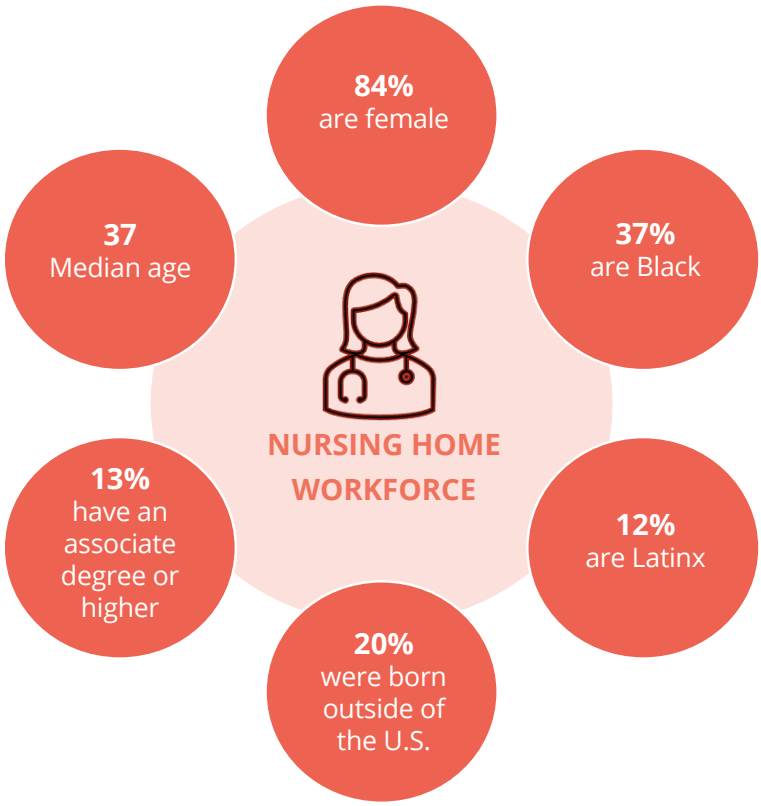
Other key nursing home resident characteristics include:

- **Residents are becoming more medically complex.** For example, from 2000 to 2019, the percent of nursing home residents who were obese more than doubled, from 12 percent to 28 percent. In 2019, 13 percent of residents were diagnosed with serious mental illness, up from six percent in 2000.[viii]
- **Racial diversity among residents is not proportional to the United States population.** In 2019, nine percent of people in the United States over 65 were Black compared to 15 percent of nursing home residents. Conversely, in 2019, nine percent of the 65+ population were Latinx compared to six percent of nursing home residents.
- **The rate of younger residents is increasing.** In 2000, 10 percent of nursing home residents were under age 65, compared to 16 percent in 2018.[ix]
- **The COVID-19 pandemic significantly changed what has traditionally been stable residency.** The total number of residents in nursing homes has remained relatively steady over time at 1.3 million individuals.[x] However, the COVID-19 pandemic reduced occupancy rates; falling from 80 percent in 2019 to 73 percent in May 2020, and 69 percent in December 2020.[xi,xii]

Staff

The workforce nursing home operators employ is more likely to be female and people of color (Figure 2) and typically includes Registered Nurses (RNs), Certified Nursing Assistants (CNAs), and Licensed Practical Nurses (LPNs).

Figure 2. Characteristics of the Nursing Home Workforc



Note: The demographics of the nursing home workforce vary by the data used and represent a range of estimates of race and ethnicity within the nursing home workforce.

Source: Kezia Scales, Arielle Altman, Stephen Campbell, Allison Cook, Angelina Del Rio Drake, Robert Espinoza, and Jodi Sturgeon. 2019. It's Time To Care: A Detailed Profile of America's Direct Care Workforce. PHI.

Staff is a nursing home operator's most important and largest expense; however, operators have historically faced challenges recruiting and retaining workers. The COVID-19 pandemic has exacerbated staffing constraints and continues to place pressure on the healthcare industry overall. Data prior to the pandemic (2017 – 2018) showed an annual median nursing home staff turnover rate of 94 percent. During the pandemic the need for staff in hospitals increased, which has driven up hospital wages (the average annual salary for RNs, not including bonus pay such as overtime, grew approximately 4% in the first nine months of 2021, compared to less than 3% growth the year before the pandemic[xiii]), worsening the typical challenges facing nursing home owners and operators in recruiting and retaining clinical staff. Facing workforce shortages, hospitals and healthcare facilities have increasingly turned to short-term contract labor through staffing agencies. In 2019, nursing homes reported spending approximately 50 percent more on contract labor compared to a salaried position across each of the most prevalent professions (CNAs, LPNs, and RNs).[xiv]

Retention Challenges

Several factors are linked to higher turnover, including nursing home star rating, for-profit status, whether the nursing home is chain-owned, and geographic location. Nursing homes operating in low-income areas likely have a higher percentage of residents covered by Medicaid. Because Medicaid reimburses at lower rates than Medicare and private pay, these facilities have fewer resources to pay staff.[lxxiii] However, higher salary may only address part of the problem. When asked to report why employees resigned, a 2021 hospital survey found that career advancement, relocation, and retirement were at the top, with salary rounding out the top ten reasons.[lxxiv]

At the same time that nursing home operators are struggling with staff retention, in many rural counties across the United States, these same nursing home facilities are also the largest employer. In rural areas, nursing care comprises approximately 35 percent of total healthcare employment (which is often the largest or second-largest employer sector), compared to 25 percent for micropolitan counties.[xv]

Reimbursement

Nursing homes that are Medicare-certified (98% of the nation's nursing homes)[xvi] rely on four major payment mechanisms to support the care of their resident and patient population:

1| **Medicaid.** State Medicaid programs cover long-term stays (i.e., residential care) for low-income individuals. Many states offer nursing home coverage to individuals with incomes up to approximately 220 percent of the federal poverty level (FPL), or about $30,000 in 2022.[6] Medicaid recipients comprise nearly two-thirds of the population in nursing homes but account for less than a third of reimbursement (Figure 3).

2| **Medicare FFS.** The Medicare program covers post-acute care services for eligible Medicare beneficiaries. Medicare FFS beneficiaries who have spent no fewer than three consecutive days within an inpatient hospital may qualify for Medicare coverage of nursing home care.[xvii] Medicare FFS beneficiaries account for 13 percent of nursing home patient/resident volume and 22 percent of reimbursement (Figure 3).

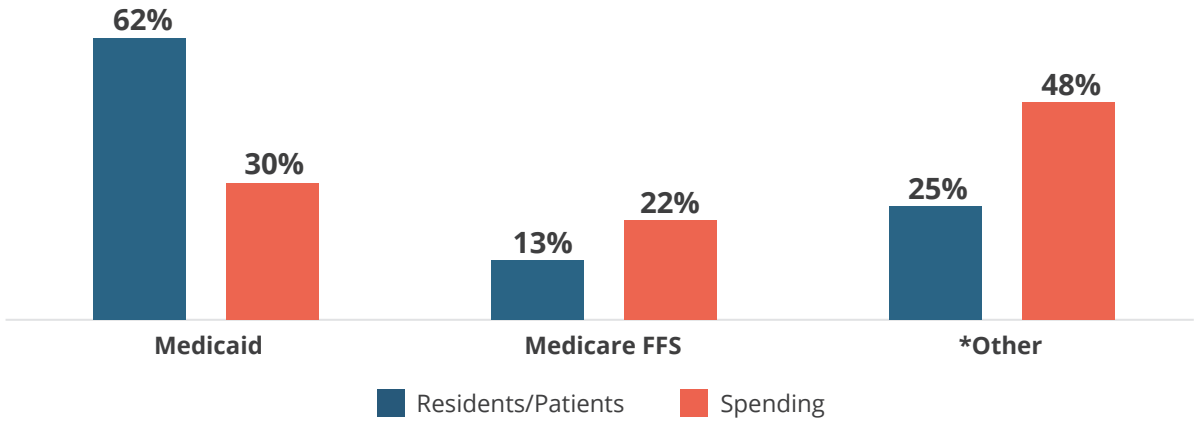
3| **Medicare Advantage.** Medicare Advantage is the private plan, managed care option for Medicare beneficiaries. In 2022, 45 percent of Medicare beneficiaries are enrolled in Medicare Advantage.[xviii] The Congressional Budget Office projects that the share of all Medicare beneficiaries enrolled in Medicare Advantage plans will rise to approximately 51 percent by 2030,[xix] with some analysts predicting 50 percent penetration by as early as 2025.[xx] Medicare Advantage plans must cover all traditional Medicare services (including post-acute care). As Medicare Advantage enrollment has grown, so too has the portion of nursing home revenue attributable to participating private plans (e.g., UnitedHealthcare).

6 Known as "special income" eligibility, states can extend Medicaid eligibility to institutionalized individuals earning up to 300 percent SSI, or approximately 220% FPL. Over 40 states offer this pathway.

4| **Private Pay.** Some residents use long-term care insurance or other private sources to pay for nursing home coverage out-of-pocket.

Spending is not proportional to the number of residents and patients by payer because the daily payments differ greatly among payers, as do the typical services rendered. Medicare FFS pays the highest daily amount at an average of $585 per day. Medicare Advantage pays an average of $454 per day. Medicaid pays under half the FFS Medicare rate at $245 per day (note this rate varies significantly by state). Those that pay privately spend, on average, $300 per day.[xxi]

Figure 3. Proportion of Residents/Patients and Spending by Payer Source



*Other represents Medicare Advantage, out-of-pocket spending, long-term care insurance, private pay, and other public funding sources including Medicaid managed care.

Source: Residents/Patients by Payer - ATI analysis of LTCFocus Public Use Data point in time measure. US Spending - Congressional Research Service analysis of 2018 National Health Expenditure data. May 2020. Overview of Federally Certified Long-Term Care Facilities.

The significant difference between Medicare FFS rates and other payer rates has led to "cross-subsidization," through which nursing home operators rely on Medicare FFS payments to subsidize payments from lower payers (including Medicaid, private pay, and Medicare Advantage). In 2019, the average margin for nursing homes for all payers and lines of business except Medicare FFS was negative two percent, compared to 11 percent for Medicare FFS-only margins in the same time period.[xxii] Higher rates from Medicare FFS have led some state Medicaid programs to rely on the cross-subsidy as a way to avoid increasing Medicaid rates.

This payment environment creates care delivery incentives that do not always align with equitable access and good outcomes; such as preferential access for Medicare FFS patients and/or hospitalization of dual eligible patients to qualify them for a Medicare-covered stay. Between the years 2000 and 2018, the portion of residents reimbursed by Medicaid declined from 67 percent to 62 percent, while the portion of Medicare FFS patients increased from nine percent to 13 percent.[xxiii] In addition to payer reimbursement influencing resident mix, the continued shift towards home and community-based services (HCBS) spending within Medicaid LTSS diverted some Medicaid residents to home-based services, which have grown from less than a third (in 2000) to almost 60 percent of Medicaid LTSS spending in 2016.[xxiv]

The reimbursement environment led to the mixture of two very different populations in nursing homes. Medicare/post-acute patients require a more therapeutic, intensive level of care compared to Medicaid residents, and similarly, long-stay residents for whom the facility is their home should not be subjected to a hospital format. Studies have long indicated mixing post-acute patients and long-stay residents tends to lead to poorer outcomes

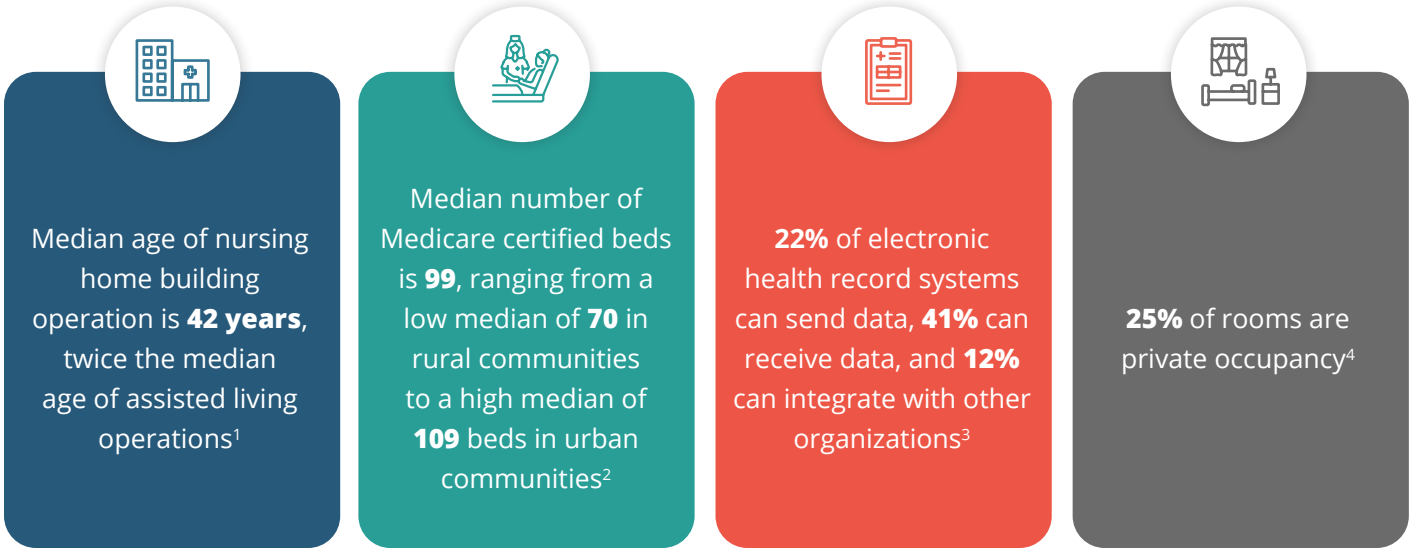
for both populations (for example, some research points to more positive outcomes achieved in smaller, more curated homes[xxv]). Other publications suggest that homes with fewer patients discharged directly from the hospital (that is, homes with fewer Medicare patients) are less likely to spread hospital-borne diseases.[xxvi]

Infrastructure

Nursing home infrastructure is old compared to other healthcare infrastructure in the United States. For example, the median age of nursing home operations in the United States is 42 years, more than twice that of assisted living facilities (Figure 4). Information technology infrastructure is similarly outdated, with only 12 percent of nursing homes able to integrate data with other organizations. Additionally, a large portion of rooms are multi-occupant rooms. This reflects decades of policymaking that have not incentivized infrastructure improvements or have excluded nursing homes from infrastructure investments (discussed in Part 2).

Recent trends, including the demand for private rooms spurred by COVID-19 as well as the continued push toward integration between acute care and long-term care, favor healthcare settings that are agile and can adapt to the needs of the nation's healthcare system. Even prior to the pandemic, nursing home operators have been struggling to keep up; more than 550 nursing homes closed between June 2015 and June 2019.[xxvii] Furthermore, during the pandemic, general acute care hospitals admitted fewer Medicare FFS patients in need of elective surgeries, which led to significant declines in short-stay patient admissions. National Medicare FFS nursing home admissions from general acute care hospitals declined up to 50 percent in April 2020 (compared to April 2019), while total general acute care hospital discharges declined 41 percent over the same time period.[xxviii]

Figure 4. Nursing Home Infrastructure



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2. Care Compare 2021.
3. Vest, J. R., Jung, H. Y., Wiley, K., Jr, Kooreman, H., Pettit, L., & Unruh, M. A. (2019). Adoption of Health Information Technology Among US Nursing Facilities. Journal of the American Medical Directors Association, 20(8), 995–1000.e4. https://doi.org/10.1016/j.jamda.2018.11.002.
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Quality

Nursing homes have long been the subject of scrutiny over quality of care, and the COVID-19 public health emergency intensified this focus. Several nursing home quality reporting mechanisms exist (including publicly available quality rankings compiled by the Centers for Medicare & Medicaid Services (CMS)), with many current quality measures derived from the Minimum Data Set (MDS), a standard summary patient assessment for each patient that nursing home operators have been using since 1990.[xxix]

Examples of key nursing home quality measures/areas of measurement include:

- Staff hours per resident or patient day
- Successful discharge to the community
- Hospitalization during a nursing home stay
- Infection control
- Emergency preparedness

Staffing Ratios

Although CMS recommends a total minimum of 4.1 hours per individual per day[lxxv] with more hours for higher acuity individuals (broken down among Nurse Aide, LPN, and RN hours), nursing homes vary in the number of hours they provide in practice. According to average reported staffing data, neither for-profit nor nonprofit facilities are meeting the CMS recommended minimum number of Nurse Aide hours per individual per day.

The most recent update to nursing home quality regulations was in 2016, and research suggests current quality mechanisms are not aligned with consumer preferences. For example, potential residents value personal recommendations (from a doctor, family, or friend) and/or nursing home proximity to family over clinical quality indicators when selecting a nursing home.[xxx] This misalignment creates challenges for operators, who may choose to focus more on efforts valued by residents rather than divert scarce funds to quality initiatives that are not valued by the end consumer (but may be required by the actual entity that funds operations, such as Medicare).

The relatively poorer outcomes within for-profit facilities have increased focus on the quality practices and protocols within these entities. As of 2021, 71 percent of nursing homes were for-profit.[xxxi] However, it is important to consider the mix of individuals in nursing homes when determining quality. Data show that for-profit nursing homes also disproportionately serve minority and low-income populations compared to nonprofits, which also tends to lead to a higher mix of Medicaid-funded residents within these facilities.[xxxii]

PART 2.
KEY POLICY DECISIONS AND THE IMPACT ON NURSING HOMES

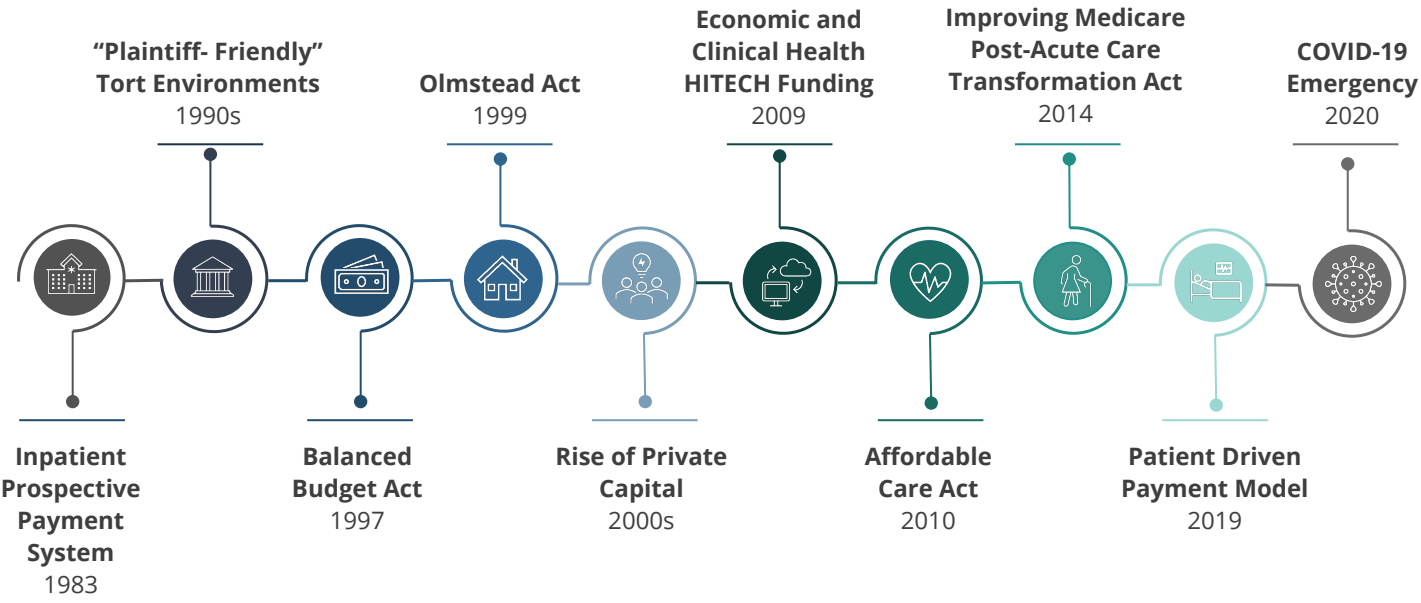
Please see the accompanying databook for further detail on the state of the nursing home industry, as described by key characteristics and constituents.

Key Points:

- Policy events that have unfolded over a 30-year timeframe have shifted the nursing home industry from one of long-term care market dominance, favorable reimbursement, and rapid growth fueled by debt financing to a challenging business environment that requires increasingly creative strategies to raise capital and finance basic operations
- Eroding Medicare FFS volume and rates have reduced nursing home operators' ability to subsidize Medicaid rates
- Past policy decisions underpin the longstanding role of debt and equity capital within nursing homes, and highlight the "cause-and-effect" relationship between nursing home public policy decision making and the capital sources nursing homes use

The current nursing home landscape originates from a history of policymaker decisions that have created a volatile reimbursement and regulatory environment. COVID-19 heightened this volatility significantly. Historical policy decisions, combined with the public health emergency, created the perfect storm that has affected all aspects of nursing home operations, including profitability, patient/resident mix, utilization of services (i.e., modes and amount of therapy), innovation, and participation in value-based care models. The increasingly challenging operating environment has driven nursing homes to seek capital from private investors. Ten key historical events and policy changes have had a particular influence on the state of the nursing home industry today (Figure 5).

Figure 5. Key Policy Events Influencing the Current Nursing Home Environment



Inpatient Hospital Prospective Payment System - 1983 Social Security Act

The inpatient hospital prospective payment system (IPPS) was created in 1983 and shifted acute care hospitals from a cost-based reimbursement system to a prospective payment system (PPS) that used a pre-set, bundled payment-based patient condition. The intent was to target inefficient hospitals that kept patients in beds longer than needed. The policy had an unintended effect on post-acute providers, especially nursing homes, as hospitals began discharging sicker, more acute patients to post-acute care. Medicare spending on nursing homes increased dramatically, rising almost 400 percent between 1990 and 1996.[xxxiii] At the same time, the nursing home cost structure (largely centered around nursing staff and geared more toward long-stay resident populations), shifted to care for a significantly more acute and complex population. This trend became even more pronounced upon the change to PPS for nursing homes.

"Plaintiff-Friendly" Tort Environments

Starting in the second half of the 1990s, plaintiff-friendly tort environments in certain states incited a significant increase in medical malpractice litigation related to nursing home patient neglect or abuse. The number of general/professional liability claims filed annually per nursing home bed more than tripled from the early 1990s to the early 2000s, with more dramatic increases in a handful of states, including Florida and Texas. Large chains operating in high litigation risk states exited the region through breaking up their operations and selling facilities to smaller owners, which in part led to the highly fragmented industry today.[xxxiv] The litigious climate also incited

"asset-shielding" behavior, such as branding chain-owned units with names that did not link them directly to the central operating corporation; notably, practices such as these are the target of current reform in corporate structure reporting. Recent literature found that high levels of malpractice threat were not particularly effective in eliminating poor operators from the market and that this dynamic failed to positively contribute to the nursing home sector. Furthermore, asset-shielding behavior abated or reversed in states that pursued tort reform intended to decrease litigation risk (such as caps on noneconomic damages).[xxxv]

The 1997 Balanced Budget Act ("BBA 97")

BBA 97 established several key elements that impacted nursing homes:

- **PPS Applied to Nursing Homes:** CMS implemented a nursing home PPS using a patient classification system called Resource Utilization Groups (RUGs). RUGs were based primarily on therapy volume to ensure residents and patients received adequate therapeutic treatment. This shift away from cost-based payment created significant revenue pressure on nursing home operators, who were suddenly caring for the same patients under very different payment incentives. Additionally, because RUGs centered around therapy volumes, there was a mismatch between payments for patients needing intensive non-therapy services (e.g., drugs) and their respective PPS rates.[xxxvi]
- **Medicare + Choice Introduced:** Eventually renamed Medicare Advantage, Medicare + Choice affected reimbursement and therefore revenue. Enrollment in Medicare Advantage has grown rapidly but payment rates to nursing homes are roughly a quarter less than those provided by Medicare FFS. In 2022, 45 percent of Medicare beneficiaries are enrolled in Medicare Advantage.[xx]
- **"Boren Amendment" Repealed:** The "Boren Amendment,"[7] which required Medicaid to reimburse nursing homes on a reasonable cost basis, was repealed. Under the Boren Amendment, all states paid similar rates to nursing homes.[xxxvii] This changed following BBA 97 and created variation across states in terms of reimbursement and facility quality. Nursing homes most negatively impacted were those unable to supplement lower-reimbursed Medicaid residents with higher-reimbursed Medicare patients.

Long-term Impacts of BBA 97

The downward pressure on nursing home operators' two largest payers led to multi-facility nursing home operators reporting a 25 percent drop in payments. Of the seven largest nursing home companies, five were in bankruptcy protection by 2000.[xxxviii] Congress responded by temporarily increasing nursing home payments through the Balanced Budget Refinement Act of 1999 and the Benefits Improvement Act of 2000. These payment enhancements expired in 2002 and 2006, respectively, leaving over-levered operators unable to make debt payments and seeking new options to finance their businesses. This dynamic propelled the utilization of a financing structure in which nursing home operators sold their underlying real estate to fund their operations. This structure, also referred to as an operating company/property company (opco/propco), was mutually appealing as real estate investors could acquire land at low prices and charge recurring lease payments to nursing home operators, while operators could pay down debt on their balance sheet and fund operations for the long-term.

7 The Boren Amendment was part of the Omnibus Reconciliation Act of 1980.

Growth in Medicaid HCBS and The Olmstead Decision

The Omnibus Budget Reconciliation Act of 1981 created section 1915(c) of the Social Security Act to allow states to target HCBS programs to certain individuals and specific geographies. Initially, 1915(c) waivers were only approved if a state could prove HCBS recipients would otherwise be in an institution (referred to as the "cold bed test"). President Clinton loosened this requirement, paving the way for rapid growth in HCBS waiver spending. In 1999, a landmark Supreme Court decision, Olmstead, tied civil rights to HCBS access and created legal exposure for states based on the availability of HCBS.

In 1988, the Medicaid program spent 88 percent of all long-term care dollars on institutional services (including nursing homes) and 12 percent on HCBS-related programs. As of 2019, this allocation had reversed, with institutional spending comprising 41 percent of Medicaid's budget compared to the HCBS portion of 59 percent.[8,xxxix] States have also used HCBS waiver authority to offer services in assisted living facilities for Medicaid beneficiaries who would otherwise qualify for a nursing home.

Rise of Private Capital Providers – REITs & Private Equity[9]

Before BBA 97, nursing home reimbursement was commensurate with provided services, and funding options outside of reimbursement were generally limited to HUD debt financing. Operator debt payments were considered costs for purposes of state (cost-based) reimbursement rates. However, the implementation of PPS and repeal of the Boren Amendment severed the state-operator connection, causing nursing homes to increasingly rely on the federal government to effectively subsidize Medicaid nursing home payments.

This cross-subsidization and lack of sufficient funding led to the emergence of different types of debt and equity capital providers to buttress and sustain nursing home operators. The mid-2000s represented a surge in investments, buoyed by inexpensive capital and growth in private equity fund sizes. The Housing and Economic Recovery Act of 2008 also initiated an increase in ownership by REITs given the legislation allowed these entities to acquire healthcare facilities.[xl] Nursing home operators found they had access to growth capital through these financing sources. The increase in private investment also influenced a slow shift away from nonprofit status toward for-profit operations. In 2003, 28 percent of the industry was nonprofit, by 2020, nonprofit operators represented 23 percent of the industry.[xli]

2009 Economic and Clinical Health (HITECH) Funding

HITECH provided billions of dollars of funding to hospitals and providers to adopt electronic health record (EHR) systems. However, this funding excluded nursing homes.[xlii] As a result, although more than 80 percent of nursing homes have an EHR, only 12 percent of nursing home EHRs can integrate with other organizations.[xliii] This has stifled nursing home assimilation into value-based care models. Managed care organizations, accountable care organizations (ACOs), and health systems prefer to partner with technologically advanced organizations because risk-based models require interoperability to track metrics, such as readmissions.

2010 Affordable Care Act (ACA) & the Rise of Risk-Based/Value-Based Care Models

The ACA accelerated the shift toward value-based payment through demonstration programs that provided nursing home operators the opportunity to assume risk directly for an episode of care or indirectly as part of referral networks in payment models addressing the full continuum of care. Additionally, programs that financially

8 The percent of LTSS expenditures going toward HCBS varies considerably by state, from a low of 33% in Mississippi to a high of 83% in Oregon in 2019, according to CMS LTSS Expenditures reports.

9 The impact of public and private capital is discussed more in Part 3 of this paper.

penalized hospitals with high rates of readmissions encouraged health systems, managed care plans, and ACOs to interact more directly with post-acute care providers to improve outcomes.

Nursing home operators responded in multiple ways to the increasingly value-based environment. Many pursued new relationships with upstream providers and managed care plans, and made investments in clinical and technological systems. These operational and clinical investments did not pay off for several reasons. First, the upstream entities, such as hospitals and physician groups, failed to include nursing home operators as key participants in value-based payment entities, such as ACOs. Furthermore, CMS discontinued the only demonstration program that allowed nursing homes to directly participate. As a result, nursing home operators have been unable to participate in savings to which they contribute. Second, ACOs and bundled payment conveners largely treated the nursing home setting as a source of savings, either through diversion to home health or reduced length of stay. Finally, the ACA value-based payment demonstrations and policies favorable to Medicare Advantage plans led to the advent of third-party post-acute convener/managers such as naviHealth and Remedy Partners.[10] These entities have helped to rationalize nursing home care through a variety of operational and clinical mechanisms that do not include shared savings with nursing homes.

Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act)

Policymakers have long been concerned about overlap and inefficiencies among different post-acute care settings, given different reimbursement methods, spending levels, and related growth. In response, the IMPACT Act:

- Implemented standardized data collection requirements across post-acute care settings to enable improvements in quality care and outcomes, comparison of quality across settings, transparency in data reporting, information exchange across post-acute settings, enhanced care transitions and coordinated care, person-centered and goals-driven care/discharge planning, and payment modeling based on individual patient characteristics (versus the amount of therapy).[xliv]
- Encouraged CMS to propose a design for a new unified payment system across all post-acute care settings. Debate continues on whether to move ahead with a unified post-acute payment system, but the discussion has signaled to the larger payer environment (e.g., ACOs, Medicare Advantage plans) the value of lower cost post-acute settings, such as nursing homes and home health, over hospital-based settings such as inpatient rehabilitation facilities and long-term acute care hospitals.
- Created the Skilled Nursing Facility Quality Reporting Program (QRP), which specifies 15 measures that nursing homes must report, and payment penalties for noncompliance.[xlv]

The IMPACT Act requires pay-for-reporting through QRP and eventually pay-for-performance through value-based purchasing that rewards and penalizes nursing homes based on quality performance. The IMPACT Act also laid the groundwork for the new patient-driven payment model[11] discussed below.

2019 Patient-Driven Payment Model (PDPM)

CMS implemented PDPM to improve alignment between patient need and utilization of certain high-cost services, and to eliminate the incentive for nursing homes to refer inappropriate therapy volume. CMS updated the PPS to address growing therapy service utilization and the increasing classification of nursing home patients into high payment RUGs categories. The previous PPS system was based on volume of services, which incentivized nursing homes to provide therapy services regardless of the level of need. The current PDPM mechanism under PPS primarily uses resident characteristics like diagnoses or functional levels, rather than therapy minutes, to determine per diem payments.[xlvi]

10 Signify Health merged with Remedy Partners in 2019.

11 PDPM replaced RUGs within the PPS.

Mixed Findings on PDPM

Some studies have found the PDPM model to minimally reduce therapy minutes (13%) with no-to-minimal impact on hospital readmission rates, length of stay, or functional status upon discharge.[xlvii] Other studies have shown that post-implementation, there was a 30 percent decline in therapy minutes (fiscal year 2020 compared to fiscal year 2019). Although the decline in therapy may represent a right-sizing of therapy utilization, the same study showed that the mode of therapy also changed (the portion of concurrent or group therapy increased from 1% in prior years to 32% and 29%, respectively, in the first month of PDPM)[xlviii] – an indication that the *quality* of therapy post PDPM may have deteriorated.

COVID-19 Public Health Emergency

The COVID-19 pandemic significantly disrupted the nation's health systems and in particular, the role of post-acute providers. Of the total COVID-19 deaths in the United States, it is estimated that close to a quarter were among nursing home residents.[xlix] As a result, for the first time in nursing home history, patients have been more influential than the federal government in dictating profitability, due to delayed elective procedures (resulting in fewer higher-margin Medicare patients) and choosing home-based options due to safety concerns related to nursing home stays.

The COVID-19 public health emergency has also contributed to policy proposals such as Build Back Better and a recent White House Fact Sheet denouncing the quality of nursing homes.[l] Although well-intentioned, these proposals address symptoms caused by the history of policymaking, rather than underlying problems. They also call for reforms that are largely unfunded by the federal government,[li] suggesting a solution buttressed by private capital is required.

PART 3. CAPITAL INVESTORS DEEP DIVE

Please see the accompanying databook for further detail on the state of the nursing home industry, as described by key characteristics and constituents.

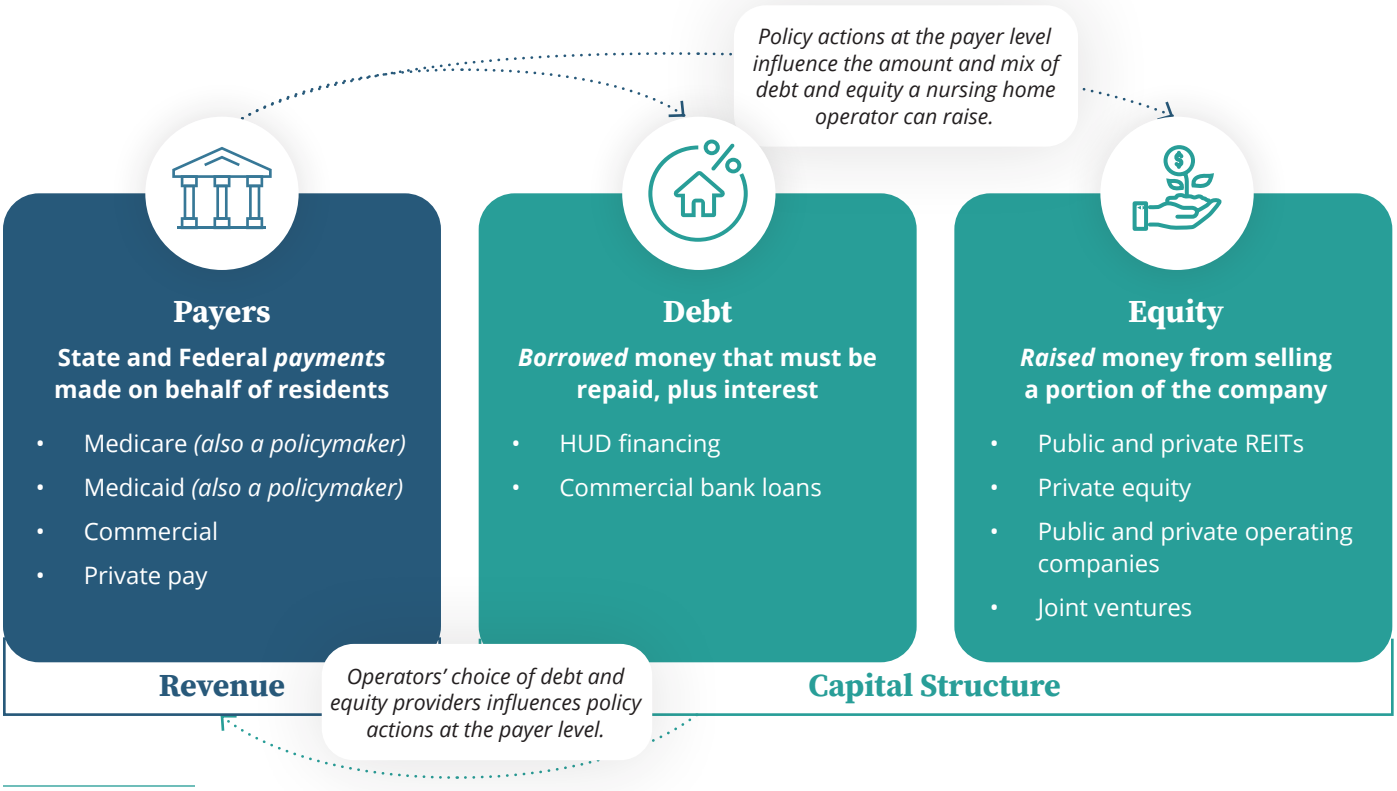
Key Points:

- A variety of debt and equity capital options are available to nursing home operators, but traditional debt sources via HUD and local commercial lenders are the most prevalent
- The industry's massive real estate footprint and the overarching regulatory environment are two significant aspects that impact the type of investor willing to provide capital to nursing home operators
- HUD's long-standing prevalence in the industry accentuates its importance as a reliable long-term funding source, however, the program could better serve operators and residents through financing structures that incentivize innovation
- In addition to debt financing – which includes HUD and local commercial banks – nursing home operators access capital via equity partners including private equity firms, REITs, and other operators
- Private equity-backed nursing homes represent between five to ten percent of the sector[ii,iii] and evidence on the impact of private equity investment in nursing homes is mixed
- Private investors such as private equity firms must predict future cash flow streams several years into the future, which are subject to changing federal government rules. This presents a significant investment risk that increases the industry's cost of capital (i.e., required investor returns) and/or limits the pool of investors
- Cost and availability of capital reflect the role of government dollars in funding nursing home care. Payment and policy reform should be mindful of its impact on public and private sources of nursing home financing

The reimbursement effects of the policy milestones and history described above have impacted nursing home operators' ability to attract and implement capital for quality efforts, technology advancements, and broader innovation. These dynamics have created a complex investment landscape for nursing homes, largely responsive to the regulatory cycle. For example, earlier in the history of Medicaid reimbursement for nursing home care, state payments to nursing home operators were based on costs reported on a government cost report.[12] These reports included a debt capital cost component generally tied to the acquisition cost of the nursing home's real estate.[13] This payment policy set a precedent for operators to prefer debt, since debt service cost was included in the state's reimbursement calculation, whereas there was no comparable equity component cost if the operator had financed assets using equity. Today, many nursing home operators rely on access to healthy debt and equity capital markets to fund operations and grow their businesses. Although nursing home policy decisions have largely influenced the availability and cost of this capital (Figure 6), increasing participation by equity investors (a trend experienced not only within the nursing home industry but across all healthcare sectors) has been driven by a confluence of federal regulation, economic, and population factors, including:

- Attractive underlying market fundamentals (i.e., the increasing portion of the nation's population older than 65);
- Generally, inexpensive debt markets underpinned by loose monetary policy; and,
- Tougher capital requirements (e.g., Dodd-Frank) after the financial crisis that tempered bank loans and enabled private firms to enter these markets, fueling innovation in capital (such as funds focused on property investment) typically serviced by banks.

Figure 6. Intersection of Reimbursement Policy and Capital Financing Dynamics



12 Thirty-two states and Washington D.C. still perform cost-based reimbursement and eleven states have wage pass-through models; however, states typically do not pay 100% of allowable costs.

13 Although Medicare FFS rates also included a capital component prior to PPS, the rate was not facility specific; thus, each facility received the same capital component within their rate. Conversely, many – if not most – states had a facility specific rate component that was tied to the original cost of the building.

Nursing home capital options are unique in that nursing home facilities bridge healthcare and housing. As a result, a nursing home's real estate significantly influences its financing options. Similar to other real estate sectors, nursing home business owners can access separate capital sources for financing operations and the underlying property. However, nursing homes also rely heavily on government sources for revenue, and, as detailed below, these government sources typically do not readily support innovation and infrastructure investments, this is in part due to payment delays (see call-out box).

The mix of debt and equity sources, as well as use of different vehicles within each category, is impacted by several variables, including:

- The relative valuation multiples of real estate compared to operating businesses. The underlying housing/real estate component of nursing home operators especially affects access to investors. Some capital sources require rates of return that may be impossible to achieve for smaller buildings with private rooms if Medicaid is the only source of reimbursement.
- The comparative risk profile of real estate versus operating company investments, with the latter likely requiring undertaking professional liability risk and incremental insurance costs that are typical in the industry.
- The perceived "headline" risk of investing in nursing home operators, which is continuously evolving as the reimbursement environment shifts.

Funding Challenges

Nursing home operators are subject to long-term receivables (state Medicaid payments are received within 30 – 75 days; federal payments within 30 – 60 days), meaning they must ensure they have adequate funding to support day-to-day business operations while they wait for payment. Operators unable to meet this demand may obtain private capital in the form of debt or equity investors. However, thin margins subject to government payment model changes can make servicing debt interest payments improbable, and further, create incremental risk for equity investors due to challenges predicting future cash flows.

Notably, private funding sources have increasingly entered the market amidst an evolving, and not necessarily favorable reimbursement environment, with the intent of acquiring nursing homes whose businesses might be enhanced under the ownership of a seasoned operator. Despite concerns about the extractive nature of some sources, they have funneled much needed capital into the nursing home industry.

Capital Structure Options

A nursing home's capital structure typically includes some combination of debt (also known as leverage) and equity to finance the business. These "capital" funds may be used to finance day-to-day operations, invest in maintenance (e.g., improvements within existing buildings), and/or fund growth activities (e.g., build or acquire new buildings).

- **Debt.** The type of debt the nursing home operator secures will generally have restrictions on how the funds are used. Common debt sources include HUD financing and commercial lenders. HUD provides financing for senior living properties ineligible for Fannie Mae or Freddie Mac financing. HUD funds can be used to purchase, build, refinance, or remodel nursing homes, assisted living centers, and board-and-care facilities.[lii] Commercial lenders include banks, finance companies, and REITs.[14] Commercial lenders offer a variety of debt instruments that vary based on seniority (i.e., whether it is the debt first in line to be repaid), security (whether a loan is "backed" by assets), maturity (time period/duration of the loan), and

14 REITs may be public, as in publicly traded on a stock exchange (e.g., Welltower, which is traded on the New York Stock Exchange) or private companies.

interest rate (which can be fixed or "floating"). Debt securities can be public or private. Public debt tends to provide a wider investor base, but also typically imposes additional financial reporting requirements. Public debt securities for a nursing home include public REIT senior debt,[15] Commercial Backed Mortgage Securities (CMBS), and high yield or subordinated debt. Senior secured or unsecured credit facilities, mortgage loans, and mezzanine debt with or without equity components are common securities on the private side.

- **Equity.** Equity financing sources include public and private operating companies, public and private REITs, and private equity, which can be derived from high net-worth individuals and institutional firms (ranging from small family offices to global firms). Joint ventures with other nursing homes are another alternative to securing equity financing. Similar to how debt securities are originated based on the lender's assessed level of risk and the nursing home operator's purpose of financing, equity sources invest in assets based on their recognized expertise and risk tolerance. Private equity firms (and the bank financing they use) invest in future cash flows in an operating business, and likewise, real estate investors such as REITs are skilled in knowing how to value underlying real estate and are therefore comfortable with the different types of risk that are inherent within property versus operating businesses.[16]

Nursing home operators must consider the asset being financed, as well as their operating needs (which are dependent on the maturity of the business) to optimize their capital structure. In a very simple example, an inappropriate financing choice would be a nursing home operator acquiring another asset of meaningful size (such as another facility) to them using a revolving line of credit. This is a mismatch of capital because a long-term asset (property) is being "paid for" or financed by a short-term line of credit designed to be periodically drawn down and then repaid in the ordinary course of business.

The considerations in Figure 7 further illustrate why nursing home owners and operators partner with different types of investors at different stages in their company's lifecycle. The cost and availability of financing are especially important in rural areas where nursing home facilities may be the only option for long-term care. Per industry experts, these entities are not typically relying on private equity but rather on local relationships with community banks. However, these relationships can be disrupted by reimbursement changes that decrease the market valuation of nursing homes, and consequently make them a higher risk client to local banks, subject to loftier interest rates, which in turn creates more pressure to seek alternative capital.

15 REITs are more typically equity investors in nursing home properties but occasionally also offer debt financing.

16 As mentioned below within Private Equity Financing & Considerations, there are private equity firms that focus exclusively on real estate investments but are not necessarily REITs. These firms vary in how large of a role they take in participating or influencing the operations side of the business (versus solely the property).

Figure 7. Nursing Home Capital Structure Benefits and Considerations

Senior Debt	Benefits & Considerations	Example Structures & Securities
KeyBank U.S. Department of Housing and Urban Development TRUIST	• Lowest return profile, but highest priority • Maturity depends on debt security[17] • Existing owners do not give up ownership • Shorter process to close funds • Covenants limiting borrower spending, additional debt incurrence, leverage ratios	• Revolving credit facility • Senior mortgage loan • Commercial mortgage backed loan • HUD loan (up to 35 years, fixed rate) • Senior secured notes (i.e., bonds) • General senior unsecured debt
Junior / Hybrid Debt	**Benefits & Considerations**	**Example Structures & Securities**
Capital Funding Group MERIDIAN CAPITAL GROUP midcap FINANCIAL	• Debt with higher thresholds given lower repayment priority in an insolvency • Longer maturity than senior debt above it • Interest can be non-cash to bolster liquidity	• High yield bonds; subordinated debt • Mezzanine debt, with or without debt-to-equity conversion provisions (instruments may start to look "equity-like")
Equity	**Benefits & Considerations**	**Example Structures & Securities**
The Carlyle Group welltower FORMATION CAPITAL VENTAS	• Highest return hurdles given insolvency risks • Majority or minority (non-control) investment • Longer time to close (due diligence, investment committee approvals, etc.) • Investor provides operating expertise • Potential for additional "portfolio company" synergies (HR, Benefits, Procurement)	• Private equity leveraged buyout • Private investment in public entity (PIPE) • Preferred equity convertible to common • Public or private REIT investment • Joint venture with another operator or REIT • Sale/leaseback – see below *

* A "sale/leaseback" transaction involves monetization of company assets (typically real estate) sold to a REIT – i.e., the assets permanently leave the balance sheet; cash raised can be used to repay existing credit facilities or remain on the balance sheet to fund future growth, however, the nursing home operator incurs additional lease costs moving forward.

17 Senior secured facilities with floating interest rates are generally 1 – 5 years, fixed debt (e.g., subordinated securities, HUD 232) are longer term.

HUD Debt Financing and Considerations

The federal government provides substantial investment in nursing home infrastructure via HUD financing, established in 1959.[18] HUD loans can be used to purchase, build, refinance, or remodel nursing homes, assisted living centers, and board-and-care facilities.[lvii,liii] HUD insures loans issued by HUD-approved private commercial lenders, which protects lenders and helps operators secure loans at potentially better pricing and terms than they would have otherwise been able to obtain outside of the program.

The key attributes of the HUD program have long made it a preferred option among nursing home operators:

- The program offers an inexpensive cost of capital for operators seeking nonrecourse, long-term financing.
- The broad usability of HUD funds allows operators to vertically integrate their businesses, and invest in ancillary services (e.g., laundry, maintenance) that give them pricing and cost control for services they utilize in the ordinary course of business. This also allows operators to improve their operating margin.

HUD Financing Statistics

In 1995, HUD insured approximately 800 facilities; by 2019 that number had grown to over 2,300 active mortgages, representing $20 billion in mortgages.[lviii] In just the 2021 fiscal year, HUD Section 232 guaranteed $4.9 billion in loans, with more than half of this capital going to nursing home operators.[lxxvi] Notably, the HUD program has experienced relatively few defaults, with officials stating that only one percent of the guaranteed loans end up defaulting.[lviii]

The stability of HUD financing is perhaps offset by program elements that can make it an inefficient vehicle to pursue growth and innovative investments. HUD financing typically requires up to one year to secure due to a long administrative process; this is longer than traditional debt financing or even equity investments. Also, HUD loans are arranged with the property side of the nursing home business[19] (an aspect which has likely supported the program in maintaining low rates), which has instilled a relatively prescriptive underwriting process that does not necessarily incentivize (or even allow, in some cases) innovative investments, such as communication and technology upgrades, that would benefit the operational side of the business. The program's inability to finance "cash-outs" (a method of refinancing in which borrowers can extract equity in the form of cash) is also a potential drawback.

Private Equity Financing and Considerations

Private equity is a form of financing that involves investing in a company. As a result of this investment, the private equity firm gains an ownership stake in the company and may engage in the management and direction of the company, in an effort to increase the company's value.[20]

The private equity industry spans a vast array of firms, from small family-run offices with less than $5 million under management to large international buyout funds,[21] such as The Carlyle Group, whose latest buyout fund targeted $22 billion.[liv] Most of these institutions are private, but a few (such as The Blackstone Group, KKR, and Apollo Global Management) are publicly traded on the New York Stock Exchange.[22]

18 Please see Section 232 HUD Handbook Chapter 3 Section 2 (3.2), or here for more details about the HUD program.

19 See Long-Term Impacts of BBA 97 and REIT Equity Financing and Considerations.

20 Private equity firms that focus exclusively on real estate investments (but are not classified as REITs) vary in how large of a role they take in participating in or influencing the operations side of the business as their investment is tied to the value of the underlying real estate.

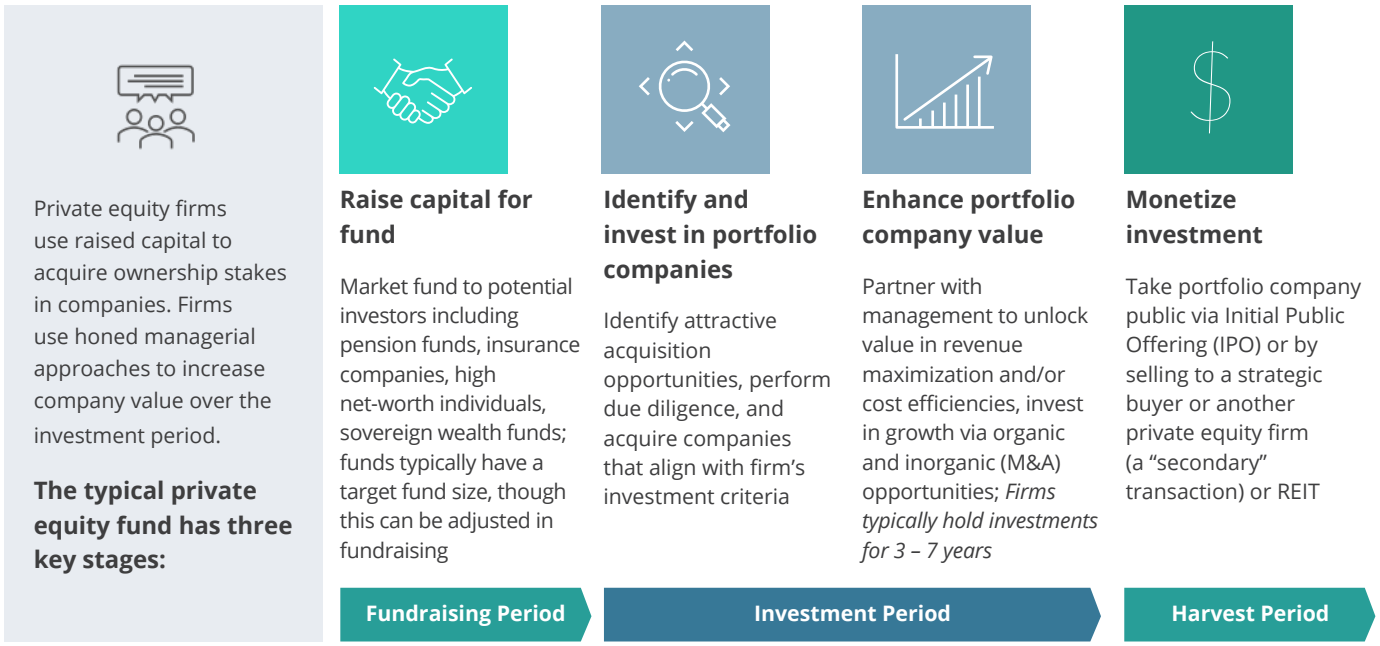
21 Buyout and private equity fund are for the most part used interchangeably.

22 Note the management companies of the buyout firms specified here are publicly traded, therefore public investors invest in the management company, not directly into the private equity firm's funds or the companies private equity firms acquire.

Private equity firms typically raise capital for specific "funds," which are pooled investments sometimes focused on a targeted area (e.g., real estate or other specific asset types and/or specific sectors).[23] The majority of private equity investment comes from United States pension funds, such as the California Public Employees' Retirement System (CalPERs) and California State Teachers' Retirement System (CalSTRS), with sovereign wealth funds and private investors comprising the remainder. In 2021, United States pension funds' private-equity investment increased to an average nine percent of pension fund holdings, after three years of consecutive growth, illustrating their importance in public pension finance.

Private equity firms generally acquire mature companies based on a multiple of their cash flow proxy known as EBITDA (Earnings before Interest, Taxes, Depreciation and Amortization), in a leveraged buyout typically financed by a combination of external debt financing raised by investment banks and internal equity from their existing fund. Firms typically own companies/assets in their portfolio for 3 – 7 years,[24] during which time they implement their vision and strategy for the business (Figure 8). These components are outlined at the time of investment and are revised as needed to reflect changes in the operating environment.

Figure 8. Stages of a Typical Private Equity Fund



Research has indicated that between five to ten percent of the nursing home industry is owned by private equity firms.[ii,iii] Beyond nursing homes, the healthcare industry has deep private equity history, with all healthcare sub-sectors experiencing exponential growth in private equity investment in the past two decades. In 2018, the valuation of private equity deals in the United States healthcare sector surpassed $100 billion, a twentyfold increase from the year 2000. These acquisitions spanned physician practices to retail health and mobile application companies[iv] and reflect an industry with:

- Favorable demographics via an aging national population;
- Fragmented markets that provide an opportunity to enter the market via a smaller investment and grow by acquiring or "rolling up" similar assets; and,

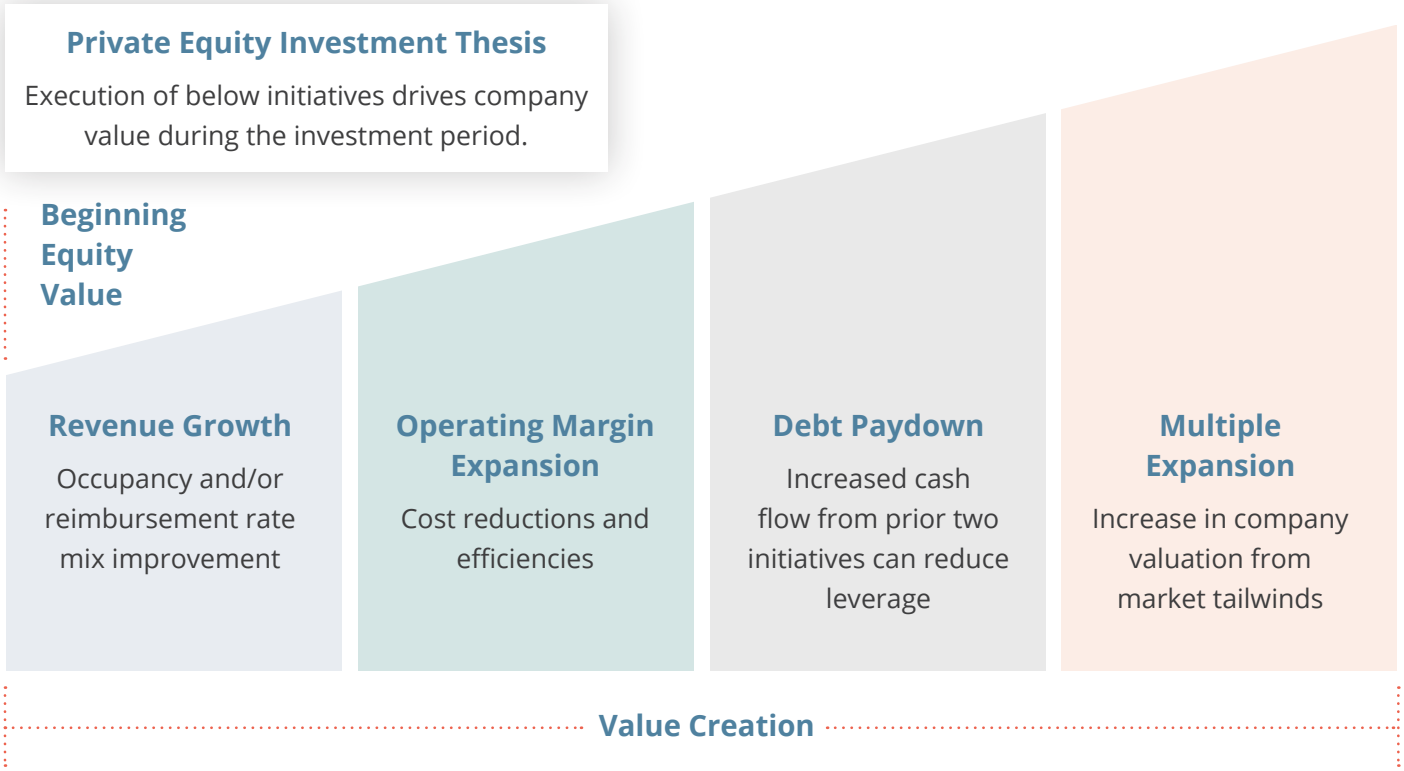
23 For example, private equity funds raised by The Carlyle Group have in the past been used to acquire companies across many sectors – in addition to healthcare – including Dunkin' Brands, Getty Images, Dex Media, and Freescale Semiconductor.

24 "Open-ended" funds do not have this limitation.

- Significant variability in operators, suggesting private equity firms can bring capital and expertise to areas marred by operational inefficiencies.

Private equity firms take significant risks when investing in healthcare, primarily due to the lack of predictability among reimbursement rates. Furthermore, as one of the most highly regulated sectors of the economy, the healthcare industry has fewer pathways for generating investor returns, and is constrained by public policy that is not necessarily aimed at rewarding innovation. When investors enter a market, they are competing against other marginal providers who, unlike investor-backed providers, are not focused on optimizing services and costs to enhance operations, but nonetheless will be reimbursed at the same amount. As part of a private equity firm's due diligence process, the firm will build a financial model that estimates investor returns under different operating scenarios. There are several key components to investor returns (see Figure 9 and detail in Appendix) that influence the financial model.

Figure 9. Illustrative Private Equity Investment Thesis: Nursing Home



The perceived lack of transparency in private equity deals has led to concerns regarding the entities behind nursing home ownership. However, larger "headline making" private equity investments are more likely to be financed with publicly-traded debt, and therefore must abide by United States Securities and Exchange Commission (SEC) disclosure rules, including filing periodic financials (similar to a company whose equity trades on the public stock exchange). Furthermore, all companies, whether public or private, must comply with state and federal tax filing requirements. Compared to public companies, when owners and operators work with private equity investors, they increase value in the company by narrowing the information gap between shareholders and management, also known as reducing "agency costs." Future disclosure and transparency requirements should focus on patient outcomes and costs to the system across all types of operators (not just those who are private equity-backed), recognizing that private equity is just one of a broad set of vehicles for accessing capital. Please see Part 4 for additional commentary around transparency and Part 2 for how historical (tort) legislation has – in part – led to the very structures that are the target of regulators today.

A Focus on Research on Private Equity in Nursing Homes

Research findings on private equity investment vary. This is due primarily to the many confounding factors affecting quality, making it difficult to comparatively assess private equity-backed nursing homes and non-private equity-backed nursing homes. The differences in services received by the long-stay Medicaid resident population and short-stay Medicare beneficiaries make assessing performance particularly complex.

General Research

The inconsistent findings among (and sometimes within) studies illuminate the complex factors across nursing homes. As an example, an article published in 2021, *"Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes"*[lii] identified that private equity ownership increases the short-term mortality of Medicare patients by 10 percent. However, the report also stated:

- Private equity-backed sites shifted their staffing mix to more RNs and fewer nursing assistants, suggesting higher clinical skill mix within private equity-backed facilities; and,
- "… [Private equity]-owned nursing homes are able to take better care of more complex patients, especially when they are on the younger side. But lower risk or older patients suffer."[liii]

COVID-19 Research

Recent research publications focused on COVID-19 experiences also reinforce the difficulty comparing nursing home performance across different ownership entities.

- Research focused on nursing homes in New Jersey (where approximately 18% of nursing homes are private equity-backed) stated residents at private equity-owned nursing homes had higher COVID-19 infection and fatality rates versus the statewide average, as well as nonprofit and other for-profit operators.[lxxvii] However, the focus on one state and the local nature of healthcare results in findings that are not attributable to nationwide private equity operators. Furthermore, the same private equity firm may own multiple properties in New Jersey, meaning that one or two owners may have driven this performance, making it even more difficult to draw any large-scale conclusions.
- On the other hand, a separate nationwide research publication also released in 2020 stated that private equity ownership was associated with a mean decrease in the probability of confirmed resident cases by seven percent among private equity-backed nursing homes.[lxxviii]

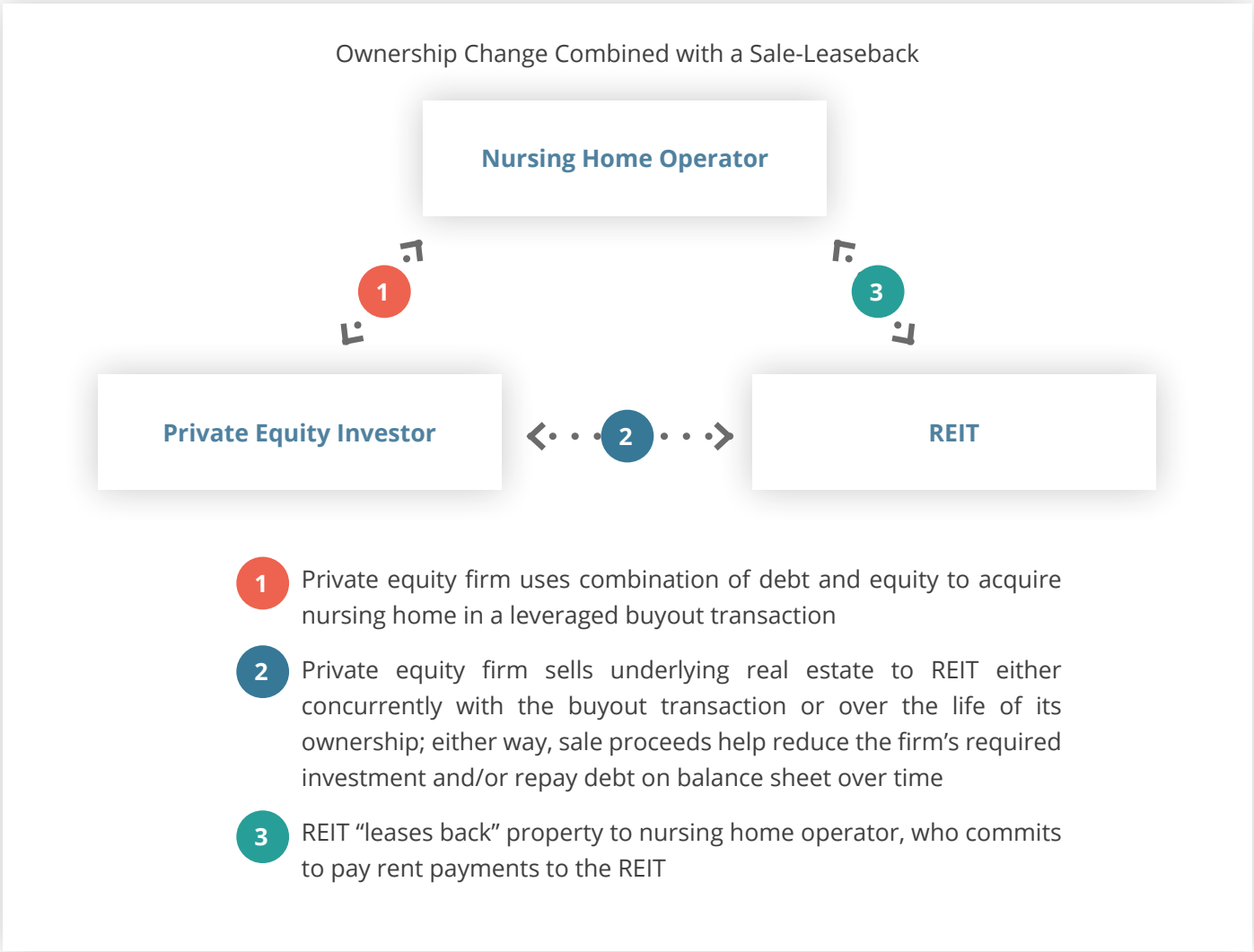
REIT Equity Financing and Considerations

Similar to consumer-retail industries that depend on a physical footprint to serve customers (e.g., dining, hospitality, shopping), nursing homes are a real estate intensive business, with over 15,000 buildings as assets.[lvi] Because of this, nursing homes attract investment from REITs. Created by legislation in 1960, REITs are an investment vehicle for owning income-generating properties across a variety of real estate sectors. REITs can be privately-owned or publicly traded on the stock exchange.

Historically, REITs have invested in properties through "triple net leases."[25] In this structure, the tenant (here, the nursing home operator) is responsible for paying the building's property taxes, building insurance, and the cost of any maintenance or repairs the building may require for the term of the lease. As the tenant is covering these costs, which would otherwise be the responsibility of the property owner, the rent charged in a triple net lease is generally lower than rent charged in a standard lease agreement, where the burden of these costs would fall on the landlord.

An estimated 145 million Americans are invested in REITs as part of their retirement funds and other investment portfolios.[lxxix]

Figure 10. Equity Financing Including Private Equity and REIT Participation



25 In 2007, Congress approved the REIT Investment Diversification and Empowerment Act (RIDEA), which made new RIDEA structures more attractive for investors from a tax perspective. The RIDEA Act allowed REITs to establish a taxable REIT subsidiary (TRS) with an in-place lease between the landlord and tenant entities, both owned by the REIT. Although this structure is more prevalent in senior housing (which is typically characterized by a higher percentage of private pay – versus government reimbursement – compared to nursing homes) rather than nursing homes, it represented an important change for real estate investors, allowing REITs to take a deeper role in the operating company portion of an agreement and underwrite a larger portion of operations and income, rather than the basic rent and escalations common in triple net leases.

Triple net leases can be mutually beneficial. The leases tend to be flexible and provide cost predictability to the lessee (here, the nursing home operator), including caps on tax increases, insurance increases, and other recurring expenses. In addition, the operator is well defended against refinancing risks. For the landlord/REIT, triple net leases can be a reliable source of income and have very few overhead costs. The landlord is also not required to play an active role in the management of the property, which confers advantages and disadvantages (see above footnote discussing RIDEA).

REITs, either alone or in partnership with private equity firms, invest in nursing homes through what is referred to as an "opco/propco" transaction.[26] Through this mechanism, the operating side of the business ("opco") is effectively carved out from the property side ("propco") of the business: the REIT acquires the real estate footprint of the nursing home, and then leases the real estate back to the nursing home operator via a long-term lease (number three in Figure 10 above). The advantage of the sale-leaseback structure is that the nursing home operator can access fresh capital by monetizing their underlying real estate footprint without giving up ownership of the nursing home operations. Proceeds from this financing can theoretically be reinvested in operations, though this does not always happen in practice.

The combination of low margins and valuable underlying real estate is not unique to the nursing home industry. Brick-and-mortar companies across several industries pursue similar models, in which the operating company is separate from the real estate. National commercial drugstores, such as Walgreens, CVS, and Rite Aid, do not own their real estate and make lease payments to third parties. Nursing homes, however, differ in that to operate the business, a license is required, which is usually procured from state governments as well as Medicaid and Medicare provider agreements which are provided by the states and federal government, respectively.

Opco/propco structures can increase nursing home expenses via higher interest payments (if the operations have been acquired by a private equity firm that has used debt to finance the transaction) as well as increased rent going towards the REIT. A recent study found that lease payments increase by about 75 percent and interest payments increase by about 325 percent after private equity acquisitions, although it should be noted that these seemingly high percentages may be skewed by operators with limited debt or few operating leases prior to the transaction. [iii] The upside of the opco/propco model is that each set of investors can focus on what they do best, whether it is running the company or managing real estate. Because this structure (an ownership change combined with a sale-leaseback) has been much discussed in headlines, it is discussed here (see Figure 10 as well), but industry experts emphasize that these transactions are closer to the exception rather than the rule. It is more common to simply have a REIT and nursing home partnership.

26 REITs typically acquire the underlying real estate of nursing homes based on a ratio of the (a) annual estimated rental income to (b) the current market value of the asset. This is also known as the capitalization rate ("cap rate"). The considerations between cap rates (a REIT valuation metric) and EBITDA multiples (a private equity valuation metric) are beyond the scope of this paper.

PART 4. IMPLICATIONS FOR NURSING HOME INDUSTRY REFORM

Please see the accompanying databook for further detail on the state of the nursing home industry.

Key Points:

- Nursing home policy has historically preferred a punitive regulatory approach alongside payment policies that produce low overall margins. This approach has placed pressure on nursing home operators to seek financial support in the form of private capital funding that can withstand a riskier environment, such as private equity
- The following are policy considerations to relieve this pressure and diversify options for capital that will help create a better nursing home care experience in the future
  - Recently proposed national staffing ratios should be paired with adequate reimbursement that holds operators accountable for how these funds are spent. Recent research found that, without additional reimbursement tied to staffing, almost three-quarters of the nation's nursing homes would be losing money caring for residents at the proposed staffing standards – particularly in states with low Medicaid reimbursement rates.[lxxx] **Mandated measures must also be paired with solutions for the long-term problem of labor shortages that nursing home operators face**, which are in part due to competing with other healthcare sub-sectors for the same staff. Policy solutions can focus on expanding labor capacity through more efficient utilization of the existing labor supply and/or ensuring nursing homes have the appropriate resources to hire, train, and retain adequate staff. Longer term, policy solutions may also support educational institutions to ensure optimal flow of nursing and clinical prospects.
  - Nursing homes not only lack public and private funding to support **investment in clinical innovation and technology, but they have also been historically excluded from funds intended to support these same investments** (see Part 2). Policy solutions may include incentives to attract private investment in modernizing not just the underlying real estate, but also the operating model.
  - **Policy decisions that fail to incorporate capital market dynamics** lead to "blunt" reform that risks unintended consequences, such as eliminating access to capital or diverting scarce resources to non-patient-centric activities. In exchange for increased oversight and accountability, quality operators may be entitled to financial upside in the form of greater revenue predictability (via reimbursement rates) and/or financial flexibility – or at the very least, be assured that this transparency cannot be used against them. Public capital markets may provide a good model of how reporting, transparency, and accountability (along with the benefits and drawbacks of said markets) interplay.
  - **Nursing home operators are experiencing serious setbacks in revenue prospects (cross-subsidization, increasing Medicare Advantage penetration, lower volume overall as a result of the pandemic environment) while simultaneously being asked to improve operations (via staffing mandates and increased technology adoption).** Together these elements make obtaining affordable long-term private capital funding – that can deliver on the innovation policymakers and consumers are soliciting – more challenging. Federal and state policymakers should renew their commitment to supporting nursing homes, starting with more coordination between these groups.

Successful policymaking will consider the historical policy decisions (see Part 2) that created the current nursing home environment. Continuing to add requirements and penalties without addressing underlying problems will only exacerbate the symptoms (such as staffing metrics that fall below recommendations) that have emerged. There are opportunities across several key categories, all of which interact with one another:

- **Staffing.** Patients, residents, and their families deserve a staffing model that supports low patient-to-staff ratios, low turnover rates, and interdisciplinary teams of physicians, nurses, care aides, and therapists.
- **Innovation.** These constituents also deserve innovation in clinical operations and care models, including underlying technology to support these initiatives. Innovation should be additive to a patient's lifestyle and promote independence – even in a facility setting.
- **Transparency and Accountability.** Increasing regulatory oversight that promotes superior operators will benefit patients, residents, and families. Regulatory measures that reflect a shared vision among operators, payers, policymakers, and investors will be relevant to patient, resident, and family needs within a facility.
- **Reimbursement & Access to Capital.** Adequate – and predictable – reimbursement levels not only support strong staffing models, but also facilitate access to affordable private capital. Revenues from reimbursement should primarily fund day-to-day operations, instead of stretching to cover these expenses as well as needed investments in long-term assets. Private capital can play an important role in supporting long-term investments that accrue to residents and patients, such as those related to innovation and quality. In an increasingly value-based reimbursement environment, such quality-driven investments will be important; through appropriate use of this capital, operators may substantiate cause for higher reimbursement. This is of particular importance given the downward trend in reimbursement rates, in part due to value-based models that have largely disadvantaged nursing homes, as well as Medicare Advantage rates that are just under 80 percent of Medicare FFS rates.

Staffing Shortages

A common focus of public and policy attention on nursing homes is the shortage of staff available to serve the patient and resident population. The American Association of Colleges of Nursing estimates the nation will need 175,900 new RNs per year through 2029, after accounting for nurse retirements and workforce exits (in part originating from emotional burnout and higher-paying options outside of the healthcare industry).[lvii] A tight labor market adds to nursing home operating expenses due to higher salary expectations, rampant turnover, and reliance on contract labor.

Staffing mandates in themselves are a relatively short-term solution as they do not acknowledge the costs associated with increased staffing, nor do they account for systemic shortages in nursing supply. However, mandates paired with public funds that hold operators accountable for how said funds are used to address staffing shortfalls could solve several issues, including supporting operators, increasing financial transparency, and benefiting the end patient/resident. Policymakers can also consider the following "upstream" alternatives to address labor pool gaps:

- Interest in nursing careers is relatively high, but **education/formal training is limited by the supply of academic institutions offering nursing degrees.** Nursing institutions lack sufficient budgets to attract faculty and establish the footprint (classrooms and clinical sites) required to support increasing applicant demand; more than 80,000 applicants to baccalaureate and graduate nursing programs were turned away in 2019 for these same reasons.[lviii] Federal and state funds could help address these gaps through loan support for prospective students and prioritized grants to recruit new faculty. Graduate nurse training

could also be supported through a Medicare program, similar to what is currently offered for physicians.

- State regulations regarding the scope of practice for RNs versus LPNs vary, which can artificially limit nursing supply. **Enabling clinical staff to "practice at the top of their license" can help expand capacity.** Some states have experimented with this during the pandemic, as CMS allowed states to waive or reduce training requirements for CNAs.[lix] The Enclave Principle model, which the National Association of Health Care Assistants (NAHCA) is attempting to implement on a national scale, is potentially another example of how operators can enlarge the CNA role and responsibilities (and bring them more in alignment with other healthcare settings), making the position a more attractive long-term career opportunity.[lx]

New State Staffing Approaches

The pandemic spurred some changes at the state-level aimed at enhancing nursing home staffing ratios. Two states (Maine and New Jersey) added new minimum wage requirements specifically for direct care staff, a new type of policy not practiced prior to the pandemic. New Jersey added a new minimum loss ratio requirement that caps nursing home profits and requires nursing homes to spend a minimum amount on staffing.[lxvii]

- Long-standing **reliance on domestic talent limits nursing supply.** Immigrants comprise a significant portion of a nursing home operator's workforce. As of 2017, nearly one in four workers who directly cared for patients were immigrants,[27] and nearly one in three housekeeping and maintenance workers were immigrants.[lxi] The pandemic also elevated awareness of the significant contribution from undocumented healthcare workers – of which there are an estimated 225,000 serving the nation as doctors, nurses, and home health aides, as well as an additional 190,000 undocumented individuals working in necessary custodial and administrative roles to ensure healthcare settings remain safe and open.[lxii] During the public health emergency, policies were relaxed to allow foreign nurses to provide services in the United States, which expanded the labor pool. This suggests immigration reform is an important component to addressing nursing staff constraints in the long term.
- Although nursing homes have historically paid less than their hospital partners, competitive wages are just one aspect driving nurse departures. Employees in nursing homes have one of the highest rates of nonfatal occupation injuries with 15.7 incidents per 100 full-time workers per year; for reference, the incident rate for mining jobs is 2.0 per 100 full-time workers and logging is 2.6.[lxiii] Furthermore, a recent survey of healthcare executives performed during the pandemic noted the top reasons for nurse departures were career advancement and relocation, with salary at the bottom of the list.[lxiv] Together **these metrics suggest the importance of a holistic approach to addressing staffing constraints, one that addresses not just salary** but all of the factors affecting care staff retention.

As policymakers start to review approaches to solving nursing home staffing constraints, it will be important not only to evaluate how they may address gaps in patient care, but also how sustainable these models are from the perspective of the typical nursing home operator.

Lack of Innovation in Delivery Model

Although it is well known that nursing home physical infrastructure is outdated, the COVID-19 public health emergency also highlighted gaps in modern technological capabilities, including telehealth/medicine applications and (especially in rural areas) telecommunication systems. As policymakers seek to improve innovation and improvements in nursing home infrastructure, there are several underlying problems to consider:

27 Includes unauthorized immigrants, legal non-citizen immigrants, and naturalized citizens.

- Regulation and reliance on government funding impede nursing home innovation. **Reimbursement is largely based on volume (versus innovation), and how nursing homes can use government funding is defined in regulation.** This limits nursing home operators – and therefore investors – in how they allocate expenses and/or spend funds. The highly regulated environment, in which marginal providers are typically reimbursed at the same level as more innovative providers, makes accessing this capital potentially cost-prohibitive as investors are not incentivized to allocate capital to initiatives that will largely not be valued by the market (here, the government, as the reimbursement entity).
- Unencumbered private capital, such as that offered by private equity firms, **can support innovation through its multiple year investment horizon.** Research has suggested that for private-equity backed primary care organizations "having stable access to capital for years allowed these organizations to experiment with new delivery models and to incur losses without worries about losing access to funding (as is the case with grants)."[lxv]
- **The nursing home industry has historically been excluded from innovation funding.** HITECH funding resulted in billions of dollars going to hospitals and providers, but not to nursing home operators, to adopt EHR systems.[xlv] Consequentially, nursing home adoption of EHRs has been relatively slow and interoperability is lagging, with only 22 percent of nursing home EHRs able to send data. This lack of interoperability further stifles innovation by hindering nursing home engagement in value-based arrangements, because managed care plans, ACOs, and hospitals prefer to partner with providers able to integrate with their systems.
- **Even outside government funding, it is difficult to secure financing for solely "operational" (e.g., technology upgrades) improvements.** Today, when operators and owners choose to access capital, they do so largely based upon real estate rather than operational attributes, which has led to a history of attracting capital to build – not renovate and improve – buildings. Separation of the operating and real estate sides of the nursing home business was in part driven by plaintiff-friendly tort environments in certain states that increased medical malpractice liability litigation, and incentivized operators and investors to either exit the region, or divide businesses to reduce operating capital exposure (see Part 2). Future policy ideally incentivizes real estate-focused capital providers (e.g., HUD, REITs) to incorporate innovative initiatives as key elements of their investment thesis. As mentioned below, HUD financing that supports or prioritizes innovation-driven investments may be one way to address gaps in funding and, given the prevalence of this financing mechanism among nursing homes, could have far-reaching effects.
- New care model initiatives through the Center for Medicare and Medicaid Innovation (CMMI) generally have not targeted broad populations and instead, have focused on specific conditions or procedures. To date, most models have failed to reward risk-taking in developing new/unique delivery approaches that are scalable outside the targeted and limited population.[28] **This has in turn limited capital sources available to fund the change needed to modernize nursing home delivery models.**

Regulation as a Blunt Instrument

Policymakers' recent focus on transparency related to nursing home corporate structure and flow of funds is potentially a good first step towards identifying quality operators. However, going forward, policymakers should keep in mind the many effects of increasing regulation in an economic market, so that it is clear the benefits of said regulation outweigh any potential costs (such as market disruption, increased operational expenses, etc.). There are several historical instances of regulation intended to protect the patient or resident that has had unexpected, if not nefarious effects on the industry. For example, state-based Certificate of Need laws have been found to promote monopolistic rather than competitive markets.[lxvi]

28 A January 2020 study concluded that bundled payment maintains or improves quality while lowering costs for lower extremity joint replacement, but not for other conditions or procedures.

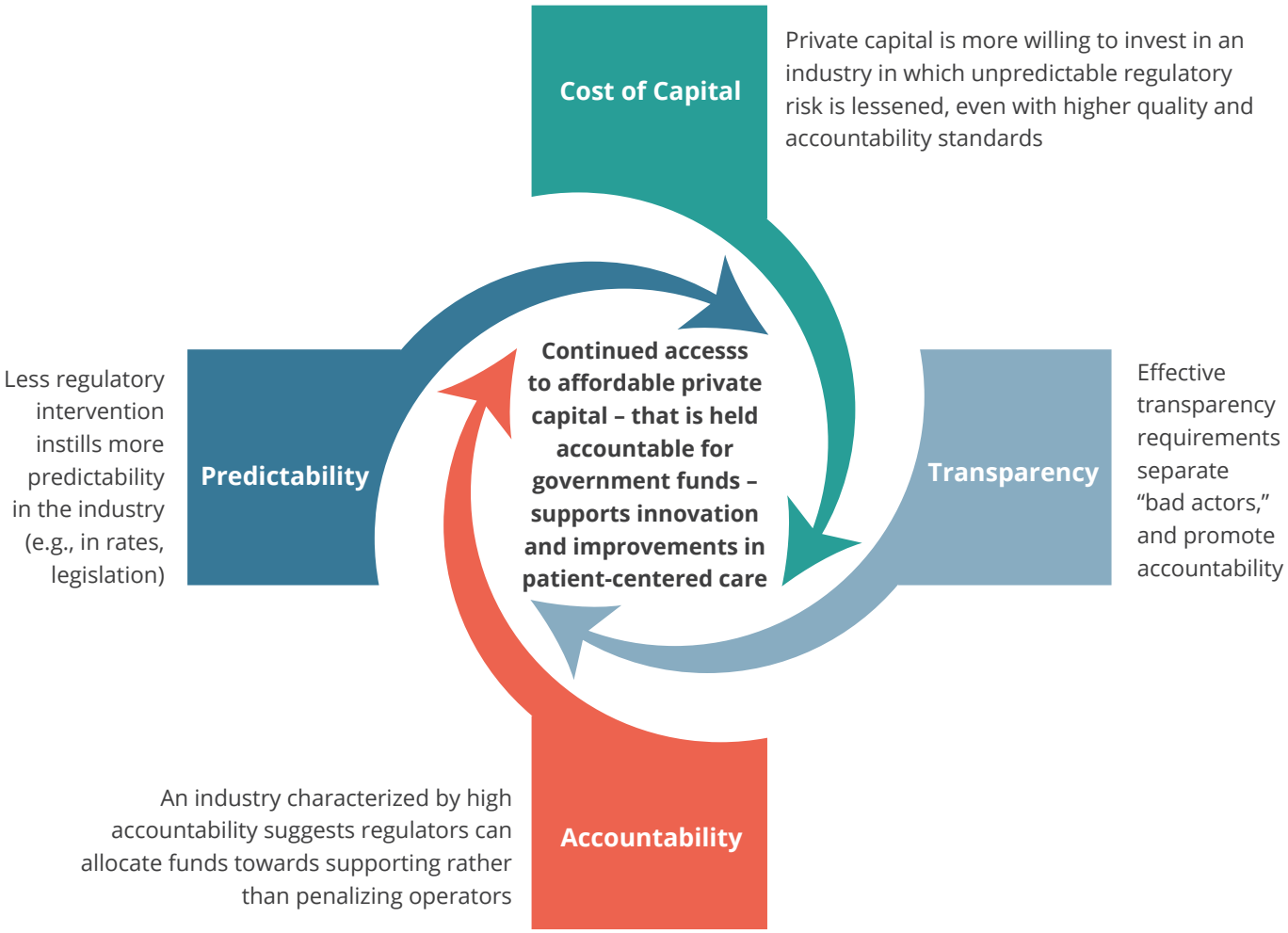
Oversight by regulators, and accountability on the part of nursing home operators, owners, and investors as recipients of significant government funding, should remain requirements for participation in this industry. However, to support the future viability of the nursing home sector, policymakers should also consider how to balance increasing regulations with greater predictability and flexibility of funds that enable operators continued access to affordable, sustainable private capital that can support needed innovation and long-term investment.

To foster long-term change, policymakers must assess how regulations that impact quality measures, transparency, predictability, and private cost of capital can interplay to support an improved experience for the nursing home patient or resident (Figure 11).

Well-Intentioned Legislation May Have Unintended Effects

In the late 1990s and early 2000s, tort-friendly legislation in certain states was not found to be particularly effective in "weeding out" poor operators.[xxxvii] These high-litigation risk environments effectively incentivized large operators to disaggregate, given increased costs (liability, insurance, and capital, among others), associated with operating a business of scale. Smaller operators (one to three facilities) had a greater chance of obtaining affordable capital due to less operating capital exposure, which in part led to today's nursing home industry characterized by high fragmentation and divorced operating and real estate assets.

Figure 11. An Integrated Approach to Reform



The following are considerations for policymakers:

- **Public capital markets demonstrate how the interplay between regulations and certain benefits dictate participation in these markets.** Companies that choose to trade publicly are subject to increased scrutiny by regulators and investors, as well as higher fees and reporting obligations. However, in return, they receive access to significant capital that can be used for long-term investments and optimizing their financial position (such as paying down debt). Other benefits include increased public awareness and network effects that can enhance access to hiring talent and increase market share. Policymakers can look to public capital markets to better understand how nursing home owners, operators, and investors will respond to increased regulation (such as that related to financial reporting and transparency) as well as how to potentially balance or offset increased costs or risks associated with such regulation.
- **Current (federal or state) reporting requirements could better align policymakers and nursing home owners/operators/investors – and provide more actionable/informative information to the public as a result.** This may include, for example, more transparency around measures that assess the quality of revenue (or the portion driven by census growth and the portion driven by rate, or by "short-term" practices such as "up-coding"). Investors are focused on these metrics day-to-day and, through these same metrics, policymakers can better understand the sustainability of an operator's business to make more informed policy decisions (by assessing, for example, if operators are driving more revenue from census growth, or from the aforementioned rate enhancing practices which are likely not accruing to the end patient). ***This will require collaborative relationships between policymakers and investors.***
- **Private capital markets can act as an extension of government policies intended to drive specific outcomes, such as those related to quality.** Reimbursement and quality mechanisms are generally developed without nursing home private investor input and therefore can lead to misaligned incentives. Policymakers could additionally leverage private capital through strategic public investments in order to achieve desired policy outcomes.
- **Awareness, trust, and properly calibrated incentives and penalties are the throughlines of effective regulation.** The costs to the system of reporting must be balanced by the potential benefits (such as meaningfully higher financial upside and more predictability). Policymakers must recognize how regulations will impact the cost and availability of private capital to support these initiatives. Furthermore, policymakers should assess whether resources allocated towards meeting these regulations could be better utilized towards other specific (e.g., quality) initiatives that directly link to the nursing home patient population.[29]

Unfavorable and Misaligned Financing Dynamics

The history of payment policy has led to nursing homes experiencing serious revenue setbacks due to unfavorable rate and volume changes, caused by reliance on Medicare revenue to subsidize Medicaid payments, increasing Medicare Advantage patient mix at payment rates that are substantially lower than Medicare FFS, and burgeoning interest in home-based models in part accelerated by the public health emergency diverting more post-acute care to home settings. These policies have also stifled innovation and investment in modernizing nursing home infrastructure.

Further, the private capital financing that has filled gaps in government reimbursement, such as that from private equity and REITs, **is often criticized without consideration for why these capital structures have emerged and are utilized.** Ultimately both private and public resources have the same goal of supporting nursing homes

29 Studies focused on nursing homes operating in high-risk medical malpractice environments have found the relationship between poor quality and litigation is not strong, implying that state-level measures to reduce litigation, such as tort reform, may be more advantageous to the nursing home population. Costs associated with litigation could be redirected toward more specific quality improvements and toward compensation of victims of poor care.

in delivering patient-centered care, however, there are limited examples of these parties working together. Unless government entities want to assume responsibility of financing the entirety of nursing home capital needs, policymakers should recognize capital market efficiencies. ***Payment and policy reform must not unintentionally narrow and stifle the various public and private (i.e., non-governmental) sources of nursing home capital, given the meaningful role these sources play in supporting the nations' nursing homes, given the likely inability of government financing to meet industry needs for capital.***

As policymakers contemplate reimbursement and financing models, there are several important considerations and opportunities:

- **Solutions require better distribution of funding.** Medicare funds Critical Access Hospitals in rural areas, yet no similar model exists in long-term care. Similarly, Disproportionate Share Hospital (DSH) payments could support high Medicaid census nursing homes, which are disproportionately for-profit entities and therefore are more likely to consider alternative financing sources.
- Medicaid and Medicare are siloed programs and payers, and the challenges associated with this fragmentation are particularly relevant to nursing homes, where individuals may transition between payers. **It is vital that federal and state payers collaboratively renew their responsibility to support the nursing home initiatives and proposals they are proposing.** Ensuring adequate reimbursement is just one aspect – payers need not shoulder the whole burden if they are also willing to better align with nursing home investors, and in turn, reduce barriers to needed private capital. This will promote the type of environment where private capital is incentivized (and properly rewarded through quality-driven reimbursement) to drive operator value through investments that address outdated technology platforms and improve patient-to-staff ratios, rather than short-term revenue/cost initiatives that do not align with patient-centered care. Better payer alignment can start now; **federal policymakers might learn from states testing new nursing home reimbursement models** (such as a managed care-like medical loss ratio[lxvii]), to further understand model challenges and learnings to support a more collaborative payment model.
- Although increasing Medicare Advantage penetration has positively impacted the market by providing nursing homes with some control over costs and operating decisions (e.g., how they manage patient length-of-stay), **managed care has failed to deliver on innovation or incentivize quality in nursing homes.** Research generally finds that Medicare Advantage plan members are served in lower quality nursing homes,[lxviii] and that efficiency gains relative to Medicare FFS are largely due to lower rates (which have been declining roughly 2% per annum over the past ten years, see databook) and length of stay, rather than innovative models for post-acute care.
- **Value-based models, which initially showed some promise in better linking healthcare quality, transparency, and economic incentives, have unfortunately been disadvantageous for nursing homes.** For example, the limited funds in a bundled payment model can lead to a downward trend in patient length of stay within nursing homes, making cost the driver of patient experience rather than patient need. Other value-based models have induced provider participation by promising more patient volume at a lower reimbursement rate. Together these data points imply these models can be misaligned with patient-centered care, with research supporting a similar perspective (a prior nursing home value-based payment demonstration project that was evaluated in 2016 was found to have little impact on Medicare spending or quality).[lxix,lxx,lxxi]
- Focusing on an operator's outcomes without incorporating the nuances around their funding choices obscures the fact that poor outcomes can be linked to policymaking that has inadvertently restricted private and public capital financing options for operators. **Policymakers should understand the benefits and drawbacks of the different types of public and private capital accessible to nursing**

homes, and consider why nursing homes have found it necessary to partner with specific sources. As mentioned above, many policymaking actions, though well-intentioned, have directly reduced the predictability – in terms of nursing home future revenue and cost prospects – that is central to ensuring private capital is accessible, and therefore driven operators to seek capital from sources that have not necessarily enabled value to reach the end-consumer.

- **Given its continued prevalence as a source of capital, HUD is well-positioned to drive growth and innovation within the nursing home industry.** As previously mentioned, this would address a long-standing issue in the sector originating from operators' inability to secure capital to upgrade operations. Importantly, as a government entity, this would entail a more direct approach to influencing operator capital choices, compared to certain payment policy changes (such as reducing reimbursement) that are indirectly aimed at disincentivizing certain investors, and ultimately penalize operators.

MOVING FORWARD

Though well-intentioned, policymaking over the past several decades has created a nursing home environment in which innovation, up-to-date infrastructure, and person-centered care are difficult to accomplish. In the absence of adequate reimbursement to support these initiatives, operators have turned to debt financing as well as capital investors such as private equity firms and REITs to fund their businesses.

Capital investors represent an important lifeline for nursing home operators, especially in this moment of renewed policymaking aimed toward modernizing the nursing home industry, without the requisite government funding. Policy choices – exemplified by dysfunctional reimbursement mechanisms and innovation models that have disadvantaged (if not left out completely) nursing homes – have made investing in the operating component of this industry increasingly risky. This dynamic divorced nursing home property and operating assets, thereby creating a capital market in which the nursing home's underlying real estate is more valuable than the operations (and therefore can be funded at a lower cost of capital). As highlighted above, historically, funds derived from real estate focused capital have not been conveyed to the operations side of the nursing home, the result being the massive amounts of outdated capital "stock" (represented by old buildings housing multi-bed rooms lacking technology) invested in nursing homes today. Successful and sustainable policy changes should consider the history of policymaking that has created misaligned nursing home capital markets, and seek to solve underlying problems rather than the symptoms that policymaking has created.

Enabling access to reliable private and public financing sources – specifically, entities that can support operational initiatives and are held accountable as indirect recipients of government-funded reimbursement – is crucial to the future viability of the nursing home industry as some traditional nursing home debt financing options have generally not evolved to match dynamics of a non-cost-based reimbursement environment. COVID-19-induced challenges such as wage pressures, supply-chain problems, and overall pandemic uncertainty further underscore the need to ensure nursing homes can secure adequate capital going forward. Unless government entities seek to assume responsibility of funding the capital needs of nursing homes, **policymakers need to understand where and how capital markets can most efficiently support this industry, starting with recognizing the crucial role private funding plays in challenging operating environments.**

Future public health policy would be wise to leverage the insights and capabilities of experts in the financial sector and use this collaboration to differentiate bad actors from constructive market participants. Policymakers and private investors in the nursing home industry have more in common than they realize, in that the same concern drives much of their action: uncertainty. Addressing investor transparency gaps (which is one of many objectives within newly proposed reform measures) is steeped in policymaker uncertainty around how and why nursing

home operators choose to partner with certain investors. Similarly, the lack of foresight around regulation and reimbursement changes presents challenges for investors who base capital allocations to nursing homes on future financial performance. The more uncertainty that exists, the more investor appetite is limited, creating higher barriers to nursing homes accessing affordable funding.

Policy should appropriately calibrate the risk and reward associated with nursing home private investment. This may require higher upfront investment thresholds (such as transparency and accountability provisions), with the tradeoff being regulatory flexibilities that incentivize innovation-driven investments and properly reward quality providers. **As the National Academy of Sciences stated more than three decades ago, "what is needed is not more regulation, but better regulation" of nursing homes.**[lxxii]

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DATA SOURCES

Bureau of Labor Statistics - The North American Industry Classification System (NAICS) code for skilled nursing facilities was 623100 and was 622100 for hospitals.

Care Compare - The Care Compare website provides an interface for patients to find quality information on a variety of providers and nursing facilities as well as aggregate data for researchers. This data includes results from inspections, a variety of minimum data set measures, as well as reported ownership on the parent level.

LTCFocus Public Use Data - LTCFocus is sponsored by the National Institute on Aging (1P01AG027296) through a cooperative agreement with the Brown University School of Public Health. This Shaping Long-Term Care in America Project supported by the National Institute of Aging at the Brown University Center for Gerontology and Healthcare Research provides data on nursing home care on the facility, county, and state level. Data was weighted to the national level from state by total number of residents if available (2011-2020) or total number of beds (2000-2010). Data available at www.ltcfocus.org. https://doi.org/10.26300/h9a2-2c26

Medicare Cost Reports (HCRIS) - CMS-2540-10 SNF HCHRIS data was collected for the fiscal year 2019. Because facilities use their own fiscal years, data does not represent one continuous year. Reports with less than one year of data have been excluded. This removes facilities that had a change of ownership during the fiscal year and facilities that changed their fiscal year. This resulted in a sample of 13,388 cost reports and 1,759 excluded facilities (15,147 total in 2019).

Medicare Current Beneficiary Survey (MCBS) - The Medicare Current Beneficiary Survey (MCBS), conducted by CMS through a contract with NORC, surveys a nationally representative sample of the Medicare population. ATI Advisory used the 2019 MCBS to characterize nursing facility residents.

NIC MAP® Vision - NIC MAP® Vision captures 140 U.S. markets. While this data is not nationally representative, the sample contains 6,510 nursing facilities across 45 states. For more information on the NIC MAP® Data Service, please visit www.nic.org/nic-map or call 844-668-3282.

APPENDIX MATERIALS

Further Education on Private Capital in the Nursing Home Industry

Figure 12 summarizes the debt capital structure for a publicly traded nursing home: Ensign Group (Ensign). Of note, this particular issuer has elected to finance the majority of its conventional debt through long-maturity HUD loans, rather than traditional bank debt, however, this number ($157 million) is relatively insignificant as a multiple of company cash flow (0.3x "EBITDAR", see footnote one) – instead, the overwhelming majority of obligations come in the form of $1.1 billion in operating leases for properties, which represent a more significant 2.3x cash flow. This illustrates how material lease liabilities can be for nursing home operators, at a level not necessarily seen throughout all industries in the economy or other areas of healthcare. Ensign Group is a particularly interesting example given that the company chose, in late 2021, to launch a "captive REIT," which is to say that it re-organized its financial reporting effective January 2022 to reflect what the company's financial profile would look like if it monetized its real estate assets by selling them to a third-party REIT. The company has elected, however, to keep these assets in-house, which avoids capital gains tax triggers, allows the future real estate footprint to grow more seamlessly, and better attributes value to real estate operations. In short, Ensign recognized the value of a REIT structure and decided to implement it itself, rather than handing those assets to a third party (note: Ensign has been keen to emphasize that they remain, first and foremost, an operator).

Figure 12. Closer Look – Ensign Group Capital Structure (As of 12/31/2021, $M)

	Note	Amount	x EBITDAR (1)	Maturity	Pricing
$350M Revolving Credit Facility	(2)	-	-	10/1/24	L+150-250
HUD Loans	(3)	156.6	0.3x	25-35 yrs.	3.1% - 4.2%
Two Promissory Notes	(4)	3.3	0.0x	<1 yr, 12 yrs.	5.0%, 5.3%
Total Debt		**160.0**	**0.3x**		
Lease Liabilities	(5)	1,108.7	2.3x	14.8 yrs	
Total Debt + Lease Liabilities		**1,268.7**	**2.7x**		
Less: Cash & Cash Equivalents		(262.2)	(0.6x)		
Net Debt (Incl. Leases)		**1,006.5**	**2.1x**		

(1) Earnings before Interest, Debt, Amortization and Rent Expense (EBITDAR) is a proxy for cash flow.

(2) Arranged by Truist Bank; 0.25% - 0.45% annual commitment fee; no amount drawn at 12/31/21.

(3) HUD mortgage loans carry a 10% prepayment fee in the first three years, with annual step-downs therafter.

(4) Two additional loans insured with HUD, with terms of 10 months and 12 years.

(5) Value under US GAAP for leases across 176 facilities (7.6% discount rate); 14.8 yrs average life remaining.

Figure 13. Private Equity Investment Thesis Components: Nursing Home Example

Revenue growth	Favorable change in reimbursement rates (via payment policy decisions and/or focus on higher acuity patient mix) and/or ability to drive volume growth through higher occupancy rates.
Operating margin expansion	Optimizing cost structure via cost reductions or efficiencies. Many private equity firms have in-house procurement, human resources, and benefits experts that can drive synergies in these respective areas once a company is part of their portfolio.
Debt paydown	As noted above, private equity firms acquire an asset using a combination of external debt and equity from their fund, with debt generally being the primary component for large, stable companies. Higher leverage at the outset of the transaction has the effect of reducing the private equity firm's required equity check, which in turn improves overall equity returns throughout the life of the investment. Furthermore, debt principal repayment over time increases the amount of residual equity in a business, and the less debt a portfolio company has at the time of exit, the higher the residual equity value, and therefore higher investor return. Private equity firms perform financial modeling on potential acquisitions to forecast the potential amount of debt paydown during the intended holding period, the net effect being that companies whose financial characteristics lend themselves to "strong debt paydown" are considered particularly attractive buyout targets.
Valuation change or "multiple expansion"	The private equity firm investment thesis will typically be tied to favorable underlying growth dynamics (e.g., in the nursing home industry, this may be demographic growth among the 65+ population); these favorable tailwinds may imply that cash flows generated by companies within that industry may be valued more highly by investors over time.

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