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"All good things arrive unto them that wait and don't die in the meantime."
-Mark Twain

District One
ACHCA
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Health Care Administrators

THE END of the PANDEMIC

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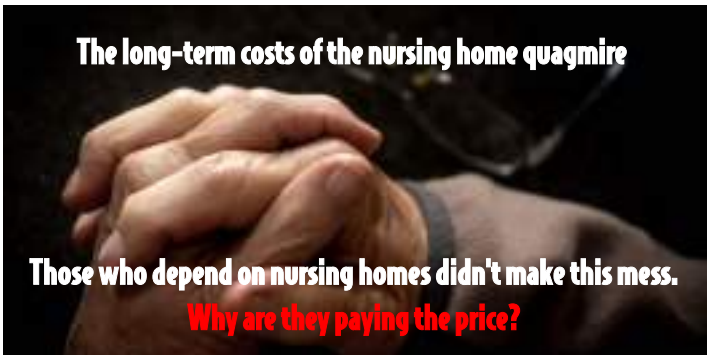
THE MARKETING GURU



by Irving L. Stackpole, RRT, MEd

No one bothers to argue anymore: Nursing homes are a mess. Legacy poor houses, consumers, and their families haven't wanted to use nursing homes for almost as long as they've existed. For several years, my company conducted large-scale surveys among case managers and discharge planners across the United States evaluating their attitudes and behaviors toward (among other things) long-term care and nursing homes. The results showed that the most knowledgeable health and human services professionals in the country dreaded the idea of nursing homes. And this was long before the COVID-19 pandemic.

Here is the situation today:

- Nursing homes are unable to hire staff, are under additional government scrutiny and further regulatory pressure, and are financially unable to raise the capital to morph into the private suite, cookies-in-the-kitchen ideal.
- The cross-subsidies to income from Medicare and managed care covered residents ("Q-Mix") are less available.
- Operating costs (labor) are through the roof.

Many nursing homes are "zombies": still functioning but not able to support themselves based on operating income. The result? Homes are closing at a much higher rate than at any time in the past. This is a "fatal contraction."[1]

Year	Beds
2018	1,660,515
2022	1,614,172
Change	(46,343)

Who pays the price for this contraction–the closure of a nursing home? The people who depend on nursing homes, i.e., residents / patients (consumers), their families, and staff.[2]

The family price

Usually, when a service business closes due to changing consumer preferences, or shifting demand, consumers migrate to another business. This is much less easily done in the market for nursing homes because the market is driven by need, not preference, and / or by third-party direction. So, when a nursing home closes, the burden of finding an alternate falls most heavily on the family. The family's "cost" associated with finding another nursing home is measured in the indirect time and effort as well as in the anxiety this disruption produces.[3] These costs are significant.

Families need to "process" the pending eviction, locate alternatives, and residents must be relocated, which has a significant indirect economic cost. Families, of course, bear the overwhelming share of this burden.

Using the most conservative estimate of closures, there were 129 nursing homes reported closed in 2022. With an average number of 129 beds, that represented 12,900 beds lost.

By these estimates (again, these are very conservative) there were 9,675 families forced to scramble to find another suitable destination residence. If we assume that the time required to navigate and negotiate the relocation to an alternate nursing home between 25 and 80 hours, it is estimated that these families spent 507,938 hours, or 254 work years on the arduous task. These are large numbers, and do not even take into account the anxiety and emotional disruption resulting from the evictions from closures. The loss of productivity and the emotional cost should get everyone's attention. Why is no one paying attention?

Right-sizing

One of the questions that emerges regarding nursing home closures is: "Aren't these closures the result of 'right-sizing,' when the supply exceeds the demand?" In certain urban marketplace areas, this makes sense. If the number of nursing home beds in an urban area exceeds the market demand, occupancy will also decline and eventually drive the home out of business. However, recent and current nursing home

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The Marketing Guru: Those who need nursing homes are paying the price for closures

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closures have disproportionately been in rural areas not urban areas. Does it make sense that the nursing home, which is the only center for 100 miles in any direction, must close, while six others operate in the nearest major metropolitan location?

Right-sizing assumes that the supply is elastic; that it can increase as well as decrease. This is not the case with nursing homes. With almost universal certificate of need requirements, and severe limits to capital formation in the sector, new nursing homes need more than four years to develop and become operational, assuming the developers can secure approvals, which often they cannot. An example of this extreme market intermediation are the struggles building nursing homes in the Green House model.

These "small house" designs had enormously better performance (lower infection rates, fewer deaths, and higher staff retention) than traditional nursing homes during the pandemic and are wildly more popular with residents, consumers, and staff. Yet they struggle to be built because of the intense intermediation of state and federal regulators.

Furthermore, we sometimes hear "Good riddance" from advocates who decry the situation in today's nursing homes. Residents being restrained with pharmaceuticals, horror stories of negligence – even abuse. These observations were the overwhelming substance of President Biden's reference to nursing homes in the State of the Union address a few years ago. Rhetorically, this is a popular move: Blame the nursing home. These are the same nursing homes strangled year after year by incrementally more regulations and draconian budgets. The US spends 54% of the OECD average on long-term care, and 243% on healthcare. Why?

Is this the right size?

What we're seeing now isn't "right sizing," but the chaos of supply contraction in a heavily regulated market where too few of the advocates really understand, and where none of the regulators have the political will to do more than make nursing homes scapegoats. What zealots cannot and will not address is what the replacement, or alternative might be. People who vaguely gesture toward home care and community-based services have clearly not recently been in a nursing home or tried to schedule a home health visit.

Staff

In any nursing home closure, direct care workers are also affected. Without a doubt, many of the direct care workforce are there because they derive great personal satisfaction from serving the old and vulnerable residents in nursing homes. News coverage of nursing home closures often places emphasis on the human side of the closure, featuring painful interviews with staff. Many of these caregivers do experience a profound personal loss.

For the sector, these workers should be cherished resources, and when they are absorbed into a job in an Amazon warehouse (which is likely with the employment rate so low), how can that compassion be replaced?

The sector has lost at least 240,000 direct care workers, perhaps more. These losses are quantifiable, but the personal empathy which so many brought to our oldest, most vulnerable people is truly immeasurable.

Who pays?

The losses of nursing homes and nursing home capacity have come at a time when demand is indeed at a nadir. Those born in 1935, the bottom point in the "demographic dip" are now 87. Over the next 3 to 5 years, we will see an increased demand for all types of aging services–including nursing homes–as the over-85 population starts to swell.

According to my back-of-the-envelope calculations, by 2030, there will be a deficit of over 400,000 congregate care beds in the US. Who will pay for the new, additional congregate care capacity that will soon be required? We are all paying now for the current closures through disruption, emotional distress, lost capacity and productivity. If we could prioritize the needs of three million Americans in congregate care, the total cost to society will be far less than the price being paid for ignoring them. And we might actually be proud of the result.

A profound realignment is needed today.

[1] Stackpole, I. Fatal Contraction. See: https://stackpoleassociates.com/long-term-care/fatal-contraction-healthcare-adjusts-to-a-shrinking-ltc-sector-free-webinar-december-1-2022/.

[2] Small Town Nursing Homes Closing. NBC News. See: https://www.nbcnews.com/health/aging/nursing-homes-small-towns-closing-staff-shortages-rcna66779

[3] Croot, E. The Financial Cost of Anxiety. Thrive Global. See: https://community.thriveglobal.com/the-financial-costs-of-anxiety/

[4] Work Years" is calculated as 1 Work Year = 2000 hours

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Changes to Medicare Advantage organizations

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name, logo, and Medicare card image in MAO marketing materials will be limited.

5. MAOs will be prohibited from using superlatives in marketing materials unless the material provides documentation to support the statement.

Closing thoughts

Applauded by healthcare professionals nationwide, the MA final rule was acknowledged as a resounding "win" for providers challenged by MAOs for decades. The new CMS regulations will have a significant impact on providers and beneficiaries alike; making it easier for providers to accept beneficiaries waiting in the hospital for placement, providing clearer coverage guidelines for providers of all types, and entitling beneficiaries to a full episode of care without fear of interruption or termination of skilled services. Ultimately, providers should feel empowered to hold MAOs accountable to this new set of rules.

Have you received baseless denials from MA insurers? Partner with the experts at Celtic Consulting to fight managed care denials. Celtic is a post-acute care advisory firm, delivering operational, clinical, and financial support to health care providers. Our team of subject matter experts provide appeals and denials management assistance to clients nationwide. Further, Celtic Consulting specializes in managed care accounts receivable and revenue collections and has helped clients collect millions of dollars of outstanding revenue.

This article was originally published in the Marcum LLP "Trending in Healthcare" newsletter.