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Painful Impact of COVID-19 on the Troubled Skilled-Nursing Industry



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Residents¹ in skilled-nursing facilities (SNFs)² make up more than half of the reported COVID-19 deaths nationwide. A leading health care publication reports that “[m]any nursing homes in the U.S. are fighting against two crises: the pandemic that is sickening and killing residents, as well as the possibility of bankruptcy.”³ Those practicing in and for SNFs reasonably expected failure and death at rates greater than other health care settings because of what the authors deem the “SNFs’ pre-existing conditions.”

The skilled-nursing industry’s pre-existing conditions have multiple causes, the most impactful being the unique financial model found in the SNF industry. First, an SNF can (and often does) have one party that owns the building, another that owns the license to operate and yet another that is hired to be the operator. Second, SNFs are now more than 50 percent for-profit and are heavily dependent on REITs, equity investors and lenders of all sorts.⁴ Third, the industry has failed to adequately prepare for this relentless virus.

These factors have set the stage for both industry-wide restructurings and bankruptcy filings for many facilities and management companies.⁵ Do

not forget that the debtors and/or restructuring clients in question are health care providers, which must yield to (1) lives that are in danger; (2) the conflicts among Bankruptcy Rules, regulations and practices and health care rules, regulations, reimbursements, and even culture; (3) the profound lack of understanding of health care settings, in particular skilled nursing; and (4) a limited tool set to assess, manage and improve health care providers. Equally important, regardless of who employs you and what your role is, SNF work will arrive concurrent with congressional hearings, cited deficiencies by regulators with fines and penalties imposed on facility owners, possible civil and criminal prosecutions, hand-wringing and finger-pointing, and many potential lawsuits.

The SNF Financial Model

An SNF is the nursing home that a friend or family member moved to when that individual’s care and safety demanded supervision and nursing care was not available at home or in the current assisted living facility. This nursing home is also a skilled-nursing provider in that it provides post-acute and/or surgery care that is far more cost- and clinically effective in an SNF setting. Skilled-care residents can also be residents in need of specialty services for psychiatric care, multiple comorbidities, complex and/or long-term treatment for demanding respiratory and renal diseases, wound care, and many other reasons that support stays for an extended period of time.

Most importantly, Medicare, managed-care organizations and other insurance companies regularly pay for skilled care at three to 10 times more than the

1 Avik Royu, “The Most Important Coronavirus Statistic: 42% of U.S. Deaths Are from 0.6% of the Population,” *Forbes* (May 26, 2020), available at forbes.com/sites/theapothecary/2020/05/26/nursing-homes-assisted-living-facilities-0-6-of-the-u-s-population-43-of-u-s-covid-19-deaths; Karen Yourish, K.K. Rebecca Lai, Danielle Ivory & Mitch Smith, “One-Third of All U.S. Coronavirus Deaths Are Nursing Home Residents or Workers,” *N.Y. Times* (May 11, 2020), available at nytimes.com/interactive/2020/05/09/us/coronavirus-cases-nursing-homes-us.html (unless otherwise specified, all links in this article were last visited on July 24, 2020).

2 For California and for some key data nationwide, the *Los Angeles Times* offers a daily reporting of the COVID-19 statistics, available at latimes.com/projects/california-coronavirus-cases-tracking-outbreak/#whoh-has. On June 9, 52 percent of the state’s COVID-19 deaths were in nursing homes.

3 “Nursing Homes on Financial Edge Could Be Wiped Out by Coronavirus Crisis,” *Kaiser Health News* (April 21, 2020), available at khn.org/morning-breakout/nursing-homes-on-financial-edge-could-be-wiped-out-by-coronavirus-crisis.

4 Eleanor Laise, “Private-Equity Takeover of Nursing Homes Has Reduced Quality of Care at Critical Moment, Research Suggests,” *MarketWatch* (March 14, 2020), available at marketwatch.com/story/coronavirus-pandemic-puts-private-equity-ownership-of-nursing-homes-under-microscope-2020-03-14.

5 Matthew Goldstein, Jessica Silver-Greenberg & Robert Gebeloff, “Push for Profits Left Nursing Homes Struggling to Provide Care,” *N.Y. Times* (May 7, 2020), available at nytimes.com/2020/05/07/business/nursing-homes-profits-private-coronavirus.html.

daily (non-skilled) custodial rate. Skilled residents bring 80 percent of any excess cash flow. Thus, a simple-but-accurate theory is that to have profits or excess cash flow, at least 20 percent of the residents must have skilled-care reimbursement.

The COVID-19 Impact on Profits and Care Resources

The COVID-19 pandemic has lessened the number of skilled residents admitted because of hospitals having fewer patients coming to the emergency room and/or being referred to acute care.⁶ Concurrently, hospitals and surgery centers have reduced the number of surgeries through no earlier than late May 2020, and in many communities, the reduced emergency room visits, surgeries and hospital admissions have continued through the publication of this article.

In addition, skilled-resident reimbursement has, for each admission category, a limited number of days as a skilled resident set by the acuity and care needs of the admitted or readmitted resident. When the skilled days are “exhausted,” the skilled resident is then discharged to his/her home or to a lower level of care, or resumes custodial care within the facility. Accordingly, the facility’s reimbursement for that resident drops greatly.

The current reduction in skilled days was mitigated starting in April 2020 with three different tranches of payments to SNFs totaling approximately \$50 billion. Some additional relief is found in regulation “waivers” from CMS that include eliminating requirements for pre-SNF hospital stays and expanding the skilled days’ coverage for COVID-19 residents who had recently or will soon exhaust their skilled days’ benefits.⁷

At this time, the authors believe that facilities will still have the challenge of reduced census and will be reaching the end of the period in which stimulus funds added skilled days to some residents while reducing the impact of the large reduction in skilled admissions and readmissions. Many facilities and multi-facility owners entered the pandemic without cash reserves and with cash flow burdened by large payments to REITS, equity funds and lenders. Therefore, the for-profit SNFs will face the greater challenges of having enough money to pay the bills and to support their investors and landlords.

In addition, for-profit providers have had (and will continue to have) a quality-of-care and safety deficit in comparison to nonprofit providers.⁸ The *New York Times*⁹ and others document that for-profit facilities were half as likely to receive the four- or five-star top ratings issued for consumer comparisons. More damning is that for-profit entities were identified two times more for having a history of serious quality issues and were more likely to be cited for patient abuse.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act saved many from immediate collapse, yet it did not slow the financially and quality challenged facilities’ rapid descent toward restructuring.¹⁰ The potential for a great increase in bankruptcy filings and/or restructuring engagements comes with the reality that many of those seeking professional services bring with them the challenge to both keep buildings open — with an equally pressing demand to improve the debtor’s quality of resident care and safety. Following are reviews of old and new options to engage in the efforts of meeting both quality-of-care and economic viability demands.

What Are Our Current Options for Safety and Improvement?

The most often used choices for regulators, payers and enforcement agencies that have to fix or close bad providers are bankruptcy by the owner, the appointment of chapter 11 trustees in reorganization cases, chief restructuring officers (CROs) in and out of bankruptcy cases, state court receiverships and, in California, skilled nursing receivers and temporary managers. Many of these remedies are limited and will not meet the current challenges.

This article is based on the authors’ belief that the temporary-management program is an effective alternative or supplement to the current strategies. Although rarely employed and neither known nor understood by most in the skilled-nursing and restructuring worlds, a temporary manager (TM) can be an effective tool for troubled SNFs and other health care providers. The TM has many of the powers of trustees and receivers, plus one big advantage: He/she can receive from the state funds from the Health Facilities Citation Penalties Account¹¹ “penalty funds” to provide for payrolls and working-capital shortfalls.¹²

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6 Danielle Brown, “SNF Industry in a ‘Challenging State’ as Occupancy Falls; Medicaid Revenue Up,” *McKnight’s Long-Term Care News* (July 9, 2020), available at mcknights.com/news/snf-industry-in-a-challenging-state-as-occupancy-falls-medicaid-revenue-up.

7 “Long Term Care Facilities (Skilled Nursing Facilities and/or Nursing Facilities): CMS Flexibilities to Fight COVID-19,” Centers for Medicare & Medicaid Services (reported April 29 and updated May 15, 2020), available at cms.gov/files/document/covid-long-term-care-facilities.pdf; “CARES Act Provider Relief Fund: General Information,” HHS, available at hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html (summary of all funding). See also Maggie Flynn, “COVID-19 Waivers from CMS ‘Not a License to Skill’ Every Patient in a Nursing Home,” *Skilled Nursing News* (March 23, 2020), available at skillednursingnews.com/2020/03/covid-19-waivers-from-cms-not-a-license-to-skill-every-patient-in-a-nursing-home; Alex Spanko, “HHS Releases \$4.9B in COVID-19 Relief for Skilled Nursing Facilities,” *Skilled Nursing News* (May 22, 2020), available at skillednursingnews.com/2020/05/hhs-releases-4-9b-in-covid-19-relief-for-skilled-nursing-facilities (each skilled nursing facility in the nation will receive a baseline payment of \$50,000, plus an additional \$2,500).

8 Debbie Zeniper, Joel Jacobs & Shawn Mulcahy, “Nursing Home Companies Accused of Misusing Federal Money Received Hundreds of Millions of Dollars in Pandemic Relief,” *Washington Post* (Aug. 4, 2020), available at [washingtonpost.com/business/2020/08/04/nursing-home-companies-accused-misusing-federal-money-received-hundreds-millions-dollars-pandemic-relief/](https://www.washingtonpost.com/business/2020/08/04/nursing-home-companies-accused-misusing-federal-money-received-hundreds-millions-dollars-pandemic-relief/).

9 See Goldstein, Silver-Greenberg & Gebeloff, *supra*, n.5.

10 Danielle Brown, “Operators Worried It Might Be 18 Months Before Skilled Nursing Occupancy Recovers,” *McKnight’s Long-Term Care News* (July 13, 2020), available at mcknights.com/news/operators-worried-it-might-be-18-months-before-skilled-nursing-occupancy-recovers.

11 Health & Safety Code § 1325.5, § 1417.2.

12 In contrast to receiver and trustee, the TM draws from state penalty funds for payroll and working capital payment, not a loan or advance. The state is limited in its ability to advance to approximately a combined for all facilities \$3 million per appointment, although there is additional funding available in the federal penalties fund or with approval of the state legislature.

Mr. Seelig's firm was appointed on Feb. 4, 2020, as TM under California Health and Safety Code § 1325.5 for Rose Garden Healthcare Facility and Legacy Healthcare Center, skilled nursing facilities licensed by the California Department of Public Health (CDPH).¹³ Both facilities are located in Pasadena, Calif. Rose Garden is licensed for 95 beds and had a census of 75 residents, with an additional 18 of the residents in a sub-acute unit¹⁴ at the time of the TM's appointment.¹⁵

The TM's appointment documents provide a first look at the TM's mandate and the problems faced, including the fact that the "residents of the long-term health-care facility are in immediate danger of death or permanent injury by virtue of the failure of the facility to comply with federal or state requirements applicable to the operation of the facility." The TM had three key mandates, which are similar to what has been seen in receiver, trustee and other interim-management appointments:

1. Stop the evictions, which will lead to transferring all of the residents. The TM brings skills to stabilize and reduce the threat to residents, plus the authority to pay current rent and to make a horrible tenant a stable, short-term tenant.
2. Ensure and maintain sufficient staffing — that is, pay the back and current payrolls, and make sure that the benefits are there and that there was in an early COVID-19 world enough personal protective equipment and other supplies for the employees. Dollars being provided by the state immediately met the costs of two payrolls and some working capital until proper billing and collecting returned about a month later.¹⁶
3. The TM must assess and act immediately to do whatever is necessary to restore staffing, supplies, training, food delivery and equipment, as well as the mundane, such as supplying cable TV to the rooms and games for the activity room — while ensuring that physicians and other caregivers attend to the needs of residents and that liability insurance is paid.

TM Is and Is Not Like a Receiver or Trustee

Given that many work in insolvency and are familiar with "troubled" health care facilities, it is important to understand the authority granted to a TM. Upon the date of appointment, a TM has the following tasks:

1. Management responsibility for all aspects of business operations, yet the TM neither temporarily owns the business nor has any relationship as shareholder or member to the corporate entity. The TM does not have the power to negotiate and then sell the business. The facility license remains, and all other licenses remain with the licensee, therefore the TM must pay or maintain the licenses and

insurance. The TM is not the nursing home administrator (NHA), who stays in place, as do the director of nursing and other key leaders. If the TM fires the NHA, then another licensed NHA must be hired. (In some situations the TM is a licensed NHA, and in those cases, for licensing and liability issues the TM will usually replace the NHA, not assume the role.)

2. Control of all the cash on hand and the cash flow post-appointment, yet the TM does not seize the bank accounts. The TM initiates new bank accounts that must be set up as DBA accounts for the business. The TM "takes title to all revenue coming to the facility" for payroll, supplies, operations and all other necessary expenditures. The licensee must cooperate fully with the TM to disclose accounts and to transmit any funds received into their accounts. Yet unlike a trustee or receiver, the TM cannot seize the licensee's accounts, and there is limited authority for the TM to seize funds that are transferred prior to appointment or to stop a party from sweeping accounts if the licensee does not cooperate with the TM. Given that a significant amount of an SNF's revenues come through electronic funds transfer (EFT) money, the TM has to move quickly and comprehensively to ensure that EFTs are sent to their accounts, a process that can be as short as a few days or, in the case of Medicare third-party payers, three to six months.

3. Unlike a bankruptcy, there is no distinction between pre- and post-petition payables, yet the TM is typically not authorized or otherwise in a position to pay for the vast majority of pre-appointment trade bills. The TM can pay past bills (at most two or three months) for goods and services pre-appointment that benefit the facility (supplies and food on hand, a billing and credentialing company that enables current cash flow, or a current vendor who is integral to the operations such as a consulting specialist or even the hairdresser). The TM can, and in some instances should, pay long-past-due bills such as liability insurance or employee insurance and benefits that must be current to maintain services. In all instances, the TM can negotiate and will often need to enter into COD contracts or agreements. The TM can make capital expenditures, make repairs and employ contractors for repairs, yet any expenditure above an amount set at time of improvement must be approved by CDPH.

4. State funding in support of a severely weakened cash flow. In the Rose Garden and Legacy facilities, the licensee had, in addition to not making two payrolls, failed to pay vendors and make basic repairs. Unpaid vendors included pharmacy, food vendors, supplies for all departments ranging from ventilators and a wide range of bedside equipment, equipment leases and everything necessary from masks and gloves, art supplies, cleaning and painting supplies, and liability and employee insurance. The state advanced \$1 million for the one current payroll to be made and the one missed two weeks prior. (A third payroll paid by a payroll service not reimbursed by the licensee created an additional approximate \$500,000 liability). An additional approximate \$500,000 of state funding was made available because the approximate \$85,000 on hand when the TM

¹³ Barbara Feder Ostrov, "The Gathering Storm: How the State Seized Control of Two Troubled Nursing Homes as Coronavirus Crisis Loomed," *CalMatters* (July 15, 2020), available at calmatters.org/health/coronavirus/2020/07/coronavirus-california-nursing-homes-pasadena (CDPH appointment of TM in "Statement of Deficiencies and Plan of Correction" form).

¹⁴ Subacute patients are residents who do not need acute care, but who are too ill to be cared for in the facility's skilled-nursing rooms. Virtually all patients are ventilator-dependent or require frequent respiratory treatments. While subacute beds are licensed as skilled-nursing beds, they are reimbursed differently and are subject to additional staffing and patient criteria requirements.

¹⁵ For links to all relevant documents and a review of this case, see Ostrov, *supra* n.13.

¹⁶ The TM's 48-hour and 20-day reports detail the zero-cash position at the start of their efforts and the factors that contributed to the dire situation at the start of the TM, as well as the shortage of working capital post-appointment. See Memorandum, available at documentcloud.org/documents/6987370-CDPH-Receiver-Lawsuit-Declaration-of-Scott.html#document/p29/a571414.

assumed control did not meet the demand for current and needed payments to key vendors.

The Need for an Expanded Tool Set

As the authors completed this article in late July 2020, COVID-19 cases were spiking in a significant number of states. There continues to be limited availability of needed testing and tracking, constantly changing rules and regulations, no national leadership and little reason to believe that the disease and the push toward insolvency and restructuring will have slowed.

Going forward, there will be a large number of new and potential skilled-nursing debtors and restructuring clients with extraordinary financial and operating challenges. The authors fear that these challenges cannot be met if those tasked with restructuring can only monitor without enforcement, enforce without mandated quality improvement, and, if the interim manager lacks the resources to rebuild, then maintain quality care and safety. Therefore, it is imperative that additional interventions such as the Temporary Management program bring public funding to the restructuring effort and concurrently create hybrids of the TM and other interim-management programs to ensure resident safety, reduce the likelihood of harm and set the foundation for needed facilities' long-term financial viability. **abi**

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