SNF Valuation: A Trend Reversal?

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This quarter begins a two-part series focused on the long-term care industry. In this first issue, we examine the sweeping changes promulgated by the Balanced Budget Act (BBA) and the implications for valuation of traditional nursing homes. Among the many cost-saving initiatives contained in the BBA, the Health Care Financing Administration (HCFA) targeted nursing homes and hospital-based skilled nursing facilities ("subacute sector" or "SNFs") for changes in reimbursement because of the accelerating growth rate of these expenditures.

In response to the growth rate of SNF spending, Congress included several important changes in the BBA that affect skilled nursing/subacute providers. Most significant is that Medicare reimbursement for post-acute care services will be restructured. Medicare’s new prospective payment system (PPS) will pay facilities an all-inclusive rate that will cover all routine, ancillary and capital-related costs. HCFA estimates that annual expenditures will be reduced by approximately 17 percent on average, totaling nearly $13 billion over the next five years.

The new reimbursement mechanism reflects a fundamental change in the incentive system for SNFs. In the near term, this change and the uncertainty it poses for the sector will likely act to constrain valuations for the average facility and reverse the upward price trend recorded throughout most of the 1990s. PPS will force many companies to shift focus away from large scale development activities back toward operations, relieving pressure on acquisition prices. Longer term, the shift to PPS will result in enhanced operational infrastructures, creating an opportunity for successful operators to increase future profitability and maximize value.

Reimbursement Reform

Medicare reimbursement for post-acute patient care includes services provided in either a freestanding skilled nursing facility or by hospital-based units. Medicare skilled nursing includes basic nursing care, medical/social services and physical, occupational, respiratory and speech therapy. Additionally, Medicare covers pharmaceuticals, laboratory work, radiology procedures, supplies and medical equipment.
Under Medicare’s old cost-based system, SNFs were reimbursed on facility-specific costs for providing services and overhead expenses, subject to a system of caps or "routine cost limits." Few restrictions existed on reimbursement for ancillary services other than that of medical necessity. As long as the provider was able to justify the clinical need for services and keep costs within reasonable limits, all costs were generally reimbursed. As such, no incentive existed for providers to maintain costs or manage utilization of services.

The BBA changes the reimbursement methodology for Medicare to a prospective payment system. PPS is based on resource utilization groups (RUGs) Version 3. RUGs-III is a case mix system that consists of seven patient classifications and 44 different categories. Revenue codes are assigned to each of these categories and paid to the SNF on a per diem basis. Per diem rates are fixed and include all routine, ancillary and capital costs for patient care. As the patient progresses through treatment and moves down the scale of categories, the per diem amount declines accordingly. SNFs are required to complete periodic RUGs-III assessments on patients at certain intervals after admission. Failure to comply will result in reimbursement for patient services at the lowest federal rate category.

Although the BBA provides a three-year transition period, PPS will be a more complicated and management-intensive reimbursement methodology for SNF operators. PPS shifts the risk for the clinical care of the patient to the provider through a fixed payment system. As a consequence, PPS will force operators to monitor the full spectrum of post-acute costs provided to each patient and compare total costs to the per diem reimbursement payment for that patient. PPS will require additional capital for sophisticated information systems, highly trained personnel and a broader array of services to capture operating margin.

**IMPLICATIONS FOR CONSOLIDATION**

In the wake of the BBA’s financial reforms, the subacute sector is likely to enter into a period of significant restructuring, characterized by continued merger and acquisition activity. As the sector transitions from cost-based reimbursement towards PPS payments, operators will begin to shift strategies away from revenue maximization in favor of strategies centered on cost containment and profitability. Providers will attempt to control each component of the post-acute spectrum, from subacute to home care. This control will be achieved through an increasing number of acquisitions, joint ventures or formal affiliation agreements with potential risk-sharing arrangements. As PPS incentives begin to shape the subacute sector, SNFs will increasingly become components of larger regional health care networks offering a full continuum of post-acute patient care. In addition to greater cost control and quality case management, these networks will provide SNF operators the ability to capture a growing number of managed care contracts and increase local market share.

With the onset of PPS, smaller SNF operators will find it increasingly difficult to compete. Under per diem reimbursement, ancillary services will become cost centers rather than profit centers. Multi-facility organizations should be able to leverage these fixed costs more effectively. As a result, companies that combine access to capital, regional scale, information systems and management expertise will be presented with an increasing number of opportunities to acquire smaller “mom and pop” operators. As shown in Chart 2, the pace of consolidation that has taken place during the past several years is likely to persist.

While the trend towards increasing consolidation is expected to continue, the characteristics of future transactions will likely differ. During the past two years, publicly-traded, long-term care chains have consolidated rapidly in so-called “mega-deals.” However, the share prices of many of these companies experienced sharp declines as the result of poorly executed integration plans. Given the mixed success with integrating large acquisitions and the added complexities now associated with Medicare reform, long-term
Standard market benchmarks such as price/bed or price/revenue will become less useful to value nursing homes under PPS.

VALUATION APPROACHES

Nursing homes are specialized-use facilities, designed to conform to health building codes and accommodate certain types of medical equipment as well as patient traffic flow. The nature of these facilities tends to be single-use or limited-use, making conversion to alternative uses highly impractical. Because of this characteristic, the value of a nursing home facility is intrinsically tied to the value of the nursing home business. Unlike many physician practices or dialysis centers, separating the value of the real estate from the value of the business may be misleading. A nursing home facility acquires value only when operated as a business.

However, many nursing home operators use their real property to secure financing or sell their facilities independent of their operating businesses. About 1,500 nursing homes are financed or owned by real estate investment trusts (REITs). The valuation of a nursing home for financing by a REIT is typically performed using an Income Approach. The discounted cash flow (DCF) method is probably the most widely used technique for evaluating the ability of the business to cover future cash obligations. DCF models can capture the uniqueness of a facility's underlying business by separately quantifying operating assumptions and consolidating them into an evaluation of the enterprise. REITs recognize that the value of a facility lies in the ability of the nursing home business to generate cash flow, therefore providing financial returns to shareholders of the REIT.

When a nursing home provider is discussing a possible acquisition with another provider, the scope of price negotiations may also include recent transactions in the market. The Comparable Transaction Approach is based on the theory that recent sales of guideline nursing homes are reasonable indicators of fair market value. An advantage of using this method is that the premiums paid for strategic or control value versus the disadvantages of illiquidity are already impounded in the observed transaction price. In some instances, the DCF method may have difficulty capturing the strategic or control value, if any, of a nursing home as reflected in current market prices paid by willing buyers and sellers for similar facilities.

As shown above in Chart 3, a regression model applied to actual market transactions provides a high degree of predictive accuracy in assessing the value of a nursing home. However, Medicare's new restrictive reimbursement system will require buyers to link valuation of a facility more closely to its expected cash flows rather than relying on the prices of recent guideline transactions. Standard market benchmarks such as price/bed or price/revenue will become less useful to value nursing homes under PPS.

PRICING BENCHMARKS

Chart 4 shows that the price paid for acquisitions of closely-held nursing homes has risen steadily throughout much of the 1990s, increasing from approximately $25,500 per licensed bed in 1990 to more than $42,000 in 1996.
Higher valuations are a result of numerous market influences, including supply and demand, increasing patient acuity levels and a sharp reduction in the cost of capital, among others. These forces have combined to fuel a compounded annual growth rate in prices of 8.8 percent.

After several consecutive years of increases, average transaction prices recorded a decline in 1997. Although the average price paid per bed declined by less than 5 percent, 1997 may be a harbinger of a trend reversal. Fundamentally, per diem payments will generally be lower for the average facility under PPS. Absent strategic considerations, reduced cash flows will negatively affect transaction prices paid for individual facilities. Facility portfolios will also be susceptible to pricing weakness. Under cost-based reimbursement, our research indicates that nursing home portfolios have historically received a valuation premium of approximately 20 percent over prices paid for individual facilities. Portfolio premiums reflect the benefits of consolidating a geographic market in a single transaction. Under PPS, portfolio premiums will potentially decline as multi-facility operators usually own a mixture of picks and pans.

**VALUE DRIVERS**

The transition from cost-based reimbursement to PPS is reshaping the key determinants of value in SNFs. Multi-facility operators that possess one or more of the following strategic characteristics will be well positioned under the PPS environment:

- **Broad Geographic Coverage:** Companies that have established regional clusters of facilities are best positioned to attract contracts with government and managed care payers seeking to consolidate the number of providers. These companies are also more likely to be successful in lowering operating expenses through sharing administrative and operational services across facilities.

- **Continuum of Care:** Multi-facility companies that can provide a broad array of services (i.e. SNF-based care; physical, occupational and speech therapy; ventilator and respiratory care, etc.) are better positioned to leverage fixed costs and capture operating margin.

**Nursing home portfolios have historically received a valuation premium of approximately 20 percent over prices paid for individual facilities.**

- **Information Systems:** Strong clinical information systems will be required to track not only total costs associated with each category of service provided but total costs provided to each patient relative to the per diem received for the RUG classification. Information systems should provide clinical and financial data to help operators standardize patient care to lower costs.

- **Management:** Companies that can build scale through successfully integrating acquisitions will achieve the intended synergy to be cost competitive. This includes not only administrative functions but the successful integration of clinical activities. In addition, the ability to properly manage staff to ensure appropriate staffing levels and minimal employee attrition is critical to the success of long-term care companies.

**OUTLOOK**

With the implementation of a prospective pay system, the long-term care industry is entering into a new and unfamiliar operating environment. The shift from cost-based reimbursement to per diem payments will build pressure to control costs, integrate operations and enhance infrastructure. In response to these industry factors, the subacute sector will continue to consolidate. Future transaction prices, however, will be more closely aligned with a facility’s cash flow characteristics under PPS. This suggests that the decline in average price paid per bed during 1997 will likely persist until operators understand how to control and monitor the full post-acute costs associated with treating a particular diagnosis. Longer term, multi-facility operators that are positioned to succeed in the changing long-term care environment can expect to attract strong buyer interest. Companies that are characterized by regional market concentrations, broad patient service offerings, sophisticated management systems and low cost structures will continue to experience increasing valuations.