
Case study

United States of America

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Abstract

Long-term services and supports (LTSS) refer to a broad range of health and health-related services and other types of assistance that are needed by individuals over an extended period of time. The need for LTSS affects persons of all ages and is generally measured by limitations in an individual's ability to perform daily personal care activities, such as eating or walking, and activities that allow individuals to live independently in the community, including shopping and meal preparation. The probability of needing LTSS increases with age. LTSS vary widely in their intensity and cost depending on the individual's underlying conditions, the severity of his or her disabilities, the setting in which services are provided and the caregiving arrangement.

There are no universal LTSS benefits in the United States, and the current system combines a small private insurance market with means-tested coverage through Medicaid. Medicaid allows for the coverage of LTSS services over a continuum of settings, ranging from institutional care to community-based LTSS. People become eligible because they have low incomes and assets and meet specific thresholds for functional impairment.

Under the Medicaid program, prices are usually set unilaterally at the state level following guidelines established at the national level. The base for payment ranges from a day of stay for nursing facilities to a unit of service for home-based care. Prices vary across and within states and are also based on adjustment factors, such as geographical location, to the base price. Managed LTSS plans play a key role in the delivery of health care to Medicaid enrollees. These plans receive capitated payments per enrollee, including both home- and community-based services and/or institutional-based services. Prices are determined through either administered pricing or competitive bidding.

Despite the strong case for risk pooling, there are few private insurance options covering LTSS available. Private insurance for LTSS remains a niche product covering only a small proportion of total LTSS costs.

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1

What are long-term services and supports and who uses them

Long-term services and supports (LTSS) refer to an extensive range of health and health-related services and other types of assistance needed by individuals who lack the capacity for self-care due to physical, cognitive, or mental conditions or disabilities¹. Most LTSS are not skilled medical care, but rather help with basic personal tasks of activities daily living (ADLs; such as eating, bathing, dressing, etc.) and instrumental ADLs (IADLs; such as housekeeping, managing money, etc.) over an extended period to maintain or improve an optimal level of physical functioning and quality of life among people with disabilities (Favreault 2020).

LTSS are delivered in a variety of settings, some institutional (e.g. intermediate care facilities for people with intellectual and developmental disabilities, nursing homes), and some home- and community-based (e.g. adult day services, assisted living facilities and personal care services at home). As of 2016, there were 4 600 adult day services centres², 12 200 home health agencies, 4 300 hospices, 15 600 nursing homes and 28 900 residential care communities. Home health agencies (80.6%) and residential care communities (81.0%) had the highest percentages of for-profit ownership (Harris-Kojetin et al. 2019). In 2016, there were 811 500 residents living in residential care communities and 1 347 600 residents in nursing homes. In 2015, about 4 456 000 persons received services from home health agencies (Harris-Kojetin et al. 2019).

The need for LTSS affects persons of all ages – children born with disabling conditions, working-age adults with inherited or acquired disabling conditions, and the elderly with chronic conditions or diseases. Although people of all ages may need LTSS, the risk of needing these services increases with age. The majority of long-term care (LTC) services users are aged 65 years and over: 94.6% of hospice patients, 93.4% of residential care residents, 83.5% of nursing home residents, and 81.9% of home health beneficiaries (Harris-Kojetin et al. 2019).

The LTC services delivery system has changed substantially over the last 30 years. Although nursing homes are still a major provider of LTC services, there has been growing use of skilled nursing facilities for short-term post-acute care and rehabilitation. Additionally, people desire to stay in their own homes as well as federal and state policy developments have led to growth in a variety of home- and community-based alternatives. The major sectors of paid LTC services providers now also include adult day services centres, assisted living and

1 Experts disagree on whether Medicare expenditure for skilled nursing facilities and home health agencies – since they are post-acute services – should be categorised as LTSS. This report – consistent with the approach used by the U.S. Congressional Budget Office – includes them as part of LTSS.

2 Adult day health centers provide social and other related support services in a community-based setting for part of the day.

similar residential care communities, home health agencies and hospices (Harris-Kojetin et al. 2019).

2

How much do LTSS cost

LTSS vary widely in their intensity and cost depending on the individual's underlying conditions, the severity of his or her disabilities, the setting in which services are provided and the caregiving arrangement (i.e. informal versus formal care). For those receiving LTSS at home, the cost for these services can vary depending on the amount and duration of the care provided. According to a survey³ on the amount of paid LTSS received by adults living at home, the median cost of homemaker services (e.g. meal preparation, housework) was US\$ 21 an hour, whereas the median cost of care provided by a home health aide (e.g., hands-on assistance with personal care needs) was US\$ 22 an hour in 2018. Adult day health centres had a median cost of US\$ 72 per day in 2018. Residential settings that provide housing and services as well as institutional settings that provide room and board tend to have higher annual costs than home care services, on average. Assisted living facilities that provide homemaker services (meals, laundry, or housework) and may provide personal care for those who need assistance with ADLs (but do not yet require constant care provided in a nursing home) had a median daily cost of US\$ 123 in 2018. Nursing home care, on the other hand, generally costs more, because it provides assistance 24 hours a day and includes the cost of room and board. In 2018, the median daily cost of nursing home care was about US\$ 245 for a semi-private room and US\$ 275 for a private room. These estimates are national figures and can vary widely by state (Table 1).

3 CareScout – a Genworth company – completed over 15 000 surveys of nursing homes, assisted living facilities, adult day facilities and home care providers. Survey respondents were contacted by phone between May and June 2018 (<https://pro.genworth.com/riiproweb/productinfo/pdf/131168.pdf>).

Table 1

Mean price and variation across state by type of service, 2018.

Type of service	Median hourly price (in US\$)	Median daily price (in US\$)	Lowest price in US\$ (State)	Highest price in US\$ (State)
Nursing home (private room)		275	174 (Oklahoma)	452 (Connecticut)
Nursing home (semi-private room)		245	153 (Oklahoma)	415 (Connecticut)
Assisted living facility		132	94 (Missouri)	305 (District of Columbia)
Home health aide	22		16 (Louisiana)	28 (Washington)
Homemaker services	21		16 (Louisiana)	28 (Washington)
Adult day services		72	35 (Alabama, Mississippi, Texas)	136 (Vermont)

Source: compiled by the Author on the basis of the Genworth Cost of Care Survey (<https://www.genworth.com/aging-and-you/finances/cost-of-care.html>).

The cost of obtaining paid assistance for these services, especially over a long period, may far exceed many individuals' financial resources. Moreover, public programs that finance this care, such as Medicaid or Medicare, may not cover all the services and supports an individual may need. Large personal financial liabilities associated with paid LTSS may leave individuals in need of LTSS and their families at financial risk. Among older adults with significant disabilities, only 40% could fund at least two years of extensive home care if they liquidated all their assets (Johnson and Wang 2019).

3 Who pays for LTSS

Spending on LTSS is a significant component of total personal health care spending. In 2016, an estimated US\$ 366.0 billion was spent on LTSS⁴, representing 12.9% of the US\$ 2.8 trillion spent on personal health expenditures (Collelo 2018). LTSS are financed by a variety of public and private sources. In 2016, public sources paid for the majority of LTSS spending (70.3%). Medicaid and Medicare were, respectively, the first- and second-largest public payers, and accounted for nearly two-thirds (64%) of all LTSS spending. Other public programs – such as the Veterans Health Administration and Children’s Health Insurance Program – that finance LTSS for specific populations account for a much smaller share of total LTSS funding (6.3%). It is important to note that the eligibility requirements and benefits provided by these public programs vary widely. Moreover, among the various public sources of LTSS financing, none are designed to cover the full range of services and supports that may be desired by individuals with LTC needs.

In the absence of public funding for LTSS, individuals must rely on private sources of funding. In 2016, private sources accounted for 29.7% of LTSS expenditures. Within the category of funding, out-of-pocket spending was the largest component (over half of private sources), comprising 15.7% of total LTSS expenditures. Second was private insurance (7.5%), which includes both health insurance and LTC insurance (LTCI). Other private funding, which largely includes philanthropic contributions, accounted for 6.5% of total LTSS.

4 A substantial amount of LTSS is also provided by family members, friends and other uncompensated caregivers. Thus, formally reported spending on LTSS underestimates total expenditures, as spending data do not include uncompensated care provided by these caregivers.

4 Medicaid

Medicaid is a means-tested health and LTSS program funded jointly by federal and state governments. Medicaid funds are used to pay for a variety of health care services and LTSS, including nursing facility care, home health, personal care and other home and community-based services. Each state designs and administers its own program within broad federal guidelines. Medicaid is the largest single payer of LTSS in the United States (Thach and Wiener 2018); in 2016, total Medicaid LTSS spending (combined federal and state) was US\$ 154.4 billion, which accounted for 42.2% of all LTSS expenditures. In 2016, LTSS accounted for 30.6% of all Medicaid spending.

Medicaid beneficiaries who use LTSS are a diverse group of people, extending from young to elderly, with many different types of physical and cognitive disabilities. About half of Medicaid beneficiaries receiving LTSS are adults age 65 and older (MACPAC 2014). Given beneficiary preferences to age at home or in a home-like setting, Medicaid spending for these beneficiaries increasingly is for home and community-based services (HCBS). With HCBS, a beneficiary may receive a few hours of personal care services each day for assistance with bathing, dressing and preparing meals. Such services usually supplement support from informal caregivers such as family members and neighbours.

Despite increasing use of home and community-based services, the organization, financing, and delivery of Medicaid-funded LTC services remains biased towards institutional care. Recognizing the challenges, the Affordable Care Act contains a number of provisions to help states balance their Medicaid long-term service delivery systems by expanding access to an array of home and community-based services and reducing dependence on institutional care, including:

- a new State Balancing Incentive Payments Program to encourage states to increase Medicaid LTSS in the home and community
- state plan options for HCBS including Community First Choice
- increased funding for rebalancing initiatives like “Money Follows the Person” (MFP)

The goal of the Medicaid balancing initiatives is to create a person-driven, long-term support system that offers people with disabilities and chronic conditions choice, control and access to services that help them achieve independence, good health and quality of life. A balanced system is (as seen at: <https://www.medicaid.gov/medicaid/long-term-services-supports/balancing-long-term-services-supports/index.html>):

- person-driven: the system gives people choice over where and with whom they live, control over the services they get

and who they get services from, the chance to work and earn money, the option to include friends and supports to help them participate in community life;

- inclusive: the system encourages people to live where they want to live, with access to a full array of community services and supports;
- effective and accountable: the system offers high quality services that improve quality of life. Accountability and responsibility are shared between public and private partners and includes personal accountability and planning for LTC needs, including greater use of private funding sources;
- sustainable and efficient: the system efficiently coordinates and manages a package of paid services appropriate for the beneficiary, paid for by the right entity;
- coordinated and transparent: the system coordinates services from various funding streams to provide a seamless package of supports and uses health information technology to effectively provide transparent information to consumers, providers and payers; and
- culturally competent: the system provides user-friendly, accessible information and services.

The goals of the MFP program are:

- increase the use of HCBS and reduce the use of institutionally-based services;
- eliminate barriers in state law, state Medicaid plans and state budgets that restrict the use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary LTSS in the settings of their choice;;
- strengthen the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions; and
- put procedures in place to provide quality assurance and improve HCBS

Medicaid policies to determine eligibility for LTSS focus on finances (income and assets) and measures of functional status, rather than the existence of a specific clinical condition. In other words, people become eligible because they have low incomes and assets and meet specific thresholds for functional impairment.

In general, states are required to provide Medicaid to individuals receiving Supplemental Security Income (SSI) benefits. In 42 states and the District of Columbia, individuals eligible for SSI are automatically eligible for full Medicaid benefits, including LTSS offered under the state plan, if they meet specific functional eligibility criteria. Some states establish more restrictive criteria for LTSS benefits – either income and resource thresholds or functional eligibility criteria – than SSI.

The federal government does not require states to use a particular assessment tool to determine eligibility or to develop a care plan. Almost all states use at least one tool that they developed themselves, and a recent review shows that there are at least 124 tools currently in use and, on average, states are using three different tools each for different populations (MACPAC 2016). Virtually all states assess functional limitations, clinical needs or health status, and behaviour and cognitive status.

States can also use one or more optional pathways designated in federal laws and regulations to provide eligibility to people with a need for LTSS. These include:

- Poverty-related pathway: this is an optional pathway allowing the state to cover individuals with incomes up to 100% of the federal poverty level (FPL) who have disabilities or are over age 65. This pathway and the Medicaid buy-in and medically needy eligibility pathways (see below) also use the SSI age and disability eligibility criteria. These enrollees are entitled to full Medicaid benefits including state plan LTSS if the individual meets the state's Level-of-care (LOC)⁵ or targeting criteria. The level of income and resources that qualify an individual for the poverty-related pathway varies by state.
- Medically needy pathway: this pathway allows states to cover individuals with high medical expenses relative to their income once they have spent down to a state's medically needy income level. The income threshold and the budget period used in medically needy eligibility determinations are state specific. States may offer full Medicaid or a more limited set of state-specified benefits to this group. They may also provide institutional LTSS and home and community-based services waiver benefits to those meeting LOC criteria.
- Special income-level pathway: under this pathway, states may cover individuals who meet LOC criteria for certain institutions and have incomes up to 300% of the SSI benefit rate (which is about 222% FPL). Functional eligibility for this pathway is determined using the state-established LOC criteria that typically require enrollees to need institutional-level services and supports. In 2018, 42 states and the District of Columbia had a special income level eligibility pathway. Most states with a special income level eligibility pathway set the income level at 222% of the federal poverty level (MACPAC 2018a).

States also have policies that allow LTSS users to protect portions of their income or resources and still qualify for Medicaid-covered LTSS. These include:

- Personal allowances: states must establish monthly levels of income that an LTSS user may retain to cover the cost of

5 A level of care determination is a decision made about an individual's physical, mental, social, and/or emotional status.

certain personal expenses after fulfilling any cost-sharing requirements. Enrolees using either institutional or HCBS LTSS may retain a monthly allowance to pay for goods and services not provided by the facility or covered by Medicaid (e.g. clothing or room and board costs of HCBS users).

- Income disregards: Medicaid law allows states to adopt rules that would prevent the impoverishment of a spouse of a Medicaid beneficiary receiving LTSS. Additionally, the law exempts a community-residing spouse's income for the purposes of Medicaid eligibility and allows the institutionalized spouse to transfer income to a limited-income community spouse, up to a state-determined maximum level (<https://www.medicaid.gov/medicaid/eligibility/spousal-impoverishment/index.html>).

Federal law also allows for the establishment of certain trusts⁶ that may not be counted for the purposes of determining Medicaid eligibility, thereby allowing individuals with higher incomes or resources to qualify for Medicaid LTSS. Pooled income trusts are run by non-profit associations on the behalf of individual beneficiaries.

Beneficiaries receiving LTC services in an institution or in the community qualifying through certain eligibility groups are required to apply their income exceeding specified amounts toward the cost of their care. Within federal guidelines, a beneficiary may retain a certain amount of income for personal use based on the services one receives (Colello 2017).

A description of the system used by Medicaid to pay for services provided in nursing facilities, at home and in the community, in residential care settings as well as through managed care programs is reported below.

4.1 Nursing facilities

Nursing facilities are institutions certified by a state to offer 24-hour medical and skilled nursing care, rehabilitation or health-related services to individuals who do not require hospital care. Nursing facility services are mandatory benefits that must be covered by all state Medicaid programs.

Medicaid is the primary payer of nursing facility services. Nationally, Medicaid covers over 60% of nursing facility residents (Harris-Kojetin et al. 2019). In fiscal year 2017, Medicaid spending on institutional LTSS was approximately US\$ 58 billion, or about 10% of total program benefit spending (MACPAC 2018a).

States have broad flexibility to determine payments to nursing facilities. Federal rules do not prescribe how nursing facilities should be paid or how much they should be paid, but require that Medicaid payment policies should promote efficiency,

⁶ Examples are Miller Trusts (also known as Qualified Income Trusts), which are used in some states that offer the special income level eligibility pathway and do not have a medically needy spend-down provision, and "Type A" special needs trusts, which are established on behalf of an individual with a disability under the age of 65 in some states.

economy, quality, access and safeguard against unnecessary utilization. Under fee-for-service (FFS) payment arrangements, state Medicaid programs typically set and pay nursing facilities a daily rate, called a per diem. States often apply a variety of adjustments and incentives to the base payment, and there is considerable variation in rates both within and across states. Nursing facility FFS payment policies differ on many dimensions, such as the inflation adjustments used in rate settings, how many days Medicaid pays for “bed holds” due to hospitalization or therapeutic leave and adjustments made based on resident acuity levels (MACPAC 2014).

As an example, in Illinois the reimbursement rates are facility specific. Individual rates are set for each nursing facility, taking into account individual facility costs, variations in patient case mix, geographical location and other facility characteristics such as occupancy level. These rates vary between US\$ 98 and US\$ 257 per day (<https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/LTC.aspx>). The reimbursement rate has three components: nursing and direct care component; support service component; and capital component. In the state of New York, the per diem reimbursement rates are facility specific too and vary between US\$ 131 in a nursing home in Yates county and US\$ 603 at the Henry J Cartes Skilled Nursing Facility in New York City (https://www.health.ny.gov/facilities/long_term_care/reimbursement/nhr/). A large variation in per day rates – ranging from US\$164 to US\$ 308 – is also reported for Florida (https://ahca.myflorida.com/medicaid/cost_reim/nh_rates.shtml).

The quality of care provided in nursing facilities has been an ongoing issue of concern to policy makers. The U.S. Department of Health and Human Services Office of Inspector General and the U.S. Government Accountability Office have called attention to nursing home quality deficiencies and identified opportunities for improvement in patient care, information shared with consumers, and federal oversight (United States Government Accountability Office, 2015; OIG 2018). Among the programs the Centers for Medicare and Medicaid Services (CMS) uses to address nursing facility quality concerns and share information with consumers are the following:

- Special Focus Facility Initiative, which requires corrective actions for nursing facilities with a history of serious quality issues (<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/SFFList.pdf>);
- Five-Star Quality Rating System, which uses nursing facility inspections, staffing data, and quality measures to assign ratings to nursing facilities (<https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcompliance/fsqrs.html>); and
- Nursing Home Compare website, which shares information including the ratings system results to consumers to aid in

their selection of a nursing facility (<https://www.medicare.gov/nursinghomecompare/search.html>).

4.2 Home and community-based services

Home and community-based services (HCBS) allow people with significant physical and cognitive limitations to live in their home or a home-like setting and remain integrated with the community. HCBS are optional benefits, and states vary considerably in how they organize their HCBS programs. Some states provide certain HCBS in the state plan, which requires that those services be made available to all eligible beneficiaries (although states may include LOC criteria). States may also use waiver authorities to limit the number of beneficiaries receiving services, target specific populations, or limit availability to certain parts of the state. States may also use Section 1115 research and demonstration waivers to provide HCBS or use some combination of state plan and waiver options.

The term HCBS encompasses a wide range of services including personal care services provided in a home or residential care setting, supported employment, non-medical transportation and home-delivered meals. States may not cover the same types of HCBS, or they may cover similar services using different service terms and payment methodologies. As a result, Medicaid spending on beneficiaries using HCBS varies widely, particularly for beneficiaries with the greatest LTSS needs (MACPAC 2018c).

Medicaid beneficiaries increasingly are receiving LTSS through HCBS. In fiscal year (FY) 2016, Medicaid programs spent approximately US\$ 94 billion on HCBS, which represented a 10% increase in HCBS spending over FY 2015 (Eiken et al. 2018). Nearly one in three HCBS users were 65 years old or more (MACPAC 2018c).

As HCBS grows as the predominant way of delivering LTSS to Medicaid beneficiaries, HCBS policy continues to evolve. Current developments in HCBS include the following:

- States are implementing new requirements that HCBS settings must meet to be eligible for Medicaid payment. These requirements are meant to ensure that beneficiaries receiving HCBS have adequate choices, their rights are protected, and HCBS is truly integrated into the community.
- States are also implementing electronic visit verification (EVV) for personal care services. These commonly are web-based applications that enable personal care services providers to verify their visits to beneficiaries' residences. EVV helps Medicaid programs ensure that authorized personal care services are delivered to prevent disruptions in beneficiaries' care and protect the Medicaid program against fraud.

- A number of efforts are underway to develop and test quality measures for HCBS to aid policymakers in the oversight of LTSS programs. These efforts, which span both Medicaid FFS and managed LTSS programs, place emphasis on beneficiary experiences and outcomes.

Under FFS payment arrangements for home health services, state Medicaid programs typically pay home health agencies a price per visit. States often apply a variety of adjustments, and there is considerable variation in prices both within and across states. As an example, in Washington State, the fee is set by county and includes a price for brief skilled nursing visit (US\$ 29), a price for a session of 15 minutes of physical therapy (between US\$ 20-23), a price for a session of speech therapy (between US\$ 87-101), a price for a session of 15 minutes of occupational therapy (between US\$ 21-25) and a price for a home health aide visit (between US\$ 53-59) (see <https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules>). In Illinois, the different types of visit – physical, speech and occupational therapy and home health aide – have the same price (US\$ 72) (see <https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/HHFeeSchedule.aspx>). In Florida, a registered nurse visit is paid US\$ 31, a licenced practical nurse visit US\$ 26 and a home health aide visit US\$ 17 (see https://ahca.myflorida.com/medicaid/review/fee_schedules.shtml). A home health aide visit, a speech therapy session by a licenced therapist and a physical therapy evaluation are paid US\$ 46, 107 and 116, respectively, in Texas (see <http://public.tmhp.com/FeeSchedules/StaticFeeSchedule/FeeSchedules.aspx>). In Colorado, a visit (up to 2 and half hours) of a registered nurse is paid US\$ 112, and a home health aide visit lasting less than one hour is paid US\$ 38 (see <https://www.colorado.gov/pacific/hcpf/provider-rates-fee-schedule>). In Mississippi, prices are provider-specific and set for four different type of services: skilled nursing care (ranging from US\$ 80 to US\$ 116); physical therapy (ranging from US\$ 65 to US\$ 68); speech therapy (ranging from US\$ 65 to US\$ 68) and home help aide (ranging from US\$ 35 to US\$ 49) (see <https://medicaid.ms.gov/wp-content/uploads/2019/10/FY2020HomeHealthRates.pdf>).

4.3 Residential care settings

Residential care settings (RCS) are a diverse set of community-based settings for individuals who are unable to live independently due to functional or cognitive limitations. RCS include homes, where a few beneficiaries reside with a provider or paid caregiver, and larger group settings, where a beneficiary may live in his or her own apartment. RCS vary in the types of services they provide and the degree of impairment of the populations they serve. Personal care services, such as assistance with ADL and IADL, are commonly offered in RCS (Carder, O’Keeffe and O’Keeffe 2015). Some RCS include dementia care units, which provide specialized services to

individuals with Alzheimer's disease or other forms of dementia. Primarily state laws regulate RCS.

The Medicaid rate-setting methodology for RCS varies by state. The methods used to set prices for services delivered in RCS are the following (the number of states that use each method is reported within brackets) (see <https://www.macpac.gov/subtopic/table-3-medicare-rate-setting-methods-for-services-delivered-in-residential-care-settings-by-state-2016/>):

- Flat rates (18): the facility receives the same payment regardless of its individual facility costs and regardless of the type and amount of services actually provided. These rates may vary by factors such as urban/rural location or single/multiple occupancy unit.
- Tiered (16): the reimbursement system is based on state-defined levels of care for the facility level or at the individual level. At the individual level, individuals are assigned to a tier based on their assessment or needs, and there is a payment level associated with each category. At the facility level, the entire facility is slotted into a tier, which could be by licensure category that varies by the level of service they provide or the disability level of the residents that they serve.
- Case mix (6): reimbursement rates vary by the case mix of the facilities or individuals. Case mix only applies when there are no tiers or categories and the payment rate is determined along a continuum based on the individual's assessment. Providers are paid based on the number of hours and level of assistance needed by the resident. The case-mix adjusted rate for a facility is calculated by averaging the assessment levels for all residents and multiplying that index by the standard rate set by the state.
- Cost based (7): the reimbursement rate of each facility varies with the costs of each facility.
- FFS (10): payment is made for each separate service provided. Payment amounts are determined by the number of units of specific types of services used by a Medicaid beneficiary, which are identified from the resident's service plan.
- Negotiated (14): reimbursement rates are not fixed, but are the result of deliberations between stakeholders (e.g., individual residents, providers, the state, or a managed care organization).

Table 2 shows the details of the rate-setting methodology for services delivered in RCS for selected states. Details of the rate-setting methods clearly show significant variations in the process of price setting, the payment unit and the adjustment factors to the base payment.

Table 2.
Rate-setting methodology for residential care services,
selected states

State	Rate-setting methodology	Details
Alaska	Flat or cost-based	Providers are reimbursed at the lesser of billed charges or a unit rate based on an established fee schedule. The fee schedule is revised at least every four years based on provider-reported costs. The unit rate varies by facility type (government-owned versus non-government-owned), size of facility (5 or fewer beds, 6–16 beds, 17 or more beds) and geographic region. Providers receive an acuity add-on payment for residents who require one-to-one staffing care 24 hours per day.
California	Tiered	The reimbursement system has five service levels for residential care facilities for the elderly (RCFEs). Daily rates range from US\$ 52 per day for tier US\$ 1 to US\$ 200 per day for tier 5. RCFEs cannot negotiate the services to be delivered or the payment rate. The reimbursement rate for tier 5 is based on the state-wide weighted average skilled nursing facility daily rate.
Connecticut	Case mix	Providers receive a base rate plus additional amounts based on the individual participant's assessed cognitive, functional and behavioural needs.
Florida	Managed Care Organisation (MCO)-negotiated	Rates are negotiated between MCOs and providers. The MCOs have the flexibility to determine their payment models.
Illinois	Flat	A flat daily rate is paid. While the rate does not vary by type or frequency of service, it does vary by geographic location. Rates are calculated at 60% of the average weighted nursing facility rate in a specific geographic area. The dementia program rates are 72% of the average weighted dementia care nursing facility rate in a geographic area.
Iowa	Cost-based	Fee schedules for the various services are determined by the Department with advice and consultation from appropriate professional groups. Providers are reimbursed the lower of their actual charges or the maximum allowance under the fee schedule for the service. Fee schedules may be increased or decreased by the Iowa legislature through its Medicaid appropriations.
Nevada	Tiered	For the frail elderly waiver program, the state uses a tiered rate system based on three levels of care for each individual that ranges from minimal assistance with an ADL to maximum assistance with four or more ADLs.
New York	Tiered	Providers are paid rates based on 16 classification groups. The rate is related to an average residential health care facility rate consisting of a direct component and an other-than-direct component. The direct component of the rate for each classification group is determined by a state-wide mean direct case mix neutral cost multiplied by a case mix index for the classification group; this amount is divided by a regional direct input price adjustment factor for the patient classification group and trended by the applicable weighted average regional roll factor.
Oregon	Tiered negotiated	The state has five rate levels for assisted living facilities. The level is based on residents' assessed needs, including the need for assistance with ADLs. Rates for adult foster home providers are collectively bargained through the Department of Administrative Services on behalf of the Department of Human Services with the Service Employees International Union. These rates are set based on a bargaining agreement at two-year intervals. The collective bargaining process is a public process.

State	Rate-setting methodology	Details
Washington	Tiered	Tiered rates are determined by assessing beneficiaries with the Comprehensive Assessment Reporting Evaluation (CARE) tool. Seventeen levels of care classifications determine rates. Reimbursement rates are also determined by the location of the facility. Facilities in King County or other counties determined to be Metropolitan or Non-Metropolitan receive different rates. Facilities that retain a Medicaid occupancy percentage of sixty percent or higher also receive a higher rate.

Source: compiled by the Author on the basis of MACPAC "Medicaid Rate-Setting Methods for Services Delivered in Residential Care Settings by State, 2016" (<https://www.macpac.gov/subtopic/table-3-medicaid-rate-setting-methods-for-services-delivered-in-residential-care-settings-by-state-2016/>).

4.4 Managed care

States design and administer their own Medicaid programs within federal rules and determine how they will deliver and pay for care for Medicaid beneficiaries. Nearly all states have some form of managed care in place – comprehensive risk-based managed care and/or primary care case management programs. As of July 2019, 40 states contract with comprehensive, risk-based managed care plans to provide care to at least some of their Medicaid beneficiaries (Hinton et al. 2019). State Medicaid programs increasingly use managed care as one of several strategies to improve care coordination and manage costs for populations with complex health care needs and disproportionately high Medicaid expenditures. The theory behind this shift is that managed care plans can do things that state Medicaid agencies cannot, such as use sophisticated network contracting, information technology and utilization management systems to (try to) squeeze out low-value care and improve the health of beneficiaries (Goldsmith, Mosley and Jacobs 2018). In addition, importantly, contracting with managed care organisations shifts responsibility for politically troublesome negotiations over provider payment to private enterprises.

Managed long-term services and supports (MLTSS) refers to an arrangement between state Medicaid programs and managed care plans through which the managed care plans receive capitated payments for LTSS, including both home- and community-based services and/or institutional-based services. In fully integrated models, these payments for MLTSS are combined with payments for primary, acute and behavioural health services, and the capitation payment is comprehensive. As of June 2019, 24 states operate MLTSS programs, in which state Medicaid agencies contract with managed care plans to deliver LTSS, up from just eight states in 2004 (MACPAC 2018b).

The administration of MLTSS is generally similar to Medicaid managed care, but the mix of services and the wide range of needs of beneficiaries who receive LTSS adds complexity, particularly for rate setting and care coordination⁷. Factors involved in setting monthly capitation rates per beneficiary include the range of services provided, the wide variability in the needs of beneficiaries receiving LTSS and the need to promote program goals through financial incentives. By law, states must develop and get CMS approval of rates that are actuarially sound. Actuarially sound rates are projected as providing for all reasonable, appropriate and attainable costs required of the managed care plan to fulfil the terms of its contract with the state. These rates must be developed in accordance with requirements for CMS's review and approval of rates (United States Government Accountability Office 2017):

- Baseline data and carve outs: to project costs, states rely on various data, such as data on demographic, health and functional factors; the setting of care; and the scope of benefits. The sources and extent of these data, referred to as base data, vary by state. States require managed care plans to provide encounter data, and states may also use financial data from the managed care plan and claims data from the Medicaid FFS population. Plans cannot arbitrarily raise provider contracts or other costs; costs reflected in the rate setting must be reasonable and are judged against industry standards.
- Expected trends and incentives: states and their actuaries project costs and set rates based on these data with adjustments and assumptions to account for missing, incomplete, or anomalous data, the extent to which covered populations and services are reflected in the data, changes in benefits and policies and trends in utilization and prices of services.
- Certification: when setting or amending rates, states must submit an actuarial rate certification that explains how the rates were developed. CMS expects the rate certification to provide sufficient detail, documentation, and transparency to enable another actuary to assess the reasonableness of the methodology and the assumptions. CMS reviews the rate certification for compliance with agency requirements, including the rate guide for that year. CMS may ask questions of the state until CMS can assess that the data, assumptions and rate development were reasonable and meet generally accepted actuarial principles and practices, at which point CMS approves the rates for the state to pay to the managed care plans.

⁷ MLTSS plans typically employ care coordinators who assess beneficiaries' needs and develop plans of care for the wide range of LTSS for which they qualify.

States typically pay for risk-based managed care services through fixed periodic (usually monthly) payments for a defined package of benefits. These payments are typically made on a per member per month basis. Plans then typically negotiate with providers to deliver services to their enrollees, either on a FFS basis, or through arrangements under which they pay providers (e.g. primary care providers) a fixed periodic amount to deliver services.

The approaches that states use for determining capitation payments to managed care plans depend on the methods that they use to contract with these plans. In general, the following approaches are used to establish rates (MACPAC 2011):

- Administered pricing: capitation payments are determined by the state; plans determine whether they wish to apply for participation in the program.
- Competitive bidding: states typically issue a request for proposals and then select managed care plans based on an evaluation of their proposed rates and services.

Administered pricing allows states to set rates at the lower end of an actuarially sound range, rather than having to accept a competitive bid potentially at the higher end of the range. States may use administered pricing, for example, when faced with budgetary limitations. States may also use hybrid approaches, such as setting a range of rates and then asking plans to bid competitively within that range, or negotiating with plans based on the administered pricing or their competitive bids.

As an example, the capitation rates set by Medicaid for LTC services to elderly and disabled in Arizona, and the lower bound, mid-point and upper bound of the capitation rate used for competitive bidding by Medicaid in California are reported in tables 3 and 4 below.

Table 3
Medicaid managed care plans capitation rates, Arizona,
January-September 2020.

Beneficiary	Contractor	Geographical service area	Annual capitation rate (in US\$)
Dual	United Healthcare	North	3125
Dual	Banner-UFC	South	3685
Dual	Mercy Care	South	3438
Dual	United Healthcare	Central	3020
Dual	Banner-UFC	Central	3889
Dual	Mercy Care	Central	3812
Non-dual	United Healthcare	North	6525
Non-dual	Banner-UFC	South	6514
Non-dual	Mercy Care	South	7211
Non-dual	United Healthcare	Central	7112
Non-dual	Banner-UFC	Central	7875
Non-dual	Mercy Care	Central	7855

Note: Dual: refers to a beneficiary enrolled in both Medicare and Medicaid programs

Source: compilation by the Author on the basis of Arizona Health Care Cost Containment System Contractor Capitation Rates (<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ManagedCare/capitationrates.html>).

Table 4
Medicaid managed care plans capitation rates, selected counties, California, FY 2017-18

County	Health Plan	Category of beneficiary	Monthly capitation rate (in US\$)		
			Lower Bound	Midpoint	Upper Bound
Fresno	Anthem Blue Cross	Adult	227.3	234.8	242.6
Fresno	Anthem Blue Cross	Seniors and Persons with Disabilities (SPD)	752.7	774.5	797.3
Fresno	Anthem Blue Cross	SPD/Dual	155.4	160.6	166.1
Fresno	CalViva Health	Adult	243.3	251.4	259.8
Fresno	CalViva Health	SPD	862.3	887.3	913.3
Fresno	CalViva Health	SPD/Dual	181.9	187.9	194.2
San Francisco	Anthem Blue Cross	Adult	248.8	257.6	266.9
San Francisco	Anthem Blue Cross	SPD	844.6	869.7	895.8
San Francisco	Anthem Blue Cross	SPD/Dual	460.6	474.2	488.5
San Francisco	San Francisco Health Plan	Adult	243.3	251.7	260.5
San Francisco	San Francisco Health Plan	SPD	755.6	777.9	801.2
San Francisco	San Francisco Health Plan	SPD/Dual	185.7	192.1	198.8

Note: Dual: refers to a beneficiary enrolled in both Medicare and Medicaid programs

Source: compiled by the Author on the basis of California Department of Health Care Services Medi-Cal Managed Care Capitation Rates (<https://data.chhs.ca.gov/dataset/medi-cal-managed-care-capitation-rates-geographic-managed-care-gmc>).

5 Medicare

Medicare is a federal program that pays for covered health services for the elderly and for certain non-elderly individuals with disabilities. Unlike Medicaid, Medicare is not intended to be a primary funding source for LTSS. Medicare covers primarily acute and post-acute care, including skilled nursing and home health services. These post-acute Medicare benefits provide limited access to personal care services both in the home care setting and in skilled nursing facilities (SNFs) for certain beneficiaries. While Medicaid nursing and home health benefits are available to eligible beneficiaries as long as they qualify, Medicare benefits are generally limited in duration. In addition, Medicare SNF and home health benefits include coverage of rehabilitation services that will, presumably, prevent a decline in the beneficiary's physical condition or functional status.

A description of the system used by Medicare to pay for services provided in skilled nursing facilities and at home as well as a description of the Medicare Advantage program is reported below.

5.1 Skilled Nursing Facilities

Medicare provides coverage for short-term stays in SNFs for specialized nursing care and rehabilitation work after spending time in the hospital. If an individual qualifies for short-term Medicare coverage in a skilled nursing facility, Medicare pays 100% of the cost (room, meals, nursing care) for the first 20 days. For days 21 through 100, a daily co-pay of US\$ 164.5 (in 2017) is to be paid, whereas if a stay is longer than 100 days, the individual is responsible for the full cost, unless she/he has additional insurance (such as Medigap⁸) that covers it.

In 2017, Medicare spent US\$ 28.7 billion to provide care to beneficiaries in 15 277 facilities (of which 71% for profit and 73% located in urban areas) (Medicare Payment Advisory Commission 2019c).

Beginning on 1 October 2019, Medicare daily payments to SNFs are unilaterally determined by CMS by summing payment rates for six components of care—nursing, physical therapy (PT), occupational therapy (OT), speech-language pathology services, nontherapy ancillary services and supplies (NTA) and non-case mix (room and board services). For each component of care, the base payment is adjusted for geographic differences in labour costs by multiplying the labour-related portion of the daily rate – 70.9% for FY 2020 – by the hospital wage index in the SNF's location; the result is added to the nonlabour portion. The wage-adjusted base rates for five of the components are adjusted for case mix, with each component having its own set of factors. In addition, payments for three

8 A Medicare Supplement Insurance (Medigap) policy helps pay some of the health care costs that Medicare doesn't cover, like co-payments, coinsurance and deductibles. Medigap policies are sold by private companies.

components (PT, OT and NTA) are adjusted for the day of the stay, with higher payments for care furnished during earlier days in a stay. Payments for NTA services during first three days are three times those for NTA services during later days. Payments for PT and OT services are the same for the first 20 days of a stay and slowly decrease for later days.

Medicare daily rates for SNF for FY 2020 are shown in Table 5.

Table 5
Medicare rates for Skilled Nursing Facilities, 2020.

Location	Per diem rate (in US\$)					
	Nursing	Physical therapy	Occupational therapy	Speech-language pathology services	Nontherapy ancillary services	Non-case mix
Urban	105.9	60.7	56.5	22.6	79.9	94.8
Rural	101.2	69.2	63.6	28.5	76.3	96.5

Source: compiled by the Author on the basis of Medicare Payment Advisory Commission (2019a).

5.2 Home health care

Medicare home health care provides a range of skilled nursing services, therapy, medical supplies and medical social services at home, which include:

- Skilled nursing care provided on a part-time basis — no more than eight hours a day over a period of 21 days or less. It includes services such as injections, feeding through a tube, and changing catheters and wound dressings.
- Physical, speech and occupational therapy from professional therapists to help the individual walk again, overcome problems in talking, or regain the ability to perform everyday tasks — whatever the medical condition requires.
- Help from home health aides in personal activities, such as going to the bathroom, dressing, or preparing a light meal if this help is necessary in relation to the person's illness or injury. However, if this personal care is the only kind of care the individual needs, she/he does not qualify for home health coverage.
- Medical supplies such as catheters and wound dressings related to the beneficiary condition.
- Medical social services such as counselling for social or emotional concerns related to the illness or injury, and help finding community resources if needed.

To get this coverage, the individual must meet all the following conditions:

- Be homebound — that is, unable to leave home without considerable effort, unaided or at all.
- A doctor must certify⁹ that the individual needs one or more specified professional services – skilled nursing, physical or occupational therapy, or speech pathology. A plan of care must be established and regularly reviewed by a doctor.
- Medicare must approve the home health agency that provides the service.

In contrast to coverage for SNF services, Medicare does not require a preceding hospital stay to qualify for home health care. In addition, unlike for most services, Medicare does not require co-payments or a deductible for home health services. Beneficiaries who meet program coverage requirements can receive an unlimited number of home health episodes¹⁰.

In 2018, about 3.4 million Medicare beneficiaries received home care, and the program spent US\$ 17.9 billion on home health services (Medicare Payment Advisory Commission 2020). Medicare spending for home health care more than doubled between 2001 and 2017, and accounted for 3% of Medicare FFS spending in 2017. In 2017, 11 844 home health agencies provided an average of 16.5 visits per episode of care – down from 18.9 in 2002 (Medicare Payment Advisory Commission 2019c).

Medicare purchases home health services in units of 60-day episodes. To capture differences in expected resource use, patients receiving five or more visits are assigned to 1 of 153 home health resource groups (HHRGs) based on clinical and functional status and service use as measured by the Outcome and Assessment Information Set (OASIS)¹¹. The HHRGs range from groups of relatively uncomplicated patients to those of patients who have severe medical conditions, severe functional limitations, and need extensive therapy. The 153 HHRGs are divided into five categories based on the amount of therapy provided and the episode's timing in a sequence of episodes. Four of the categories are based on a combination of whether the episode is an early episode (first or second episode) or late episode (third and subsequent episode) and whether the

9 Medicare requires that a physician certify a patient's eligibility for home health care and that a patient receiving services be under the care of a physician. In 2011, Medicare implemented a requirement that a beneficiary have a face-to-face encounter with the physician ordering home health care. The encounter must take place in the 90 days preceding or 30 days following the initiation of home health care. Contacts through nonphysician practitioners or authorized telehealth services may be used to satisfy the requirement.

10 In 2017, the average number of 60-day episodes per user was 1.9, and the average payment per episode was US\$ 3039 (Medicare Payment Advisory Commission 2019c).

11 The Outcome and Assessment Information Set is a group of standard data elements developed, tested and refined over two decades through a research and demonstration program funded primarily by CMS, with additional funding from the Robert Wood Johnson Foundation and the New York State Department of Health. OASIS data elements were designed to enable systematic comparative measurements of home health care patient outcomes at two points in time.

episode has zero to 13 therapy visits or 14 to 19 visits. A fifth separate category exists for episodes that have 20 or more therapy visits, and it is not affected by episode timing. These separate categories permit the case-mix system to differentiate between the resource use of different levels of therapy utilization and multiple episodes. The system is calibrated to provide higher payments for later episodes in a sequence of consecutive episodes (third and subsequent episodes) and raises payment as therapy visits increase¹². The HHRG model has the highest predictive power among case-mix models for home health care payment mainly due to the inclusion of previous health service use to predict future use (van den Bulck et al. 2020).

Each HHRG has a national relative weight reflecting the average relative costliness of patients in that group compared with the average Medicare home health patient. The payment rates for episodes in each local market are determined by adjusting a national average base amount—the amount that would be paid for a typical home health patient residing in an average market—for geographic factors and case mix. The base payment amount for 2018 is US\$ 3039.6. To adjust for geographic factors, the per episode payment rate is divided into labour and non-labour portions; the labour portion (77%) is adjusted by a version of the hospital wage index to account for geographic differences in the input-price level in the local market for labour-related inputs to home health services. The total payment is the sum of the adjusted labour portion and the nonlabour portion. To adjust for a case mix, the base rate is multiplied by the relative weight for each HHRG. When a patient's episode of care involves an unusually large number or a costly mix of visits, the Home Health Agency (HHA) may be eligible for an outlier payment. To be eligible, imputed episode costs must exceed the payment rate by a certain amount set annually by CMS.

The home health prospective payment system has two programs intended to improve quality. The first is a pay-for-reporting program under which HHAs must report quality-of-care data for standardized measures (e.g., OASIS) to avoid a two-percentage point reduction in their annual basket update (see <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Requirements.html>). Medicare also implemented a home health value-based purchasing program in 2016 in nine states (see <https://innovation.cms.gov/initiatives/home-health-value-based-purchasing-model>). The program adjusts HHAs' Medicare payments (upward or downward) based on their performance on a set of quality measures relative to their peers. Agencies received bonuses or penalties based on their performance on a set of 24 quality measures. The size of any bonus or penalty varied according to

12 In 2020, three major changes to the payment system will be implemented: a new 30-day unit of payment in place of the current 60-day unit; the elimination of the number of therapy visits as a variable in the payment system; and the use of a new case-mix system, the Patient Driven Grouping Model (432 home payment groups) (Medicare Payment Advisory Commission 2020).

performance, but the program's design capped any increases or decreases at 3% of Medicare payments. Quality bonus payments were funded through a payment withhold of 5% in 2018, increasing to 8% by 2021. Performance will be evaluated on outcomes measures collected in the OASIS, patient experience survey measures from the Home Health Consumer Assessment of Health Providers and Systems and claims-based quality measures.

5.3 Medicare Advantage

Medicare Advantage (MA) is a type of Medicare health plan offered by a private company that contracts with Medicare. MA plans include Health Maintenance Organizations; Preferred Provider Organizations; Private FFS Plans; Special Needs Plans; and Medicare Medical Savings Account Plans. If a beneficiary is enrolled in a MA plan, most Medicare services are covered through the plan. Enrolment in MA plans reached 21.9 million beneficiaries – more than one third of all Medicare beneficiaries – in 2019 (Medicare Payment Advisory Commission 2019c).

CMS determines the amount paid to MA plans for each beneficiary based in part on bids submitted by MA plans for what they expect Medicare covered services for their enrollee population will cost, on average. CMS then sets the plan's base payment rate—that is, the payment rate for a beneficiary of average health status—based on how the bid compares with a pre-established benchmark. The benchmark is an administratively determined bidding target. Benchmarks for each county are set by means of a statutory formula based on percentages (ranging from 95% to 115%) of each county's per capita Medicare spending. Plans with quality ratings of 4 or more stars may have their benchmarks raised by up to 10% of FFS spending in some counties. If a plan's bid is above the benchmark, then the plan receives the benchmark as payment from Medicare, and enrollees have to pay an additional premium that equals the difference. If a plan's bid is below the benchmark, the plan receives its bid plus a "rebate," defined by law as a percentage of the difference between the plan's bid and its benchmark. The percentage is based on the plan's quality rating, and it ranges from 50% to 70%. The plan must then return the rebate to its enrollees in the form of supplemental benefits, lower cost sharing, or lower premiums.

Medicare then uses beneficiaries' characteristics, such as age and prior health conditions, and a risk adjustment model—the CMS-hierarchical condition category (CMS-HCC)—to develop a measure of their expected relative risk for covered Medicare spending. The payment for an enrollee is the base rate for the enrollee's county of residence multiplied by the enrollee's risk measure, also referred to as a risk score (Medicare Payment Advisory Commission 2019b).

Some important changes were recently made to the MA program through the passage of the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act

and new rules published by CMS. MA plans and providers who work with them will soon have greater flexibility to offer additional supplemental non-medical benefits to address the health of people with chronic illnesses. Starting in 2020, MA plans will be allowed, but not required, to offer chronically ill enrollees nonmedical services for social needs that affect health as long as there is a “reasonable expectation that the services will help people with chronic conditions improve or maintain their health or overall function.” Examples of these services include home-delivered meals, transportation for nonmedical needs, indoor air quality equipment (e.g., air conditioner for someone with asthma), and minor home modifications (e.g., permanent ramps, widening of hallways or doorways to accommodate wheelchairs). The effects of this policy will – most likely – vary among MA plans (Thomas et al. 2019) and remain uncertain (Sorbero and Kranz 2019).

6

The Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) established as a permanent Medicare and Medicaid benefit by the Balanced Budget Act of 1997, attempts to help nursing home eligible seniors avoid institutional care by providing them with a mix of coordinated acute and LTC services in the community.

Individuals who are 55 or older, certified by their state of residence as being eligible for nursing homes, and live in the service area of a PACE program are eligible to enrol in PACE. Designed for the frail elderly or people with disabilities, PACE programs are centred around the adult day health centre, where participants receive medical and social services and an interdisciplinary team comprising physicians, nurse practitioners, social workers, nutritionists, therapists, personal care attendant, and drivers. The typical PACE enrollee is dually eligible for both Medicare and Medicaid, over 75 years old and female with multiple chronic conditions as well as more than one ADL limitation. As of January 2019, 31 states had PACE programs with over 44 000 individuals participating, most of whom were dually eligible (ICRC 2019). Enrolment in PACE is voluntary and PACE is optional for states.

PACE is a Medicare managed care program and a Medicaid state plan option. Therefore, PACE organizations receive two capitation payments per month for their dually eligible enrollees and assume full financial risk for all the health care services that beneficiaries use. The Medicare portion of the capitated payment is derived from a formula that reflects the high frailty level of PACE beneficiaries, while the Medicaid payment is negotiated between the PACE provider and the state Medicaid agency. While CMS does not account for the functional status directly in the risk adjustment model used to

set payment rates to Medicare Advantage plans, it does make an additional payment adjustment, known as the “frailty adjustment”, for plans that disproportionately enrol beneficiaries with functional limitations— including the PACE organizations. To implement this adjustment, CMS adds a fixed amount to the risk score of each community-residing beneficiary in a given plan to reflect the higher average costs of caring for beneficiaries with functional limitations. To calculate this adjustment, CMS first estimates frailty adjustment factors based on functional status information for Medicare FFS beneficiaries from the Consumer Assessment of Healthcare Providers and Systems survey and then applies these factors to a given plan based on functional status information from the Health Outcome Survey (United States Government Accountability Office 2018).

The literature provides evidence associating PACE with reduced risk of hospitalization, but findings for other outcomes – including nursing facility use, effects on spending and mortality – are mixed (MACPAC 2019).

7

Other public payers, out-of-pocket spending and other private funds

Of all LTSS expenditures, a relatively small portion of the costs is paid for with public funds other than Medicare or Medicaid. Collectively, these payers covered 6.3% of all LTSS expenditures in 2016, totalling US\$ 23.1 billion. Among these public payers, over half of spending (US\$ 12.8 billion, or 55.5%) was for LTSS provided in residential care facilities for individuals with intellectual and developmental disabilities, mental health conditions and substance abuse issues. Spending in this category also includes LTSS paid for or operated by the Veterans Health Administration¹³ (US\$ 5.7 billion, or 24.6%). Another US\$ 3.8 billion, or 16.4%, includes state and local subsidies to providers and temporary disability insurance. A smaller percentage was spent on general assistance, which includes expenditures for state programs modelled after Medicaid, as well as federal and state funding for nursing facilities and home health under the Children’s Health Insurance Program (CHIP). In addition, some public LTSS spending includes two types of programs that capture federal health care funds and grants to various federal agencies and Pre-existing Conditions Insurance Plans. Spending from these sources totalled US\$ 800 million, or 3.5%.

Out-of-pocket spending was 15.6% of total LTSS spending, or US\$ 57.0 billion, in 2016. Expenditures in this category include deductibles and co-payments for services that are primarily paid for by another payment source as well as direct payments

¹³ The Veterans Health Administration (VHA) is America’s largest integrated health care system, providing care at 1,243 health care facilities, including 172 medical centers and 1062 outpatient sites of care of varying complexity (VHA outpatient clinics), serving 9 million enrolled Veterans each year.

for LTSS. While there are daily co-payments for skilled nursing services after a specified number of days under Medicare, there are no co-payments for Medicare's home health services. In addition, some private health insurance plans provide limited skilled nursing and home health coverage, which may require co-payments. Moreover, private LTCI often has an elimination or waiting period for policyholders that requires out-of-pocket payments for services for a specified period of time before benefit payments begin. Once individuals have exhausted their Medicare and/or private insurance benefits, they must pay the full cost of care directly out-of-pocket. With respect to

Medicaid LTSS, individuals must meet both financial and functional eligibility requirements. Individuals not initially eligible for Medicaid, and not covered under a private LTCI policy, must pay for LTSS directly out-of-pocket. Eventually, these individuals may spend down their income and assets and thus meet the financial requirements for Medicaid eligibility.

Other private funds generally include philanthropic support, which may be directly from individuals or obtained through philanthropic fund-raising organizations such as the United Way. Support may also be obtained from foundations or corporations. In 2016, other private funding accounted for 6.5% of total LTSS spending, or US\$ 23.9 billion.

8 Private Insurance

Private health insurance and LTCI play a small role in financing LTSS: 7.5% of total LTSS spending, or US\$ 27.6 billion, was funded through these sources in 2016. Private insurance expenditures for LTSS include both health and LTCI. Similar to Medicare LTSS funding, private health insurance funding for LTSS includes payments for some limited home health and skilled nursing services for the purposes of rehabilitation. Private LTCI, on the other hand, is purchased specifically for financial protection against the risk of the potentially high costs associated with LTSS. In addition, a number of hybrid products that combine LTCI with either an annuity or a life insurance policy have emerged. The Medicaid Long-Term Care Insurance Partnership Program¹⁴ offers a LTCI policy that is linked to Medicaid eligibility.

At the end of 2017, there were 6.8 million LTC insurance policies in force. The number of policies has been constantly decreasing since 2012, when a spike of 7.4 million policies was reached (National Association of Insurance Commissioners 2018). The average age of buyers in 2015 was 60 years, about the same as over the previous decade. The shift of sales toward higher-income individuals continues. The median income of

¹⁴ The Partnership Program is designed to encourage the purchase of LTCI by offering a plan that will allow Medicaid to disregard an amount of the policyholder's assets equal to the dollar amount of LTCI benefits paid under a qualified Partnership Policy for the purpose of determining eligibility and estate recovery for Medicaid.

current buyers doubled between 2000 and 2015, and the assets of new buyers are also increasing: 4 in 5 had assets in excess of US\$ 100 000 in 2015 (LifePlans, Inc. 2017).

Private insurance companies sell two basic types of LTC insurance policies: individual policies and group policies. Individual policies (also called “nongroup” policies) are sold directly to individuals, usually by insurance agents but sometimes through direct mail or phone solicitations. These policies must meet certain minimum standards set by the Division of Insurance that regulates the insurance market in each state. They usually are renewable or non-cancellable; provide at least 730 days (or a comparable dollar amount) of coverage; do not include an elimination period (waiting period) of more than 365 days; provide benefits based upon no more than two ADLs; offer an applicant the opportunity to buy inflation protection and nonforfeiture benefits; do not have a pre-existing condition limitation that lasts for more than six months after the policy’s effective date; do not limit benefit payments because an individual develops Alzheimer’s Disease, mental illness, alcoholism or other chemical dependency after the policy is issued. Group policies are sold through employers and associations who sponsor group plans as a benefit to their employees and members. Some insurers also sell group policies directly to individuals through out-of-state “group trust” arrangements. Employer, association and group trust policies are not subject to all the same state protections (minimum standards). At the end of 2017, more than two thirds of policies were individual (National Association of Insurance Commissioners 2018).

LTC policies can vary greatly from one insurer to the next. Policies may include benefits for care in a nursing home, care provided in an assisted living facility, home health care or personal care provided at home. Some may pay for family benefits, such as caregiver training, but most will not pay for services provided by family members. The most flexible policies allow for the use of benefits to cover any necessary LTC service in whatever setting eventually needed by the insured person. Most LTC policies limit both the amount they will pay each day (daily maximum benefit) and over the life of the policy to a maximum number of days or dollars (lifetime maximum benefit). These limits depend on the choices made when a policy is first subscribed. Lifetime maximum benefits usually are stated in number of days of coverage and usually range between two years and unlimited coverage. Although individual policies are required to cover the equivalent of two years of care, group policies may offer less. Daily maximum benefit amounts also vary, and usually do not cover the entire cost of a day of LTC services.

Inflation protection maintains the level of coverage even as the cost of LTC care rises. There are two basic types of inflation protection: “automatic” and “special offer,” each of which can take a variety of forms. Automatic inflation protection increases benefits each year by a fixed percentage. Special offer inflation

protection gives the option to purchase inflation protection at set intervals, such as every three years. Nonforfeiture benefits provide something back to the insured person if, for whatever reason, coverage is dropped ("let it lapse") after years of paying premiums. If the nonforfeiture benefits is not purchased and the policy is allowed to lapse, premiums paid over the years will "forfeit".

"Benefit triggers" refer to the conditions under which an insured person is eligible to claim benefits under the policy subscribed. The way benefit triggers are defined in the policy can have an impact on how easily an insured person may qualify for benefits. Not only do benefit triggers vary between policies, but also the same policy might use a different trigger for home or community-based care than it does for nursing home care. Most policies use inability to perform certain ADLs to determine if an insured person is eligible for policy benefits. Before paying benefits, insurers usually require certification by a physician or licensed health care practitioner that the insured person cannot perform certain ADLs because of physical or cognitive impairments. Many policy benefits usually do not start the first day that the insured person enters a nursing home or use other LTC services. Instead, the policy's elimination period (waiting period) or a deductible must be satisfied. An elimination period or deductible requires the insured person to pay for LTC expenses for a specified number of days or a dollar amount before the insurer will pay benefits. The longer the elimination period or higher the deductible, the lower the premium paid.

The main features of the LTC insurance policies in force from 1990 to 2015 are reported in Table 6. Coverage limited to nursing homes or institutional alternatives has virtually disappeared from the market, whereas such coverage represented 63% of new sales in 1990. Almost all policies sold at the end of 2015 provide coverage for both institutional and home-based services (integrated policies). The average daily nursing home benefit has increased by only 5% over the last five years, and the home care benefit amount remains close to the nursing home level, reflecting the dominance of integrated policies. The decline in benefit duration continues, with the average falling to a new low of four years, and 3 in 5 policies had a duration of coverage of three years or less. There has been a drop in policies with unlimited (lifetime) durations, which are no longer sold by most companies because of insurers' general aversion to uncapped liabilities as well as rating agencies negative view of them.

In theory, the significant financial uncertainties in terms of potential need, intensity and duration of LTC provide a powerful rationale for sharing this risk across individuals. Yet, in countries such as the United States where private LTC insurance is sold, population coverage remains low due to demand and supply side issues (Colombo et al. 2011). First, well-known market failures due to asymmetric information in the private LTC insurance market, such as adverse selection and moral

hazard, lead insurers to protect themselves by limiting access to coverage. Adverse selection would translate in only those with high-perceived LTC risk buying in or keeping the insurance policy, while moral hazard would translate in the insured using more LTC services than they would have required because they are covered. Second, insurers face significant uncertainty regarding future costs, or the evolution of supply and organisation arrangements for LTC. For instance, future trends in the onset of dependency are unknown, and there is uncertainty with respect to the costs of providing a unit of care as well as with the projected return from the invested accumulated reserves. This may result in insurers setting relatively higher premiums or paying lower benefits. Premium mark-up may lead to lower demand for private LTC coverage because of its higher prices. Third, challenges associated with the ability of insurers to control the covered LTC risk might also lead to premium volatility. To ensure the financial viability of an insurance plan, insurance contracts include clauses that allow for the level of premiums to increase if the overall level of risk shared within a pool of insurer's increases. Premium volatility makes the cost of private LTC coverage less predictable and may reduce the confidence in these types of insurance plans. Fourth, low demand for private LTC insurance may also reflect individuals' myopia in planning for the financial risk associated with LTC. For instance, the risk associated with dependency is often deemed as too remote to warrant coverage starting at a relatively young age. Last, low demand may also reflect competing financial obligations and priorities faced by individuals and families, such as paying for children's education, schooling, and buying a house. For households with low income, the cost of subscribing to a private LTC coverage can represent a high share of their disposable income.

A recent report (U.S. Department of Treasury 2020) found that insurers have dramatically increased premiums for policies, both new and in-force, and this has led to much lower demand. Also, the total number of insurers actively selling in the market has dramatically contracted.

Table 6
Main features of private long-term care insurance.

	Mean by year			
	2000	2005	2010	2015
Policy type				
Nursing home only	14%	3%	1%	1%
Home care only	9%	7%	4%	3%
Nursing home and home care (integrated)	77%	90%	95%	96%
Daily benefit amount for nursing home	US\$ 109	US\$ 142	US\$ 153	US\$ 161
Daily benefit amount for home care	US\$ 106	US\$ 135	US\$ 152	US\$ 155
Nursing home only elimination period	65 days	80 days	85 days	49 days
Combined policies elimination period	47 days	81 days	90 days	91 days
Nursing home benefit duration	5.5 years	5.4 years	4.8 years	4 years
Annual premium ¹⁵	US\$ 1677	US\$ 1918	US\$ 2283	US\$ 2727

Source: compiled by the Author on the basis of LifePlans, Inc. (2017).

¹⁵ Given that LTC policies are level-funded (i.e. benefits are prefunded) and the LTC risk is highly correlated with age, if everything else is held constant, premiums will increase as purchase age goes up. Thus, premiums for 75-year-old buyers are twice as high as for those between 55 and 64, even though the latter purchase more comprehensive products.

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