4
Approaches to setting prices

Any payment method has several dimensions: the base upon which prices are defined and set; the process by which the price level is determined; and the price level per unit of payment (Reinhardt 2006, 2011, 2012). The process by which prices are determined can be grouped into three main approaches, including individual negotiations between providers and purchasers, collective negotiations between associations of providers and purchasers, and unilateral decision by purchasers. A comparison of the three approaches is discussed elsewhere (Barber, Lorenzoni and Ong 2019; Barber, Lorenzoni and Roubal 2020).

Price setting refers to an administrative process or negotiation upon which prices are determined and the unit for payment (e.g. health professional visit, a day of care in a nursing facility, or a hospital admission) is established. These processes can be grouped into three main methods (Reinhardt 2012): individual negotiations between providers and purchasers, collective negotiations between associations of providers and purchasers, and unilateral decisions by purchasers. We examine each in the context of the country case studies.

4.1. Base for payment

The type of service, for the most part, is the base for payment for pricing home-based care across most countries studied (Table 4). The exception is the Home Care Package program in Australia, which uses a package of care; the APA in France, which uses an hour of home care and support services; a global budget for intensive home care in Germany; and a visit as the base for payment in the Republic of Korea.

As for residential care, a day of care is the most used base for payment across countries in this study. In a few cases, where skilled nursing facility care is funded by SHI, a global budget is used to pay providers. Most countries differentiate prices between care services (such as nursing) from living services (such as meals and accommodations).

In France, SHI funds the medical care package in residential nursing homes based on iso-weighted care groups classification, whereas Medicare in the USA uses the Home Health Resource groups to set the base for payment.

Table 4. Base for payment

Country	Institution/ program/ financing scheme	Line item budget	Global budget	Fee for service	Per diem	Patient classification systems (e.g. Diagnosis Related Group or Resource Utilisation Groups)	Bundled episode	Capitation, other
Australia	Residential care				Personal, clinical, and social care, accommodation and hotel services			
	Home care package program (HCP)							Personal and clinical care for complex care needs
	Commonwealth Home Support Program (CHSP)			Home support				
France	Social Health Insurance (SHI)	Residential nursing homes (medical care)	Skilled nursing facilities	Self-employed nurses		GME in Skilled nursing (post-acute) facilities (750 groups). GMPs in Residential facilities (250 need groups). Hospital at Home: DRG-based		Home nursing services: capitation
	Personal Autonomy Allowance (APA)	Residential nursing homes (personal care)			Day care in residential nursing homes			Home care and support services: hourly rates
	Social aid & tax benefits	Accommodation in nursing homes; home help services		Non-medical residential care				
	Private			Self-employed domestic help				
Germany	SHI/Private Health Insurance (PHI)			Outpatient palliative care	Hospice	Inpatient palliative care		

Country	Institution/ program/ financing scheme	Line item budget	Global budget	Fee for service	Per diem	Patient classification systems (e.g. Diagnosis Related Group or Resource Utilisation Groups)	Bundled episode	Capitation, other
	SHI/PHI, Social/ private Long-term care insurance (LTCI)		Intensive home care					
	Social/private LTCI			Home care	Care substitutes for informal care givers.			Care allowances to beneficiaries: per capita. Home care help (Haushaltshilfe): per hour.
	Social/private LTCI				Residential care			
Japan	Social Health Insurance (SHI)			Basic principle for all services				
	Long-term care insurance (LTCI)			All services				
Republic of Korea	Social Health Insurance (SHI)				Palliative care	Long-term care hospitals		
	Long-term care insurance (LTCI)				Nursing (assistance, personal); Residential (assistance, personal)			Home-based care: pay per visit
The Netherlands	Social LTC insurance		Nursing facilities (medical, assistance, personal) including palliative care (medical, assistance, personal)		Nursing facilities (medical, assistance, personal) including palliative care (medical, assistance, personal)			

Country	Institution/ program/ financing scheme	Line item budget	Global budget	Fee for service	Per diem	Patient classification systems (e.g. Diagnosis Related Group or Resource Utilisation Groups)	Bundled episode	Capitation, other
	Social health insurance		Home-based care (medical and personal) including palliative care (medical and personal)	Home-based care (medical and personal) including palliative care (medical and personal)				
	Social support act			Home-based (assistance); social care in the community				
Spain	National long-term care (LTC) System			Home care	Day/night centres, residential care			
	National Health System		Hospital care		Palliative care			
Sweden	Municipal programs			Home care	Institutional care			
	Medicaid			Home care	Nursing facilities			
	Medicare				Skilled nursing facilities	Home care: Home Health Resource groups		

Notes:
DRGs: Diagnosis Related Groups
GME: Groupes médicoéconomiques en soins de suite et de réadaptation
GMPs: Groupe iso-ressource (GIR) moyen pondéré

Sources: Authors

4.2. Unilateral price setting

The first method of setting prices is unilateral administrative price setting by a regulator. When prices are administered, a form of yardstick competition rewards a given firm depending on its standing vis-a-vis an exogenous benchmarking independent of the costs incurred by each provider (Shleifer 1985).

In France, prices are set unilaterally based on the average level of resources required to provide medical and nursing services for the 238 profiles of care established in the health needs assessments. This allows the measurement of the case mix in a comparable way across facilities and to have a cost scale. The price per point (on the cost scale) is fixed at the national level by a Ministerial decree. The prices for social residences are regulated and fixed unilaterally by local authorities.

In the Republic of Korea, there is a formal price negotiation process for LTCI as in the case of collective price negotiation between the provider association and the national health insurance system for health care services. An LTC committee plays a key role in the pricing of LTC. It discusses and finalizes decisions about various aspects of LTCI, such as premiums, benefits, and pricing for providers. It consists of 21 members with the Vice Minister of Health and Welfare as the Chair: seven from payers (employer associations, labour unions, civic groups), seven from providers (associations of LTC facilities and home-care providers, medical association, nurse association), and seven representing public interests (ministries of health, finance, insurance program, and four experts).

In Japan, not only the fee (price), but also the volume of each service is controlled by setting strict conditions of billing in the Fee Schedule. The Fee Schedule is revised every three years in LTCI. The prime minister first decides the global revision rate which respectively sets a de facto global budget for LTCI expenditures. Next, the fees and conditions of billing are revised on an item-by-item basis within the budget following negotiations with provider organizations. Some fees are increased; others are lowered. Conditions of billing are relaxed in some; tightened in others. The impact of revising each item on the global budget is calculated from the national claims database.

Under the USA 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. Starting in 2019, the Medicare program applies per diem case-mix adjusted payments for nursing homes using the Patient-Driven Payment Model (PDPM). Five case-mix adjusted components are used: Physical Therapy (PT), Occupational Therapy (OT), Speech-Language Pathology (SLP), Non-Therapy Ancillary (NTA), and nursing. Each resident is classified into one group for each of the five components, mainly based on the

primary diagnosis clinical category, and function and cognitive levels. A resident may be assigned to one of 16 PT groups, 16 OT groups, 12 SLP groups, 6 NTA groups, and 25 nursing groups. Each component has its own associated case-mix index and per diem rate. Additionally, the PDPM applies per diem payment adjustments to three components (PT, OT, and NTA) to account for variations in resource use. The adjusted PT, OT, and NTA per diem rates are then added together with the unadjusted SLP, nursing component rates and the non-case-mix component to determine the full per diem rate for a given resident.

Table 5. Ways in which prices are negotiated

Country	Institution/ program/ financing scheme	Individual negotiations	Collective negotiations	Unilateral administrative	Other
Australia	Residential care			Level of subsidy individuals receive set by the federal government	Set by the market
	Home care package program (HCP)			Level of subsidy individuals receive set by the federal government	Set by the market
	Commonwealth Home Support Program (CHSP)			Level of subsidy individuals receive set by the federal government	Set by the market
France	Social Health Insurance (SHI)		Self-employed nurses	Residential nursing homes (medical care); palliative care ; skilled nursing facilities; Home nursing services	
	Allocation personnalisée d'autonomie, APA ("Personal autonomy allowance") (Local authorities and Caisse nationale de solidarité pour l'autonomie)	Free negotiations for Home care and support services (in 77% of local authorities) and day care (in 43% of local authorities)		Residential nursing homes (personal care); Social Aid; self-employed domestic help; Home care and support services (in 23% of local authorities); day care (49% of local authorities)	Reference prices used for self-employed domestic help
	Social aid, tax benefits, central government			Accommodation in nursing homes (at local level)	
	Private				Market based: accommodation fees in residential nursing home + home help
Germany	Social LTC insurance	Home care	Home care		
	Social LTC insurance	Residential care	Residential care		
Japan	Social Health Insurance (SHI)		Hospital care (personal); home-based care (medical);palliative care (medical, personal)	All fee decisions made by Minister of Health	
	Long-term care insurance (LTCI)			Nursing facilities (medica, assistance, personal care); residential facilities (assistance, personal); home-based care (assistance, personal)l palliative care (assistance)	

Country	Institution/ program/ financing scheme	Individual negotiations	Collective negotiations	Unilateral administrative	Other
Republic of Korea	Social Health Insurance (SHI)		Long-term care hospitals (medical); palliative care (medical, assistance, personal)		
	National Health Insurance for the Elderly (LTCI)			Nursing facilities (assistance, personal care); residential facilities (assistance, personal); home-based care (medical, assistance, personal)	
The Netherlands	Social LTC insurance	Nursing facilities (medical, assistance, personal); palliative care (medical, assistance, personal) based on eligibility			Room for negotiations limited by regulation
	Social health insurance	Home-based care (medical, personal); palliative care (medical, assistance, personal)			Room for negotiations limited by regulation
	Social support act	Home-based (assistance); social care in the community			Room for negotiations limited by regulation
Spain	National LTC System			In kind (prevention, tele-assistance, home care, day/night centres, residential care), cash (services purchase, informal care, personal assistance)	
	National Health System			Health services (includes palliative care)	
Sweden	Municipal programs			Institutional care, home care	
United States	Medicaid			home care; nursing facilities	Managed care: competitive bidding
	Medicare			home health care; skilled nursing facilities	Managed care: competitive bidding

Sources: Authors.

4.3. Collective negotiations

Under collective negotiations, a national purchasing agency or an association of purchasers (i.e. health insurers) negotiate with associations of hospitals or health providers.

In France, fees for services provided by self-employed nurses are negotiated between the SHI and the representatives of self-employed nurses. The prices are defined for three types of basic nursing activities: "medical nursing", which refers to activities such as wound management, injections and swabs; "nursing care", which refers to ADL (e.g. hygiene and surveillance); and "nursing approaches" to prepare an individual nursing care plan.

In Germany, beneficiaries can choose to receive services from any provider registered with LTCI funds at the state level. Providers of home and residential care come from the public, not-for-profit and private sectors. Individual providers or provider associations negotiate the fees they are paid for the services with LTCI funds and social welfare authorities. Although these fees are negotiated on a local level – in order to offer flexibility to meet local needs – they are governed by state- and national-level contractual frameworks. Following the principle of subsidiarity, Germany has sought to develop a stable and competitive provider market by creating a national regulatory framework to coexist alongside market principles.

In the Netherlands, the Dutch Health Care Authority sets maximum prices for legally defined types of activities for home-based nursing and personal care – that is personal care, nursing care, specialized nursing care and advice, instruction and counseling - based on calculated average costs per activity. Health insurers and providers negotiate the prices for these activities, which may not exceed the regulated maximum prices. However, instead of paying regulated maximum prices or negotiating lower prices for legally defined types of activities, providers and insurers may also opt for negotiating a single integrated price for a bundle of agreed-upon activities. In practice, this has become the standard way of price setting. The Health Care Authority also sets maximum prices for `care packages' in nursing home care based on researching the actual costs across of these packages across providers. These care packages do not describe the exact type and hours of care required; instead, the integrated (per diem) price for a care package should cover all the care needed for a certain health profile. Regional purchasing offices negotiate prices with providers, which must be below the regulated maximum price.

4.4. Individual negotiation

Under individual negotiations, prices are agreed upon through negotiations between an individual purchaser and a provider of services. In the context of LTC, this may include personal services provided to older persons at home, for example, that result in market prices in which the government plays mainly a regulatory role. In Australia, all home care is publicly funded (with a small means tested contribution), and this funding is paid to the purchaser who negotiates care services with one or more regulated providers. Prices are market-based, but the level of government-subsidy paid to individuals is set unilaterally.

Individual negotiation for prices is typically associated with private health insurance in the USA. Despite the strong case for risk pooling, there are few private insurance options for LTC. Private insurance for LTC remains a niche product covering only a small proportion of total LTC costs. Given that the role of private health insurance in covering LTC services for older persons is quite limited, individual negotiations of prices between purchasers and providers is also limited.

In Germany, nursing care charges are negotiated individually between the nursing home, welfare organizations and LTC funds, whose enrolees contribute at least 5% of the nursing home's nursing days. During these negotiations, nursing homes explain any increase in fees. In the Netherlands, health insurers and providers negotiate a single integrated price for an agreed-upon bundle of home-based nursing and personal care activities. In this case, a contract between the provider and insurer is required. Integrated prices are typically set per hour, although an increasing number of providers and insurers switched to monthly prices.

In France, prices for self-employed domestic help are freely fixed on the market respecting the French labour code (e.g. minimum wage, social security contributions). To be included in the "care plan" of the APA (a cash-for-care scheme for personal care), self-employed workers need to be accredited by a regional labour and employment agency.

It is worth noting that in some countries, such as France, Spain and Sweden, subnational governments play a key role in setting prices for LTC services at home. In France, local authorities fix an APA reference price for self-employed domestic help for the amount reimbursed from APA to people employing self-employed domestic aid; however, the actual prices can be much higher. In Spain, the reference prices for self-employed help are much lower than those in the public LTC system (*Sistema para la Autonomía y Atención a la Dependencia*, SAAD), ranging from €8-13/hour (US$ 9-15), because local authorities support the deployment of SAAD in which they can control the care standards.

4.5. Bidding or tendering

Another mechanism to set prices is through bidding or tender processes, mainly used to price managed care plans' service packages to Medicaid enrolees in the USA and social assistance in the Netherlands. The original goal of contracting with private managed care plans was to harness their ability to use care-coordination tools to offer high-quality care, while providing enhanced benefits for beneficiaries and saving money for taxpayers.

In the USA, states can select state-established and administered capitation rates (e.g. fixed offer), competitive bid capitation rates, or a hybrid model (e.g. range and soliciting bids). After developing an actuarially-sound administratively set payment "benchmark", which loosely reflects the level of spending for an "average risk" enrolee, states provide interested plans with a data book of information needed to develop rate bids. The state selects plans based on the bids and accompanying technical proposals.

To help ensure participation, many states require minimum provider rates in their contracts with managed care organizations that may be tied to fee-for-service rates (Kaiser Family Foundation 2020a). Furthermore, over three-quarters of capitated Managed Long-term Services and Supports (MLTSS) states have network adequacy standards for home and community-based services providers, with time and distance as the most common (Kaiser Family Foundation 2020b).