

IMPLEMENTING AN INTEGRATED LONG-TERM SERVICES AND SUPPORTS BUY-IN PROGRAM: A COST ESTIMATE

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EXECUTIVE SUMMARY

The need for long-term services and supports (LTSS) in the United States will continue to grow as the nation ages. Formal LTSS is largely provided through the Medicaid program, limiting these services to individuals who are low-income and already in need of an institutional level of care. This results in a considerable portion of individuals with LTSS needs lacking access to necessary services, and forces many to “spend down” their income and assets to qualify for Medicaid. In addition, Medicaid recipients who also qualify for Medicare receive acute care benefits and LTSS benefits administered by two disjointed programs. As the magnitude of individuals with unmet need rises, so does the long-term cost to both the Medicaid and Medicare programs through increased and fragmented utilization of acute care and institutional settings.

This study was undertaken to estimate the federal costs associated with subsidizing an LTSS “buy-in” to the Medicare program or alternatively, as a buy-in to Medicaid benefits. The program would integrate LTSS and acute care services for Medicare beneficiaries living in the community with LTSS needs, and who are not receiving full Medicaid benefits.

Initial cost estimates included in this study are limited to Medicare beneficiaries aged 65 and older. LTSS need was determined based on level of assistance needed with activities of daily living, level of assistance needed with instrumental activities of daily living, and presence of cognitive impairment. Different combinations of LTSS coverage, program eligibility, subsidy levels, and longer-term savings expectations were modeled, resulting in annual federal costs for providing subsidized coverage between \$1.1 billion and \$12.8 billion.

Model Inputs

The key model inputs used to estimate federal costs included per person “value,” acute care savings, subsidy eligibility and amount(s), and program enrollment. Each of these model inputs is described in greater detail below.

Per Person “Value”

Four approaches were developed to approximate the possible per person per month (PPPM) value based on the monetary value of LTSS and the assumed services that would be provided to enrolled individuals.

- 1. Base Benefit Package - \$450 PPPM**

The monetary value of this approach was based on industry trends within private market and other programs similar to this buy-in option, such as the CAPABLE program¹ and previously proposed legislation for a Community-Based Independence Special Needs Plan (CBI-SNP).² It allows a limited benefit and assumes that the total combination of services used would be equivalent to \$450 PPPM. This package does not specify services.

- 2. Personal Care Services Only - \$914 PPPM**

¹ Johns Hopkins School of Nursing. “Community Aging in Place – Advancing Better Living for Elders (CAPABLE).” https://nursing.jhu.edu/faculty_research/research/projects/capable/index.html.

² Community-Based Independence for Seniors Act of 2019, H.R. 3461, 116th Cong. (2019). <https://www.congress.gov/bill/116th-congress/house-bill/3461/text?r=6&s=1>.

This approach was based on reimbursement amounts within Medicaid and the private market for personal care services. It assumes 10 hours of services per week would be provided to an enrolled individual, based on the national median of unpaid caregiver hours. The average reimbursement amounts of personal care services from Medicaid fee schedules across a variety of states were blended with the national averages for private sector home care to calculate the hourly rate, \$21.10, of the services provided.

3. **Median State Home and Community-based Services (HCBS) Spend on Older Adults - \$1,391 PPPM**

This approach assumes the buy-in benefit levels would approximate state Medicaid HCBS expenditures for older adults. It uses the median/50th percentile 1915(c) per person spending for aged and physically disabled individuals to account for the substantial variation that exists across states in terms of Medicaid HCBS benefit design and expenditures. The PPPM amount also incorporates a 14 percent adjustment based on the likely increase above Medicaid fee schedules that would occur if similar benefit levels were provided through Medicare. This approach does not account for any unmet need that might exceed state benefit limits or other HCBS and HCBS-like services that individuals might receive through other sources, such as state plan services.

4. **90th Percentile State HCBS Spend on Older Adults - \$2,803 PPPM**

This approach replicates all aspects of the median HCBS approach described above but uses the 90th percentile of 1915(c) spending for aged and physically disabled individuals. The associated monetary value represents the likely upper bound cost of providing HCBS in the Medicare program.

Acute Care Savings

This model input represents the assumed medical care savings created as a result of integration of LTSS and acute care needs and services. Three savings values (minimum, average, and maximum) were identified based on findings from the Financial Alignment Initiative and CAPABLE. A higher PPPM value is expected to be associated with greater acute care savings and was modeled as such in this study.

Subsidy Eligibility and Amount(s)

Three subsidy components are included as inputs in this model: whether full *and* partial subsidies are provided (versus full only); the income level threshold(s), as a percentage of the Federal Poverty Level, for the full and partial subsidy participants; and, the amount of the partial subsidy as a percentage of the cost. The subsidy eligibility and amounts act as independent variables in this study and will ultimately need to be defined by further research and policy specifications.

Enrollment

The enrollment input represents the anticipated demand among fully subsidized, partially subsidized, and unsubsidized individuals. Medicare Advantage enrollment rates, 40 percent nationwide across all Medicare beneficiaries as of December 2020, informed likely enrollment demand since the program would be tied to a Medicare Advantage plan. In addition, as enrollment demand will likely vary based on out-of-pocket costs, enrollment rates vary in each model scenario. For example, for scenarios with higher PPPM values, lower enrollment demand is expected among unsubsidized and partially subsidized individuals.

Outcomes

Twelve cost scenarios were run based on unique combinations of the model inputs described above. These scenarios resulted in annual net federal costs for providing subsidized coverage between \$1.1 billion to \$12.8 billion (bolded in Figure 1). In addition, based on the “Base Package” scenario outputs, the federal government could subsidize a limited LTSS benefit for up to 675,052 Medicare beneficiaries (excluding unsubsidized beneficiaries) at an annual cost of \$1.1 billion to \$3.1 billion (bolded in Figure 1). It is important to note this study’s savings estimates likely are conservative, and costs to the federal government could be lower. For example, a single prevented hospital stay would save the Medicare program an average of \$12,800, which is more than the annual per person cost of two of the four scenarios provided in Figure 1.³

Figure 1: Abbreviated Version of Coverage Scenarios and Resulting Outcomes

Cost Approach	Full Subsidy	Partial Subsidy	Standard Eligibility Population	Expanded Eligibility Population
Base Package \$450 PPPM	≤100% FPL	No partial subsidy	Total Served: 632,633 Total Subsidized: 226,453 Net Annual Cost: \$1,144,420,997	Total Served: 671,706 Total Subsidized: 239,346 Net Annual Cost: \$1,209,578,093
	<221% FPL	221-400% FPL	Total Served: 803,687 Total Subsidized: 633,929 Net Annual Cost: \$2,911,402,009	Total Served: 851,987 Total Subsidized: 675,052 Net Annual Cost: \$3,094,244,091
Personal Care Services Only \$914 PPPM	≤100% FPL	No partial subsidy	Total Served: 470,161 Total Subsidized: 226,453 Net Annual Cost: \$2,406,217,113	Total Served: 498,762 Total Subsidized: 239,346 Net Annual Cost: \$2,543,214,005
	<221% FPL	221-400% FPL	Total Served: 728,123 Total Subsidized: 606,867 Net Annual Cost: \$6,002,982,663	Total Served: 772,059 Total Subsidized: 645,677 Net Annual Cost: \$6,377,297,949
Median State HCBS Spend \$1,391 PPPM	≤100% FPL	No partial subsidy	Total Served: 388,925 Total Subsidized: 226,453 Net Annual Cost: \$2,489,497,468	Total Served: 412,290 Total Subsidized: 239,346 Net Annual Cost: \$2,631,235,890
	<221% FPL	221-400% FPL	Total Served: 652,558 Total Subsidized: 579,805 Net Annual Cost: \$5,922,200,824	Total Served: 692,131 Total Subsidized: 616,302 Net Annual Cost: \$6,284,809,261
90 th Percentile State HCBS Spend \$2,803 PPPM	≤100% FPL	No partial subsidy	Total Served: 307,689 Total Subsidized: 226,453 Net Annual Cost: \$5,111,777,012	Total Served: 325,818 Total Subsidized: 239,346 Net Annual Cost: \$5,402,813,744
	<221% FPL	221-400% FPL	Total Served: 601,245 Total Subsidized: 552,743 Net Annual Cost: \$12,022,089,512	Total Served: 637,480 Total Subsidized: 586,927 Net Annual Cost: \$12,754,836,128

³ \$12,800 was the average Medicare fee-for-service payment of a hospital stay in 2019. Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy. (March 2021).

Considerations and Conclusion

This study provides an initial cost estimate of subsidizing some level of LTSS for Medicare beneficiaries with LTSS needs and without current Medicaid coverage. The study also highlights the value of additional analysis and policy conversation on addressing increasing unmet LTSS need among an aging nation. Further, the program concept modeled in this study could reduce longer-term Medicare and Medicaid spending that results from a current lack of integration and spend-down into long-term residence in an institutional setting.

The following considerations related to program design were considered out of scope for this study:

- Emerging policy efforts and policy design, including proposals to expand Medicaid HCBS
- Cost inflation and wage increases year-over-year
- Growing Medicare population and projecting costs out in relation to growth in LTSS need
- Medicare solvency and related political considerations
- Integration experiences of individuals ebbing in and out of program eligibility, or of those already qualified for Medicaid LTSS
- State versus federal administration
- Adverse selection and approaches to mitigate its effects
- Policy considerations
 - Program eligibility, including age and frailty requirements
 - Program design and administration, such as whether the program becomes a new type of Medicare Advantage special needs plan (SNP)
 - Intersection with other programs, for example whether state Medicaid programs should contribute funding
 - Program payment and savings, including who shares in the resulting savings

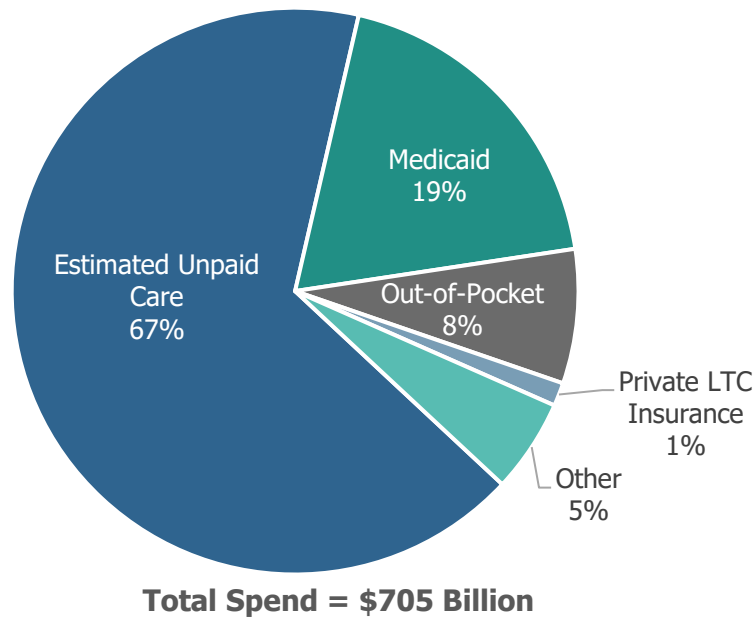
Addressing these identified considerations and defining the policy specifications remain an important next step of this research and are essential to long-term success of efforts to provide LTSS to Medicare beneficiaries.

INTRODUCTION ON THE ISSUE

Researchers and policymakers continue to seek solutions to improve access to long-term services and supports (LTSS). The vast majority of LTSS is provided through informal supports (see Figure 2). However, the changing age demographics in our nation are destabilizing the current dependence on informal and unpaid LTSS supports, with the caregiver support ratio⁴ declining rapidly from 4.8 in 2010, to 3.5 in 2020, 2.8 in 2030, and 2.5 in 2050.⁵

For formal LTSS, our nation relies heavily on the Medicaid program, limiting these important services to the lowest income individuals in the nation and typically to those who already need a nursing home level of care. Those who do not qualify for full Medicaid benefits may choose to purchase LTSS through the private market, although the cost often exceeds a person's income. Individuals may also depend on a private long-term care (LTC) insurance policy; however, research suggests 10 percent of these individuals will still spend-down to Medicaid eligibility due to insufficient coverage.⁶ Additionally, many individuals with LTSS needs also qualify for Medicare, which results in acute care benefits administered by one program and LTSS benefits (if any) administered by another.

Figure 2. Annual LTSS Spend by Payer, 2017⁷



⁴ "Caregiver support ratio" is defined as the ratio of potential caregivers per potential individual needing care. In this report, the ratio includes caregivers aged 18-64 and individuals in need who are 65 years and older.

⁵ Age Wave and Merrill Lynch. The Journey of Caregiving: Honor, Responsibility and Financial Complexity. 2020.

⁶ ATI Advisory and LeadingAge LTSS Center @UMass Boston. (2021). "Why State Support for the Long-term Care Insurance Industry Makes Good Financial Sense" <https://atiadvisory.com/wp-content/uploads/2021/01/LTCi-Policy-Research-Summary.pdf>.

⁷ Data from AARP Public Policy Institute. Valuing the Invaluable (Nov 2019). Long-term Services and Supports Fact Sheet (Aug 2019).

The consequence of this fragmented and limited approach to covering LTSS is many individuals with unmet need and a bias toward institutional care. Research suggests as many as 70 percent of individuals who reach age 65 will experience “severe LTSS needs” before they die, but only 48 percent will receive any paid care. Further, paid care is limited in nature, with only 24 percent of these individuals receiving at least two years of coverage.⁸ While unpaid care is not a direct indication of unmet need, unpaid care experienced today may be borne out as Medicaid institutional spending in the future. In particular, those with insufficient support networks will experience unmet need, reflected in increased acute care utilization and admission to institutional settings. As the nation continues to age, the amount of unmet need will increase, and the long-term cost to the Medicaid and Medicare programs will continue to grow.

The purpose of this study was to estimate federal costs associated with a new program through which Medicare beneficiaries without full Medicaid coverage could “buy-in” to an integrated acute care/LTSS managed care plan, with federal “premium” subsidies for lower income individuals. The analysis in the study examines the federal costs associated with the subsidies, taking into account the potential for overall savings resulting from integrated care delivery, care management, and access to the purchasing power and assistance of a large payer. It also examines how premium costs would compare with what an individual would experience if purchasing services through the private market. This analysis is intended as preliminary and is based on highly stylized and broad policy assumptions.

Although this analysis assumes the expansion would occur through Medicare, alternatively, the proposed new program could be implemented through a Medicaid expansion if implemented through an integrated plan.

METHODS

Sizing the Population

The current study was limited to Medicare beneficiaries aged 65 and older who live in the community or an assisted living facility, and who are not eligible for full Medicaid benefits. The 2017 Medicare Current Beneficiary Survey was used to estimate how many Medicare beneficiaries likely would be eligible for a federal subsidy under an LTSS buy-in program, using the following characteristics:

- Age
- Income as a percent of the Federal Poverty Level (FPL)
- Medicaid eligibility
- Assistance needed with activities of daily living (ADLs)
- Assistance needed with instrumental activities of daily living (IADLs)
- Cognitive impairment including Alzheimer’s disease and Dementia

The buy-in program is intended for individuals living in the community who have a need for home and community-based LTSS but are not fully eligible for Medicaid. To estimate the size of this population, two levels of buy-in “eligibility” criteria were developed to address the diversity

⁸ Office of the Assistant Secretary for Planning and Evaluation. What is the Lifetime Risk of Needing and Receiving Long-term Services and Supports? (Apr 2019).

in Medicaid LTSS assessments and eligibility across states. The approaches are not intended to establish eligibility standards for the program but rather, to quantify likely need for LTSS in Medicare beneficiaries without full Medicaid coverage. Because a focus of the project was to estimate the cost of federal subsidies for an LTSS benefit, counts were further broken into different FPL levels (Figure 3).

Figure 3. Estimated Number of Medicare Beneficiaries in Need of LTSS, by FPL

"Eligibility" Category	Criteria	Number of Medicare Beneficiaries, by FPL					Total (FPL)
		≤100%	101-135%	135-221%	221-400%	>400%	
Standard Eligibility	<ul style="list-style-type: none"> Needs help with 3+ ADLs, <i>or</i> Alzheimer's disease/ Dementia/ other cognitive impairment, and needs help with 2 ADLs, <i>or</i> Alzheimer's disease/ Dementia/ other cognitive impairment, and needs help with 0-1 ADLs and 3+ IADLs 	452,905	210,696	387,758	541,243	485,023	2,077,625
Expanded Eligibility	<ul style="list-style-type: none"> Needs help with 2+ ADLs and 3+ IADLs 	25,786	14,928	23,028	46,258	20,504	130,504
TOTAL (Standard and Expanded Eligibility)		478,691	225,625	410,786	587,501	505,527	2,208,130

Estimating Costs

In order to estimate federal costs associated with subsidizing some portion of the "buy-in" benefit for a portion of the Medicare population, we applied the four broader model inputs:

- **Per person value:** monthly monetary value of LTSS to be provided to enrolled individuals;
- **Acute care savings:** anticipated savings created as a result of integration of LTSS and acute care needs and services;
- **Subsidy eligibility and amount(s):** FPL eligibility for full and partial subsidy coupled with amount of subsidy support for each category; and,
- **Enrollment:** likely enrollment demand among fully subsidized, partially subsidized, and unsubsidized individuals.

The following describes the analyses and assumptions performed for each of these inputs.

Per Person "Value"

For the model, we estimated federal costs using varied approaches to benefit levels, resulting in four different options for the per person per month (PPPM) amount or "value." Assumptions about service utilization also are included.

Approach 1: Base Benefit Package

A stylized standard "base package" value was estimated to reflect similar programs that are either operating or have been proposed. The base package reflects an estimated value of \$450 PPPM and assumes individuals would use the entirety of the value each month. The base

package does not establish specific services but rather, uses a monetary value similar to experiences from the following programs:

1. **Community Aging in Place—Advancing Better Living for Elders (CAPABLE).** CAPABLE was developed at the Johns Hopkins School of Nursing and targets low-income older adults with difficulty with at least one ADL. The structured program is time-limited and focuses on helping participants decrease fall risks, improve functional status and independence, and age safely at home.⁹ Key components of the program include home-based, one-on-one care from a registered nurse (who provides four visits to each participant), an occupational therapist (who provides six visits to each participant), and a handyman (who provides up to \$1,200 in services including home modification). CAPABLE costs approximately \$3,000 in total per person, over a four-to-five-month period, and evidence suggests cost savings to the Medicare and Medicaid programs.¹⁰ This translates to a monthly cost of \$667 PPPM; however, the program is intended to provide a discrete benefit over a limited number of months, making it difficult to price out the longer-term, recurring monthly cost.
2. **Industry Trends.** Private sector home care programs available for approximately \$450 PPPM may include limited care coordination, handyman services, personal emergency response, home assessment/evaluation, and connection to services that help an individual maintain the home.¹¹ The home care model requires a participant to use an approved provider network, which helps mitigate risk to an individual who would otherwise purchase disparate services individually.
3. **Community-Based Institutional Special Needs Plan (CBI-SNP).** The CBI-SNP pilot has been introduced by Congress numerous times, including in 2015, 2017, and 2019. This pilot would span five years and provide a limited set of HCBS benefits to low-income Medicare beneficiaries aged 65 and older who are unable to perform at least two ADLs. The proposed legislation limits benefits to \$400 PPPM and includes homemaker services, home delivered meals, transportation services, respite care, adult day care services, safety and other equipment, and other services the Secretary deems appropriate.¹²

Drawing from the above programs, the base package assumption for this study is a limited benefit valued at \$450 PPPM. This dollar amount could purchase approximately 20 hours of agency-based personal care services per month,¹³ or 26-30 hours of self-directed personal care services per month.¹⁴ Other combinations of services that could be provided within this value

⁹ Johns Hopkins School of Nursing. "Community Aging in Place – Advancing Better Living for Elders (CAPABLE)." https://nursing.jhu.edu/faculty_research/research/projects/capable/index.html.

¹⁰ National Council on Aging. https://d2mkcg26uvq1cz.cloudfront.net/wp-content/uploads/ProgramSummary_CAPABLE.pdf.

¹¹ Home care provider interviews completed as part of the current study.

¹² Community-Based Independence for Seniors Act of 2019, H.R. 3461, 116th Cong. (2019). <https://www.congress.gov/bill/116th-congress/house-bill/3461/text?r=6&s=1>.

¹³ Includes both homemakers and home health aides. Genworth. <https://www.genworth.com/aging-and-you/finances/cost-of-care.html>. **Note:** Genworth estimates based on national monthly median costs in 2020.

¹⁴ Paying for Senior Care. (2020). <https://www.payingforseniorcare.com/homecare/agency-or-independent-caregiver>.

include home modifications, handy person support, food support, transportation, respite care, and adult day.

Approach 2: Personal Care Services Only

A stylized personal care services only benefit was modeled using financial experiences in Medicaid and the private market. An assumed benefit of 10 hours of services per week was used to calculate total cost, at an hourly rate of \$21.10. The assumed hours were based on the national median unpaid caregiver hours in 2019.¹⁵ The hourly rate was calculated by blending the average of 2020 Medicaid fee schedule values across a sample of 14 states with national averages for private sector home care, detailed below.

Medicaid

State Medicaid programs use different reimbursement approaches including per diem, overnight, hourly, and quarter-hour increments. Reimbursement amounts typically vary based on setting, individual complexity, number of individuals served in a single session, agency versus self-direction, and geography.

Personal care services reimbursement was analyzed from a sample of 14 states with geographic, demographic, and programmatic diversity: California, Colorado, Connecticut, Florida, Idaho, Maine, Mississippi, Montana, North Carolina, Nevada, Oklahoma, South Carolina, Washington, and Wisconsin. Services categorized as “homemaker,” “attendant care,” “personal care,” or “personal support” and reimbursed hourly (or less) were included for both agency and self-directed care. Calculated hourly rates in the sample ranged from \$14.00 to \$30.48, with an average across the states of \$18.45.

Private Market

Similar to Medicaid, private sector personal care services reimbursement varies by geography, a person’s level of need, and agency-directed versus self-directed care. A 2020 survey of private home health aides found the hourly rate ranged from \$17.00 in Louisiana to \$33.00 in Minnesota, with a national average cost of \$24.00 per hour. The national average cost for private homemaker services in 2020 was \$23.50.¹⁶

Approach 3: Median State HCBS Spend on Older Adults

This stylized approach assumes that the buy-in benefit levels would mirror Medicaid HCBS. Because state Medicaid programs have considerable cost experience providing HCBS to older adults, state spending on these services were modeled out and adjusted to reflect the likely increase above Medicaid fee schedules that would occur if similar benefit levels were provided through Medicare. The same adjustment factor applied to Approach 2, Personal Care Services, was applied to Approaches 3 and 4 in this study. This amounts to an increase of approximately 14 percent above state spending.

Substantial variation exists across state Medicaid HCBS benefit design, including the amount of services available, financial and level of need eligibility, and the Medicaid authorities used. The study focused on 1915(c) experiences because the majority of Medicaid HCBS expenditures are

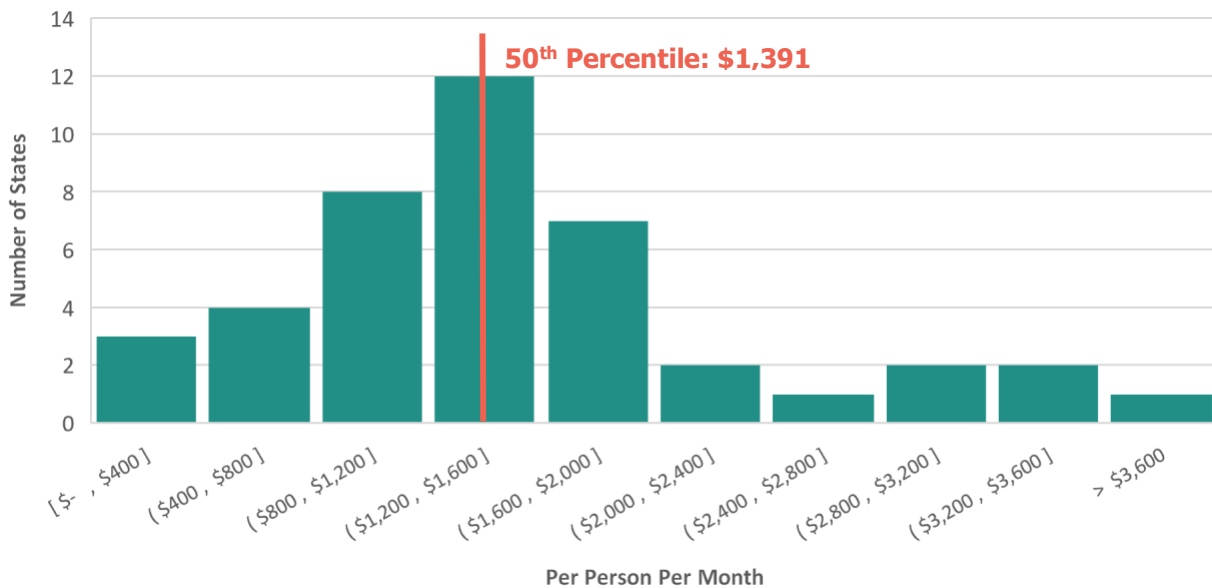
¹⁵ National Alliance for Caregiving and AARP. (2020). “Caregiving in the U.S.”

¹⁶ Genworth. (2020). “Cost of Care Survey”

<https://pro.genworth.com/riiproweb/productinfo/pdf/282102.pdf>.

associated with these waivers, and data are available specific to aged and physically disabled program participants (versus all Medicaid recipients who use LTSS). To account for differences in program design and expenditures, the study model used the 50th percentile of adjusted average state spending on HCBS services for aged and physically disabled individuals, or \$1,391 PPPM, with the assumption that the average program participant would use this level of services. Even with variation in state Medicaid approaches to HCBS, the distribution of adjusted spending across states most commonly clustered between \$1,200 and \$1,600 PPPM (Figure 4).

Figure 4. 1915(c) Adjusted Spending PPPM for Aged/Physically Disabled by Number of States, FY2018¹⁷



This approach estimates the average PPPM cost if the program were to allow individuals full access to needed HCBS, assuming care planning and prior authorization would be used in the program similar to the Medicaid program. A limitation to this approach is that it does not account for potential unmet need that exceeds state benefit limits, nor does it reflect other HCBS and HCBS-like services individuals might receive through other sources, such as state plan services or Medicaid managed care plan value-added benefits.

Approach 4: 90th Percentile State HCBS Spend on Older Adults

This approach is a variant of Approach 3, Median State HCBS Spend on Older Adults, but with the assumption that the average spending in the buy-in program matches the 90th percentile of state spending on 1915(c) waiver services. To estimate the likely highest scenario cost for providing HCBS in the Medicare program, the study modeled out the 90th percentile state per capita spend on 1915(c) waiver services for older adults, adjusted to reflect the likely increased cost of providing the services through Medicare. The PPPM associated with this approach was \$2,803.

¹⁷ Kaiser Family Foundation. (2020). Medicaid HCBS Program Surveys, FY 2018. **Note:** Graph excludes states with no 1915(c) spending for aged/physically disabled in FY2018.

Acute Care Savings

Assumed medical care savings from the provision of home and community-based LTSS that address unmet need, along with integration of Medicare acute care benefits and LTSS, are an important component of this study. Using findings from the Financial Alignment Initiative (FAI) and CAPABLE, the model assumes medical care savings associated with reduced hospitalizations, readmissions, emergency department visits, observation stays, and other post-acute care utilization.^{18,19} The model applies a medical care savings assumption commensurate with the total per person value of the monthly benefit, with a higher value HCBS benefit in the model assuming greater medical care savings. The minimum savings value was determined by taking the average PPPM of capitated FAI programs medical care savings (three states with no savings and three states with savings ranging from \$28.89 to \$78.90). This estimate likely is conservative given the FAI coordinated *existing* benefits but did not provide *new* LTSS benefits. Additionally, the programs tend to serve all dual eligibles regardless of complexity, whereas the current program would be exclusive to individuals with LTSS needs. The maximum savings value was set at the CAPABLE program savings level to reflect new services provided to a higher complexity population (see Figure 5).

Figure 5. Anticipated PPPM Medicare Savings Experiences

Minimum Savings	\$28.86
Average Savings	\$475.26
Maximum Savings	\$921.67

Subsidy Amounts

Three subsidy components are included in the model: whether full *and* partial subsidies are provided (versus full only); what the income level threshold(s) are for the full and partial subsidy participants; and, what the amount of the partial subsidy is as a percentage of the cost.

A limitation of the underlying data source is insufficient detail around individual assets; as a result, the subsidy calculation only considers income level as a percentage of the FPL. The total population likely to be eligible for the program was assessed against various FPL thresholds based on existing federal programs using subsidies or tax credits, including the Medicare Savings Program, Medicare Part D Low Income Subsidy, and Health Insurance Exchanges. Three subsidy scenarios were included in the model (see Figure 6 for different threshold levels). For model iterations including a partial subsidy, the partial subsidy amount was set at 50% premium coverage.

¹⁸ MACPAC. (August 2020). "Evaluations of Integrated Care Models for Dually Eligible Beneficiaries: Key Findings and Research Gaps" <https://www.macpac.gov/publication/evaluations-of-integrated-care-models-for-dually-eligible-beneficiaries-key-findings-and-research-gaps/>.

¹⁹ Health Affairs. (March 2017). "Innovative Home Visit Models Associated With Reductions In Costs, Hospitalizations, And Emergency Department Use" https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1305?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%20pubmed.

Figure 6. Subsidy Levels

Full Subsidy Levels	≤100% FPL <135% FPL <221% FPL
Partial Subsidy Levels	No partial subsidy 135-221% FPL 221-400% FPL

Enrollment

The percentage of each subsidized population (full, partial, unsubsidized) likely to enroll in the program was varied in each model iteration depending on out-of-pocket costs. Current Medicare Advantage enrollment rates also informed likely HCBS program enrollment because the program would be tied to a Medicare Advantage plan. As of December 2020, Medicare Advantage enrollment rates averaged 40 percent nationwide across *all* Medicare beneficiaries.²⁰ In the underlying data used for this study, enrollment in Medicare Advantage compared with Traditional Fee-for-Service (FFS) Medicare was statistically identical (p<0.01) for individuals categorized as having and not having LTSS needs, among those aged 65 and older and without full Medicaid benefits (Figure 7).

Figure 7. Enrollment in Medicare Advantage or Traditional FFS, by LTSS Need

	Medicare Advantage	Traditional FFS
Has LTSS Need	34.4%	65.6%
No LTSS Need	33.7%	66.3%

OUTCOMES

Twelve scenarios were run for the current study against both the standard and expanded eligibility beneficiary count and with assumptions for subsidy eligibility and amount, anticipated federal savings, and likely enrollment demand:

- Subsidy eligibility and amounts are purely independent variables, ultimately to be defined by policy and program specifications.
- Federal savings and expected enrollment demand are dependent on the PPPM value associated with each cost approach – a higher PPPM value is expected to result in higher PPPM savings, and conversely, lower enrollment demand among individuals with out-of-pockets costs.

Annual net federal costs for providing subsidized coverage ranged from \$1.1 billion to \$12.8 billion (see Figure 8).

²⁰ CMS Medicare Advantage/Part D Contract and Enrollment Data. (December 2020). <https://www.cms.gov/research-statistics-data-and-systemsstatistics-trends-and-reportsmcradvpartdenrolldata/monthly/monthly-enrollment-state-2020-12>.

Figure 8. Coverage Scenarios and Resulting Annual Federal Costs

Cost Approach	Full Subsidy	Partial Subsidy	Medicare Savings	Enrollment	Total Individuals Served and Net Federal Cost ²¹	
					Standard	Expanded
Base Package <i>\$450 PPPM</i>	≤100% FPL	N/A: No partial subsidy	Minimum	Full: 50% Partial: N/A Unsubsidized: 25%	Total Served: 632,633 Total Subsidized: 226,453 Net Annual Cost: \$1,144,420,997	Total Served: 671,706 Total Subsidized: 239,346 Net Annual Cost: \$1,209,578,093
	<135% FPL	135-221% FPL	Minimum	Full: 50% Partial: 15% Unsubsidized: 30%	Total Served: 697,845 Total Subsidized: 389,965 Net Annual Cost: \$1,813,715,521	Total Served: 741,684 Total Subsidized: 413,776 Net Annual Cost: \$1,924,722,896
	<221% FPL	221-400% FPL	Minimum	Full: 50% Partial: 20% Unsubsidized: 35%	Total Served: 803,687 Total Subsidized: 633,929 Net Annual Cost: \$2,911,402,009	Total Served: 851,987 Total Subsidized: 675,052 Net Annual Cost: \$3,094,244,091
Personal Care Services Only <i>\$914 PPPM</i>	≤100% FPL	N/A: No partial subsidy	Minimum	Full: 50% Partial: N/A Unsubsidized: 15%	Total Served: 470,161 Total Subsidized: 226,453 Net Annual Cost: \$2,406,217,113	Total Served: 498,762 Total Subsidized: 239,346 Net Annual Cost: \$2,543,214,005
	<135% FPL	135-221% FPL	Minimum	Full: 50% Partial: 10% Unsubsidized: 20%	Total Served: 575,830 Total Subsidized: 370,577 Net Annual Cost: \$3,724,907,481	Total Served: 611,843 Total Subsidized: 393,237 Net Annual Cost: \$3,953,051,132
	<221% FPL	221-400% FPL	Minimum	Full: 50% Partial: 15% Unsubsidized: 25%	Total Served: 728,123 Total Subsidized: 606,867 Net Annual Cost: \$6,002,982,663	Total Served: 772,059 Total Subsidized: 645,677 Net Annual Cost: \$6,377,297,949
Median State HCBS Spend <i>\$1,391 PPPM</i>	≤100% FPL	N/A: No partial subsidy	Average	Full: 50% Partial: N/A Unsubsidized: 10%	Total Served: 388,925 Total Subsidized: 226,453 Net Annual Cost: \$2,489,497,468	Total Served: 412,290 Total Subsidized: 239,346 Net Annual Cost: \$2,631,235,890
	<135% FPL	135-221% FPL	Average	Full: 50% Partial: 5% Unsubsidized: 12.5%	Total Served: 479,472 Total Subsidized: 351,189 Net Annual Cost: \$3,698,918,748	Total Served: 509,327 Total Subsidized: 372,698 Net Annual Cost: \$3,925,759,430
	<221% FPL	221-400% FPL	Average	Full: 50% Partial: 10% Unsubsidized: 15%	Total Served: 652,558 Total Subsidized: 579,805 Net Annual Cost: \$5,922,200,824	Total Served: 692,131 Total Subsidized: 616,302 Net Annual Cost: \$6,284,809,261
90th Percentile State HCBS Spend <i>\$2,803 PPPM</i>	≤100% FPL	N/A: No partial subsidy	Maximum	Full: 50% Partial: N/A Unsubsidized: 5%	Total Served: 307,689 Total Subsidized: 226,453 Net Annual Cost: \$5,111,777,012	Total Served: 325,818 Total Subsidized: 239,346 Net Annual Cost: \$5,402,813,744
	<135% FPL	135-221% FPL	Maximum	Full: 50% Partial: 0% Unsubsidized: 7.5%	Total Served: 408,771 Total Subsidized: 331,801 Net Annual Cost: \$7,489,822,278	Total Served: 434,135 Total Subsidized: 352,158 Net Annual Cost: \$7,949,345,643
	<221% FPL	221-400% FPL	Maximum	Full: 50% Partial: 5% Unsubsidized: 10%	Total Served: 601,245 Total Subsidized: 552,743 Net Annual Cost: \$12,022,089,512	Total Served: 637,480 Total Subsidized: 586,927 Net Annual Cost: \$12,754,836,128

²¹ Net federal costs do not include unsubsidized payments made by individuals.

DISCUSSION AND NEXT STEPS

The current study estimates the potential cost to the federal government of adding an LTSS benefit to the Medicare program or alternatively, as a buy-in option in Medicaid, for individuals without full Medicaid coverage and living in the community. It also estimates the likely number of Medicare beneficiaries aged 65 and older who reside in the community and who need LTSS. As noted in the report, similar program proposals have been explored by others, for example the Community-Based Independence for Seniors Act of 2019 (CBI-SNP), bipartisan legislation that would test a limited HCBS benefit in up to 5,000 low-income Medicare beneficiaries with two or more ADL limitations.²² Of note, the CBI-SNP legislation assumes the program becomes budget neutral in aggregate across Medicare and Medicaid spending by year 3 of the demonstration.

This study suggests that the federal government could subsidize a limited LTSS benefit for up to 675,052²³ Medicare beneficiaries at an annual cost of \$1.1 - \$3.1 billion. Depending on the frailty of program enrollees, a limited benefit package could ultimately avoid Medicare and Medicaid expenditures that would otherwise occur. Findings from the CAPABLE model have resulted in Medicare and Medicaid savings of \$922 and \$867 PPPM, respectively.²⁴ In addition, Medicare savings from capitated FAI programs have ranged up to \$78.90 PPPM.²⁵

Furthermore, this benefit would provide some financial relief to individuals who would otherwise have to purchase these services privately. Even in the absence of a federal subsidy, an individual would benefit from the federal government's purchasing power and total enrollment volume. This study estimates a savings to individuals of between 12 and 23 percent,²⁶ based on current Medicaid fee schedules and the assumption that the savings would be reflected in reduced premiums/ buy-in amounts. However, these savings could be higher as a result of decreased acute care needs and the expectation that The Centers for Medicare & Medicaid Services (CMS) could deploy some part of the resulting acute care savings into premium buy-downs for unsubsidized individuals (see Figure 9 for other policy considerations).

While this analysis focuses on piloting an LTSS benefit in the Medicare program, it could also be deployed as a buy-in to Medicaid through an integrated plan. Medicaid implementation of this benefit could potentially result in lower federal costs than those estimated in this study, depending on the percentage of federal matching amounts.

²² Community-Based Independence for Seniors Act of 2019, H.R. 3461, 116th Cong. (2019). <https://www.congress.gov/bill/116th-congress/house-bill/3461/text?r=6&s=1>.

²³ This is the total full and partial subsidized beneficiaries; this number does not include unsubsidized beneficiaries.

²⁴ CAPABLE Bundle Payment Model: Community Aging in Place—Advancing Better Living for Elders. Proposal for Physician-Focused Payment Model Technical Advisory Committee. (Oct 2018)

²⁵ MACPAC. (August 2020). "Evaluations of Integrated Care Models for Dually Eligible Beneficiaries: Key Findings and Research Gaps" <https://www.macpac.gov/publication/evaluations-of-integrated-care-models-for-dually-eligible-beneficiaries-key-findings-and-research-gaps/>.

²⁶ This range is based on the difference between Medicaid and private sector personal care reimbursement, with an overall difference of 23 percent between the two payers, and an average that results in a 12 percent decrease on private payer reimbursement.

Considerations

Certain program design and related considerations were out of scope for the current study but should be addressed through future research efforts. Key considerations are detailed below.

Emerging Policy Efforts and Program Design

This research was finalized in December 2020, and numerous proposed policy efforts would impact the cost estimates in this study. For example, federal efforts to expand Medicaid HCBS eligibility would decrease the total population eligible for the Medicare-only program, thereby decreasing this program's costs. Conversely, increasing the minimum wage would increase the total per person costs associated with federal subsidies.

Additionally, advancing technology and HCBS approaches will influence PPPM costs. The Novel Coronavirus of 2019 (COVID-19) increased and expedited the role of technology and virtual care in the home, but the potential lasting impacts of these advancements are not clear. Similarly, as Medicare Advantage plans increasingly use supplemental benefits to address LTSS needs, unmet need for lower complexity individuals may decline.

Cost Inflation

Since 2016, the cost of private market home care has increased by 20 percent. A small portion of this is attributable to COVID-19 (e.g., added expense of personal protective equipment), but costs jumped considerably between 2018 and 2019, prior to COVID-19.²⁷ State Medicaid cost growth associated with HCBS is more difficult to determine because states adjust services based on annual budget targets and programs are redesigned as state and federal political administrations change. However, research suggests an annual HCBS expenditure growth rate similar to private sector home care of 5.0 percent between 2013 and 2016, for Medicaid recipients categorized as aged or physically disabled.²⁸

Growing Medicare Population

The underlying data used to size the population and estimate costs reflect 2017 Medicare enrollment. The Medicare population in total grew by approximately 5 percent between 2017 and 2020.²⁹ However, because much of the new-to-Medicare population is becoming eligible due to turning age 65, a similar 5 percent growth factor cannot be applied to the numbers in this study.³⁰ Data from this study suggest only a small portion of individuals aged 65-74 without full Medicaid benefits have LTSS needs (2 percent in the current study, compared with 14 percent of Medicare beneficiaries aged 85 and older), and among all Medicare beneficiaries aged 65 and older with LTSS needs, more than two-thirds are over the age of 75.

²⁷ Genworth. (2020). "Costs of Care Trends & Insights" <https://www.genworth.com/aging-and-you/finances/cost-of-care/cost-of-care-trends-and-insights.html>.

²⁸ Eiken S, Sredl K, Burwell B, and Amos, A. (May 2018). "Medicaid Expenditures for Long-Term Services and Supports in FY 2016" <https://www.medicaid.gov/sites/default/files/2019-12/ltssexpenditures2016.pdf>.

²⁹ ATI Advisory analysis of CMS enrollment files.

³⁰ In 2018, 83 percent of all new-to-Medicare beneficiaries were aged 65-74, and 99 percent of those aging into Medicare were aged 65-74.

CMS. "2018 Medicare Enrollment, Section AB 23" <https://www.cms.gov/research-statistics-data-systems/cms-program-statistics/2018-medicare-enrollment-section#New>.

Medicare Solvency

The Congressional Budget Office estimates the Medicare Part A Trust Fund will become insolvent by 2024,³¹ amounting to a spending cut of approximately 17 percent per Medicare beneficiary on average. And although limited HCBS and practice-extender benefits in a targeted population have been shown to provide both Medicare and Medicaid savings, these benefits could net a cost to the Medicare program in the absence of state or other stakeholder contribution depending on program design.

Integration

This program would target individuals without full Medicaid benefits and does not address the broader system's lack of integration between acute care and long-term care for full dual eligibles. Individuals churn in and out of Medicaid eligibility, and some could become fully dually eligible during their participation in this program. Shifting out of the program and into separate Medicare and Medicaid programs likely would result in dis-integrated care, disruption, and confusion for these individuals, particularly if churn is frequent. The Bipartisan Policy Center separately has published recommendations that would require full integration for dual eligibles.³²

State Versus Federal Administration

Because formal LTSS generally is limited to the Medicaid program, fee schedules, provider certification, quality standards, and eligibility vary considerably across states. Conversely, much of this is standardized in the Medicare program for non-LTSS providers. Various provider payment approaches could be used for this program, including Medicaid fee schedule rates, a Medicare inflation factor on state Medicaid fee schedule rates, or allowing plans to negotiate rates with LTSS providers based on a blend of commercial, Medicaid, and Medicare experience. Medicare Advantage plans currently are permitted to provide a limited set of HCBS using supplemental benefit authority, and early findings suggest plans are using prevailing Medicaid rates for these provider relationships, but providers are finding this insufficient to support the more limited volume of services.³³

Adverse Selection

This research was performed with the intent to enroll individuals at the time of need and quantified costs based on an assumption that all enrollees would use services, versus a traditional insurance program that enrolls individuals before a high level of need exists. Research has shown that the highest cost HCBS users are disproportionately *under* age 65.³⁴ However, because program benefits would be available at enrollment, a robust benefit package

³¹ Congressional Budget Office. The Outlook for Major Federal Trust Funds: 2020 to 2030. (Sept 2020).

³² Bipartisan Policy Center. (2020). "A Pathway to Full Integration of Care for Medicare-Medicaid Beneficiaries" <https://bipartisanpolicy.org/report/a-pathway-to-full-integration-of-care-for-medicare-medicaid-beneficiaries/>.

³³ ATI Advisory and Long-Term Quality Alliance. (2020). "Providing Non-Medical Supplemental Benefits in Medicare Advantage: A Roadmap for Plans and Providers" <https://atiadvisory.com/wp-content/uploads/2020/11/Providing-Non-Medical-Benefits-in-Medicare-Advantage-a-Roadmap-for-Plans-and-Providers.pdf>.

³⁴ MACPAC, June 2018. Medicaid Home- and Community-Based Services: Characteristics and Spending of High-Cost Users

would attract individuals with the highest levels of complexity, thereby increasing the average monthly cost overtime if the benefit was not limited. A permanent program likely would apply late enrollment penalties, similar to approaches used in Medicare Part B and Part D, to address costs associated with adverse selection.

Policy Specifications

Given the considerations detailed above, an important next step of this research is to define the policy specifications necessary to maximize program success. Key policy questions are listed in Figure 9.

Figure 9. Policy Questions Essential to Long-term Program Success

Program Eligibility	<ul style="list-style-type: none"> • Should the program be available to Medicare beneficiaries of all ages, or limited to specific age cohorts (e.g., 65+)? • What is the appropriate level of need/functional eligibility to qualify for program benefits? • How is program eligibility affected if an individual becomes fully dually eligible for Medicaid?
Program Design and Administration	<ul style="list-style-type: none"> • Should the program be limited to a discrete benefit, or should the covered benefits be open-ended? Should the benefits be tiered to account for beneficiary complexity? Should a person be permitted to purchase additional hours or services at the prevailing federal rate? Is prior authorization permitted? • Should the program become a new type of special needs plan and similarly limited to individuals who meet plan eligibility criteria; should the program be delivered through supplemental benefits; or, do the benefits become a new “Part” of Medicare? • Should the program be provided through Medicare Advantage only, or should it also be made available to beneficiaries in fee-for-service accountable care models? Alternatively, should it function as a buy-in to Medicaid? • Is there a formal Model of Care requirement associated with the program?
Intersection with Other Programs	<ul style="list-style-type: none"> • What is the role of state Medicaid agencies, given the likelihood this benefit program would delay or prevent spend-down to full Medicaid coverage? • Can Long-term Care insurance policies be used to pay for program premium costs? • Should Medicare Advantage plans be required to participate in the program, and/or is it limited to specific Medicare Advantage organizations based on their participation in D-SNP, I-SNP, and Medicaid MLTSS programs?
Program Payment and Savings	<ul style="list-style-type: none"> • How should anticipated acute care savings be accounted for in Medicare Advantage benchmark payments? • How are savings reinvested into reduced premiums?

Policymakers continue to seek solutions to address unmet LTSS need. This study offers insights for policymakers to consider, and adds to existing literature and program options by estimating the costs based on varying levels of home and community-based LTSS coverage and for a broader population, as well as different subsidy approaches based on income level.

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