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Valuation of Senior Healthcare: Reimbursement

As noted in the first installment of this five-part series, senior healthcare options have dramatically expanded in the past decade, and seniors have more healthcare service choices than ever before to meet varied care needs and income levels. These myriad available options, each of which are discussed further below, also have differing reimbursement levels and coverage from Medicare, Medicaid, and/or commercial insurance, or, in some cases, no coverage at all; many long-term care options are paid for solely by the senior.

Independent Retirement Community

The cost of retirement communities can vary greatly. Some communities, such as subsidized senior housing, are funded by the *U.S. Department of Housing and Urban Development* (HUD), making this option more affordable.[1] Other communities are targeted at affluent seniors and offer numerous amenities to community residents, such as spas and housekeeping services.[2] Retirement communities branded as *all-inclusive* will often have an entrance fee,[3] and generally, the more expansive the amenities list, the more expensive the option. Entry fees to retirement communities can range from $1,800 to $600,000.[4] Additionally, retirement communities may have monthly fees based on the level of service chosen and the scope of benefits.[5] Retirement communities do not necessarily provide any medical services, but rather housing and amenities.

There is no Medicare or Medicaid coverage for housing or non-medical services provided in these communities, and minimal commercial insurance reimbursement. Consequently, retirement communities receive entry fees and monthly fees from the resident.

Continuing Care Retirement Community (CCRC)

The flexibility of CCRCs render them a more expensive option, and thus are typically marketed to the more affluent senior community. Two-thirds of CCRCs charge an entry fee,[6] with the average at $329,000, but with some charging well over $1 million.[7] Further, seniors pay additional fees upon moving in, such as monthly maintenance or service fees averaging $2,000 to $4,000 per month.[8] For CCRCs offering no up-front cost, rental units average $3,000 to $6,000 per month in addition to the maintenance or service fees.[9]

There are five categories of residency agreements offered by CCRCs:[10]

(1) *Extensive*: Residents pay an entry fee and a monthly fee that does not increase upon transfer to an assisted living or skilled nursing facility at the CCRC. The entry fee and monthly fee prepay the costs of healthcare and long-term care.

(2) *Modified life care*: Residents pay an entry fee and monthly fee that may increase upon transfer to higher levels of care, but not to the full cost of the care. There is still a prepayment of some future healthcare and long-term care costs through the entry fee, but it is limited.

(3) *Fee-for-service*: Residents pay an entry fee and monthly fee that changes as the level of care changes. Residents must pay the full costs of any care provided, and there is no prepayment.

(4) *Equity model*: Residents do not have to pay an entry fee, but instead must purchase a unit, membership, or equity stake in the community. Upon death, the resident's estate sells the unit, membership, or equity stake to a new resident, which provides additional funds to the estate. Future healthcare is provided by prepayment via monthly fees or a separate healthcare fee.

(5) *Rental/Lease*: A monthly fee is paid that increases with the level of care—no prepayment or entry fee is required.

Additionally, CCRCs may offer a variety of services on-site, including pharmacies, wellness centers, and outpatient centers.[11] A CCRC may provide some or all of the other service lines mentioned throughout this article. Depending on the service(s) provided, the CCRC may be reimbursed by Medicare, Medicaid, or the patient.

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Adult Day Care (ADC)

State Medicaid programs are increasingly covering the care provided at ADCs,[12] and many programs are insisting on the use of ADCs over the use of nursing homes, because it reduces the number of nursing home admissions, which are also paid for by Medicaid, and usually at a much higher rate.[13] In 2019, the average annual cost for ADC was $19,500.[14]

As of 2019, all states offer some form of Medicaid assistance for ADC, although the circumstances under which Medicaid will pay for ADC varies.[15] The state programs most likely to cover ADC facilities are called Medicaid waivers, also referred to as *HCBS Waivers*, *1915(c) Waivers*, *1115 Demonstration Waivers*, or *Home and Community Based Waivers*.[16] Medicaid waivers allow states to provide long-term care outside of nursing homes.[17] The states with Medicaid waiver programs often have higher income limits than regular Medicaid programs,[18] resulting in a greater number of potential ADC patients; however, this often leads to enrollment caps and waiting lists.[19] Fifteen states offer ADC benefits through regular Medicaid programs,[20] which enrollments are not capped; however, there may still be waiting lists.[21]

Access to ADCs has become more prevalent as such facilities have begun providing services for patients with dementia or Alzheimer's disease.[22] Significantly, ADCs offering such specialized services may be costly to the patient, or their family, if those services are not covered by Medicaid.[23]

In addition to Medicaid coverage, many Medicare Advantage plans provide partial coverage for ADC services.[24]

Assisted Living Facilities (ALFs)

ALF services are not reimbursed by most private payors, Medicare, or Medicaid.[25] Due to the lack of reimbursement, this option can be a costly endeavor for many seniors – in 2019, the average annual cost for an ALF was $48,612.[26] However, certain ALF services may be reimbursed by Medicaid, such as nursing care, medical exams, and medication management.[27] While 44 states now provide some form of financial assistance to seniors in assisted living,[28] no Medicaid program is permitted to pay for room and board.[29] Additionally, the state may offer supplemental Social Security assistance to cover some ALF living costs.[30] Consequently, most ALF reimbursement comes from the patient.

Adult Foster Care

As with other senior care options, the cost of adult foster care can vary depending on the geographic region,[31] as well as other factors, but averages between $24,000 and $48,000 per year.[32] Further, seniors seeking more privacy and a higher level of service can expect a 30% premium or more.[33] Nevertheless, adult foster care generally costs less than an ALF or a nursing home.[34]

Adult foster care is increasingly popular in the private pay market, allowing facilities to cater to specific clientele at different price points.[35] Consequently, the majority of adult foster care reimbursement comes from individual senior payment.[36] While Medicare offers no coverage for adult foster care, Medicaid may cover a portion of the monthly fee for these facilities.[37] The model has been adapted to work for low income and Medicaid-eligible seniors, with states utilizing adult foster care as an alternative to nursing homes for Medicaid waiver beneficiaries.[38] However, Medicaid does not typically cover room and board.[39] Notably, state-specific social security benefits, in some cases, can be paid directly to an adult foster care facility to help cover the cost of care.[40]

Nursing Care Facilities

Nursing care facilities dominate the senior healthcare industry in terms of market share and house approximately 1.3 million people in a given year.[41] Nursing facilities generally care for older patients who are more prone to injury and illness and thus are more likely to require more intensive medical services.[42] The two senior nursing care service lines, which are typically located within the same building, are skilled nursing facilities (SNFs) and nursing home facilities.

SNF facilities provide care to patients for short durations after an inpatient hospital stay.[43] Medicare fully covers SNF stays for up to 20 days, and partially covers SNF stays over 20 days and up to 100 days.[44] SNF admissions and payments have declined in recent years as hospital inpatient stays (a prerequisite to a Medicare coverage of a SNF stay) have decreased.[45] Declines in SNF use may also reflect broader trends toward value-based reimbursement such as accountable care organizations (ACOs) and bundled payment models, which incentivize lower use of SNF facilities.[46] ACOs have lowered spending by shortening stays in SNFs.[47] Value-based healthcare delivery and reimbursement trends have negatively affected SNFs, causing the reduced volume of patients, mandatorily shortened length of stays, and claims denials.[48] Currently, Medicare's SNF payment model favors treating rehabilitation patients over medically complex patients.[49] However, in October 2019, CMS adjusted the SNF payment model to better reflect the clinical needs of patients.[50] The redesign seeks to increase payments for medically complex patients who may have higher costs.[51]

In 2018, the SNF value-based purchasing (VBP) program began providing incentive payments[52] to SNFs based on the achievement of certain quality measures, such as readmissions for any cause within 30 days of hospital discharge.[53] In 2019, 73% of SNFs failed to meet the proscribed quality measures (resulting in payment reductions), and only 3.1% of SNFs have achieved the "*best performance*" category.[54] Payment reductions are likely to persist in the industry due to the mixed quality results.[55]

The Medicare margin of profit varies widely across facilities, which may reflect the shortcomings of SNFs or of the payment system generally.[56] In 2018, the average

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Medicare margin for SNFs was 10.3%, the 19th year it was above 10%.[57] Perhaps in a move to rectify this discrepancy, CMS increased 2020 SNF payments 2.4% from 2019 levels.[58]

Long-term nursing care (nursing homes) caters to an older demographic, with 80% of all nursing home residents over 65 years old (i.e., Medicare beneficiaries).[59] However, despite this fact, long-term nursing care (100+ days) is not covered by Medicare and is primarily reimbursed by Medicaid, the patient, or the patient's private insurance.[60] The care provided at a long-term nursing facility is less intensive than at an SNF.[61] Despite some reimbursement from Medicaid, approximately half of all nursing home residents self-pay.[62] Once a patient's savings and resources are exhausted, the patient is then eligible for Medicaid, which in some states may reimburse for long-term care.[63] While Medicaid eligibility varies significantly from state to state,[64] the average patient must typically have assets valued under $2,000 and monthly income under $2,313 to qualify.[65]

While Medicaid is unlikely to pay for a separate room for patients in long-term nursing care unless there is a medical need, some states allow for "*family supplementation*" to enable the patient to have a separate room.[66] Medicaid reimbursement rates can vary depending on the state, but on average, Medicaid reimburses at 70% of private payors.[67] In 2019, the average cost of a shared room was $90,155 annually or $247 per day.[68] There is a considerable variation based on geographic location, with shared rooms ranging from $150 per day to well over $1,000.[69]

Hospice Care Facilities

As discussed in the first installment of this series, hospice care is palliative, end-of-life care. Due to the demographics of individuals (mainly seniors) requiring end-of-life care, 90% of hospice industry revenue is derived from Medicare (which will reimburse hospice charges if the patient has been certified by a physician with less than six months to live[70]) or Medicaid.[71] Due to the heavy reliance on government reimbursement, any change in reimbursement by Medicare can have profound effects on hospice profit margins; these margins, which were 12.6% in 2017,[72] were estimated to dip to 10.1% in 2019.[73] The decline in profit is partly due to the reductions to the annual Medicare payment update; in 2014, CMS established a quality reporting program, which reduced by 2 percentage points a non-compliant hospice's reimbursement.[74] Further, the annual updates to the Medicare payment rate, which are based on the inpatient hospital market basket update, are reduced by a multi-factor productivity adjustment, as required by the *Patient Protection and Affordable Care Act* (ACA).[75]

There are four levels of hospice care, each of which garners a different base rate:[76]

Category	Description	2020 Base Rate
Routine Home Care (RHC)	Home care provided days 1-60	$194.50
RHC 61+	Home care provided days 61+	$153.72
Continuous Home Care (CHC)	Home care provided during a patient crisis	$1,395.63 (Hourly rate: $58.15)
Inpatient Respite Care (IRC)	Inpatient care for a short period to provide respite for a caregiver	$450.10
General Inpatient Care (GIC)	Inpatient care to treat symptoms that cannot be managed in other settings	$1,021.25

Additionally, Medicare imposes limits (hospice caps) on the total amount of annual payments that a hospice provider can receive for specific services and in aggregate.[77] There are two hospice caps – the *inpatient* cap and the *aggregate* cap.[78] The hospice inpatient cap is calculated as a percentage of all hospice days that were provided as inpatient days through a specific period.[79] The inpatient cap limits the number of inpatient days for which a hospice provider can provide services.[80] Once the cap is exceeded, inpatient days are paid at the lower RHC rate.[81] However, most hospice providers do not exceed the inpatient cap limit.[82] The aggregate cap limits the total payments that may be received in a year in aggregate for an entire patient population.[83] Medicare multiplies the aggregate cap by the total number of patients, and if that number is lower than the actual amount paid to the hospice provider, then repayment is necessary.[84] In 2020, CMS set the aggregate cap to $29,964.78.[85] In 2017, 14% of hospices exceeded the aggregate cap and were forced to repay the excess amount to Medicare.[86]

Future Trends

The variation in senior healthcare delivery is likely to persist well into the future, driven by the differing needs of their patients. Further, government reimbursement for these services may be forced to expand as seniors become an increasingly more significant segment of the population. Senior care models that can scale to different income levels and reimbursement methods will likely be well positioned for future changes.

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