Time for a Change: The COVID-19 Nursing Home Disaster and the Urgency of LTSS Reform.

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Introduction

As increasing numbers of nursing home residents and workers receive the COVID-19 vaccines in early 2021, policymakers may be lulled into thinking a problem has been solved and they can move on to other priorities. That would be a mistake. The deaths of 150,000

* This article draws upon discussions by the authors in "The Future of Long-Term Care in the United States," in The Future of Long-Term Care, Chapter 3, Pablo Villalobos Dintrans (editor), Hauppauge, NY: Nova Science Publishers, residents and workers in nursing homes in 2020 are not an inevitable result of the pandemic. Instead, responsibility for the exponential spread of disease and its terrible consequences in nursing homes lies in the nation's long-standing failure to effectively manage public policies toward long-term services and supports (LTSS). Today, one and a half million people who need LTSS are nursing home residents and another twelve and a half million people with LTSS needs live, and want to stay, in their homes and in the community (Hado and Komisar 2019; CRS 2019). Without substantial policy reform, they (along with people who become impaired in the future) will remain at risk from the inadequate enforcement of quality standards in nursing homes, the over-reliance on underand unpaid caregivers both in nursing homes and in the community , and--crucially--the insufficient public investment in support that characterize the nation's current approach to LTSS.

These fundamental shortcomings will not be easy to fix; indeed, they have been tolerated for decades. But the public attention they have garnered in the pandemic offers policymakers an opportunity to transform our LTSS "system." In this article, we call on the Biden Administration and the new Congress to do just that--in the short-term, by redressing the glaring inadequacies the pandemic has revealed, and, over the longer term, by building a quality system that assures universal access to LTSS through social insurance.

Background and Fundamental Problems

The LTSS experience with COVID-19. As of this writing (mid-April 2021), the US had a cumulative total of more than 31 million confirmed cases and almost 575,000 deaths attributed to COVID-19 (Gamio 2021; Johns Hopkins University Coronavirus Resource Center, April 2021). Nursing home residents and staff accounted for more than 125,000 of those deaths through December 2020 (an estimated 40 percent of all COVID-19 deaths at that time) (Chidambaram, Garfield, and Neuman 2020; Chidambaram et al. 2021); in more than half the states, the proportion exceeded 50 percent. By another measure, the median case fatality rate in nursing homes--the number of deaths among people who tested positive (i.e., cases)--was estimated to be 10% by mid-March 2021 (New York Times, March 31, 2021)--more than five times the case fatality rate of 2% for the US as a whole between March 2020 and March 2021.

By June 2020, analyses of differences in case fatality rates among facilities implied that community spread of the virus was a key factor in explaining differences among areas where there were high and low case fatality rates in facilities. As one executive of a nursing home with few cases said, "It's there but for the grace of God go I." (Crimaldi 2020). The pattern of community spread and outbreaks in nursing homes was repeated in July in Florida, Texas and Arizona, where the numbers of COVID-19 cases rose sharply by late July, and again in a third wave between November 1, 2020 and February 8, 2021 when 35 state had more than half their total deaths occur (Gamio 2021).

But tagging community spread as the culprit is too simple. Policies and management decisions explain much of how COVID-19 affected residents and workers in some nursing facilities but not in others. In the first two months of the pandemic, at least four factors created a perfect storm for community spread to hit some LTC facility providers especially hard. First, many of the hardest hit facilities depended primarily on the federal-state Medicaid program to finance the low-income residents they served. Low Medicaid payment rates left these facilities poorly prepared--with gaps ranging from cleaning supplies to personal protective equipment (especially masks and disposable gloves). Second, facilities with COVID-19 outbreaks were disproportionately located in urban areas. These facilities rely heavily on low-paid workers who often live in densely populated neighborhoods and use public transportation that exposes them to community spread. Third, illness among caregivers left many facilities with far fewer workers than necessary to deal with contagious diseases, exacerbating long-standing staffing deficiencies and high turnover rates. Finally, well-intentioned but, as it turned out, greatly mistaken state policies in several states to free up hospital resources brought the virus to nursing homes. These policies promoted the movement of hospitals' non-COVID-19 patients and recovering COVID-19 patients, some of whom were asymptomatic but, as it turned out still shedding virus, into nursing homes, where they rapidly infected this highly susceptible patient population. Without the capacity for rapid testing, a year into the pandemic, the risk of discharging asymptomatic COVID-19 patients to nursing home persists.

Persistent failure to assure quality care. Inadequate nursing staffing and shortages of resources to prevent contagious diseases - revealed by COVID-19 - reflect long-standing failures to enforce federal standards for nursing home care (Harrington 2017; Edelman 2018; GAO 2019(a); GAO 2019(b); GAO 2020; Cenziper, Jacobs and Mulcahy 2020). Based on state compliance surveys, the Centers for Medicare and Medicaid Services (CMS) can impose civil money penalties (fines) either per day or per instance, deny payment for some services, or terminate the nursing home from Medicare and Medicaid when standards are not met. However, these enforcement actions have been used sparingly.

Recent research found that 75% of nursing homes almost never meet prescribed staffing levels, especially weekend staffing for registered nurses (Geng, Stevenson, and Grabowski 2019). During the first six months of the COVID-19 pandemic, when all nursing homes were quickly surveyed about their infection prevention and control measures, almost one in four were found to have violations; most were issued small or no fines (Cenziper, Jacobs, and Mulcahy 2020). But even fines are poor deterrents. As one former state chief health inspector said, "Unless the fines and penalties have teeth and significance, [nursing homes would] just as soon pay them and move on." (Cenziper, Jacobs, and Mulcahy 2020).

Beyond its responsibility for the general enforcement of quality standards, CMS is required to provide special oversight of nursing homes that have a pattern of serious deficiencies over at least three years, a category known as Special Focus Facilities (SFF). Only 88 nursing homes have been on the list of SFFs in recent years. In June 2019, two Senators released a report naming almost 400 nursing homes that should have been but were not included due to lack of funding for monitoring (Casey and Toomey 2019).

Research shows that nursing home quality is systematically associated with types of ownership. Ownership is not regulated by CMS, but the performance of for-profit--especially chain-affiliated--providers suggests the need for greater oversight and accountability for these providers in particular. For-profit homes (80 percent, NCHS 2019, p. 9) and chain-affiliated homes (58 percent, NCHS 2019, Fig. 5) have shown substantially higher rates of PPE shortages (though not staff shortages) than non-profit or governmentowned facilities (McGarry, Grabowski, and Barnett 2020). By one estimate, 18 of the 30 largest corporations that operated nursing homes in 2019 managed 12% of all nursing homes (IQVIA 2019). Furthermore, pre-COVID-19 research found evidence of a decline in the number of "frontline" caregivers (certified nursing assistants and licensed practical nurses) in the year following a private equity buyout of a nursing home (Gupta et al. 2020). Recent findings build on a large body of research tying quality deficiencies to chains whose opaque ownership structures defy public accountability for both quality and financial performance (Stevenson and Grabowski 2008; Harrington et al. 2012; Stevenson, Bramson, and Grabowski 2013; You et al. 2016; Grabowski et al. 2016; Rau 2018; Gupta et al. 2020). Almost three quarters of the nation's facilities purchase services or hire staff through separate companies that they or family members fully or partially own--rewarding themselves with excessive payment and reaping substantial profits, while underserving their residents (rau 2018). Such behavior has led consumer advocates to call for new rules that would make ownership and tax returns transparent, pre-approve ownership changes, and adopt payment strategies that direct spending toward service and wages, rather than profit and administrative costs (Cenziper et al. 2020).

Research also shows that nursing home quality is systematically associated with "payer mix"--or the degree to which a facility serves low-income Medicaid patients rather than short-stay Medicare patients and long-term residents who pay for some or all of their own stays (Grabowski 2019; Mor et al. 2011). The predominance of lower-income residents is associated with greater staff shortages, particularly among frontline workers (echoing findings by Gupta et al. (2020)), which in turn reflect the "underpayment of Medicaid for nursing home costs."

Differences in Payer Rates Disadvantage Low-Income People. Nursing homes have historically demonstrated their considerable ability to select among patients based on the profits or net revenues they are likely to generate (Feder and Scanlon 1982; Smits, Feder and Scanlon 1982; Feder 2013; Silver-Green berg and Harris 2020). Medicaid is the federalstate program that is the nation's safety net for people who need long-term care when they are or have become impoverished. It is the primary payer for 60 percent of all nursing home residents (Rudowitz, Garfield and Hinton 2019), and two-thirds of all nursing home "resident days," when short-stay rehabilitation versus long-stay residency are accounted for (Spanko 2019(a)). But prior to the COVID-19 pandemic, Medicaid accounted for only about 30 percent of nursing home revenues (MACPAC 2020(b), Exhibit 3). Other primary sources of nursing home revenues are Medicare, the federal health insurance program for people at least 65 years of age and some non-elderly with qualifying disabilities, and "private-pay" patients who pay for some or all of their own stay.

Private-pay patients are favored over other patients because nursing homes are free to set the prices they charge and the level of care they provide; they are a source of strong profit margins. Medicare is prohibited by statute from paying for long-term "custodial" or nursing home care. But it does pay nursing homes for "post-acute care"- up to 100 days of skilled care (nursing or rehabilitation services) following an inpatient hospital stay of at least three days. Medicare-covered nursing home stays average about 25 days. (MedPAC 2020). Because of its higher payment rates, however, Medicare's share of facilities' revenues (20 percent in 2019) was almost double its share of resident days (11 percent in 2019) (Spanko 2019(a)). Medicare has generated nursing home profit rates above 10% in each of the last 20 years (MedPAC 2020, 234); in 2017 one in four homes had Medicare margins exceeding 20 percent (MedPAC 2019, 210). Medicare payment rates are set by formula and paid "prospectively," that is, independent of costs incurred. Although proponents argue that approach promotes efficiency, profit levels along with other evidence show that, in practice, prospective payments promote patient selection and under-provision of care (Feder 2013).

Rates paid by Medicare and private-pay patients "cross-subsidize" patients covered by Medicaid (MedPAC 2020, Ch. 8; MedPAC 2019, Ch. 8; Novotney 2020) - albeit inefficiently, given the variation in payer mix across homes, and the lack of oversight or accountability for the dollars received. Despite laws that are intended to prevent nursing homes from avoiding

Medicaid beneficiaries, people who lack the resources to pay for nursing home care on their own and have to become Medicaid beneficiaries often have no choice but to live in nursing homes that deliver lower quality care because they depend so heavily on the low-paying Medicaid program.

In their response to COVID-19, policymakers paid more attention to raising Medicaid's low payment rates than to enforcement of quality standards in the nursing home industry. Many states used some of the federal stimulus funds from the March 2020 CARES Act to increase Medicaid payment rates to nursing homes. At least 23 states and the District of Columbia increased their Medicaid payments to nursing homes with most states simply raising their per diem rates by a percent or a flat amount (Flinn 2020; Musumeci, Dolan, and Guth 2020; Gifford et al. 2020). A number of states, following advice by public health experts, chose to contract with nursing homes to care only for COVID-19 patients and used federal stimulus monies to pay extraordinarily high rates. However, contracts included many nursing facilities with low quality ratings in the past year (Severns and Roubein 2020).

Dependence on Under-paid Caregivers. People need LTSS because they are unable to manage basic tasks of daily living--like bathing, eating or dressing--without assistance from another person. Nursing assistants, personal care aides and other so-called direct-care workers constitute the bulk of the paid workforce providing hands-on care in nursing homes as well as at home. In response to COVID-19, these workers were declared "essential" and recognized by many policymakers in emergency measures taken to increase their pay or benefits (Denny-Brown et al. 2020).

But this emergency recognition highlights the glaring shortcomings of these workers' ongoing terms of employment (Scales and Lepore 2020). In 2019, the median annual income of nursing assistants and orderlies, who typically work in nursing homes and residential care facilities, was $29,640--equivalent to 143% of the federal poverty level for a person in a family of three people. Home care aides earned even less, with a median income of $24,000 in 2019 (BLS 2020). Low incomes are associated with a heavy reliance on public supports. In 2017 a third of direct-care workers providing home care and a fifth of those working in nursing homes were themselves dependent on Medicaid, and almost as many on SNAP to receive adequate food (PHI National 2020). Almost nine in ten directcare workers are women, three in five are people of color, and one in four are immigrants (PHI 2020).

Low incomes result from both low wages and often disjointed hours of work per week. Many employees (including registered nurse supervisors of home care aides) of home health agencies and nursing homes work for more than one agency or employer in order to earn more money. Although full-time home health aides typically work 40 to 44 hours a week, many work 50 or more hours if their client-patient needs overnight assistance. Others may provide care for more than one client each week - perhaps one 6-hour client and a second 4-hour client - with an unpaid hour or more while going to the second client. In these situations, employees rarely earn overtime pay for the longer work-week. The work that aides do is hard, usually physically demanding, and often for clients who resent their need for assistance. Between the low wages and difficult work, turnover rates are high in nursing homes and home health agencies, and contribute to the staff shortages nursing homes have experienced.

Although COVID-19 cases and deaths among nursing home direct-care workers have attracted public attention, little has been written about COVID-19's impact on the 12.5 million recipients of LTSS who live in the community. The fact that so many employees of nursing homes also work for home health agencies or private-pay clients living in their homes strongly suggests that community-spread of COVID-19 caused a substantial number of people with LTSS needs who live in the community to become sick or die. Even though the vast majority of community-dwelling adults with LTSS needs rely predominantly on friends and family to provide such care, as many as 4.8 million of these adults receive some services which Medicaid pays for and some of the other 7.7 million pay for some services themselves. Thus, both paid-caregivers and unpaid family members could have unwittingly exposed people with LTSS needs to COVID-19. As of this writing (April 2021), it is not possible to definitively say how many such people and their caregivers died as a result of COVID-19. However, between March 2020 and the end of March 2021, more than 515,000 people who were at least 50 years of age died of COVID-19 (82,000 of them were 50 to 64 years of age) (CDC website). At least 185,000 of these deaths were among nursing home residents and staff, which suggests at least 330,000 community-dwelling people 50 years old and older died of COVID-19. We do not know how many of these people were receiving or providing LTSS but the number could be substantial.

Thus, concerns about the low incomes of direct-care workers in nursing homes extend to direct-care workers who provide LTSS for people who live in the community. Wages for such workers ostensibly are determined by supply and demand conditions but state policies that set Medicaid payment rates for nursing homes and HCBS care dominate the wages for direct-care workers. The "gray" market for direct-care workers who are paid directly by people with LTSS needs often indicates a higher take-home wage but typically the wages are not reported to the IRS and taxes are not paid to the workers' Social Security and Medicare accounts. However one looks at the market for direct-care workers, the conclusion is the same - they are poorly paid and have few benefits, and the result is high turnover and difficulty in maintaining good quality of care.

Underfinancing of LTSS. COVID-19 revealed the abdication of public policy in assuring adequate financing and care for people who need LTSS in nursing homes. Medicare and Social Security, respectively, promote health and income security for older people and some people with disabilities. In contrast, Americans are on their own to manage a need for LTSS, with public support limited to a last resort social assistance program, contingent on impoverishment. Medicaid is invaluable to people who need long-term care. But to receive Medicaid LTC benefits, individuals must either be or must become impoverished due to spending on care. Many elderly and non-elderly with a disability exhaust their savings to pay for medical and LTC expenses, which qualifies them as "medically needy" and therefore eligible for Medicaid (Musumeci

and Chidambaram 2019). Virtually all of their incomes also must go toward the costs of care. These pathways are how many formerly middle-class seniors with only Social Security retirement incomes have become Medicaid beneficiaries.

Moreover, Medicaid LTSS benefits continue to vary considerably across states (Rudowitz, Musumeci, and Garfield 2021; Watts, Musumeci, and Chidambaram 2021). Although the availability of those services has increased over the last decade (Rudowitz, Garfield, and Hinton 2019), variation and inadequacies in home care persist (Hauser, Fox-Grage, and Ujvari 2018). Policies that limit access to care take many forms - arbitrary limits on the number of visits a beneficiary receives, requirements for financial contribution or "spend-down," and, most important, caps on enrollment, which are allowable under "waivers" from Medicaid's statutory guarantee of benefits to persons assessed as eligible for covered care (Watts, Musumci, and Chidambaram 2020). Despite the design of Medicaid's federal match to provide greater support to lower than to higher income states, federal support has never been sufficient to overcome variation in state commitments.

These conditions predate COVID-19, but the pandemic's powerful impact on states' fiscal capacity poses a significant threat to states' support for LTSS (as well as other Medicaid services), no matter how willing states are to pay. The magnitude and duration of states' revenue losses associated with the COVID-induced economic shutdown in 2020 is of historic proportions. The National Association of State Budget Officers reported that compared to pre-pandemic revenue projections, states' general revenues declined by 10.8 percent for fiscal year 2020 (which ends June 30, 2021 for most states) (NASBO 2020). Drawing on other experts' estimates as well as its own, the Center on Budget and Policy Priorities recently revised its projections of revenues for fiscal year 2021 and now expects state revenue shortfalls to be less than were forecast in the fall of 2020 (Leachman and McNichol 2021). However, states will still face higher costs for fighting COVID-19 (including mitigation efforts in schools), providing social and health assistance to individuals, and assistance to local businesses than they did before the pandemic began. Given states' balanced budget requirements and past budget experiences in economic downturns (especially the great recession), the current fiscal situation of states does not bode well for adequate LTSS support under current financing arrangements.

Looking further into the future, the simple fact that the population is aging poses a significant threat to the adequacy of state-based financing of LTSS. Beginning in just ten years (2031), as the oldest baby boomers start turning 85, the number and the share of the population aged 85 and older will start to increase. Before COVID-19's impact on life expectancy, the number of Americans aged 85 years or older was expected to double between 2030 and 2050, to 18 million, and their share of the population to grow from 2.5% to 4.5% (Ortman et al. 2014). In 2018, just over four in ten people age 85 or older needed long-term care, more than twice the rate among people aged 75-84 (Hado and Komisar 2019).

Thus, even before the COVID-19 pandemic's effect on states' revenues, it was questionable whether any state will have the fiscal capacity to meet the growing demand for LTSS in the next few decades. The greater the imbalance between the older population and the working age population, the greater the challenge states will face in sustaining, let alone improving, the adequacy of long-term care services. Without the federal government financing a larger share (or all) of LTSS, the inadequacy and inequity that already characterizes Medicaid LTSS across the states is likely to grow substantially worse in the years to come (Feder 2020; Miller, Nadash and Cohen 2020).

Actions Needed Now to Assure Access to Quality LTSS

A number of specific policy actions can be taken to remedy the flaws in LTSS policy that the COVID-19 pandemic revealed--most notably to address nursing home quality, redress underpayment and poor treatment of caregivers, reform provider payment mechanisms and enhance federal Medicaid financing to support both of the above. Though the steps outlined below are necessary, simply shoring up our flawed system will not be enough to meet the needs of our aging society. As we argue in the next section, assuring adequate LTSS--just like insuring retirement or disability income and health security - is a collective responsibility that demands social insurance.

Raise the FMAP. An increase in the federal share of Medicaid spending--technically an increase in the Federal Medical Assistance Percentage or FMAP--is a tool Congress has used in the past to provide fiscal relief to the states. Congress has raised the federal share of Medicaid's funding twice in the recent past in response to economic recessions (Mitchell 2020). In 2003, as the country was only slowly recovering from the 2001 economic recession, Congress passed the Jobs and Growth Tax Relief Reconciliation Act, which provided a temporary 2.95 percentage point increase to the FMAP rates for the last two quarters of FY 2003 and the first three quarters of FY 2004. And when the 2008 Great Recession caused millions of people to become unemployed and eligible for Medicaid, and states' tax revenues had fallen, Congress increased the federal share of state FMAPs by 10 percentage points, on average, between October 2008 and June 2011 (Aron-Dine et al. 2020).

Numerous analysts have made the argument that the COVID-19-caused recession and its expected duration would be even more severe than the Great Recession. They urged a larger federal increase in the FMAP and a permanent mechanism for increasing the federal match rate in response to increases in states' unemployment levels (e.g., Aron-Dine et al. 2020; Fiedler and Powell 2020; Holahan et al. 2020). The first of the four COVID-19 related federal relief acts, known as the CARES Act and signed into law in March 2020, included a temporary 6.2 percentage point bump in the federal share of the Medicaid match (Broaddus 2020).

Alongside consideration of a general increase in the FMAP, LTSS advocates have promoted an increase specifically targeted to home and community-based services (HCBS), and measures to accomplish that were included in House-passed legislation that the Senate rejected in 2020. However, in 2021 a new Administration and a (barely) Democraticmajority Congress included a temporary 10 percentage point FMAP bump for HCBS in the American Rescue Plan. Consistent with his campaign commitment to eliminating "institutional bias" in Medicaid support for Medicaid,

President Biden included a $400 billion commitment to improve Medicaid HCBS in the infrastructure or American Jobs Plan he released on March 31, 2021 (Parlapiano and Tankersley 2021).

Although the future of that legislation (and the HCBS piece) remains uncertain as of this writing, the LTSS advocacy community and some in the Congress would go even further. Rather than simply boosting the matching rate to encourage states to expand LTSS, they propose to make HCBS, like nursing home care, a "mandatory" Medicaid service that all states would have to provide rather than leave such services as optional for states (National Health Law Program 2021). That change--not an easy political lift--would likely require a far greater increase in federal funding than what President Biden has proposed, perhaps even full federal funding of HCBS.

Raise Caregivers' Wages and Increase Caregiver Training. To improve the quality of LTSS quickly, enhanced federal funding for Medicaid LTC should come with conditions as to how the additional funds will be spent--most importantly a requirement that ties the funding increase to the wages and benefits of direct-care workers. Invoking this "wage pass-through requirement," which ties increased Medicaid payments to wage rates, can improve nursing staff to resident levels by reducing staff turnover and attracting more people to the caregiver workforce, and improve caregivers' lives (Weller et al. 2020; Osterman 2019). Additionally, training requirements for nurse assistants and personal care aides, accompanied by federal funding directed to community colleges that offer accredited training programs, could relatively quickly increase the supply of well-trained caregivers, further justifying raising caregivers' wages and benefits.

It is difficult to project how the COVID-19 mortality rates and high incidence of cases in nursing homes will affect people's preferences for remaining in their homes rather than moving to a nursing home to receive LTSS. It seems likely, however, given the media attention to poor conditions in many nursing homes, that more people with LTSS needs will resist moving to nursing homes. This will increase pressures on states to improve HCBS options, which will depend on retaining and increasing the supply of direct-care workers with appropriate training. A recent survey of 43 states' Medicaid directors found that a majority reported concerns about reductions in the numbers of such workers (Gifford et al. 2020). Raising caregiver wages and improving benefits would encourage more people to become nurse assistants and personal care aides and meet the future need for them in both nursing homes and agencies providing LTSS in people's homes.

Enforce Quality Standards. Greater federal funding for Medicaid LTSS should be coupled with requirements that states conduct more frequent inspections of nursing homes to determine if they are meeting minimum requirements for staffing and safety (as well as quality of care metrics related to residents' health). States are responsible for surveying nursing homes to enforce quality standards, which include an up-to-date plan for preventing and controlling contagious infections. But the Government Accountability Office (GAO) revealed in a recent review that in every year from 2013 to 2019, 40% of homes had deficiencies in this standard, with half being cited in multiple consecutive years (GAO 2020). Almost all of these deficiencies were identified as "not severe" (causing harm to patients) and virtually no enforcement actions were taken. Yet, as GAO noted, failure to implement these measures is "critical to preventing the spread of infectious diseases, including COVID-19."

The GAO and others have been saying for years that more aggressive federal oversight of quality enforcement actions is clearly required. That requires both resources and commitment. Currently, states receive 75% federal matching funds to inspect nursing homes every 12 to 15 months. However, the Medicare certification of nursing homes is funded by discretionary appropriations by Congress (Musumeci and Chidambaram 2020). Pressure from the nursing home industry to ease up on what they view as "punitive approaches" to enforcement measures has seemingly thwarted efforts to increase the budget appropriations for certificaton. Moreover, total fines for deficiencies have dropped 10% since 2017 (Cenziper, Jacobs, and Mulcahy 2020). As a former administrator of CMS noted, "Enforcement without consequences is not enforcement at all."

CMS also could expand consumer education efforts intended to help people avoid poor quality homes. Medicare has the "Nursing Home Compare" website (at Medicare.gov), which provides a five-star rating system to indicate how nursing homes rank overall on the rating metrics used. However, because Medicare only pays for post-acute, skilled nursing services and not long-term residential care, the rating system does not favor the types of quality metrics needed by people looking for residential LTSS (Brauner et al. 2018; Konetzka, Yan, and Werner 2020). The website could provide separate quality information about nursing homes' residential care and their skilled nursing facilities. The website also could more actively advise the public to avoid low quality homes. More than a third of all nursing homes received poor quality ratings (one or two stars out of five) under the CMS quality rating system in 2015 (Bucutti et al. 2015). The low ratings reflect deficiencies along the metrics used to measure quality, but the website is not clear that such deficiencies often are not remedied before a nursing home's subsequent inspection. The Special Focus Facilities (SFF) list of the worst nursing homes provides a red flag warning to consumers, but they have to know to look for the list and too often they may not have the ability to learn about it. Relying on the Nursing Home Compare's rating of nursing homes as a mechanism to pressure facilities to fix quality problems is not sufficient.

Greater state and federal enforcement of minimum standards for staffing, safety and infection control procedures, and quality of care can only happen if more funding is allocated for inspections and stronger legal steps are taken to obtain compliance from the nursing home owners and operators. Closing more nursing homes that have persistent patterns of non-compliance with federal and state efforts to rectify particular deficiencies would send a strong signal of no longer tolerating persistent poor quality. Such homes present a danger to residents. Another step would be to forbid such homes' owners (including private equity groups) and manager-operators from ever owning or operating nursing homes in any state in the future.

Improve Medicare and Medicaid Payment Policies to Assure Appropriate Payment.

Reforming payment mechanisms to emphasize care over profit and reducing incentives to favor some patients over others also should be a priority. Currently, Medicare typically overpays and Medicaid underpays for services provided (Spanko 2019(b)). While some nursing homes claim that Medicare profits are "necessary" to subsidize their Medicaid expenses, that approach is both inefficient and insufficient. Policy changes should instead assure adequate payment by each program to promote quality services that each program covers. Medicare and Medicaid cover different services because they have different objectives. By statute, Medicare is prohibited from covering "custodial care" - the term that applied to maintenance long-term care when the law creating Medicare was passed in 1965. Medicare's coverage of post-acute services in skilled nursing facilities was intended to shorten hospital stays and reduce Medicare's overall expenditures. By contrast, Medicaid is expected to cover services and supports to assist individuals who can no longer care for themselves.

A comprehensive plan for appropriate payment should tie Medicare and Medicaid payments in both programs to actual (auditable) spending on at least the following: wages and fringe benefits necessary to meet minimum ratios of nursing staff to residents, the annual refreshing of a stock-pile of supplies for infection control and emergencies, costs of equipment for various types of therapies, and capital improvement costs for building maintenance and improvements to ensure the safety of residents and caregivers (such as upgrading the electrical system and creating more areas where people with infectious diseases can be isolated). Requiring capital improvements of nursing home buildings has the advantage of altering private equity/corporate investors' incentives to take money out of the homes they acquire. Such a comprehensive plan necessitates more thorough inspections of nursing homes and enforcement of rules and regulations when homes are found in violation.

Long-Term Strategy to Ensure LTSS for All

Build a social insurance system for L TSS. Even if the above reform actions were implemented now, the country would still have a system of "last-resort" assistance with

LTSS, a system that overburdens family caregivers and impoverishes and underserves people who need long-term care. It is time to end this system and replace it with a social insurance program for long-term care that acknowledges that everyone has some risk of needing very costly LTSS at some time in their life.

We and others have described why a market for private insurance for long-term care has not grown in the US and why policy efforts to expand it have not succeeded and cannot succeed (e.g., Sloan and Norton 1997; Feder, Komisar and Friedland 2007; Brown and Finkelstein 2007; Barr 2010; Brown and Finkelstein 2011; Bergquist, Costa-Font and Swartz 2016). The bottom line is that uncertainty about conditions that are yet years in the future prevents markets for private long-term care insurance from being efficient in terms of actuarially fair prices. People and insurers - the demand side and the supply side of a market - cannot forecast the costs and risks of needing LTSS a decade from now let alone two or three-plus decades from now. Especially when there is uncertainty as to future diseases or future costs of LTSS (ways of caring for and treating conditions), "voluntary private insurance becomes highly problematic." (Barr 2010, p. 365).

By contrast, social insurance can manage both uncertainty and risks that affect everyone (beyond a person's own risk of some event). For example, future changes in medical therapies may cause current chronic conditions to be cured, new diseases (such as COVID-19) may cause many more people to need assistance or substantially alter life expectancy rates, and inflation may reduce retirees' ability to pay for LTSS. Efficiently managing these risks is beyond the capacity of a private insurance market. By contrast, public or social insurance for everyone allows for policy decisions about covered benefits and financing needed for those benefits--in short, a poitical process that can adapt to changes as they unfold.

It is time to develop a social insurance program for LTSS for the simple reason that neither private insurance nor the current system of public support for LTSS is working and more and more people are at risk of inadequate care and financial ruin.

Components of a program of social insurance for L TSS. Social insurance for LTSS could take a variety of forms, but, as demonstrated by other OECD countries, such a program should be grounded in an expectation of shared responsibility among the person, the person's immediate family, and society (Swartz 2013). Several key components for a program of social insurance for LTSS follow from this foundational principle.

First, shared responsibility requires that everyone in the country will financially contribute to the program, and that the program will be financed by both earned and unearned income. The funding will not come solely from payroll taxes or contributions related just to wages and salaries. Such an approach also could rely on a contributory approach, as in Medicare or Social Security. Contributions would be made during a person's working years, thereby partially funding future benefits as well as creating a sense of ownership. However, total "pre-funding" would take decades, leaving the current elderly and much of the aging baby boom generation unprotected. Broader tax-based funding is therefore essential to better serve people who need care now or will need it in the near future.

Second, when people need LTSS, any out-of-pocket contributions to financing those services should reflect their ability to pay. One way to effect this component could be to provide benefits after an income-related waiting period, as in proposals for "catastrophic public long-term care insurance" (Cohen, Feder, and Favreault 2018). But even with these protections, stronger federal financing for and support of Medicaid will likely remain critically important to broaden benefits or lower cost-sharing for the lowest-income population beyond protections universally provided. To that end, current Medicaid provisions that allow beneficiaries to retain certain assets (homes and assets shared by a spouse, for example) should be expanded to create an income or asset floor--perhaps at median resource levels--that will allow people who need substantial care to retain their standard of living when they need LTSS.

Finally, the new social insurance program for LTSS should improve the current Medicaid federal-state partnership to achieve equity and enhance adequacy across the nation. The federal government should assume full responsibility for financing Medicaid long-term care and set national eligibility criteria for receiving LTSS, eliminating current disparities in Medicaid eligibility for LTSS across the states. The federal government also should be responsible for oversight and enforcement of regulations related to minimum quality of care standards, much as it does now for hospitals and Medicare certification of nursing homes. With stronger oversight, states could remain responsible for inspecting certified nursing homes and assessing eligibility for services, consistent with national standards. States also could be responsible for setting certification standards for caregivers. People will be permitted to hire their own caregivers but costs will be covered only if care is delivered by certified caregivers and individuals are assessed as having care needs that qualify for coverage under the program. If a family member or friend is hired to provide care and is certified, the program will ensure that the caregiver is credited with Social Security and Medicare earnings, paid sick leave, and any other program that requires evidence of employment.

Together, these components would strengthen the social compact for providing assistance to people with LTSS needs. A social insurance program for LTSS would shift the US away from a welfare-based, last-resort assistance program to a universal entitlement program. Such a program would reduce everyone's fear of impoverishment if they should need costly long-term care. Social Security and Medicare, the country's very popular social insurance programs, have greatly benefited Americans of all ages. Social Security's obvious benefit is its assurance that people will have at least a minimum retirement income or income if they suffer a disability. Younger generations, too, have benefited by being able to use savings for longer term investments rather than having to have cash on hand to help aging parents. Medicare also has supported the development of innovative treatments for many conditions that used to be viewed as chronic illnesses of old age, such as cardiac disease and orthopedic conditions. These new treatments have provided benefits for younger people as well. Most importantly, however, both social insurance programs address the broadly shared risks related to uncertainties about the future: in particular, risks of living longer than anticipated or of future inflation that would cause a person's savings for their older years to disappear.

The case for a social insurance program for LTSS builds on that for Social Security and Medicare. The shared risks specific to uncertainties about what the future holds for the needs and costs of LTSS can best be addressed with a social insurance program with the components we have outlined.

Conclusion

The COVID-19 pandemic has exposed weaknesses in the US "system" of assistance for LTSS that have been building for decades. It is clear that the nation's welfare-based, lastresort system is under-funded and under-regulated. COVID-19 may have upended public tolerance for so flawed an approach to so critical a need. That recognition should enable a new Biden administration to marshal public support for an expansion of the federal role with Medicaid and long-term care in the immediate term and, ultimately, create a social insurance program for LTSS.

The task before us is to educate the public and policy leaders that uncertainties about the future of what long-term care will be needed for and what such services will cost make the risk of needing costly LTSS a threat shared equally by everyone. Moreover, it is a threat to lifelong economic security that requires the same collective policy approach taken when Social Security and Medicare were established.

A social insurance program to which everyone is entitled provides a broad base of interest in making sure the program is run well and provides quality care. This can best be accomplished at the national level with financing based on the entire population. As noted, the states differ substantially in the share of their populations who are seniors and in their fiscal capacity to fund a state-based social insurance program for LTSS. The disparities across states in terms of access to various LTSS services covered by Medicaid provide clear evidence for why the US needs a social insurance program for LTSS with federal responsibility for financing and management oversight. A national program will ensure that people who are alike in terms of needs for LTSS and income will no longer face different rules for access to LTSS because they live in different states.

Gathering support for a social insurance program for LTSS will take work. But the tragedies of so many COVID-19 deaths of nursing home residents and careworkers are fresh in people's memories in many small towns and cities. The benefits of a social insurance program for LTSS and its role within an initiative to build infrastructure that supports people and families need to be emphasized by policy makers and community leaders.

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Judy Feder is a professor of public policy and, from 1999 to 2008, served as dean of what is now the McCourt School of Public Policy at Georgetown University. A nationallyrecognized leader in health policy, Judy has made her mark on the nation's health insurance system, through both scholarship and public service. A widely published scholar, Judy's health policy research began at the Brookings Institution, continued at the Urban Institute, and, since 1984, has flourished at Georgetown University. In the late 1980s, Judy moved from policy research to policy leadership, actively promoting effective health reform as staff director of the congressional Pepper Commission (chaired by Sen. John D. Rockefeller IV) in 1989-90; principal deputy assistant secretary for planning and evaluation at the Department of Health and Human Services in former President Bill Clinton's first term; a senior fellow at the Center for American Progress (2008-2011) and, today, as an Institute Fellow at the Urban Institute. Judy matches her own contributions to policy with her contributions to nurturing emerging policy leaders. As dean from 1999 to 2008, she built Georgetown's Public Policy Institute into one of the nation's leading public policy schools, whose graduates participate in policymaking, policy research, and policy politics, throughout Washington, the nation and the world. Judy is an elected member of the National Academy of Medicine, the National Academy of Public Administration, and the National Academy of Social Insurance; a former chair and board member of AcademyHealth and former board member of the National Academy of Social Insurance;and a member of the Center for American Progress Action Fund Board and of the Hamilton Project's Advisory Council. In 2006 and 2008, Judy was the Democratic nominee for Congress in Virginia's 10th congressional district. Judy is a political scientist, with a B.A. from Brandeis University, and a master's and Ph.D. from Harvard University.

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