



Improving Care for Medicare Beneficiaries in Long-Term Care

John Connolly, Anthony DiGiorgio, and Brian J. Miller

America is home to a large and growing population that requires institutionalized care. Already, over 1.2 million Americans live in nursing homes, and approximately 2 million Americans require long-term, residential care due to illness or inability to care for themselves.¹ As birthrates stagnate and the American median age climbs, the number and percentage of Americans requiring specialized elder care will likely continue to rise. Demographers project that the share of the American population aged sixty-five or older will increase from 17 percent to 23 percent by 2060, a silver tsunami that could overwhelm the present capacity for institutionalized care with an estimated 39 percent of the American populace over sixty-five expected to require care, at some point, in a facility that provides long-term services and supports (LTSS).²

Despite popular support for home-based care programs for many elderly and ill patients, institutionalized care at some point during the winter years of life is a necessity for many Americans. Many patients have conditions such as severe neurodegenerative diseases or dementia that render them incapable of performing instrumental activities of daily living such as cooking and driving, or even more basic activities of daily living (ADLs) such as bathing or dressing.³ Further, many patients unable to care for

themselves frequently have weak social support networks or complex medical comorbidities that necessitate around-the-clock observation or care.

This paper reviews the history of specialized plans designed to meet the needs of these Medicare beneficiaries—called Institutional Special Needs Plans (I-SNPs)—along with the challenges that institutionalized Medicare beneficiaries face in constructing a holistic health benefits package. Next, trade-offs among the various formulations of Medicare coverage available to institutionalized Medicare beneficiaries are considered, along with potential policy improvements.

BACKGROUND ON INSTITUTIONAL SPECIAL NEEDS PLANS

I-SNPs are a type of Medicare Advantage (MA) plan for individuals who are expected to spend ninety or more days in a long-term care (LTC) facility (which is a general term encompassing nursing homes, inpatient facilities, etc.) and require significant functional support for ADLs.⁴ The inspiration for these plans was UnitedHealthcare's (UHC) "Evercare" model, where UHC paid for nurse practitioners (NPs) to be embedded in participating LTC facilities and

provide regular clinical care aimed at reducing hospitalizations.⁵ These NPs were also tasked with facilitating goal-of-care conversations with beneficiaries, often frail elders with significant multimorbidities, and their families in order to ascertain their wishes for their care plan (e.g., whether escalation of care to hospitalization is within their goals of care). The Evercare model represented a vanguard in providing health coverage integrated with care tailored specifically to the institutionalized beneficiary.

The modern I-SNP model has several consistent features. In traditional Fee-for-Service (FFS) Medicare, most of the financial risk is borne by the taxpayer for services, as there is no global population-based payment. The payment for each component of care is separated, with physicians billing on a per-service basis for outpatient care, hospitalizations paid for as part of diagnosis-related group-bundled episode payments, and so forth. In contrast, I-SNPs are financially at risk for *all* Medicare-eligible costs regardless of setting, while the nursing home stay (i.e., residential fee) is typically paid by Medicaid for dual-eligible beneficiaries or through private funds for those not enrolled in Medicaid.⁶ The federal government pays I-SNPs a risk-adjusted capitation payment (i.e., population-level payment) for the Medicare benefit, functionally setting a budget for the population. The I-SNP then typically contracts directly with the LTC facility in determining Medicare-eligible costs, with the facility often accepting the risk of cost overruns via financial tools such as risk corridors.⁷ This approach is distinct from FFS and MA, where the facility is not broadly accountable for Medicare costs.

Because the I-SNP receives risk-adjusted capitated payments from the Centers for Medicare & Medicaid Services (CMS) and is financially aligned with facilities, both the plan and the facility have an incentive to invest in up-front care delivery and to help patients avoid inappropriate care escalation including unnecessary emergency

room visits and avoidable hospitalizations. Under typical arrangements, I-SNP plans employ on-site advanced practitioners such as NPs, physician assistants (PAs), registered nurses (RNs), and Certified Nursing Assistants (CNAs) who deliver direct care to facility residents who are also plan members, supplementing the direct-care workforce at long-term care facilities.⁸

The presence of an expanded care team is key to the I-SNP model. There is evidence that non-physician providers, even registered nurses and social workers, can improve quality of life for adults with chronic conditions.⁹ Recent research found that I-SNPs are associated with 33 percent fewer hospital admissions compared to nursing home residents covered by FFS or MA. Evidence also suggests that provider teams that include PAs and NPs in addition to physicians outperform solo physicians on quality metrics associated with chronic disease management.¹⁰ The presence of on-site PAs and NPs permits facilities to effectively care for more-complex patients outside of the hospital through mechanisms such as improved advanced care planning, appropriate medication deprescribing, and the availability of prescribing providers on-site to triage acute issues.¹¹ Not only can these on-site providers augment facility staffing for I-SNP patients, but there are likely spillover effects from their presence that benefit facility residents who have FFS or general MA coverage. Augmented staffing also likely improved care during the COVID-19 pandemic, with research demonstrating clear links between staffing levels and reduced mortality in nursing homes.¹²

Even though I-SNPs may be the best option for many beneficiaries living in nursing homes, enrollment in I-SNPs constituted only 7.5 percent of eligible beneficiaries in 2019. The number of MA beneficiaries residing in nursing homes was nearly double the number of those enrolled in I-SNPs, and the majority (78 percent) were enrolled in FFS Medicare (table 1). The reason that nursing

TABLE 1 CHARACTERISTICS (MEAN) OF MEDICARE BENEFICIARIES LIVING IN NURSING HOMES (2019)

	Full sample	I-SNP	MA	FFS
Sample Size	983	51	151	781
<i>Characteristic</i>				
Male	0.33	0.31	0.34	0.42
Married	0.21	0.12	0.20	0.22
Urban	0.75	0.90	0.77	0.73
Dual-eligible	0.52	0.96	0.65	0.46
Has children	0.81	0.67	0.83	0.82
<i>Race/Ethnicity</i>				
White	0.86	0.76	0.83	0.88
Black	0.08	0.13	0.09	0.07
Hispanic	0.03	0.06	0.05	0.02
Asian	0.01	0.02	0.01	0.02
Other	0.02	0.02	0.02	0.02
<i>Age</i>				
<65	0.05	0.04	0.03	0.06
65-74	0.11	0.10	0.11	0.12
75-84	0.35	0.25	0.33	0.36
85+	0.48	0.61	0.53	0.46
<i>Personal Income</i>				
<\$5K	0.03	0.02	0.06	0.02
\$5K-\$9,999	0.14	0.24	0.17	0.13
\$10K-\$14,999	0.24	0.45	0.21	0.23
\$15K-\$19,999	0.15	0.17	0.17	0.15
\$20K-\$24,999	0.08	0.10	0.07	0.08
\$25K-\$29,999	0.07	0.04	0.07	0.07
\$30K-\$39,999	0.10	N/A	0.07	0.11
\$40K-\$49,999	0.06	N/A	0.09	0.06
>\$50K	0.14	N/A	0.09	0.16

Data source: 2019 Medicare Current Beneficiary Survey Limited Data Set, based on the most recent data available, prior to implementation of the COVID-19 policy waiver of the FFS three-day stay requirement for skilled nursing facilities.

home-dwelling beneficiaries favor FFS may be related to the underlying choice factors associated with benefit design.

THE CHALLENGE OF CHOICE FOR INSTITUTIONALIZED BENEFICIARIES

All Medicare beneficiaries, including those in institutionalized care settings, face an annual choice of how to receive their Medicare-funded health benefits. Nursing home residents can choose traditional FFS Medicare, a general Medicare Advantage plan, or an I-SNP. This choice holds enormous ramifications for beneficiaries and the financial incentives that institutional care facilities face.

Under FFS Medicare, beneficiaries have maximal service choice; there are no network restrictions, and beneficiaries may select any physician who accepts FFS Medicare through an any-willing-provider network. This insurance design was typical during the 1960s, and the benefit of broad service choice continues to appeal to many beneficiaries today. The downside of exercising FFS choice is the out-of-pocket cost implications for beneficiaries. To mitigate financial exposure, 42 percent of the broader FFS population pay for an annual supplemental (Medigap) plan, while others have employer or union retiree coverage (24 percent) or Medicaid (19 percent).¹³

Comparatively, Medigap is not an option for beneficiaries who elect MA, primarily because it is not needed. Beneficiaries electing MA receive the equivalent of supplemental insurance and Medicare Part D coverage for the average price of the annual Medicare Part B premium. This design flexibility allows MA plans to offer benefits at a more competitive price. For example, in 2022 the average out-of-pocket cost was \$6,227 for FFS with Medigap coverage and \$3,811 for MA.¹⁴

On the other hand, unlike in FFS Medicare, MA plans carry network restrictions that may limit beneficiary choice though the implementation of a preferred provider organization (PPO) or health maintenance organization (HMO) network.¹⁵ However, while network restrictions may constrain beneficiary choice, they are also positively associated with MA star ratings, which may reflect improved quality due to selective contracting with high-quality providers.¹⁶

Beyond coverage decisions, institutionalized FFS Medicare beneficiaries face an important restriction of choice, the so-called “3-day rule.” The FFS Medicare program only covers a skilled nursing facility (SNF) stay if a beneficiary has had a minimum stay of at least three days in an acute care inpatient hospital prior to the SNF stay.¹⁷ The 3-day rule has been regarded as a disincentive for providing on-site care, as it allows SNFs to rely on hospitals to provide skilled clinical care to long-stay residents. MA plans, including I-SNPs, are not subject to the SNF 3-day rule.¹⁸ Rather, MA and I-SNP beneficiaries may be admitted at the time when it would be “medically appropriate to begin an active course of treatment,” highlighting a distinct advantage over FFS for SNF residents.¹⁹

COMPARING FFS MEDICARE AND I-SNPS

Research comparing I-SNPs with traditional benefits for Medicare beneficiaries requiring long-term care is not definitive, but it does support policy efforts to educate and promote beneficiary choice in selecting a plan. There are three major studies comparing utilization and outcomes for I-SNP plans compared with FFS Medicare, and the results of this study seem to favor I-SNPs.²⁰ A 2017 study, which looked specifically at UHC’s I-SNP population compared to FFS Medicare beneficiaries, showed that I-SNP members had fewer

emergency department visits, fewer hospitalizations, and more hospice enrollment compared with FFS beneficiaries.²¹ These results may be attributable to improved care coordination and customization for members rather than simply eliminating hospital care. I-SNP plans and facilities can partner to provide improved care on-site at the nursing facility that negates the need for some hospitalizations.²²

In a subsequent 2024 study, nursing homes with no I-SNP members were compared against nursing homes with at least 33.75 percent of members enrolled in I-SNPs; nursing homes with a significant number of I-SNP enrollees experienced fewer hospitalizations and pressure ulcers, but they also saw higher rates of undesirable outcomes, including antipsychotic use and members requiring assistance with ADLs.²³

A third major study found that I-SNP enrollment reduced quarterly hospitalizations in long-stay nursing home residents aged sixty-five and older with dementia by an absolute 3–4 percent. The study authors estimate that over the six-year study period, 80,000 hospitalizations out of 240,000 could have been avoided with I-SNP enrollment. The study found no additional effects on quality (including one- and two-year mortality), in addition to finding no significant association between I-SNP adoption and resident demographics or health status measures aside from an association between dual eligibility status and I-SNP participation.²⁴

There are other potential benefits to I-SNPs over FFS. As a specialized MA plan, I-SNPs can provide supplemental nonmedical benefits such as transportation, social needs companion support, and over-the-counter allowances.²⁵ Further, I-SNPs offer the potential benefit of payer-provider integration, which may simplify beneficiary experience through operational integration. Risk-based contracting, a core component of the I-SNP

model, incentivizes payer-provider vertical integration given the administrative overlap, shared incentives for risk management, and the ability to use claims data to improve clinical practice.²⁶ At present, LTC providers own 36 percent of I-SNPs, representing 29 percent of all beneficiaries enrolled in I-SNPs.²⁷ In sum, the potential advantages of I-SNP plans support a case for improving beneficiary education about Medicare coverage options in order to support an active choice by Medicare beneficiaries or their healthcare decision makers.

On the other hand, the benefits of FFS Medicare over I-SNPs should not be overlooked. While avoiding hospitalizations may be beneficial in some clinical situations, escalating to hospital-level care is often appropriate. Because MA plans rely on utilization review to manage capitated payment from Medicare, tools such as prior authorization have been used to limit access to certain services. In these scenarios, it may be advantageous for institutionalized patients to have a health plan that incentivizes the facility to transfer sick patients to a hospital. Further, FFS Medicare offers the broadest member choice of physicians, hospitals, and other clinical services and facilities, including SNFs. For many patients, choice of physician and facility is paramount.

Preliminary evidence suggests that I-SNPs may offer some quality benefits over FFS Medicare, but this is not definitively known. Further, while MA plans have a quality star rating based upon technical measures in nine domains of quality, the FFS Medicare plan lacks a quality star rating beyond the evaluation of individual nursing homes, thus making direct comparisons difficult at the county level.²⁸ It is also difficult to compare I-SNP plans to FFS Medicare with regard to longitudinal cost, as there have been no studies making this direct comparison.

POLICY RECOMMENDATIONS TO IMPROVE MEDICARE CHOICE FOR INSTITUTIONALIZED BENEFICIARIES

The challenges of health insurance literacy are well-documented, with prior research demonstrating that only half of Americans understood basic health insurance terms, a problem still present, albeit at smaller scale, in the Medicare market.²⁹ Responsibility for beneficiary education about Medicare options should be a shared responsibility of the Medicare program, independent entities such as State Health Insurance Assistance Program (SHIP) counselors, health plans, and the care delivery ecosystem including acute care hospitals and SNFs. Americans living in LTC facilities should have an explicit choice among FFS Medicare, a general Medicare Advantage plan, and an I-SNP. Under the current state of play, not all institutionalized Americans have this clear, explicit choice.

FACILITATE INFORMED PLAN SELECTION AT SKILLED NURSING FACILITIES

CMS can improve Medicare for institutionalized beneficiaries by facilitating active beneficiary selection among the various Medicare coverage options and health plan competition to drive care delivery innovation, reduce costs, and improve the convenience and quality of care. Medicare beneficiaries residing in nursing homes remain subject to the annual Medicare enrollment cycle and general MA plan switching, with no consideration of benefits election when the beneficiary transitions from a community dwelling to a residential long-term care environment.

Consequently, as of 2024, only 42 percent of beneficiaries living in nursing homes are enrolled in any type of special needs plan.³⁰ Currently, the most common path toward enrollment in an I-SNP involves enrollment once residing in an

SNF, which typically occurs only when an SNF has a preexisting contract with an I-SNP. But SNFs are not required to offer or participate in I-SNP networks, or even to educate beneficiaries about I-SNPs. The SNF requirements of participation should be updated to require SNFs to partner with the Medicare program and provide access to independent entities such as SHIP counselors to educate all eligible LTC beneficiaries or health-care proxies annually about the range of Medicare health benefits options, including FFS, MA, and I-SNPs. This could be implemented by naming or identifying delegated officials at all SNFs to partner with SHIP counselors, brokers, and other entities in order to abet enrollment flexibility.

REFORM MARKETING AND ENROLLMENT RULES FOR I-SNPS

Recognizing that the institutionalized beneficiary population is a distinct market with specific consumer protection needs, I-SNP marketing and advertising regulations should be customized compared to those regulating general MA plans. Typical methods of advertising in the general MA market include billboards, television, and radio, any or all of which may not be appropriate for institutionalized beneficiaries, many of whom have a legal guardian or authorized healthcare decision maker. One simple reform is that I-SNPs should be allowed to market to hospitalized beneficiaries who are reasonably expected by their clinical care team to have LTC needs after discharge. Social workers and care managers are discussing insurance coverage and nursing home placement (inclusive of long-term care) with hospitalized beneficiaries every day prior to discharge. From a practical standpoint, marketing of facilities by hospital staff is already occurring.

Regulators should modify rules governing contacts between I-SNPs and beneficiaries. Currently, I-SNPs need permission from SNFs to contact residents directly, and I-SNPs rely on SNF social workers to identify and speak with

potential beneficiaries and caretakers. These contacts also must take place in an open or public place. Moreover, even when I-SNPs meet with potential beneficiaries or healthcare proxies, a forty-eight-hour waiting period is required after any meeting, during which time potential beneficiaries are not permitted to enroll in plans.³¹ This rule is designed, understandably, to alleviate sales pressure tactics for vulnerable beneficiaries, yet for many current or potential institutionalized beneficiaries, family members are present at meetings and may be prepared to make immediate decisions. This regulation should be adjusted; patients and families should be permitted to waive the forty-eight-hour waiting period if they so choose, provided they are granted a window (e.g., seven calendar days) to reverse their decision (outside of the existing annual window where beneficiaries can exit managed care or switch managed care plans). These proposed rule changes would respect patient and family autonomy, make it easier for beneficiaries to enroll in I-SNPs in the setting of a group conversation with important family members visiting from other geographies, and simultaneously provide greater flexibility for reversing the decision to enroll.

ADDRESS AUTO-ENROLLMENT OF DUAL-ELIGIBLE BENEFICIARIES INTO FFS

One additional barrier to I-SNP participation is the functional auto-enrollment of dual beneficiaries in FFS Medicare. Beneficiaries receiving Social Security disability income are auto-enrolled in FFS Medicare after the two-year waiting period that triggers Medicare eligibility.³² While auto-enrollment may be the most administratively simple way for the CMS to provide coverage to disabled dual-eligible beneficiaries, FFS Medicare may not be the best health benefits delivery vehicle for institutionalized beneficiaries. On an annual basis, institutionalized beneficiaries or their proxies should be incentivized to review plan choices so that they can ultimately choose a coverage option that best suits their needs. Incentives could be

varied and could include small decrements in premiums for beneficiaries who compare coverage.

CUSTOMIZED HEALTH BENEFITS NECESSITATE CUSTOMIZED REGULATIONS

Updated regulations should also recognize that I-SNPs are a specialized class of MA plans that require distinct regulations. Currently, I-SNPs are subject to general MA plan regulations.³³ However, I-SNP beneficiaries are functionally a residential population that has needs that are distinct from those of the broader MA population, which is largely community dwelling. I-SNP beneficiaries, by definition, have significant physical or cognitive limitations that distinguish them from community-dwelling beneficiaries. Their health benefits should reflect this, as they require *both* comprehensive social and medical support. On the other hand, benefits for the broader MA and FFS populations can be focused primarily on medical services. Policymakers should strive for customized MA plan regulations for I-SNPs that encourage competition through small-plan entry, business formation, and vertical integration that promotes integrated care delivery and wraparound services.

DEVELOP QUALITY METRICS FOR THE INSTITUTIONALIZED POSITION

In order to allow beneficiaries and their families to compare performance across FFS, MA, and I-SNPs, regulators should create a customized “institutional” star rating methodology for institutionalized beneficiaries.³⁴ In general, quality metrics should be simple, difficult to game, and routinely measured and assessed for validity; data should be automatically generated using AI and large language models.³⁵ Implementation of institutional star ratings should be done thoughtfully, and policymakers should consider whether small plans, which may have greater year-to-year variance in performance, should be considered

separately from large plans with the potential for a two- or three-year data basis for star rating.

To improve the validity of measures for institutionalized beneficiaries, CMS should evaluate and construct metrics specific to personal functional status priorities and medical outcomes. In addition, LTC-owned I-SNP plans that are exclusive to individual facilities could be evaluated on a composite scale that incorporates metrics from the Nursing Home Care Compare Five-Star Quality Rating System with star ratings. For instance, incidence of pressure ulcers is currently a metric on the nursing home rating system but not on Medicare Advantage star ratings; for facilities owned by I-SNPs, where payer and provider are the same entity, a composite metric may better reflect actual quality of care and aid beneficiary selection. To support both transparency and informed beneficiary and family choice, CMS should construct a specific set of metrics for institutionalized beneficiaries to facilitate meaningful comparison of the performance of FFS, MA, and I-SNP options. Execution can occur via a public workshop with stakeholders, followed by a proposed rule.

TAILOR NETWORK ADEQUACY REQUIREMENTS TO ACTUAL UTILIZATION

Network adequacy requirements for I-SNPs should also be reexamined, as rules governing general MA plans may not be applicable to the institutionalized LTC population. For instance, institutionalized beneficiaries benefit very little from increased numbers of plastic surgeons, allergists, or gynecologists within a twenty-mile radius. Instead, network adequacy requirements should focus on primary care, podiatry, audiology, dental, and other medical specialties that provide routine care on-site or near the site of the LTC facility. A survey of 2019–2021 claims that data for institutionalized beneficiaries revealed that 85 percent of primary care and specialty care is provided in the member facility, primarily by NPs and PAs.³⁶

Of the 15 percent of care provided off-site, most is rendered near the facility; 90 percent of off-site claims for beneficiaries in urban facilities occur within thirty miles of the facility, and 77 percent of claims for beneficiaries in rural facilities occur within forty-five miles.³⁷ Moreover, of thirty-three listed specialties, twenty-six constitute less than 3 percent of claims, demonstrating that I-SNP plans should be subject to customized network adequacy regulations that balance access for rare cases that require advance specialty care with pragmatism around plan contracting.³⁸

CMS should allow variation in network adequacy requirements, with use of recent historical use data based upon either encounter data or survey data for the I-SNP population, and with a focus on beneficiary convenience and ease of care coordination, reflecting a preference toward on-site care for routine clinical and rehabilitative services. Moreover, plans should receive baseline credit for telehealth for select specialty services when measuring network adequacy for plan market participation, a move that would build off the prior exception network adequacy request process modification implemented during the Biden administration.³⁹ Concurrently, out-of-network providers should be required to have “hold harmless” policies for I-SNP beneficiaries, with out-of-network rates pegged to FFS rates. In sum, network adequacy requirements should not be waived for I-SNPs; rather, they should be customized to reflect real-world beneficiary needs.

CONCLUSION

Patients who require institutionalized care present unique challenges. I-SNPs are designed for institutionalized Medicare beneficiaries and appear to better align incentives for institutional care. Whether this alignment consistently translates into improved welfare remains an empirical question, but current evidence suggests meaningful differences in hospitalization patterns and care

coordination. To improve care for institutionalized beneficiaries, policymakers should pursue regulatory reform that allows for improved health plan customization, care delivery innovation, and greater beneficiary choice. Regulatory reform is needed to improve selection of the I-SNP model. Changes oriented toward market flexibility and more pragmatic oversight, including marketing guidelines, network adequacy requirements, and customization of quality metrics, may improve enrollment in I-SNPs. As part of regulatory reform, program oversight must capture changes so that reforms can be evaluated in a causal fashion, generating evidence that can be weighed to justify long-term maintenance of new policies or their further adjustment. Additionally, more research is needed to understand the current state and clinical and financial performance of I-SNPs.

NOTES

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ABOUT THE AUTHORS



JOHN CONNOLLY

John Connolly, MD, is a physician in the Department of Medicine at the Johns Hopkins University School of Medicine, where his work focuses on healthcare delivery and policy for vulnerable populations. His research interests include Medicare benefit design and the intersection of insurance structure and clinical outcomes for institutionalized patients.



ANTHONY DIGIORGIO

Anthony DiGiorgio, DO, MHA, is a neurosurgeon and health policy researcher at the University of California, San Francisco, where he also holds appointments in the Department of Neurological Surgery and the Philip R. Lee Institute for Health Policy Studies. His research spans healthcare financing, quality measurement, and the application of artificial intelligence in medicine.



BRIAN J. MILLER

Brian J. Miller, MD, MBA, MPH, is a visiting fellow at the Hoover Institution focused on Medicare payment policy and FDA regulatory policy. A practicing hospitalist at Johns Hopkins Hospital and an associate professor of medicine and business (courtesy) at Johns Hopkins University, he is also a commissioner of the Medicare Payment Advisory Commission and a trustee of the North Carolina State Health Plan.

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**Hoover Institution
Stanford University**
434 Galvez Mall
Stanford, CA 94305-6003
650-723-1754

**Hoover Institution
in Washington**
1399 New York Ave. NW, Ste. 500
Washington, DC 20005
202-760-3200

**Hoover Institution
in Texas**
3889 Maple Ave., Ste. 600
Dallas, TX 75219
hoovertexas@stanford.edu

