CHAPTER 5

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Chapter summary

About 1.2 million beneficiaries live in nursing homes (NHs) due to functional and/or cognitive impairments that prevent them from living in the community. Compared with other beneficiaries, this group is older and has higher medical costs. Medicare's coverage of NH care is largely limited to coverage of short-term skilled care after a hospitalization, although Medicare covers other services received by beneficiaries living in nursing homes, such as physician and ancillary services (e.g., lab tests and physical therapy). More than 80 percent of Medicare beneficiaries in NHs are also covered by Medicaid, the predominant payer for NH care.

In 2023, there were about 15,000 nursing homes nationwide. Nearly all NHs operate as both nursing facilities that provide long-term care and as skilled nursing facilities (SNFs) that provide short-term skilled care. The industry is characterized by independent providers and regional chains. The industry reports an average low profit margin across all payers (0.4 percent in 2023), but that average margin may be understated due to the ways some NHs report their payments. The reported average profit margin on Medicare-covered SNF care is much higher, at 22 percent in 2023.

The quality of care provided to many NH residents is a long-standing problem that has been well documented. The National Academies have

In this chapter

described the financing, delivery, and regulation of NH care as "ineffective, inefficient, fragmented, and unsustainable." Among other problems, NHs have a financial incentive to hospitalize residents so they qualify for Medicare-covered SNF care (for residents who have Medicare coverage), and Medicaid's base payment rates often do not cover the cost of care.

NHs are subject to regular quality and safety inspections, but evaluations have concluded that these inspections, for a variety of reasons, sometimes fail to identify serious quality problems and may not lead to effective and sustained corrections. To encourage NHs to improve their care, CMS publicly reports a star rating for each NH, which evaluators have found modestly helps consumers select NHs with higher ratings and encourages NHs to improve. However, when a beneficiary needs NH care, a higher-rated facility may not have an available bed or be willing to admit a Medicaid-funded stay (or a stay that is likely to become one).

Medicare has made a variety of efforts to improve care for beneficiaries in NHs. In fee-for-service (FFS) Medicare, the payment system for SNF care includes a value-based purchasing (VBP) program that raises or lowers payment rates to SNFs based on their quality performance. In 2021, the Commission examined the design of this program and recommended that it be replaced. Since then, CMS has made several improvements that address some of the issues raised by the Commission, but the VBP program still has other important design flaws that would require congressional action to correct. We and others have noted that the size of the VBP incentives may be too small to change behavior. Accountable care organizations (ACOs)—groups of providers that agree to bear financial risk for meeting spending and quality targets for their assigned FFS beneficiaries—generally are not designed to focus on beneficiaries in NHs, although one type of ACO, the High Needs ACO, focuses on beneficiaries with complex medical conditions, including those in NHs. However, High Needs ACOs are few, numbering just 13 in 2024. Thus, the Commission has not focused on ACOs as a way to influence care for NH residents.

In the Medicare Advantage program, institutional special needs plans (I–SNPs) are specialized plans that serve beneficiaries who need NH care. I–SNPs now cover about 12 percent of Medicare NH residents. These plans aim to reduce the use of expensive services such as inpatient care (which is often disorienting for residents) by using teams of physicians and nurse practitioners to deliver more preventive and coordinated care within the NH and reimbursing NHs in ways that encourage facilities to deliver more care on-site. The available

evidence suggests that I–SNPs reduce the use of inpatient care and emergency department visits and perform better on some quality measures. However, the evidence base is still somewhat limited and there is little information on important areas such as patient experience. Enrollment in I–SNPs has been growing, but their ultimate reach may be limited because insurers may not want to contract with all NHs, some NHs may not want to participate in an I–SNP (in some cases due to the financial incentives in traditional Medicare to hospitalize residents), and many beneficiaries who have access to I–SNPs do not enroll.

The Commission may consider future work in two areas. First, building on the modest success of the star ratings and the clear relationships between NH staffing and quality, new work could examine alternative designs that would elevate the role of staffing in calculating the overall rating of NHs. Second, given the low enrollment of beneficiaries in I–SNPs despite the evidence of the model's success, new work could examine factors that limit the use of I–SNPs and consider potential policy changes that encourage the broader use of I–SNPs and reduce barriers to expansion, while enabling more rigorous measurement and oversight of I–SNPs. ■

About 1.2 million Medicare beneficiaries live in nursing homes (NHs) due to functional and/or cognitive impairments that prevent them from living in the community. Medicaid finances most NH care, but Medicare does provide limited coverage of skilled care following a hospitalization.

NH residents have significant care needs, but there are long-standing concerns about the quality of care that many of them receive. Numerous studies by the National Academies (and its predecessor, the Institute of Medicine), the Office of Inspector General (OIG), and the Government Accountability Office (GAO) have documented quality problems and the shortcomings of efforts to correct them. The poor quality furnished by many NHs is partly the result of low Medicaid base payment rates that often do not cover the cost of care. In addition, NHs have a financial incentive to send long-stay residents, especially dual-eligible beneficiaries, to the hospital for inpatient care or emergency care (which are both covered by Medicare) instead of treating them in place, thereby shifting the cost of care to other providers. Further, when beneficiaries return to the NH after a hospital stay, the NH can receive higher Medicare rates if the beneficiaries meet coverage rules. While many hospitalizations and emergency department visits are appropriate, some may not be, and all are disorienting for these vulnerable beneficiaries.

In this chapter, we provide an overview of the long-stay NH population, the NH industry, and the major challenges facing this sector. We then review federal nursing home regulations and staffing requirements that establish minimum standards of care. Next, we turn our attention to programs that CMS has implemented to improve NH quality, including the Quality Reporting Program (QRP), NH Compare 5-star ratings, and the Quality Improvement Organization (QIO) Program. We also discuss fee-for-service (FFS) Medicare policies aimed at improving quality, including the skilled nursing facility (SNF) value-based purchasing (VBP) program and accountable care organizations (ACOs). Finally, we consider specialized Medicare Advantage (MA) plans known as institutional special-needs plans (I–SNPs). We find that some of the regulations and quality programs have had modest success at identifying quality problems or improving the care of NH residents, while others have not. Overall, the efforts have fallen short, and the quality of care provided to many beneficiaries living in NHs remains a serious concern.

Overview of nursing home residents and the nursing home industry

Nursing homes provide services such as 24-hour medical and skilled nursing care, rehabilitation services, meals, and assistance with activities of daily living. Nearly all NHs operate as both nursing facilities (NFs), where they provide lower-intensity routine nursing care (often referred to as "custodial care") for individuals with functional and/or cognitive impairments, and as SNFs, where they provide short-term skilled care following a hospitalization.

For long-stay residents, NH services that are considered long-term care—room and board services, routine nursing care, and assistance with activities of daily living—are largely covered by Medicaid or residents' out-of-pocket payments. NHs may also provide a variety of medical services, such as physical and respiratory therapies, lab tests, and X-rays, that are covered by Part B.

Medicare does not cover long-stay NH care but does pay for short-term skilled care after a hospitalization. When a NH resident is hospitalized for at least three consecutive days, Medicare covers post-acute care (PAC) for up to 100 days per spell of illness if the beneficiary requires daily skilled nursing or rehabilitation services.[1] (Medicaid may cover skilled care for beneficiaries who do not meet Medicare coverage rules or who have exhausted Medicare's benefit.) Thus, long-stay residents can shift back and forth between receiving short-term skilled care following a hospital stay, and once discharged from that care, receiving less intensive long-stay care. In addition, Medicare covers hospice care for beneficiaries who have opted to enroll in that benefit. Hospice enrollees are not eligible for any services that treat their terminal condition (such as Part A–covered SNF care), but they can be covered for care that is unrelated to their terminal condition.

The three-day requirement dates back to the beginning of the Medicare program in 1965. It was established to ensure that SNF care was a continuation of acute medical treatment and not long-stay care. While the requirement may distort stays (by, for example, extending some hospital stays unnecessarily to ensure SNF coverage), it helps prevent the current SNF post-acute benefit from

expanding into a long-term care benefit. In 2015, MedPAC recommended that the Congress revise the rule to allow up to two days spent in outpatient observation care to count toward the requirement (Medicare Payment Advisory Commission 2015).

Physicians are also required to visit NH residents on a regular basis. A physician must visit each long-stay resident within 30 days of admission, every 30 days for the first 90 days, and every 60 days thereafter. Other clinicians, such as nurse practitioners, may also visit long-stay residents, but their visits cannot replace the required physician visits. The same visit requirements also apply to residents who are receiving short-term skilled care, but there is more flexibility about the use of other practitioners. In those cases, visits by a nurse practitioner (NP), physician assistant (PA), or clinical nurse specialist (CNS) can substitute for physician visits on an alternating basis. In 2025, 27 states plus the District of Columbia had granted full practice authority to NPs, allowing them to perform the required physician visits (American Association of Nurse Practitioners 2025). Physician and other clinician services and ancillary services (such as lab tests and physical therapy) are covered by Medicare as long as the services meet coverage rules.[2]

Long-stay residents differ from other beneficiaries in many respects

Long-stay NH residents (defined as those who have been in a NH for more than 90 days) make up a relatively small share of the Medicare population (Table 5-1).[3] In 2023, 1.2 million beneficiaries—about 1.7 percent of the total—were long-stay residents for at least one month of the year. Between 2013 and 2023, the long-stay population dropped in both absolute terms, from 1.4 million to 1.2 million, and as a share of the Medicare population, from 2.6 percent to 1.7 percent (data not shown).[4] The number of beneficiaries who are long-stay residents at a given point in time is lower because many residents do not live in the NH for the entire year; for example, in July 2023, there were about 840,000 long-stay residents.

As would be expected, in 2023 long-stay residents tended to be older, with a median age of 81 compared with 72 for other beneficiaries, and nearly a quarter of long-stay residents were 90 or older. Consistent with their older age profile, long-stay residents were more likely than other beneficiaries to be female (62 percent vs. 54 percent). The long-stay population was also more likely to be Black and less likely to be Hispanic or Asian.

Long-stay residents were far more likely than other beneficiaries to have Medicaid coverage (82 percent vs. 14 percent), reflecting that program's role as a major payer for NH care. (We discuss Medicaid's role in more detail below.) Beneficiaries who qualify for both Medicare and Medicaid are commonly referred to as "dually eligible beneficiaries."

Long-stay residents were also more likely to live in rural areas (24 percent vs. 18 percent), in part because alternatives to NH care, such as home health aides, personal care attendants, and assisted living facilities, were less available in those areas.

The long-stay population has much higher mortality rates: In 2023, 24 percent of long-stay residents died during the year, compared with 3 percent of other beneficiaries. The mortality rate for long-term residents spiked during the coronavirus pandemic, reaching 33 percent in 2020, but it has otherwise ranged between 24 percent and 25 percent over the past decade.

Although long-stay residents must, under our definition, be in a nursing home for at least 90 days, their length of stay can vary considerably. In 2023, the median length of stay was 26 months, or a little more than two years. However, about a quarter of these beneficiaries had been in a NH for less than a year, while a fifth had been in a NH for more than five years. Women tended to have longer stays, on average, than men (3.7 years compared with 2.2 years) (Administration for Community Living 2024). Relatively few long-stay residents are discharged back to the community, so length of stay effectively measures how long these beneficiaries live in a nursing home at the end of their lives. Given how we defined the long-stay population for this analysis, it is worth noting that a beneficiary's stay can include periods in which they receive short-term skilled care, periods in which they receive long-stay care, and periods in which they are in the hospital.

Long-stay residents also tend, on average, to have much higher medical costs. In 2022, among beneficiaries enrolled in FFS Medicare, average

TABLE 5–1

Medicare beneficiaries who were long-stay nursing home residents differed from other beneficiaries in several respects, 2023

Characteristic	Long-stay nursing home residents	Other beneficiaries
Number of beneficiaries (millions)	1.2	67.0
Median age (years)	81	72
Age distribution		
Under 65	10%	11%
65–69	8	22
70–74	13	24
75–79	15	19
80–84	16	12
85–89	16	7
90 and older	23	5
Sex		
Female	62	54
Male	38	46
Race		
White, non-Hispanic	74	73
Black	15	11
Hispanic	6	8
Asian	2	4
Other/unknown	2	4
Eligible for full Medicaid benefits	82	14
Residence		
Urban	76	82
Rural	24	18
Died during the year	24	3

Note: We classified beneficiaries as long-stay residents if they had at least one month during the year in which they had been in a nursing home for more than 90 days in total. Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare administrative data.

annual program spending on Part A and Part B services was $31,200 for long-stay residents, compared with about $11,300 for other beneficiaries. Medicare's per capita spending on long-stay residents was thus almost three times as high as its spending on other beneficiaries in 2022.

Beneficiaries receiving long-stay care differ from those receiving skilled care

Beneficiaries in NHs include those living in the NH who need less intensive nursing care (generally, assistance with activities of daily living such as bathing or dressing) and those recuperating from a hospital

TABLE 5–2

Beneficiaries who received only long-stay care were generally more impaired than beneficiaries who received skilled care, October 1, 2023, through March 30, 2024

Characteristic	Long-stay residents		Community-dwelling beneficiaries receiving skilled care
	Receiving only long-stay care	Receiving skilled care	
Number of unique beneficiaries in analysis	1,169,317	571,502	80,226
Share of beneficiaries with:			
Bowel incontinence	62%	53%	42%
Urinary incontinence	62	43	33
Swallowing difficulty	5	22	19
Medically complex conditions	33	41	44
Dementia	53	24	18
Serious mental illness	20	9	6
Cognitive functioning:			
Intact cognition	39%	54%	59%
Moderate impairment	27	27	24
Severe impairment	34	19	17
Median motor score (maximum = 66; higher is better)	30	31	35

Note: Figures were calculated using the most recent assessment for each beneficiary from the Minimum Data Set (MDS) during the analysis period. "Serious mental illness" is defined as having bipolar disorder, a psychotic disorder, or schizophrenia. Cognitive functioning is measured using the Brief Interview for Mental Status (BIMS) test. BIMS scores between 0 and 7 indicate severe cognitive impairment, scores between 8 and 12 indicate moderate cognitive impairment, and scores between 13 and 15 indicate intact cognition. The motor score is a composite of 11 self-care and mobility items recorded in the MDS, including eating, oral hygiene, toileting hygiene, toileting transfer, showering/bathing, lower body dressing, transferring sit to lying, lying to sitting on edge of bed, sitting to stand, chair/bed-to-chair transfer, and walking 10 feet.

Source: MedPAC analysis of MDS data, fourth quarter of 2023 and first quarter of 2024.

stay and requiring daily skilled nursing or rehabilitation services. The majority of long-stay care is paid for by Medicaid and beneficiary out-of-pocket spending, while skilled care is typically covered by Medicare under certain circumstances (such as having a preceding hospital stay of at least three days). However, beneficiaries can shift back and forth between receiving short-term skilled care following a hospital stay and, once discharged from that care, reverting to long-stay care.

In this analysis, we used patient assessment data gathered in the Minimum Data Set (MDS) to compare beneficiaries who received care in NHs between October 1, 2023, and March 30, 2024 (the first six months that uniform function items were gathered for all assessments). Both Medicare and Medicaid require NHs to use the MDS, which is an instrument that gathers information about patient and service characteristics at set intervals (such as at admission, quarterly, and annually) for both long-stay residents and short-stay patients receiving skilled care. We divided beneficiaries in NHs into three mutually exclusive groups: (1) long-stay residents who received only long-term care, (2) long-stay residents who received short-term skilled care after an acute hospitalization, and (3) community-dwelling beneficiaries who received short-term skilled care after an acute hospital stay.

Table 5-2 compares the shares of beneficiaries with selected impairments and their cognitive and motor scores across the three groups. The left column includes long-stay residents who did not receive any skilled care during the study period. The middle column reports the characteristics of long-stay residents during their posthospital skilled care stay. The right column includes community-dwelling beneficiaries who received short-term skilled care following a hospital stay. In making comparisons across the groups, it is important to keep in mind that some information gathered in the MDS is used to adjust payments and may create incentives for providers to record certain characteristics as worse than they are to boost payments. For example, the Medicare SNF payment system adjusts payments for functional status, depression, difficulty swallowing, and cognitive impairment. Although the case-mix classification systems used by Medicaid vary across states, most systems adjust payments for resident acuity (such as the use of special services, the presence of a limited set of clinical conditions, and functional status).

Long-stay residents who did not receive skilled care were, in most cases, more likely to have impairments compared with either group receiving skilled care. They were more likely to have bowel or urinary incontinence, dementia, and serious mental illness (defined as having bipolar disorder, a psychotic disorder, or schizophrenia). Among the two groups of beneficiaries receiving skilled care, long-stay residents had higher shares of these impairments and conditions compared with community-dwelling beneficiaries, indicating that this latter group was generally less impaired than the institutionalized group.

Interestingly, both groups of beneficiaries receiving skilled care were more likely to have difficulty swallowing compared with residents receiving only long-stay care. This contrast may be partly explained by the greater shares of beneficiaries with medically complex conditions (such as diabetes and chronic kidney disease) as the primary medical condition among the skilled care groups (41 percent and 44 percent vs. 33 percent for the long-stay care–only group). It is also possible that revisions to the case-mix system used to adjust Medicare's payments for skilled care created an incentive to record this impairment. The new case-mix system (which was implemented in October 2019) adjusts speech–language pathology payments for related comorbidities such as difficulty swallowing. We have found that the share of SNF stays for patients with swallowing disorders increased from about 5 percent in fiscal year 2019 (prior to the new case-mix system) to 20 percent in fiscal year 2022. While most Medicaid case-mix systems for nursing home services adjust payments for resident characteristics, they do not include a separate payment for speech–language pathology services, for which swallowing disorders would be most relevant.

We measured cognitive functioning using the Brief Interview for Mental Status (BIMS) test, which is administered as part of the MDS. Beneficiaries with scores of 7 or lower are considered severely cognitively impaired, those with scores between 8 and 12 are considered moderately cognitively impaired, and those with scores between 13 and 15 are considered cognitively intact (Saliba et al. 2012). We found that a higher share of residents receiving only long-stay care were severely impaired (34 percent) compared with beneficiaries receiving skilled care (19 percent of long-stay residents and 17 percent of community-dwelling beneficiaries). Conversely, a smaller share of the residents receiving only long-stay care were cognitively intact (39 percent) compared with over 50 percent for each of the two groups of beneficiaries receiving skilled care.

The motor score is a composite of the scores on 11 self-care and mobility items collected in the MDS. The median motor score was the lowest (30) for residents receiving only long-stay care, slightly higher (31) for long-stay residents receiving skilled care, and the highest (35) for community-dwelling beneficiaries who received short-term skilled care.

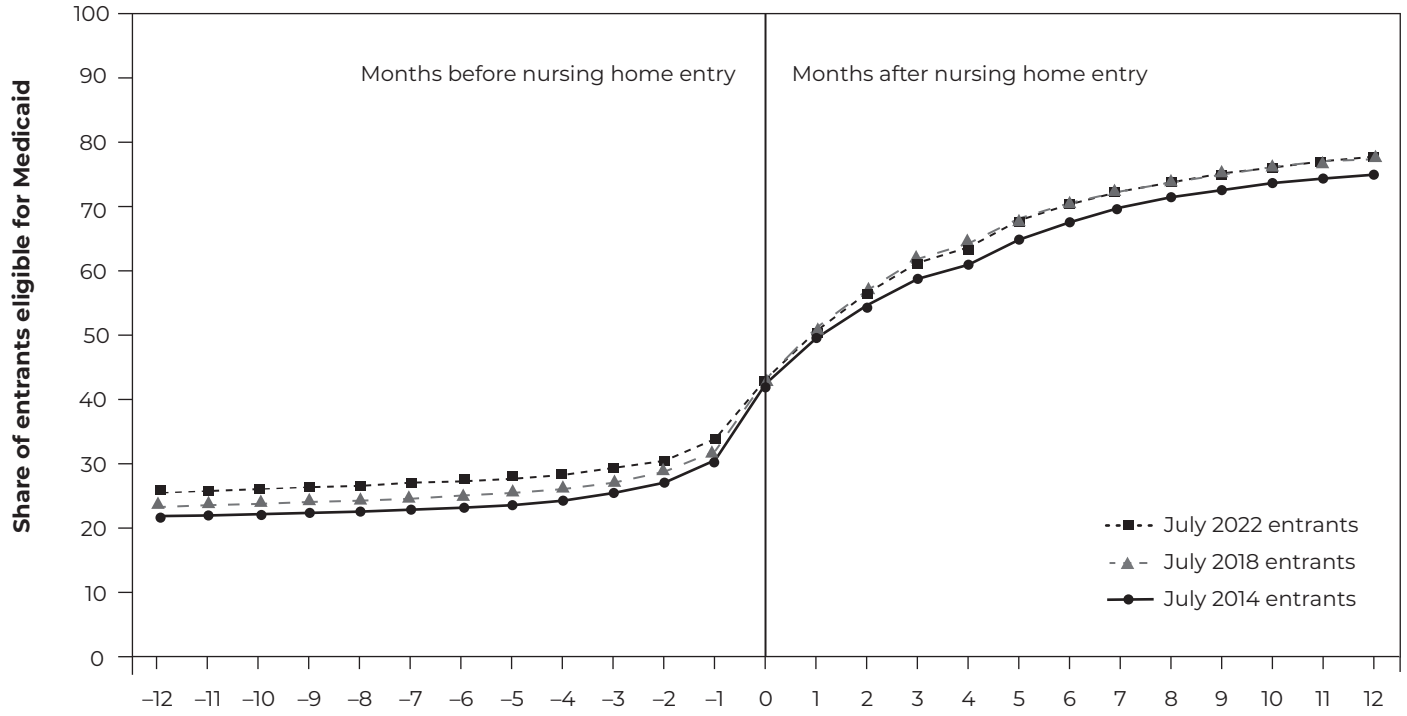
Medicaid plays a key role for long-stay residents

Medicare does not cover long-stay NH care, but the Medicaid program requires states to do so. (Each state Medicaid program also covers other types of long-term services and supports for people who live in the community.) Because of the limited roles played by Medicare and other payers, Medicaid is the predominant payer for NH care: In 2023, the program covered 63 percent of all patient days in nursing homes (Medicare Payment Advisory Commission 2025).

Medicaid's eligibility rules are complex but generally require individuals who live in the community to have

FIGURE 5–1

Most Medicare beneficiaries become eligible for Medicaid within a few months of entering a nursing home



Note: Figure is limited to Medicare beneficiaries who had a nursing home stay that lasted for more than 90 days. "Eligible for Medicaid" means the beneficiary is eligible for full Medicaid benefits, including nursing home care. Figure does not include beneficiaries who had a previous nursing home stay of 90+ days or entered a nursing home less than 12 months after becoming eligible for Medicare.

Source: MedPAC analysis of Medicare enrollment data and Minimum Data Set assessment data.

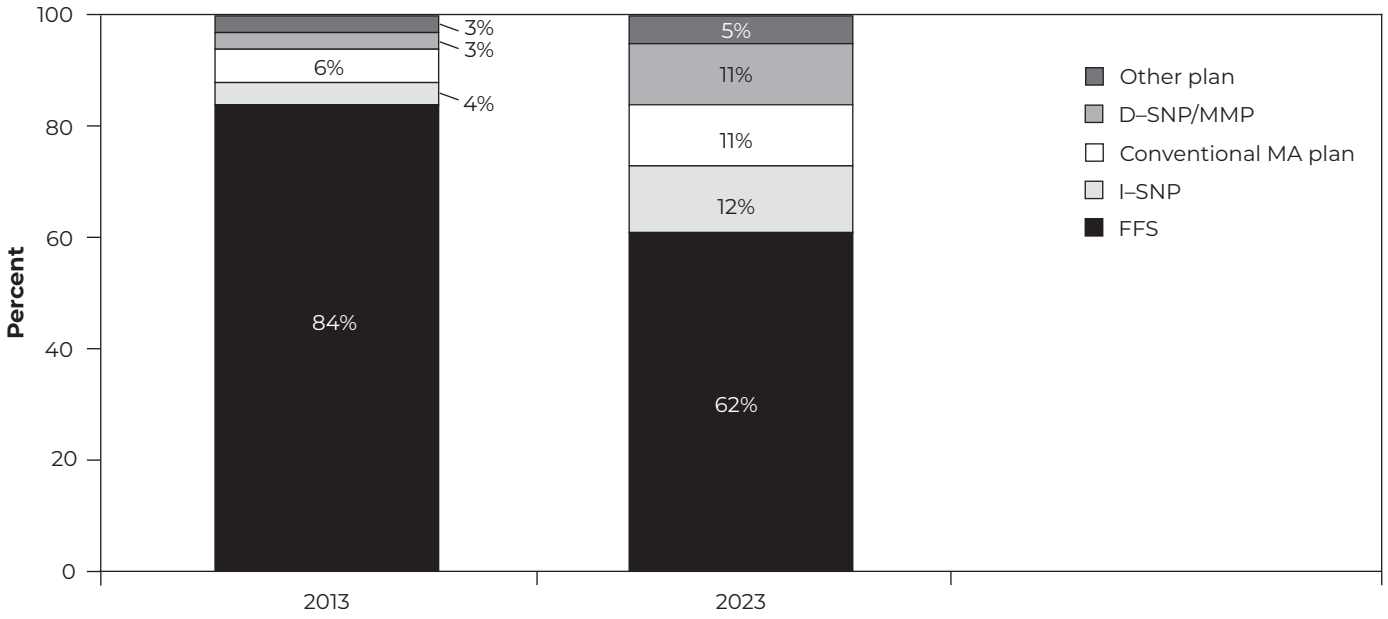
both limited incomes and limited assets. However, all states have at least one eligibility pathway that allows individuals who have higher incomes and need NH care to qualify for coverage (Medicaid and CHIP Payment and Access Commission 2023). Under these pathways, higher-income individuals must still meet Medicaid's regular asset limits, which are quite low (for an aged individual, roughly $2,000 in liquid assets). As a result, individuals who have assets that exceed these limits must first deplete them by spending them on NH care before they can qualify, a process often known as "spending down." Once beneficiaries who need NH care qualify for Medicaid, they must contribute nearly all of their income, except for a small allowance for personal needs, toward the cost of their care.[5] Medicaid then covers the difference between the program's payment rate for NH care and the individual's contribution.

Due to the high cost of NH care, the share of residents with Medicaid coverage rises steadily as the length of stay increases (Figure 5-1). We used MDS assessments to identify cohorts of beneficiaries who entered a nursing home in the same month. We then used monthly enrollment data to track how the share of beneficiaries with Medicaid in each cohort changed over time. In the figure, beneficiaries entered the NH in month zero.

About a third of beneficiaries are already eligible for Medicaid when they enter the NH. After entry, the share with Medicaid rises rapidly, reaching about 60 percent after 3 months and nearly 80 percent after 12 months, indicating that many beneficiaries can pay for only a few months of NH care on their own. The experiences of the 2014, 2018, and 2022 cohorts follow

FIGURE 5–2

The share of long-stay nursing home residents enrolled in FFS Medicare declined between 2013 and 2023



Note: FFS (fee-for-service), D–SNP (dual-eligible special-needs plan), MMP (Medicare–Medicaid Plan), MA (Medicare Advantage), I–SNP (institutional special-needs plan). The "other plan" category includes employer-sponsored MA plans, the Program of All-Inclusive Care for the Elderly, cost plans, and MA special-needs plans for beneficiaries with chronic conditions. We counted beneficiaries as long-stay residents if they had been in a nursing home for 90+ days. Figure does not include long-stay residents who do not have both Part A and Part B (about 3 percent of all residents in 2023). Figures are based on July data. Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare enrollment data and Minimum Data Set assessment data.

similar trajectories, which suggests that this pattern has been fairly stable over time.

Long-stay residents are more likely to have FFS Medicare than MA

Like other beneficiaries, long-stay residents who have both Part A and Part B can receive their Medicare benefits through the traditional FFS program or a managed care plan offered in their area. In 2023, 62 percent of eligible long-stay residents (about 505,000 beneficiaries) were enrolled in FFS Medicare and 38 percent (about 310,000 beneficiaries) were enrolled in managed care, usually an MA plan (Figure 5-2). The share of long-stay residents with FFS coverage is higher than the corresponding figure for all other Medicare beneficiaries, which was 53 percent (data not shown). However, like other beneficiaries, the share of long-stay residents in FFS Medicare has declined steadily as managed care enrollment has grown (for example, in 2013, 84 percent of long-stay residents were in FFS Medicare).

Among those in managed care, roughly equal shares were enrolled in three plan types:

- institutional special-needs plans (I–SNPs), which are specialized MA plans that serve beneficiaries who need the level of care provided in a nursing home (12 percent, or about 96,000 beneficiaries);
- conventional MA plans, which are open to all beneficiaries who have both Part A and Part B and live in the plan's service area (11 percent, or about 89,000 beneficiaries); and
- dual-eligible special needs plans (D–SNPs) and Medicare–Medicaid Plans (MMPs), which are

specialized plans that serve beneficiaries who have both Medicare and Medicaid (11 percent, or about 87,000 beneficiaries).[6]

Since 2013, the shares of long-stay residents enrolled in I–SNPs or D–SNPs/MMPs have each increased by about 8 percentage points, somewhat faster than the share in conventional MA plans, which has increased by 5 percentage points.

Medicare gives all NH residents (not just those who have been in a facility for 90 or more days) more flexibility than other beneficiaries to change their MA or Part D plan. Nursing home residents can change plans—such as switching from FFS Medicare to an MA plan, switching from MA to FFS, or changing their MA or stand-alone Part D plan—on a monthly basis, while other beneficiaries are largely limited to changing plans during the annual enrollment period.[7]

We tracked the cohort of beneficiaries who entered a nursing home in July 2022 and found that their enrollment in FFS Medicare or managed care did shift somewhat in the 12 months after they entered a nursing home. The share of beneficiaries enrolled in conventional MA plans decreased by about 11 percentage points, while the share enrolled in I–SNPs increased by 7 percentage points, and the share in FFS Medicare increased by 4 percentage points. Enrollment in other types of plans changed relatively little, decreasing by 1 percentage point overall. (These are national figures; the figures for individual NHs could easily differ.)

Structure of the nursing home industry

In 2023, there were 15,071 nursing facilities nationwide (Table 5-3). Nearly all facilities (94 percent) participate in both Medicare (as SNFs) and Medicaid (as NFs).[8] Since 2015, the supply of facilities has steadily declined, by an average of −0.7 percent per year, with larger declines for hospital-based and Medicaid-only facilities (data not shown). The industry is evenly split between large (100 beds or more) and small (under 100 beds) providers, though 12 percent have fewer than 50 beds. The industry is overwhelmingly freestanding (96 percent) and predominantly for profit (72 percent) and urban (73 percent), with 2 percent of facilities located in frontier counties (counties with fewer than six persons per square mile, data not shown).

In October 2024, the median occupancy rate was 84 percent, but rates varied by ownership and star rating. Nonprofit facilities had higher occupancy rates compared with for-profit facilities (88 percent and 73 percent, respectively) and facilities with 5-star ratings had higher occupancy than 1-star facilities (83 percent and 76 percent, respectively) (these figures come from MedPAC analysis of first-quarter 2024 Care Compare data and 2023 Medicare cost-report data).

In terms of payer mix, Medicaid covers 63 percent of days; Medicare's FFS coverage of skilled care makes up 8 percent of facility days but 14 percent of revenues because of Medicare's high payment rates. The share of days covered by Medicare is actually higher than 10 percent because the "other payers" category used in Medicare's cost reports includes days covered by MA plans. All private-sector and other payers make up the other 29 percent of days. That category also includes days covered by private insurance, which plays a relatively small role in financing NH care (see text box on the long-term care insurance market, pp. 240–242). Compared with nonprofit facilities, for-profit NHs receive more of their revenues from Medicaid (Assistant Secretary for Planning and Evaluation 2023).

Payment rates vary considerably by payer. In 2019, the average base payment for Medicaid was $200 while the average Medicare payment was $487 (Medicaid and CHIP Payment and Access Commission 2023, Medicare Payment Advisory Commission 2020). However, these rates are not directly comparable because Medicare pays for skilled care whereas Medicaid typically pays for long-stay care. We do not have data on MA payment rates, but we have gathered information from publicly traded SNF companies. In 2019, MedPAC reported that for three SNF companies, FFS Medicare's payment rate averaged 21 percent higher than MA payment rates (Medicare Payment Advisory Commission 2020). We do not know whether the differences in payment rates reflect differences in service intensity, lower payments for the same service, or some combination. We also do not know how these rates compare with rates for other companies. For private-pay residents, one private long-term care insurer, Genworth, reported that the median nursing home cost in 2019 for a semiprivate room was $250 a day (PR Newswire 2019). The payment differentials could create incentives to rehospitalize NH residents, similar to what has been reported for

TABLE 5–3 **Characteristics of nursing facilities, 2023**

Characteristic	Facility count	Percent
All nursing homes	15,071	100%
Medicare/Medicaid participation		
Both programs	14,202	94
Medicare only	591	4
Medicaid only	278	2
Facility size		
0–49 beds	1,798	12
50–99 beds	5,768	38
100–199 beds	6,651	44
200+ beds	854	6
Ownership		
For profit	10,912	72
Nonprofit	3,198	21
Government	961	6
Facility type		
Freestanding	14,538	96
Hospital based	533	4
Location		
Urban	11,002	73
Rural	4,069	27
Share of days covered by:		
Medicaid		63
Fee-for-service Medicare		8
Other payers (includes MA plans)		29
Total margin (all payers, all lines of business)	12,851	0.4
Non-Medicare margin	12,745	–4.1
Medicare margin	12,844	22.0

Note: MA (Medicare Advantage). Components may not sum to 100 percent due to rounding.

Source: Supply, size, type, and ownership are based on QCOR.CMS.gov/main.jsp for 2023. "Location" is based on data from the CMS Provider of Services file. Share of days and margin data are from 2023 Medicare cost reports and exclude the Medicaid-only facilities.

residents who have both traditional Medicare and Medicaid (Grabowski 2007). We do not know if these incentives are as strong for residents enrolled in MA plans or private-pay residents because we have limited data on their payment rates.

Partly reflecting the differences in payment rates, margins vary considerably by payer. The aggregate Medicare margin in 2023 was 22 percent, compared with a non-Medicare margin of –4.1 percent. The aggregate total margin (including all payers and all lines

The long-term care insurance market

Approximately 7.5 million people (including people under 65 years old) have private long-term care insurance (LTCI) that covers at least some nursing home care (Congressional Research Service 2023). The coverage varies widely across policies. Policies have different daily benefit amounts, levels of inflation protection (which protect policyholders from changes in the cost of care between the initial purchase of the policy and the point when care is needed, which could be many years later), duration (the length of time that the policy provides coverage), and waiting periods (between the point when a policyholder first needs care and when the policy begins paying benefits). Eligibility generally begins when an individual has a documented inability to conduct two activities of daily living.

Early policies covered only institutional care (skilled and residential), but over time coverage expanded to include home- and community-based care (Cohen et al. 2013). Initially, policies were sold as stand-alone policies but have gradually shifted to so-called hybrid policies that combine long-term care (LTC) coverage with life insurance or an annuity (Congressional Research Service 2023).

The sale of private LTCI policies took off when they were promoted as a way to protect an individual's assets without having to spend down to qualify for Medicaid. In 1996, there were 2.5 million stand-alone policies in force, and that number grew to 7.4 million in 2012 (Congressional Research Service 2023). Since then, the number of policies has steadily declined (to 6.4 million in 2020) as many insurers exited the market because of the poor financial performance of the product (U.S. Department of the Treasury 2020). In 2002, there were 102 companies that sold LTCI policies (Cohen et al. 2013), but by 2020, fewer than a dozen companies sold policies (Rau and Aleccia 2023).

Similarly, since 2022, the federal government has paused applications for its voluntary LTCI program so that it could assess benefit offerings and sustainable premiums (Office of Personnel Management 2024, Office of Personnel Management 2022). This program is not subsidized by the government; it uses private insurers and thus is vulnerable to the same pressures discussed below. Though many companies have "left" the market and no longer issue new policies, they continue to pay out for policies issued in earlier years.

There are many reasons, on both the supply and demand sides, why the market for long-term care insurance is small and relatively few individuals purchase policies. On the supply side, projecting future costs for LTCI policies is challenging because of adverse selection and the long periods of time between when a policy is first issued and when benefits are paid. During the lag time, the risk of the insured pool changes as policyholders age and some low-risk policyholders let their policies lapse as they decide they can no longer afford the policy (or the expected value of the policy is less than the cost). Further, especially once LTCI policies covered

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of business) was 0.4 percent. The margin for any given NH will depend on its payer mix and its costs.

For the approximately 18 percent of NH residents who are not enrolled in Medicaid, the cost of nursing home care are substantial. In 2024, the median cost of a semiprivate room was $9,277 a month (or $309 a day), with rates varying more than twofold depending on location (for example, the monthly cost in Little Rock, AR, was $7,072 compared with $15,330 in San Jose, CA) (Genworth 2025).

The NH industry is characterized by independent providers and regional chains. There has been increasing concern about the role of complex ownership arrangements and private equity (PE) investment in nursing homes and their implications for quality.[9] One study funded by the Department of

The long-term care insurance market (cont.)

home-based care, moral hazard was an issue as policyholders were more inclined to use care than if they did not have LTCI (Konetzka et al. 2019). To manage moral hazard and adverse selection, companies began to stop issuing new policies to individuals with limited function or cognition or with specific diagnoses (Cohen et al. 2013).

Underwriters also made several miscalculations. They assumed that investment returns on LTCI premiums would match historical interest rates, but actual interest rates were much lower (e.g., interest rates in the 1990s ranged from 5 percent to 8 percent, but in the 2000s they were 3 percent to 5 percent), meaning that premiums were too low to cover expected claims (Cohen et al. 2013). Voluntary lapse rates were lower than anticipated, leaving insurers at risk for more policyholders (Congressional Research Service 2023). At the same time, morbidity was somewhat worse than expected (raising the cost of claims), and mortality rates decreased (extending the risks for insurers).

High premiums and large rate increases dampened the demand for LTCI. Between 1990 and 2010, the average annual premium more than doubled from $1,071 to $2,283—well above the effects of inflation, which would have increased premiums to $1,787 (Cohen et al. 2013). Consumer preferences also changed, as people chose comprehensive policies (that cover all LTC expenses, not just institutional care) and better coverage (meaning policies with higher daily benefit amounts), both of which raise the cost of policies. Coupled with the actuaries' miscalculations, premiums shot up, curtailing demand for new policies and encouraging existing policyholders to drop coverage.

The demand for LTCI may always be somewhat limited: Many wealthy individuals would prefer to self-insure (rather than pay LTCI premiums or spend down to qualify for Medicaid), and middle-income individuals cannot afford the policies. Furthermore, researchers found that the presence of Medicaid discouraged the purchase of LTCI for the lower two-thirds of the wealth distribution (Brown and Finkelstein 2008). Another factor lowering demand is that many individuals are confused about how LTC is financed. A KFF survey conducted in 2022 found that 23 percent of adults thought Medicare covered long-term care; this percentage rose to 48 percent for older adults (65 years and older) (Hamel and Montero 2023). Another survey found that 29 percent of individuals thought they had coverage, yet only 3 percent of individuals actually did (LIMRA 2022).

The use of underwriting by insurers may also discourage the people most likely to need LTC from buying it (Cornell et al. 2016). Insurers limit coverage for older, sicker, and/or cognitively impaired individuals. In 2022, applicant denial rates were 47 percent for 70- to 74-year-olds. Premiums for women are about 60 percent higher than identical policies for men, reflecting women's greater life expectancy and anticipated use of LTC (American Association for Long-Term Care Insurance 2022).

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Health and Human Services Assistant Secretary for Planning and Evaluation found that about 5 percent of all NHs are at least partly owned by PE funds and another 9 percent are at least partly owned by real estate investment trusts (REITs) (Stevenson et al. 2023).[10] This study found that the PE- and REIT-owned facilities are similar to other for-profit facilities in size, resident acuity, and payer mix but have lower overall star quality ratings. Compared with nonprofit facilities, PE- and REIT-owned facilities are larger and have higher Medicaid shares of revenues, higher acuity mix, and lower star ratings. A recent study found that one-fifth of NHs had changed ownership between 2016 and 2022 and that, after the change, there were small but statistically significant declines in the staffing and health inspection components of the NH star ratings but an increase in the quality component of the ratings

The long-term care insurance market (cont.)

So, although women are more likely to benefit from LTCI given their greater longevity, they may get priced out of the market.

Past policy efforts (at both the state and federal levels) to expand the LTCI market have had little or modest effect. In Medicaid, the Partnership for Long-Term Care Program encourages people to purchase LTCI policies by allowing them to protect more of their assets if they later exhaust their LTCI coverage and need to spend down to qualify for Medicaid.[11] One evaluation found that the program had a modest effect on expanding coverage (mostly among wealthy individuals) and was unlikely to have lowered Medicaid spending (Lin and Prince 2013). Policymakers have also tried to expand the LTCI market by offering tax breaks to individuals who purchase policies, thereby effectively lowering their price.[12] Studies found that the tax change increased coverage but the loss in revenue from granting the tax incentives exceeded the savings to Medicaid (Courtemanche and He 2009, Goda 2011). The Community Living Assistance Services and Supports (CLASS) Act was enacted in 2010 as part of the Affordable Care Act of 2010 (ACA) and was intended to establish a voluntary LTCI program funded entirely by enrollee premiums. However, the program was never implemented; in 2011, the Secretary determined that the program was not financially viable, and the Congress repealed it in 2013.

In 2020, a federal task force convened by the Department of the Treasury made recommendations to remove barriers to innovation and increase regulatory efficiency and alignment but did not promote or discourage LTCI (U.S. Department of the Treasury 2020). Its recommendations were aimed at making LTCI more affordable and accessible while letting market forces shape this product. For example, it recommended that state insurance regulators allow for flexibility and experimentation to enable product innovation that best meets consumer needs. It encouraged research on the impact of various product designs (such as newer policies that offer benefits for 12 months) on consumer demand and risk protection. It also recommended that the inflation protection standard (at least a 5 percent compound rate) included in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) should be revised due to its costly effects on premiums. It did not recommend any specific alternative financing mechanism, such as products that offer limited coverage for short periods (with no deductions or waiting periods) or catastrophic coverage products. It concluded that additional tax incentives beyond those currently in place would not benefit middle- or lower-income individuals who need financial protection.

Given the factors that limit the supply of LTC insurers and the lack of demand for the product, LTCI may always play a limited role in financing long-term care. ■

(Ryskina et al. 2024). Across all facilities, for-profit NHs have lower levels of staffing and worse quality of care (Assistant Secretary for Planning and Evaluation 2023).

In 2023, rural NHs made up 27 percent of all facilities but much smaller shares of total days and revenues (20 percent and 16 percent, respectively) (Table 5-4). These lower shares are partly explained by the size of rural facilities, which were smaller and had lower occupancy rates compared with urban facilities. In terms of ownership, a larger share of rural facilities were government owned (such as county owned), and a smaller share of rural facilities were for profit. Compared with urban facilities, rural facilities had lower shares of FFS Medicare days and higher shares of Medicaid days. Rural and urban facilities had similar shares of residents who were eligible for Medicare and Medicaid. Rural facilities had lower average cost per day ($337 compared with $479), but their average

TABLE 5–4 **Comparison of nursing homes by location, 2023**

Characteristic	Urban nursing homes	Rural nursing homes
Share of:		
Providers	73%	27%
Total days	80	20
Total revenues	84	16
Average daily census	91	62
Average occupancy rate	78%	72%
Ownership		
For profit	72%	68%
Nonprofit	19	18
Government	8	14
Share of days covered by:		
Medicaid	54%	60%
Fee-for-service Medicare	18	9
Other payers (includes MA plans)	28	31
Share of residents who are dually eligible	46%	46%
Average cost per day	$479	$337
Average payment per day	$478	$339
Total margin (all payers, all lines of business)	–0.9%	0.2%

Note: MA (Medicare Advantage). The table does not include providers that do not participate in the Medicare program. Components may not sum to 100 percent due to rounding. "Dually eligible" refers to the share of residents who are eligible for Medicare and Medicaid.

Source: MedPAC analysis of 2023 Medicare cost reports.

payments more than covered their costs, so their average total margin (across all payers and sources of revenue) was positive (0.2 percent). In contrast, urban NHs had high payments per day ($478) that did not cover their costs per day, so their average total margin was slightly negative (–0.9 percent).

As shown in Table 5-4, the profitability of the NH industry appears low based on the information submitted on Medicare cost reports. However, the lack of transparency in the reporting of third-party transactions with related entities makes it difficult to know whether the financing of nursing facilities can be accurately assessed. Nationally, over three-quarters of NHs reported payments to related third parties (including real estate companies, management companies, pharmacies, and medical supply companies) (Harrington et al. 2024). One study of NHs in Illinois (a state that requires detailed financial reporting) examined costs before and after they entered into a related-party agreement (Gandhi and Olenski 2024). The study found that those facilities' costs increased due to inflated sale-leaseback agreements and costly management fees owed to the related-party entity. After reestimating NH profits based on what costs would have been without the effects of the related-party transactions, the study found that the reported profits were only 37 percent of actual industry profits—that is, 63 percent of the actual profits were "hidden" in inflated costs. The margins reported here would thus be higher if this study's findings held across NHs nationwide.

Challenges to improving care for beneficiaries living in nursing homes

In a 2022 report, the National Academies concluded that "the way in which the United States finances, delivers, and regulates care in nursing home settings is ineffective, inefficient, fragmented, and unsustainable" (National Academies of Sciences, Engineering, and Medicine 2022). For example, differences in payment rates by payer give NHs a financial incentive to hospitalize their long-stay residents to requalify those with Medicare coverage for a higher-payment Medicare-covered stay once they return to the NH, even when the resident has a clinical condition that does not require a hospitalization (Grabowski 2007). These inpatient stays are financially beneficial to the NH, but they are disorienting to residents and unnecessarily expose them to risks associated with hospitalizations.

The quality of care provided to many long-stay residents in NHs is a long-standing problem (Institute of Medicine 2001, Institute of Medicine U.S. Committee on Nursing Home Regulation 1986, National Academies of Sciences, Engineering, and Medicine 2022). The poor quality in many NHs is partly the result of low Medicaid payment rates that on average do not cover the cost of care: The Medicaid and CHIP Payment and Access Commission (MACPAC) reported that, in 2019, 81 percent of NHs had base payment amounts that did not cover their acuity-adjusted costs and that the median Medicaid base payment rate was 86 percent of reported facility costs (Medicaid and CHIP Payment and Access Commission 2023).[13] However, MACPAC found wide variation across states, with Medicaid base payments ranging from less than 60 percent to over 110 percent of facilities' acuity-adjusted costs. (This study did not account for the possible effects of NHs using transactions with related parties to obscure some of their profits, discussed above.) The relatively low Medicaid rates for many NHs appear to affect staffing levels that, in turn, affect the quality of care.[14] MACPAC reported that NHs with a high share of Medicaid-covered residents were much more likely to have 1- or 2-star staffing ratings in Nursing Home Compare relative to facilities with lower Medicaid shares (Medicaid and CHIP Payment and Access Commission 2022).

Medicaid's payment rates mean that many NHs offer low wages for what can be physically and emotionally demanding jobs. NHs compete, often unsuccessfully, with hospitals and the retail sector for aides (Chidambaram et al. 2024). Low wages contribute to low worker-to-patient ratios that create an undesirable work environment, as reflected in high annual turnover rates for nursing staff. As of October 2022, the 12-month turnover rate for nursing staffing (which includes registered nurses, licensed practical nurses, and nurse aides) was 53 percent, and one-quarter of facilities had rates greater than 64 percent—that is, nearly two-thirds of their nursing staff left the facility during the year (Medicare Payment Advisory Commission 2024b). Worker-to-patient ratios and turnover ratios could worsen as the population expected to need NH care grows, lives longer, and has more complex care needs.

Another problem facing institutionalized beneficiaries is the long-standing and extensive racial segregation in NHs that results in worse outcomes for minorities (Bowblis et al. 2021, Konetzka and Werner 2009, Mor et al. 2004, Travers et al. 2021). Racial and ethnic minorities are more likely to reside in communities with NHs that have lower staffing levels and lower quality. From earlier work, we know that beneficiaries' decisions about where to get their post-acute care is complex, but proximity to family members is important (Medicare Payment Advisory Commission 2024a). Beneficiaries who live in disadvantaged neighborhoods and wish to remain close to home may therefore be choosing among poor-quality homes. Dually eligible beneficiaries are often faced with limited choices among facilities and are more likely to reside in low-quality nursing homes (Sharma et al. 2020). Their choices could be further limited by the NHs willing to take them (due to the relatively low Medicaid payment rates).

One commonly cited measure of NH quality is the rate of transfers of residents to hospitals for inpatient care, emergency department visits, and observation stays. One study of residents with certain common conditions—advanced dementia, congestive heart failure, or chronic obstructive pulmonary disease—found that in 2016 the rates of potentially avoidable hospital transfers were 20 percent, 43 percent, and 41 percent, respectively (McCarthy et al. 2020). Despite the increasing acuity of NH residents between 2015

and 2023, the hours of nursing care per resident day declined by 9 percent. Between 2015 and 2020, the hours per resident day (HPRD) slowly declined until 2020, but then rose in 2021 due to a 17 percent drop in residents during the COVID-19 pandemic. From a low HPRD in 2022, the ratio has slowly increased but in 2024 remained below the 2015 level. Over the same nine-year period (between 2015 and 2023), the share of facilities with serious deficiencies increased from 17 percent to 26 percent (Chidambaram et al. 2024).

CMS uses a mix of data sources and measures to gauge the quality of care in nursing homes. Several measures are based on MDS assessment data, which are gathered on each resident. Other measures are based on claims and have the advantage of being harder to manipulate by providers compared with patient assessment information (see discussion below). On the other hand, the claims-based measures exclude residents not enrolled in Medicare and, among Medicare beneficiaries, exclude those enrolled in MA. For providers with large shares of these residents, the measures may not be good reflections of their care. Staffing measures (HPRD and staffing turnover ratios) are based on payroll data that each nursing home submits to CMS.

The Commission has raised two concerns about quality reporting for NHs. First, many measures are based on patient assessment data that may not be accurate because they are reported by providers and used to establish payments. Providers have long had a financial incentive to record patients' abilities as worse than they are to boost payments (Medicare Payment Advisory Commission 2023, Medicare Payment Advisory Commission 2019). In 2012, OIG reported that one-quarter of SNF claims had billing errors and that the majority of those were "upcoded" (Office of Inspector General 2012). More recently, CMS reported that the majority of the 14 percent of improper payments to SNFs were due to insufficient documentation to support payment for the service billed (Centers for Medicare & Medicaid Services 2024a). A review of studies of Nursing Home Compare reported evidence of "gaming"—that is, some "improvements" may reflect a more concerted focus on scoring rather than actual improvement (Konetzka et al. 2021b).

Second, there are no measures of resident quality of life, resident satisfaction, and end-of-life and palliative care. Given that nursing home residents live in the facility and are very unlikely to move back to the community, these measures are key. In 2021, the Commission recommended that CMS finalize development of patient-experience measures and begin to report them (Medicare Payment Advisory Commission 2021).

Regulatory requirements for nursing home survey and certification and staffing

NHs must meet federal regulations aimed at maintaining a safe environment for residents and ensuring a minimum level of quality. To receive Medicare and Medicaid funding, NHs must pass a regularly scheduled survey and correct any deficiencies. NHs must also meet minimum nurse staffing requirements.

Survey and certification

Federal oversight of nursing homes began with the enactment of Medicare and Medicaid in 1965 and the establishment of requirements to participate in the programs.[15] The Nursing Home Reform Act of 1987 laid out federal requirements for quality of care, quality of life, residents' rights, and the safety of the physical environment. Since then, CMS has implemented many changes aimed at improving ownership transparency, staff training, infection control, and quality of care. However, the general structure of the oversight and regulations remains relatively unchanged (National Academies of Sciences, Engineering, and Medicine 2022).

Surveys of NHs are jointly funded by the federal and state governments. States are directed to conduct the on-site inspections at least every 15 months. A team of surveyors (that includes at least one registered nurse) conducts the inspections and documents their findings about the scope and severity of any deficiencies.[16] In an attempt to standardize the surveys, CMS has established national standards for NH inspections in a State Operations Manual. In addition, all surveyors must complete an orientation program, a surveyor course, and annual job-related training courses, in addition to passing a qualifications test (National Academies of Sciences, Engineering, and Medicine 2022).

The on-site survey consists of an unannounced, multiday inspection and interviews with residents.

Each deficiency is rated from "A" to "L" based on its severity and scope. Deficiencies that resulted in no actual harm with the potential for minimal harm are rated from A to C, while widespread deficiencies that pose immediate jeopardy to residents are rated L.

Surveyors prepare a report on the findings of the inspection, detailing the deficiencies, that is shared with the facility. Facilities must draw up and complete a corrective plan to avoid enforcement remedies, and CMS must approve the plan. Depending on the findings, enforcement remedies can include assessing per day or per instance civil monetary penalties (CMPs), denying payments until the deficiencies are corrected, or terminating the nursing home's participation in Medicare and Medicaid. In fiscal year (FY) 2024, CMPs made up 76 percent of the 8,167 enforcement actions (affecting 4,076 NHs), and denial of payments for new admissions made up another 15 percent.[17] Almost all of the remaining enforcement remedies imposed monitoring, directed plans of action, and directed in-service training (Centers for Medicare & Medicaid Services 2024g). Terminations, which numbered 23 nationwide in FY 2024, are infrequent. Beginning in FY 2025, a facility that is out of compliance can be assessed CMPs per day and per instance (Centers for Medicare & Medicaid Services 2024c).[18] CMS's funding for mandatory surveys and certifications for all health care providers has remained at $397 million since FY 2015 with some additional funding in single years from the CARES Act or CMS (Centers for Medicare & Medicaid Services 2025d). In FY 2023, the last year with complete data, states performed 179,766 surveys, of which 83 percent were for NHs (Centers for Medicare & Medicaid Services 2025e).

Although select outcomes for residents have improved after focused attention on specific problems identified in these surveys (such as the use of restraints or antipsychotic drugs), overall quality in many NHs remains a persistent problem (National Academies of Sciences, Engineering, and Medicine 2022). Numerous reports by GAO and OIG over the last two decades have covered topics such as inadequate infection control, concerns about resident safety, elder abuse, underreporting of serious deficiencies, and inadequate staffing on weekends (Government Accountability Office 2020, Government Accountability Office 2019, Government Accountability Office 2009, Government Accountability Office 2008, Government Accountability Office 2007, Government Accountability Office 2005, Office of Inspector General 2019).

NH inspections should play a key role in ensuring that minimum quality standards are met. But for many reasons, these efforts often fall short. In 2022, OIG assessed CMS's oversight of state survey agencies from 2015 to 2018 and found that over half of states repeatedly did not meet performance standards, most often because the surveys were not timely. It raised questions about the effectiveness of CMS oversight and the ability of CMS to hold states accountable when problems arise (Office of Inspector General 2022). OIG also noted that its previous reports found that states did not always verify whether nursing homes had corrected deficiencies cited during the surveys or conduct timely surveys following serious complaints. The National Academies recently stated that it was unclear whether the recurring challenges to quality reflect inadequate implementation and enforcement of existing regulations or the inherent limits to what regulation can achieve (National Academies of Sciences, Engineering, and Medicine 2022). The Academies noted that there was a dearth of evidence indicating which regulatory approaches would improve quality.

There are two persistent problems with the state-run inspections. First, as noted by the U.S. Senate Special Committee on Aging, the inspection agencies are "woefully underfunded" such that required inspections are frequently delayed (U.S. Senate Special Committee on Aging 2023). In its FY 2025 budget request, CMS stated that at its 2024 funding level, it would be able to complete only 65 percent of the required inspections (Department of Health and Human Services 2025). The underfunding also results in high vacancy rates for surveyors. In 2022, 31 states plus the District of Columbia had vacancy rates of at least 20 percent for surveyor positions (U.S. Senate Special Committee on Aging 2023). Second, there is large variation across states in whether they achieved survey performance standards (such as the timeliness of surveys and whether survey findings were appropriately documented) (Centers for Medicare & Medicaid Services 2024d). In its assessment of results from state surveys from 2015 to 2018, OIG found large differences across states in how routine inspections are implemented, sanctions are imposed, and complaints

are investigated, and the office raised questions about states' performances in conducting the surveys (Office of Inspector General 2022).

In addition to the variation in state survey performance, there are large differences across states in the citation of serious deficiencies in NHs (defined as causing or likely to cause serious injury, harm, impairment, or death to a resident). KFF reported that, at the state level, the share of NHs with serious deficiencies in 2024 ranged from less than 10 percent to over 40 percent (KFF 2024). It is not possible to know the extent to which the variation in citation of serious deficiencies across states reflects real differences in quality versus differences in surveyors' detection and gradings of deficiencies.

CMS targets the lowest-performing NHs—those with a sustained pattern of numerous and serious survey deficiencies—for more frequent surveys as part of the Special Focus Facility (SFF) Program.[19] These facilities are inspected every six months until they either "graduate" from the program (having improved) or their participation in Medicare and/or Medicaid is terminated. CMS has criteria for graduation but has not established criteria for termination, though SFFs where residents were harmed or the facility's actions caused death (or where residents were likely to experience these serious adverse events) on two surveys are candidates for such action.[20]

Because of the lack of resources, CMS can include only a fraction of the poorest-performing homes in the SFF Program. In November 2024, there were about 80 SFFs; about 400 more facilities were candidates but not part of the program due to insufficient funding (Centers for Medicare & Medicaid Services 2024h).

The SFF Program has not been studied recently, but older reports indicate that it had mixed results. One 2019 study of the 21 "graduates" of the program found that almost one-third were cited for serious deficiencies (the worst categories of deficiencies, involving harm or immediate jeopardy for residents) in the previous year (Center for Medicare Advocacy 2019). A *New York Times* analysis found that of the nursing homes that had graduated from the SFF Program before 2017, over half were cited for serious harm or jeopardy in the next three years (Rau 2017).

Staffing requirements

Numerous studies have found a relationship between staffing—particularly registered nurse (RN) staffing—turnover, and quality of care. A review of studies published between 2008 and 2014 found that higher RN staffing and a higher ratio of RNs to other nursing staff was associated with fewer pressure ulcers, lower restraint use, decreased probability of hospitalization, fewer inspection deficiencies, decreased mortality, and decreased incidence of urinary tract infections (Dellefield et al. 2015). A systematic review of the relationship between nurse staffing and resident outcomes in nursing homes concluded that RN staffing and higher skill mix (greater share of licensed nurses) was likely associated with fewer pressure ulcers, fewer COVID-19 infections, and lower rates of moderate to severe pain (Jutkowitz et al. 2023). Another systematic review of studies during the pandemic found that, in facilities with known cases, higher staffing was associated with fewer deaths from COVID-19 (Konetzka et al. 2021a). Recent studies that have examined staff turnover using payroll-based data have found that higher nursing staff turnover was associated with lower star ratings (for inspections, quality, and staffing), infection control citations, and quality of care (Gandhi et al. 2021, Loomer et al. 2022, Zheng et al. 2022).

Since 1989, federal staffing standards have required nursing homes certified for Medicare and Medicaid to have (1) a director of nursing who is an RN; (2) an RN on duty 8 consecutive hours per day for 7 days a week; and (3) a licensed nurse—either an RN or a licensed practical nurse (LPN)—on duty for 24 hours per day, 7 days a week. These standards translate to 0.3 hours of nursing time per resident per day for a 100-bed facility (Medicaid and CHIP Payment and Access Commission 2022). The law also requires facilities to have "sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident," but does not specify a minimum number of nurses per resident to define "sufficient." Thirty-eight states and the District of Columbia have implemented stricter minimum staffing requirements than the federal requirements (Medicaid and CHIP Payment and Access Commission 2022). The state requirements vary in terms of the staffing affected by them (e.g., RNs or total nursing staff) and their stringency.

In May 2024, CMS issued new requirements that specify the minimum HPRD for total nurse staffing (including RNs, LPNs, and nurse aides (NAs)) (Centers for Medicare & Medicaid Services 2024b). The new rule also required NHs to have an RN on-site 24 hours a day, 7 days a week. The Commission has not taken a position on the new regulations. Industry representatives filed lawsuits against CMS and the Department of Health and Human Services (HHS) to dismiss the staffing rule, arguing that CMS exceeded its statutory authority. On April 7, 2025, a federal judge determined that the new requirements exceeded CMS's authority and dismissed the staffing rule (U.S. District Court for the District of Texas 2025). As this report went to press, CMS had not indicated plans to appeal the decision.

CMS's quality programs for nursing homes

CMS has three programs focused on improving quality: the Quality Reporting Program (QRP), the 5-star quality rating system, and the Quality Improvement Organization (QIO) Program. Many of the measures required by the QRP are included in the rating program. The 5-star system is designed to compare quality across nursing homes. The QIO program is not specific to NHs, but some of its activities have focused on NHs.

SNF Quality Reporting Program

The SNF Quality Reporting Program (SNF–QRP), mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT), requires SNFs to submit quality data to CMS.[21] There are 15 quality measures in the SNF–QRP. Three-quarters of the measures are based on SNF-reported patient assessment information (such as discharge function score and changes in skin integrity) while the other quarter consists of claims-based outcome measures (e.g., readmission rates) or cost measures that CMS calculates. NH performance on 13 of the QRP measures are publicly posted on the Care Compare website after providers have had a chance to review and correct data (if warranted). (The measures regarding the transfer of health information to the patient and provider post-acute care are not posted.) SNFs that do not submit complete data for at least 80 percent of their patient assessments receive a lower update to their payment rates (the market basket update percentage minus 2 percentage points). About 2 percent of facilities do not meet the threshold. Starting in FY 2026, facilities must report complete data for 90 percent of their assessments to receive a full update.

In addition to QRP measures, the Care Compare website includes other short- and long-stay measures and resident and staff vaccination rates. In total, 33 measures are reported on the website.

5-star quality rating system for nursing homes

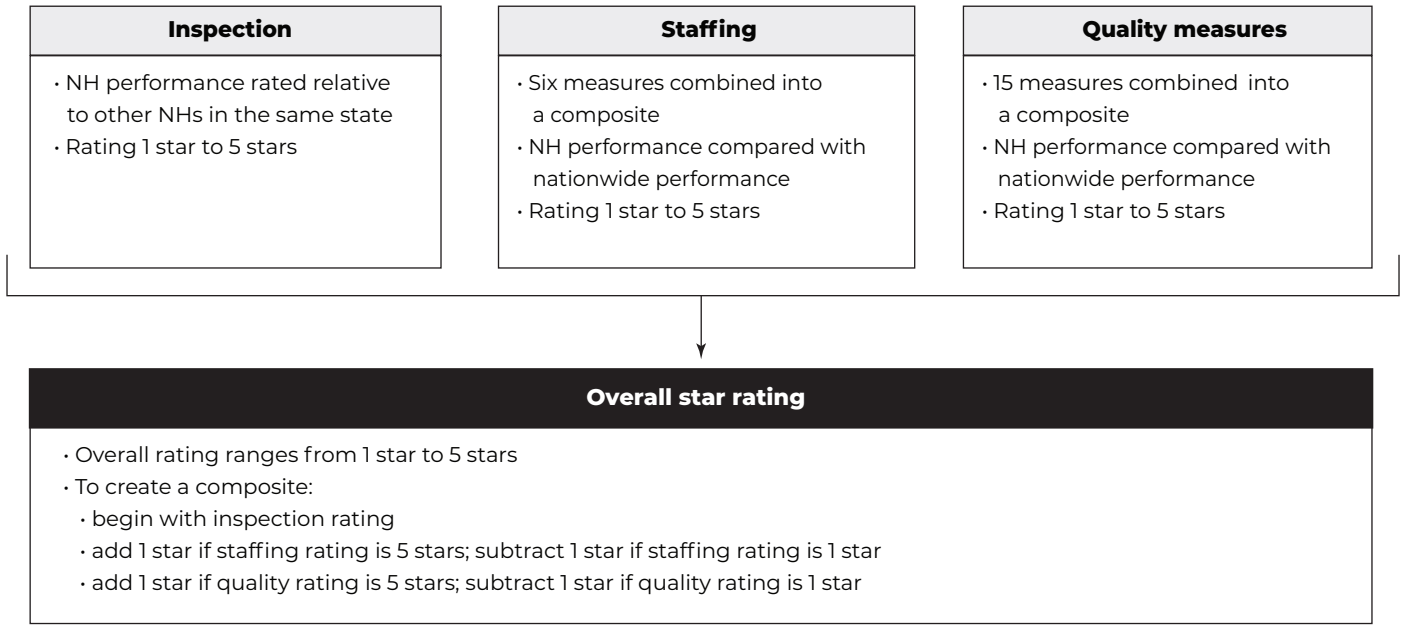
One lever that CMS uses to improve the care furnished in NHs is to publicly report the quality of individual providers. Consumers, their families, and hospital discharge planners can use the information when selecting a facility for post-acute care or long-term care. Managed care organizations, ACOs, and hospital systems can consider the information when determining which providers to include in their network of providers. In 1998, CMS began publicly reporting NH performance on inspections and staffing. In 2009, CMS began publishing star ratings on its website. The idea behind public reporting is that publishing the quality of individual providers would motivate them to improve their care.

To make the publicly reported information easy to understand, NHs receive an overall star rating that is a composite of separate ratings for three domains—the NH inspection, staffing levels, and quality measures (Figure 5-3). For each domain and the overall rating, NHs can receive 1 to 5 stars based on their performance. The overall rating and the three domain ratings are displayed on the Care Compare website. Special Focus Facilities are not rated; instead, a warning icon appears on the Care Compare website.

The inspection rating uses information from the NH's three most recent surveys about safety, quality of life, medication management, resident assessment, NH administration, resident rights, the environment, and kitchen/food services (with the most recent survey's results weighted more heavily than the earlier surveys). Performance is based on the number, scope, and severity of the deficiencies.[22] Each deficiency is assigned points; deficiencies that are widespread and put residents at immediate jeopardy count more than other deficiencies. Results from the most recent 36 months of complaint investigations and focused infection-control surveys and the number of repeat visits required to

FIGURE 5–3

Nursing home star ratings



Note: NH (nursing home).

Source: CMS Care Compare website, November 2024.

confirm that the deficiencies have been corrected also add points to the total inspection score.

Because state surveyors do the inspections, the inspection rating is based on the relative performance of the NHs in each state. Within each state, the distribution of star ratings is prescribed in advance: The top 10 percent of NHs receive 5 stars (highest performance), the bottom 20 percent receive 1 star, and the middle 70 percent receive between 2 and 4 stars. Because NHs are compared within a state but not across states, the worst (or best) performers in one state could be better (or worse) than the average performers in another state in terms of actual deficiencies.

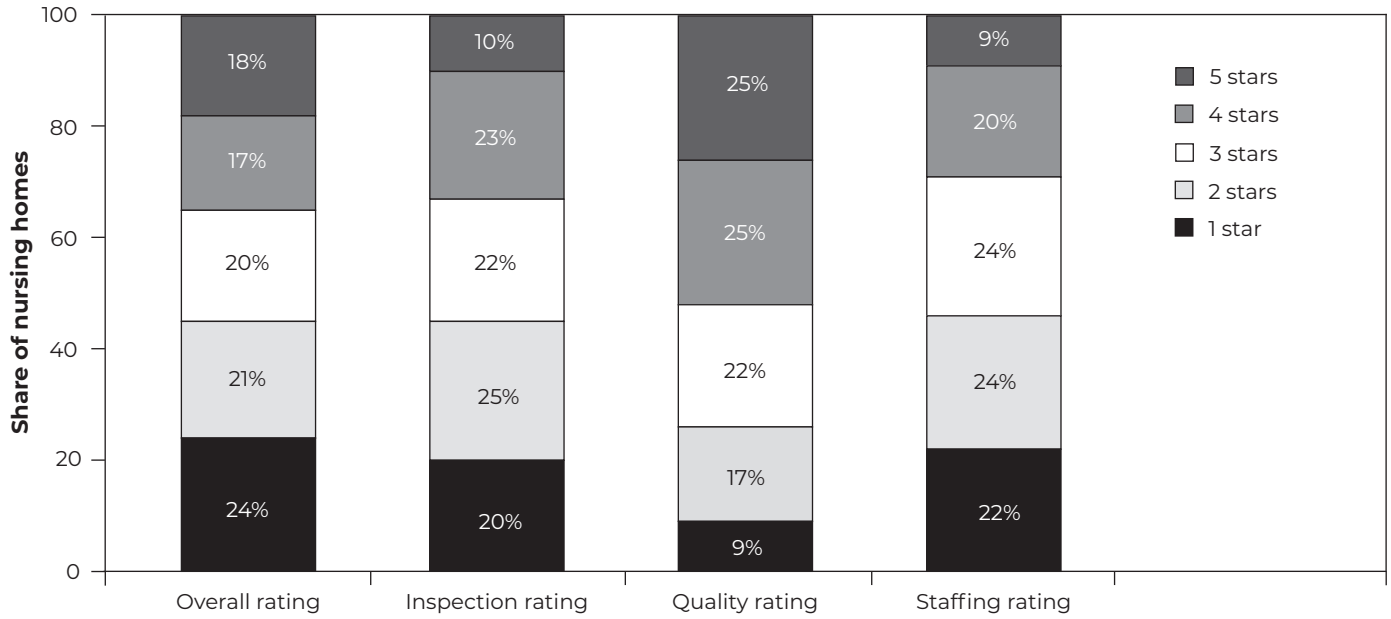
The staffing rating is a composite of six staffing measures that are calculated from payroll data that NHs must report quarterly. Three are risk-adjusted measures of staffing levels: total nurse staffing (RNs, LPNs, and NAs) across all days, RN staffing across all days, and weekend total nurse staffing. The other three measures relate to turnover for three categories of workers: total nursing staff, RNs, and administrators. Because the turnover measures look at rates averaged over an entire year, they do not fully capture the day-to-day variation in staffing that has been shown to be related to various health outcomes (Mukamel et al. 2023).

All staffing measure performances are compared nationwide (not by state). Points are assigned based on a NH's performance on each measure and then summed. The measures do not have equal weighting: The maximum number of points a NH can receive is 100 points each for total staffing and RN staffing; 50 points each for total nurse staffing on weekends, total nurse turnover, and RN turnover; and 30 points for administrator turnover. Stars are assigned based on the total points earned across the six measures.

The quality domain is a composite of 15 quality measures: 9 long-stay measures and 6 short-stay measures.[23] The quality-measure performances are compared nationwide. Five of those measures are claims based; 10 are based on patient assessment data. In calculating the composite quality rating, some

FIGURE 5–4

Nursing home star-rating performance, November 2024



Source: CMS Care Compare website, November 2024.

measures have more weight than others. Based on expert opinion, measures that NHs have a greater opportunity to improve and measures with higher clinical significance count more than others. In addition to posting the overall quality rating, the Care Compare website reports a facility's performance on some individual quality measures.

The ratings for the inspection, staffing, and quality domains are not averaged to create an overall rating. Rather, the overall rating starts with the inspection rating, and the staffing and quality ratings each can add or subtract one star from it.[24] CMS explained that the inspection domain was given the most weight because it reflects an on-site inspection conducted by a trained surveyor. CMS also developed its basic approach for calculating the overall rating before the availability of more accurate and timely staffing data, which may have contributed to its decision to give the rating for the staffing domain less weight. Staffing and quality ratings are updated quarterly, while the inspection rating is updated when there are new survey results for the facility.

Our analysis of November 2024 star-rating information found that almost one-quarter of NHs had 1-star overall ratings, and 18 percent of facilities had 5-star ratings (Figure 5-4).[25] The distributions of ratings for the three domains differed considerably. Smaller shares of NHs had 5-star ratings for inspections and staffing (10 percent and 9 percent, respectively).

For-profit NHs were much more likely to have a 1-star rating than a 5-star rating (28 percent compared with 13 percent) (Table 5-5). In contrast, nonprofit NHs tended to have higher ratings: 11 percent had a 1-star rating and 32 percent had a 5-star rating. Larger facilities were more likely to have a 1-star rating compared with smaller facilities. The average share of residents who were low income was much lower in 5-star facilities (33 percent) compared with 1-star facilities (59 percent).

TABLE 5–5

Distribution of star ratings by nursing homes' characteristics, 2024

Characteristic	1 star	2 stars	3 stars	4 stars	5 stars
For profit	28%	23%	19%	16%	13%
Nonprofit	11	15	21	21	32
Urban	24	21	20	16	18
Rural	24	20	19	19	17
0–49 beds	11	14	16	22	36
50–99 beds	20	20	20	18	21
100–199 beds	30	22	20	15	12
200+ beds	30	26	19	11	12
Average low-income share	59	52	46	41	33

Note: Except for the row displaying low-income shares, the values represent the percentage of facilities within each row with the indicated star rating. "Low-income share" is the share of beneficiaries who receive the low-income subsidy in the Part D drug benefit. The shares for the star ratings may not sum to 100 due to rounding.

Source: CMS Care Compare website, November 2024.

The distribution of star ratings varied widely across states. For example, 7 percent of the NHs in one state earned 5-star overall ratings compared with 27 percent of facilities in another state. Because the distribution of inspection ratings within each state is prescribed and uniform (see p. 249), the variation in the overall ratings is due to differences across states in the staffing and quality domains. The differences in the staffing ratings could in part reflect the variation in state staffing requirements. Among the counties with facilities that had star ratings, 37 percent did not have any 4- or 5-star nursing homes (data not shown).

One study surveyed the literature on the Care Compare ratings (71 articles in all) and drew several conclusions (Konetzka et al. 2021b). Overall, consumers use the ratings to select higher-quality facilities, and providers try to improve their ratings. In the first two years of the program, the use of 1-star NHs decreased and the use of 5-star NHs increased (Konetzka et al. 2015). However, the authors noted that the shifts were modest, in part because the use and general awareness of the website was low. An older national survey found that 12 percent of respondents remembered using the website but often only to gather names and addresses, not to examine quality scores (Castle 2009).

The survey article also noted some important unintended consequences. First, the program may have exacerbated inequities because higher-income beneficiaries were more likely to use the website. Second, providers focus on the measures that are used in the ratings and pay less attention to other aspects of care that may be equally important (like patient experience, discussed below). The study's authors also mentioned that, to improve their scores, some providers use coding and documentation strategies for the self-reported data, such as increased coding of end-stage renal disease, because some quality measures exclude residents with this disease from the rate calculations (Konetzka et al. 2021b). The Commission has raised concerns about the self-reported patient-assessment items, particularly those used for payment, such as a patient's functional status (Medicare Payment Advisory Commission 2019). In an article on NH reporting of major-injury falls, researchers matched patient assessments with inpatient hospital claims and concluded that the NH-reported data could be

highly inaccurate (Sanghavi et al. 2020). In 2027, CMS will begin to validate some of the patient-assessment information (including functional status).[26]

The NH star ratings do not include measures of patient and family satisfaction. Studies found that resident and family satisfaction were key items that consumers would like added to the Care Compare website (Konetzka and Perraillon 2016, Schapira et al. 2016). In 2021, the Commission recommended that CMS move forward with finalizing the development of and beginning to report patient-experience measures for SNFs (Medicare Payment Advisory Commission 2021). For FY 2024, CMS proposed but did not implement the adoption of a patient-experience measure using the CoreQ survey for short-stay residents, which includes four items that ask beneficiaries if they would recommend the facility, how they rate the staff and the care they received, and whether their discharge-planning needs were met. In 2025, CMS requested information on patient-experience measures and said it would consider those comments in future measure development.

One potential area of future work is to consider alternative designs of the overall rating of a NH. Given the clear relationship between staffing and quality and the availability of good staffing data, the staffing domain could play a larger role in determining a NH's overall rating.

Quality Improvement Organization Program

In 1992, CMS began the QIO Program to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries and to make sure that those services are reasonable and necessary.[27] The program is not specific to nursing homes, and its focus on this setting has been inconsistent over time. More recently, the program has offered quality improvement tools, training, and other resources to help nursing homes improve their star quality rating (Centers for Medicare & Medicaid Services 2024e). In FY 2023, spending on the QIO Program (across all providers and topics) totaled about $814 million (Centers for Medicare & Medicaid Services 2024f).

In its 12th multiyear scope of work (covering the period from November 2019 to November 2024), the program had 12 partners who worked directly with NHs to reduce adverse drug events and health care–associated infections. Partners also helped train NH staff regarding infection prevention and control in NHs serving small, rural, vulnerable, and disparate populations (Centers for Medicare & Medicaid Services 2024e). Results from this cycle of work have not been evaluated.

A consensus report conducted for the National Academies concluded that there is a lack of evidence showing that the QIO Program is effective (National Academies of Sciences, Engineering, and Medicine 2022). Earlier reports completed by the Institute of Medicine and the Assistant Secretary for Planning and Evaluation drew similar conclusions (Assistant Secretary for Planning and Evaluation 2007, Institute of Medicine 2006). Studies have had serious methodological problems, such as selection bias and the lack of controls for confounding factors. A review of 25 years of external evaluations found that the effects of the program have been small or difficult to interpret and that the program lacked consistent data collection and reporting to compare results across individual projects it has supported (Shaw-Taylor 2014).

FFS payment policies aimed at improving quality in nursing homes

FFS Medicare has payment policies that aim to give NHs and other providers financial incentives to improve the care furnished to NH residents. The SNF value-based purchasing (VBP) program and ACOs increase and decrease payments based on the care they provide to beneficiaries. Because the policies apply only to Medicare-covered services, they have limited ability to improve quality. In addition, between 2012 and 2020, there was a demonstration to reduce avoidable hospitalizations among NH residents.

SNF Value-Based Purchasing Program

Quality payment programs—also known as VBP programs—can create incentives for providers to furnish high-quality care. These programs adjust payment rates or make separate payments based on a provider's performance on one or more quality measures. Providers with relatively good quality receive higher payments than those with poorer quality. Medicare has had a VBP program in place for SNFs since October 1, 2018.

Key design features of the VBP program were established in the Protecting Access to Medicare Act of 2014 (PAMA). The law mandated the use of a single measure (all-cause readmissions to hospitals within 30 days of discharge from the hospital) to gauge the quality of care; required the Secretary to develop a methodology to ensure that the measure results are reliable and valid; and specified the performance scoring (40 percent of SNFs must have their payments lowered by the VBP), the funding for the incentive payments (a 2 percent reduction to the payment rate), and the distribution of those payments to SNFs (between 50 percent and 70 percent must be paid out to providers). CMS opted to return 60 percent of the withhold (or 1.2 percent, before factoring in performance).

In a mandated report to the Congress, the Commission compared the design features of the SNF–VBP program with a general set of principles regarding the design of quality-incentive programs (Medicare Payment Advisory Commission 2021, Medicare Payment Advisory Commission 2018). The Commission concluded that the SNF–VBP program design was sufficiently flawed that it should be eliminated and replaced with a new program that (1) scores a small set of performance measures, (2) incorporates strategies to ensure reliable measure results to avoid rewarding random variation rather than actual performance, (3) establishes a system to distribute rewards that minimizes cliff effects (so that providers with similar measure results do not receive very different payments), (4) accounts for differences in patient social risk factors using a peer-grouping mechanism, and (5) completely distributes a provider-funded pool of dollars. MedPAC modeled an illustrative VBP design with these features, including peer groups to address differences in shares of low-income beneficiaries, and found that such a design was feasible and would result in more-equitable payments across SNFs.

Since then, CMS has made important changes to the VBP program that, to varying degrees, address the Commission's concerns. In 2020, the Secretary of HHS was granted the authority to add up to eight measures. Over the next two years, CMS plans to add seven measures: infections requiring hospitalization, total nurse staffing per resident day, staff turnover rates, discharge to community, percentage of residents with a fall with major injury for long-stay residents, discharge function score for SNF patients, and hospitalizations per 1,000 long-stay residents (Centers for Medicare & Medicaid Services 2024c). In addition, CMS will replace the 30-day all-cause readmission rate with a potentially preventable readmission rate for SNF patients in FY 2028. This change is consistent with comments that the Commission made in 2017, encouraging CMS to rethink its readmission measure so that SNFs were held accountable for hospitalizations during the entire stay, not just the first 30 days (Medicare Payment Advisory Commission 2017).

CMS also revised the reliability standards, though improvements could still be made. For some measures, the measure must have "moderate" reliability but does not meet a commonly used standard of "good" reliability, whereby 70 percent of the variation is explained by differences in performance and 30 percent is explained by random variation. In addition, providers do not have to meet the minimum case counts for all measures. In FY 2028, when there will be eight measures in the program, providers will be required to meet the minimum counts for four of them.

Beginning in FY 2027, the VBP will consider social risk factors in scoring a SNF's performance. An adjustment will increase VBP payments for SNFs that provide high-quality care and care for high proportions of low-income beneficiaries. The size of the adjustment will vary based on how many top performances the SNF has and its share of dually eligible beneficiaries. In April 2025, CMS proposed eliminating this adjustment, but when this report went to press, the adjustment remained in place (Centers for Medicare & Medicaid Services 2025c).

Two other features of the VBP program do not meet the Commission's principles and would require congressional action to change. First, the design may not encourage all providers to improve because, by statute, the program must lower payments for 40 percent of SNFs. As a result, not every improvement may be rewarded. Second, the program does not pay out the entire provider-funded incentive pool of dollars. Even in FY 2027, when the payback percentage will increase from 60 percent to 66 percent of the pool, the VBP program will be used to achieve Medicare savings.

Since the VBP program began in 2019, average SNF performance has worsened. The average risk-standardized 30-day readmission rate increased slightly (from 19.4 percent in FY 2019 to 20.4 percent in FY 2023). Over the same period, the penalties and rewards have been relatively small, ranging from increases or decreases of about 2 percent.[28] In 2024, CMS estimated that the VBP program would result in $185 million in Medicare savings (Centers for Medicare & Medicaid Services 2024c). Although the statute requires that payments be lowered for providers in the bottom 40 percent of readmission rates, about 70 percent of providers typically have their payment lowered. The modest impact on readmissions and payments likely reflects that the withhold is small (2 percent of Medicare's payments, or about 0.3 percent of aggregate NH revenues). SNFs may have concluded that the small increment to the payment rates would not fund the investment required to substantially improve their readmission rates.

Our evaluation of the first three years of the SNF–VBP program (covering FY 2019 through FY 2021) found that facilities were more likely to have larger payment reductions if they were smaller, treated more complex patients, had higher shares of dually eligible beneficiaries, were freestanding, or were for profit (Medicare Payment Advisory Commission 2021).[29] These results were consistent with research done by others (Daras et al. 2021, Hefele et al. 2019). Two studies found that SNFs with the lowest margins were more likely to be penalized by the VBP program, which might make it harder for them to invest resources to improve their quality (Qi et al. 2020, Sharma et al. 2021). SNFs with lower RN staffing levels were less likely to receive VBP rewards, though we did not find consistent relationships between payment adjustments and staffing (Daras et al. 2021, Medicare Payment Advisory Commission 2021). After examining rates of preventable critical incidents, GAO concluded that the payment incentives were insufficient to get SNFs to increase their RN staffing levels (Government Accountability Office 2021).

Demonstration to reduce avoidable hospitalizations

From 2012 to 2020, the CMS Innovation Center conducted a demonstration, known as the Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents, aimed at lowering hospitalizations for long-stay NH residents.

The demonstration had two phases. The first phase (2012 to 2016) funded seven entities to implement a variety of clinical and education-based initiatives in 143 NHs. Grants to entities funded the hiring of RNs or advanced practice RNs to provide direct care and/or education and to manage medications. Some used funds to enable the adoption of technology that would enhance the coordination among the home, physicians, pharmacies, and hospital.

CMS's evaluation of the first phase found that the demonstration lowered the probability of avoidable hospitalizations and emergency department visits but, after accounting for the grants provided to participants, this phase raised program spending by $28 million (RTI International 2017). There was no impact on resident mortality. The demonstration had no effect on MDS-based quality measures.[30] Of the varying approaches taken by the seven participating entities, models that included consistent, hands-on daily care showed larger changes compared with models that did not include direct care or included intermittent care or a rotating set of staff across the participating NHs.

The second phase (2016 to 2020) provided financial incentives to counter the FFS incentives to send residents to the hospital for six potentially avoidable conditions and to increase physician presence in NHs.[31] Participants included some NHs from Phase 1 that opted to continue (this group had the clinical and educational funding of Phase 1 plus the financial incentives of Phase 2) and a new group of NHs that had only financial incentives. In total, there were six entities with 263 NHs, including 115 from Phase 1. There were three financial incentives. First, NHs received an additional per diem payment ($218 per day) for a period of in-house treatment for residents. Second, physicians, NPs, and physician assistants (PAs) received a higher (hospital-level) payment when they treated residents ($206 for an initial visit compared with $138). These two incentives aimed to encourage facilities and clinicians to treat in place rather than send residents to the hospital for potentially avoidable conditions. The third incentive allowed practitioners to bill once a year for an evaluation to coordinate care ($80 for the visit), which may have enhanced early detection of changes in residents' clinical conditions.

The evaluation of the second phase found no clear evidence that the financial incentives lowered hospitalizations, ED visits, or spending (RTI International 2017). Hospital and ED use and spending did not decrease further than what was achieved by entities in the clinical and educational phase. Hospitalizations, ED visits, and Medicare spending increased, relative to a national comparison group, among NHs that received the combination of clinical and educational activities and financial incentives. Among NHs with only financial incentives, there was no consistent evidence that utilization and spending were lowered. Participants reported that they did not change their practices in response to the financial incentives because reducing hospitalizations by treating in place was already a goal. High staff and administrator turnover at some NHs undermined the program's success because the frequent training of staff meant that the initiative did not move beyond a start-up phase. The evaluators concluded that there was value in providing on-site clinical care but that any financial incentive needs to be sufficient and appropriately structured to change behavior.

A separate study also found that the financial incentives alone or in combination with the clinical and educational incentives did not lower hospitalizations or spending (Tyler et al. 2022). Based on interviews with participants, the authors concluded that three components are needed for successful implementation: low turnover in staff and leadership; leadership and staff support; and provider engagement and support. Financial incentives alone were insufficient to reduce hospitalizations of long-stay NH residents.

Accountable care organizations

An ACO is a collection of providers that voluntarily enter into arrangements that hold the providers accountable for the quality and cost of care for a defined group of beneficiaries. ACOs are largely comprised of physician groups, health systems, or hospitals, but they may also partner with other providers, including NHs/SNFs, to help meet spending and quality benchmarks. If an ACO is successful at both, the ACO earns savings; if it is not, it is potentially at risk for losses.[32] Common ACO strategies for managing spending include reducing hospitalizations, avoiding or reducing the use of post-acute care, and managing the use of ancillary services. ACOs have curbed the use of SNFs by shortening SNF stays and by avoiding the setting altogether (Barnett et al. 2019).

Beneficiaries are eligible for assignment to an ACO if they had Part A and Part B coverage for at least one month and had no MA enrollment or Part B–only months during the prior two-year assignment window. Beneficiaries are assigned to an ACO based on where they receive the plurality of their primary care.[33] During a payment year, participating providers generally continue to receive FFS payments, but at the end of the year, total spending is compared with the ACO's financial benchmark.[34] If spending for the assigned beneficiaries is below the benchmark, the ACO earns a share of the savings; if spending is above it, the ACO may be at risk for a share of the difference (the "loss"). An ACO selects a level of risk it will accept (subject to CMS approval).

There are two types of Medicare ACOs—the Medicare Shared Savings Program (MSSP) and ACO Realizing Equity, Access, and Community Health (REACH). MSSP ACOs must have at least 5,000 beneficiaries assigned to them and focus on the over-65 population without specific care needs.[35] In 2025, there are 476 MSSP ACOs providing care to 11.2 million assigned beneficiaries (Centers for Medicare & Medicaid Services 2025b). REACH ACOs are part of a CMS Innovation Center demonstration that began in 2021 and will run through 2026 and tests different risk-sharing options. In 2025, there are 103 REACH ACOs with 2.5 million assigned beneficiaries, down from 122 REACH ACOs with 2.6 million beneficiaries in 2024 (Centers for Medicare & Medicaid Services 2025b).

ACOs generally are not designed to focus on managing the care of NH residents, so it is difficult to draw conclusions about their impact on nursing home care.[36] However, one part of the ACO REACH initiative is testing the use of High Needs ACOs, which are smaller (a minimum of 1,200 assigned beneficiaries in 2025) and focus on beneficiaries with complex medical conditions. To be eligible for assignment to a High Needs ACO, a beneficiary must have at least one chronic condition or a high risk score, have frailty or impaired mobility, or have received a substantial amount of SNF or home health care in the past year. High Needs ACOs must have a model of care that is designed to address the complex care needs of their assigned beneficiaries and their health disparities within their beneficiary populations. In 2025, there are

TABLE 5–6

Share of long-stay residents assigned to ACOs, 2023

Type of ACO	Number of ACOs	Total enrollment	Long-stay residents as a share of ACO-assigned beneficiaries
MSSP	453	10,019,782	1%
REACH	132	1,967,836	1
Standard and new	118	1,948,983	1
High Needs	14	18,853	28

Note: ACO (accountable care organization), MSSP (Medicare Shared Savings Program), REACH (Realizing Equity, Access, and Community Health). High Needs ACOs are small ACOs (maximum assignment of 3,000 beneficiaries) that focus on beneficiaries with complex medical conditions.

Source: MedPAC analysis of ACO assignment data and nursing home assessment data.

13 High Needs ACOs, down from 14 in 2024 (Centers for Medicare & Medicaid Services 2025a).

Nursing home participation in ACOs

To gain insight into NH participation in ACOs, we conducted 15 interviews with a variety of stakeholders, including ACO representatives, trade associations, beneficiary advocates, and consultants. We asked interviewees about a NH's decision to participate in an ACO, the types of NHs that ACOs seek to partner with, how ACO care models work in NHs, and how ACO care models compare with I–SNP care models. Some interviewees (representing companies that offered both models in NHs) said they saw ACOs and I–SNPs as complementary businesses. I–SNPs were for beneficiaries who preferred MA, and ACOs were for beneficiaries who prioritized retaining their existing relationships with clinicians through the FFS program. NHs that want to participate in some form of an alternative payment model might choose between an I–SNP and an ACO, depending on the amount of risk they were willing to assume. NHs that wanted to gain some experience with risk sharing might start with an ACO affiliation, while those ready for more risk might partner with an I–SNP.

Other interviewees spoke about competition between the two models. Some reported that when a NH has both an ACO and an I–SNP, they compete for residents, especially among those who are likely to be low cost. Although physicians are not precluded from participating in both an I–SNP and an ACO, one interviewee told us that some ACOs try to switch physicians from being part of an I–SNP to an ACO, contending that the physicians and their patients would face fewer hassles with the ACO.

Most ACOs do not have much experience with long-stay NH residents. (When ACOs focus on NHs, they mostly try to manage the SNF services of their assigned beneficiaries, who will largely be admitted from the community.) The lack of experience reflects the composition of most ACOs' assigned beneficiaries. On average, long-stay residents make up about 1 percent of the beneficiaries assigned to ACOs (Table 5-6). In contrast, about 28 percent of High Needs ACOs' assigned beneficiaries were long-stay residents.

However, there is some variation across individual ACOs in the shares of beneficiaries who are long-stay residents (Table 5-7). While two-thirds of ACOs had less than a 1 percent share, 15 ACOs had 10 percent or more (including three MSSP and three REACH ACOs that had greater than 50 percent shares, data not shown). In one MSSP ACO, 86 percent of its assigned beneficiaries were residents of NHs. All REACH ACOs with greater than 10 percent shares were High Needs ACOs. The low shares for the majority of ACOs are not surprising since most physician practices do not focus on the long-stay population or furnish care in NHs.

The ACOs with high shares of long-stay residents are smaller than other ACOs. MSSP ACOs with 10 percent

TABLE 5–7

On average, ACOs with a high share of long-stay residents were smaller compared with other ACOs, 2023

ACO model	Long-stay beneficiaries as share of total enrollment	Number of ACOs	Mean ACO size
MSSP	10+%	6	8,434
	1% to 9.9%	138	20,094
	Less than 1%	309	23,169
REACH	10+%	9	1,314
	1% to 9.9%	37	15,070
	Less than 1%	86	16,261

Note: ACO (accountable care organization), MSSP (Medicare Shared Savings Program), REACH (Realizing Equity, Access, and Community Health). "Size" is measured by the mean number of all assigned beneficiaries.

Source: MedPAC analysis of ACO assignment data and nursing home assessment data.

or more long-stay residents averaged about 8,400 assigned beneficiaries compared with over 20,000 for ACOs with lower shares of long-stay beneficiaries. The size differences are larger for the REACH ACOs: Those with the highest shares of long-stay beneficiaries (10 percent or more) were less than one-tenth the size of ACOs with higher shares (about 1,300 compared with about 15,000).

Interviewees told us that ACOs seek partnerships with NHs/SNFs that have low spending and hospitalization rates. Many MSSP ACOs may affiliate with SNFs/NHs so they can apply for a waiver from the three-day prior hospital stay requirement for Medicare coverage of SNF care.[37] In addition to seeking efficient NHs (those with low spending and high quality), we heard about the importance of the "fit" between the ACO and the NH's leadership and culture, especially for ACOs focused on NH residents because care coordination is key to the ACO's success. We were told that the physicians working in a NH determine whether a NH participates in an ACO and whether the partnership is successful. When an ACO includes physicians treating residents without the NH's support (or even knowledge), the NH has no incentive to make the ACO successful.

A SNF may be an "affiliate" of or a "participant" in an ACO. An affiliate has a formal agreement with the ACO that allows the ACO to apply for a waiver from the three-day hospital stay requirement for Medicare coverage.[38] A participant is part of the ACO's network and will receive referrals for care but is not on the affiliate list for stays to be waived from the three-day hospital stay requirement.

ACOs often do not have SNF participants or affiliates, which could be optimal. In 2023, 68 percent of ACOs had no SNF participants, 74 percent had no SNF affiliates, and 49 percent had neither participant nor affiliated SNFs (based on MedPAC analysis of 2023 CMS ACO participation data). A survey of 366 ACOs conducted between October 2015 and January 2016 found that over half of them did not have a formal relationship with SNFs, though most had preferred SNF networks (Kennedy et al. 2020). The respondents reported that factors considered in establishing a partnership with a SNF included the NH's star rating, the average length of its SNF stays, its hospital readmission rate, its capacity to manage high-acuity patients and administer intravenous medications, its ability to admit patients within a short window, and a 24/7 referral line.

Just as ACOs are largely not focused on NHs, many NHs do not track whether their residents are assigned to an ACO, which may be appropriate given that the majority of their residents are not in an ACO. Across all NH residents in 2023, 55 percent met the ACO eligibility criteria, but only 16 percent were actually assigned to one (Table 5-8, p. 258). Of the NH residents who were

TABLE 5–8

Most nursing home residents were not assigned to an ACO, 2023

Nursing home residents	All long-stay residents	Share of all NH residents	Nursing home residents as a share of ACOs' eligible beneficiaries
All	838,561	100%	
ACO eligible	458,314	55	100%
ACO assigned	131,060	16	29
MSSP	108,862	13	24
REACH	22,198	3	5

Note: ACO (accountable care organization), NH (nursing home), MSSP (Medicare Shared Savings Program), REACH (Realizing Equity, Access, and Community Health). Beneficiaries are eligible for assignment if they had Part A and Part B coverage for at least one month and no Medicare Advantage enrollment or Part B–only months during the prior two-year assignment window. Figures are based on July data.

Source: MedPAC analysis of ACO assignment data and nursing home assessment data.

ACO eligible, less than one-third (29 percent) of them were assigned to one. An interviewee said that while a NH might partner with a High Needs ACO, not all of their residents met the eligibility requirements.

We were told that physicians are key in deciding whether a NH works with an ACO. If the ACO's physician groups work in NHs, they are more likely to get the NH to affiliate with the ACO. One interviewee told us that some ACOs try to entice physicians to participate in the ACO by offering night and weekend coverage by nurse practitioners. We also heard of ACOs that partnered with physician practices that worked in the NH, but the NH was unaware of their ACO participation, making it harder for the ACO to be successful.

NHs are generally not participating entities that share risk with CMS. Therefore, a NH relies on the agreement it reaches with an ACO about whether the NH will receive a portion of any earned savings. Having an affiliation or partnership with an ACO or being in a preferred network does not mean that the ACO shares its earned savings (these data are not collected by CMS). In a survey of 138 ACOs in the program from July 2019 through 2020, over half had a preferred network of SNFs, and of those almost all (91 percent) did not offer financial incentives to the preferred SNFs (Secordel et al. 2024).[39] Affiliations also do not guarantee referrals since ACOs cannot recommend SNFs or NHs to their assigned beneficiaries, who retain their freedom to choose another SNF/NH. (From earlier work, we know that beneficiaries' decision about where to get their post-acute care is complex, but proximity to family members is important in making their selection (Medicare Payment Advisory Commission 2024a).) We were told that NHs do not always know that some of their residents are in an ACO, and their residents may not know that they have been assigned to one.

Interviewees said that when NHs decide whether to affiliate with an ACO, they weigh the lost revenue from fewer high-payment SNF days and other services against the opportunity to receive some share of the ACO's earned savings. One interviewee told us that a NH needs to have between 30 percent and 40 percent of its revenues in risk-bearing arrangements (either an ACO, an I–SNP, or both) before it shifts away from a FFS mentality. In ACOs where the NHs and the physician group practices share in the earned savings, all caregivers have a financial incentive for the ACO to succeed. One ACO company told us that their NHs received about 20 percent of the ACO's share of earned savings. However, since NHs often do not receive any of the earned savings, the benefit of partnering with an ACO is the referral volume and perhaps the preference for ACO volume over managed care volume.

Partnerships are also a function of the relative negotiating positions of the ACO and SNF. A highly rated SNF in a market with few other SNFs would have little incentive to affiliate with an ACO just to get referral volume, and it could have the leverage needed to negotiate a share of earned savings. In a market saturated with SNFs, a higher-quality home might be able to get a partnership that helps with only referral volume but not a portion of any earned savings.

ACO model of care in nursing homes

The ACO and NH representatives we spoke with reported that ACOs use a less intensive model of care compared with I–SNPs. (See below for a full discussion of the I-SNP model of care.) They told us that ACOs generally do not provide on-site care and instead rely on the NH staff combined with patient monitoring and, for those with the capital and trained staff, telemedicine visits. The evaluation of the Next Generation ACOs described activities to improve the quality and management of SNF care (which is provided to both short-stay and some long-stay NH residents), including embedded staff (such as care managers or NPs), to better manage patient care and transitions (NORC at the University of Chicago 2024b). High Needs ACOs with high shares of NH residents are more likely to provide hands-on care, but even then, the ACO is likely to provide fewer visits per week than it would in the typical I–SNP model. One ACO with a high share of long-stay residents told us they provided "wellness visits" to detect clinical conditions that warrant attention and a variety of services that enabled physicians to treat residents in place, such as monitoring changes in patients' conditions, managing medications, and reporting lab results. In addition, when the ACO's beneficiaries went to the ED or hospital, the ACO managed their transition to the ED and their return to the NH after discharge from the hospital. One NH representative who participated in both an I–SNP and an ACO said that its NH's clinical staff used the same model of care for all residents (even those not in either program) to simplify care decision-making.

We found no studies that examined the care models that ACOs used for long-stay residents, but there were studies of ACOs' management of SNF services. One study found that, compared with ACOs without formal relationships, ACOs with formal relationships with PAC providers (including SNFs) were more likely to have advanced care-transition management, end-of-life planning, readmission preventions, and care management (Colla et al. 2016). A study of 138 ACOs' preferred SNF networks found that ACOs expected the SNFs to share quality and cost data, notify the ACO about patient transfers to the hospital, and meet length-of-stay targets for their SNF stays (Secordel et al. 2024). This study's respondents reported little use of virtual visits for care on the weekends or for consultations. Another study of 366 respondents to the National Survey of ACOs reported that the primary mechanism ACOs used to manage care in their preferred SNF networks was to have clinical staff visit ACOs' beneficiaries across multiple SNFs and provide on-call advice. The ACOs said they established performance measures for lengths of stay and readmission rates and had clinical protocols for ambulation, pressure-ulcer prevention, pain management, and other condition-specific guidelines (Abt Associates 2020, Kennedy et al. 2020).

Service use and quality results

Previous evaluations conducted for CMS of an earlier ACO model called the ACO Investment Model (AIM) and the Next Generation ACOs found that reductions in SNF use (fewer admissions and shorter stays) were a contributing factor to lowering ACO costs, but they did not examine the impacts of ACOs on long-stay residents (Abt Associates 2020, NORC at the University of Chicago 2024b).[40] However, one study examined spending and use among NH residents in ACO-affiliated NHs (Chang et al. 2021). It found that NH residents assigned to ACOs had statistically significant lower hospitalization rates, fewer ambulatory care–sensitive conditions, and fewer ED visits, but there was no difference in Medicare spending per resident.

It is hard to draw any conclusions about the quality of care furnished to NH residents because the quality results are reported for the entire attributed population for an ACO, not for their NH residents separately. In addition, the measures are not tailored to the NH population, and, in fact, NH residents are excluded from some of the measures (such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures).

In contrast, the evaluation of the Global and Professional Direct Contracting Model separately examined High Needs ACOs. Compared with other

TABLE 5–9

I–SNP participation, 2015–2025

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Insurers	17	21	24	28	31	37	39	39	36	31	32
Contracts	44	37	41	49	57	72	82	87	85	82	80
Plans	57	79	83	97	125	150	172	184	190	175	163
Enrollment (in thousands)	51	60	66	77	91	94	90	102	112	125	122

Note: I–SNP (institutional special-needs plan). Enrollment figures for 2015–2024 are based on July data; figures for 2025 are based on March data. The 2023 figure for total I–SNP enrollment differs somewhat from the corresponding figure in Table 5-10 because the two tables use different data sources.

Source: MedPAC analysis of Medicare enrollment data.

ACOs, High Needs ACOs generally have larger shares of their assigned beneficiaries living in NHs and thus are more likely to reflect ACOs' effects on NH residents.

The most recent evaluation of the High Needs ACOs included eight ACOs (NORC at the University of Chicago 2024a). It found that of their almost 8,000 assigned beneficiaries, two-thirds were dually eligible and about half had a NH stay of more than 100 days in the prior year. On average, each beneficiary had 12 conditions.

Compared with a group of beneficiaries with similar characteristics, the model lowered hospitalizations (–6.1 percent), ED visits and observation stays (–5.0 percent), SNF days (–12.3 percent), home health episodes (–5.1 percent), and specialty care (–8.9 percent), and all but the declines in home health use were statistically significant. We note, however, that declines in utilization are not necessarily indicative of higher quality. Spending on hospice care increased, which is consistent with improved end-of-life care.

Relative to a comparison group, High Needs ACOs had small improvements in certain quality measures, but those changes were not statistically significant. Reductions in hospitalizations for ambulatory care–sensitive conditions (–0.8 percent), unplanned hospitalizations for beneficiaries with multiple chronic conditions (–1.4 percent), and all-condition readmissions (–5.0 percent) were consistent with improved quality but were not statistically significant.

Institutional special-needs plans

At a conceptual level, private health plans could potentially be more effective than traditional Medicare at delivering care to long-stay NH residents because plans have stronger incentives to coordinate care and manage overall spending. In the MA program, insurers can offer several types of special-needs plans that are only available to certain types of beneficiaries with distinct care needs. One type of special-needs plan, the I–SNP, is of particular interest because it targets beneficiaries who have lived (or are expected to live) in a NH for at least 90 days or live in the community but need the level of care provided in a NH.[41] I–SNPs provide Medicare-covered services only; they do not provide any Medicaid-covered benefits such as nursing home care.

Although this section focuses on the experience with I–SNPs, Medicare has three other plan types that, to varying degrees, target beneficiaries who either live in NHs or live in the community but need a NH level of care (see text box (pp. 262–263) on Medicare plans that target beneficiaries who live in NHs or who need a NH level of care).

Insurers have been able to offer I–SNPs since 2006, but the concept of using capitated health plans to care for long-stay NH residents dates back even further, to a demonstration from 1994 to 2005 known as Evercare. Making Evercare and certain other demonstrations a

TABLE 5–10

Distribution of I–SNP enrollment, by plan type and share of enrollees living in nursing homes versus the community, July 2023

I–SNP type	Plans	Enrollees	Nursing home share	Community share
Facility based	76	80,945	99.1%	0.9%
Hybrid	71	25,188	66.3	33.7
Institutional equivalent	43	7,041	0.9	99.1
Total	190	113,174	85.7	14.3

Note: I–SNP (institutional special-needs plan). We considered enrollees to be living in a nursing home if they had a nursing home assessment from the Minimum Data Set that covered the first day of the month. The figure for total I–SNP enrollment differs somewhat from the corresponding figure in Table 5-9 because the two tables use different data sources.

Source: MedPAC analysis of Medicare enrollment data and nursing home assessment data.

permanent part of Medicare was one motivation for the creation of special-needs plans (Schmitz et al. 2008).

MedPAC last examined I–SNPs in depth in 2013, when the authority for insurers to offer special-needs plans was still temporary. At the time, the Commission found that I–SNPs performed better than other MA plans on some quality measures and recommended that the Congress permanently authorize them (Medicare Payment Advisory Commission 2013). In 2018, the Congress permanently authorized all types of special-needs plans, including I–SNPs.

Aside from the limits on the types of beneficiaries who can enroll, I–SNPs are generally subject to the same rules and requirements as other MA plans. For example, they are paid using the same payment system, are largely required to ensure that their provider networks meet the same adequacy standards, and can require enrollees to obtain prior authorization before using particular services.[42] However, like all special-needs plans, I–SNPs must also follow an evidence-based model of care, complete annual health assessments for their enrollees, and report some additional quality data.

The I–SNP market has always been relatively small (Table 5-9). In 2025, a total of 32 insurers offer I–SNPs, and they collectively have about 122,000 enrollees. (For comparison, the MA program as a whole has 168 participating insurers and 34.5 million enrollees.) The share of long-stay NH residents who are enrolled in I–SNPs is also low, about 12 percent in 2023 (data not shown). However, over the past decade, the number of insurers that offer I–SNPs has grown, and total enrollment has more than doubled.

CMS allows insurers to offer three types of I–SNPs:

- Facility-based institutional SNPs (FI–SNPs) cover only beneficiaries who live in NHs that are part of the plan's provider network;
- Hybrid institutional SNPs (HI–SNPs) cover beneficiaries who either live in NHs that are part of the plan's provider network or live in the community; and
- Institutional-equivalent SNPs (IE–SNPs) cover only beneficiaries who live in the community.

The vast majority of I–SNP enrollees are in facility-based or hybrid plans (Table 5-10). We compared I–SNP enrollment data with NH assessment data to determine which enrollees lived in NHs and found that about two-thirds of the enrollees in hybrid plans lived in NHs and about one-third lived in the community. (That ratio rarely held for an individual hybrid plan—35 of the 41 hybrid plans with more than 100 enrollees had more than 90 percent of their enrollment in one setting or the other.) Across all I–SNPs, we found that about 85 percent of enrollees lived in NHs.

Experience with other Medicare plans that target beneficiaries who live in nursing homes or need a nursing home level of care

In addition to institutional special-needs plans (I–SNPs), Medicare offers three plans for beneficiaries who live in nursing homes (NHs) or need a nursing home level of care: dual-eligible special-needs plans (D–SNPs), Medicare–Medicaid Plans (MMPs), and the Program of All-Inclusive Care for the Elderly (PACE).

D–SNPs are specialized MA plans that serve people who have both Medicare and Medicaid. The level of integration between these plans and Medicaid varies, but some D–SNPs that are more highly integrated cover Medicaid long-term services and supports (LTSS), including NH care. In 2023, D–SNPs had 5.2 million enrollees, but only 63,000 (about 1 percent) were long-stay residents. However, long-stay residents are a much higher share of the enrollment in some individual plans; for example, they represent more than 10 percent of the enrollment in most D–SNPs in Minnesota.

MMPs are part of a demonstration testing the use of highly integrated plans for dually eligible beneficiaries. Ten states have tested MMPs, and they are still in operation in eight states. CMS will end the demonstration at the end of 2025; when that happens, we expect most MMPs to convert into D–SNPs. In 2023, MMPs had 306,000 enrollees, and 23,000 (about 8 percent) were long-stay residents. As with D–SNPs, the share of enrollees who are long-stay residents varies considerably across plans.

PACE plans serve beneficiaries who are 55 or older and need the level of care provided in a NH. The program aims to keep people living in the community instead of going into NHs, and it uses a distinctive model of care based on adult day-care centers that are staffed by interdisciplinary teams that provide therapy and medical services. PACE plans provide all Medicare- and Medicaid-covered services. In 2023, PACE plans had about 58,000 enrollees, and 3,000 (about 5 percent) were long-stay residents (who lived in the community when they first enrolled).

These plans have the potential to improve care in several ways for beneficiaries who need a NH level of care. Since they cover both medical services and Medicaid LTSS (this is true for all MMPs and PACE plans but only some D–SNPs), they can better coordinate care for beneficiaries who need both types of services. Since Medicaid pays these plans for LTSS on a capitated basis, they have incentives to encourage the use of community-based forms of LTSS, which are usually less expensive than NH care on a per capita basis and often more in line with beneficiaries' preferences. For example, the use of community-based LTSS could potentially avoid or delay some NH placements or enable some NH residents to return to the community. Finally, for long-stay NH residents, these plans (like I–SNPs) have incentives to avoid costly inpatient stays and emergency department visits by providing more care in the NH setting.

I–SNPs differ from these three plan types because they provide Medicare benefits only and do not include any Medicaid LTSS coverage. Some observers have criticized this lack of integration, arguing that I–SNPs (particularly facility-based I–SNPs) have incentives to keep enrollees in NHs instead of trying to return them to a community setting. However, it is unclear how many residents can plausibly return to the community after being in a NH for 90 days (a requirement for enrolling in an I–SNP). One interviewee said that efforts to return NH residents to the community are more likely to succeed if they target residents shortly after they have been admitted and become progressively harder when residents have been in a NH for longer periods of time. If the number of long-stay residents who could be returned to the community is relatively small, requiring I–SNPs to be more closely integrated with Medicaid may have little effect.

For D–SNPs, relatively little research has looked specifically at their effects on long-stay NH residents or on NH admissions. One study of dually

(continued next page)

Experience with other Medicare plans that target beneficiaries who live in nursing homes or need a nursing home level of care (cont.)

eligible beneficiaries in Minnesota compared those enrolled in highly integrated D–SNPs with those enrolled in a combination of FFS Medicare and Medicaid managed care; the study found that D–SNP enrollees were more likely to receive community-based LTSS but did not have a lower likelihood of NH admission (Anderson et al. 2016). Another study of highly integrated D–SNPs in Massachusetts found that enrollees, relative to a comparison group of dually eligible beneficiaries, had lower rates of NH use and lower mortality rates (JEN Associates Inc 2013).

For MMPs, CMS has contracted with RTI to evaluate the effects of each demonstration on areas such as program costs and service use. The evaluations that have been released so far typically cover the first four to five years of a demonstration (Feng and Greene 2023a, Feng and Greene 2023b, Feng and Greene 2023c, Feng and Greene 2023d, Feng and Greene 2023e, Feng and Greene 2023f, Feng and Greene 2023g, Feng and Greene 2022a, Feng and Greene 2022b, Feng and Greene 2021a, Feng and Greene 2021b).

One key question about the demonstrations had been whether MMPs could achieve more desirable patterns of service use—for example, reducing the use of NHs and expanding the use of community-based forms of LTSS. As a result, one metric that RTI has tried to calculate for each demonstration has been the change in the likelihood that enrollees will have a long NH stay. RTI produced estimates for 7 of the 10 states with demonstrations. The results have been mixed: RTI found that the likelihood of having a long NH stay increased in two states, decreased in four states, and did not change by a statistically significant amount in one state.

The findings from the evaluations are somewhat challenging to interpret given the analytic approach that was used. RTI measured the effects of the demonstration by comparing dually eligible beneficiaries who are eligible for the demonstration (whether or not they actually participated) with similar groups of dually eligible beneficiaries in other states. The participation rates for many demonstrations have been lower than expected, often between 20 percent and 40 percent overall, with even lower rates for long-stay residents as many either opted out when states tried to passively enroll them in MMPs or disenrolled from MMPs after a short period of time.[43] The low participation rates make it less clear that any differences between the demonstration-eligible and comparison populations are due to the demonstration rather than other factors.[44]

For PACE, the research literature is somewhat dated, with many studies now more than 10 years old. In 2014, the Assistant Secretary for Planning and Evaluation (ASPE) reviewed the literature on PACE and found that the quality of the existing studies varied and that identifying a good control group to compare with PACE enrollees was a particular challenge (Ghosh et al. 2014). The review found "strong evidence" that PACE reduces inpatient hospitalizations and "some evidence" that PACE enrollees have a lower mortality rate. The review also found that PACE enrollees had higher rates of NH admissions but noted that existing studies did not distinguish between short-term (post-acute) and long-term NH stays.

Following the literature review, ASPE commissioned a study to look at the effects of PACE on short-term versus long-term NH use (Ghosh et al. 2015). The study found that, relative to beneficiaries enrolled in Medicaid home- and community-based services (HCBS) waiver programs, PACE enrollees were more likely to have short-term NH admissions but they "tended to be limited in duration." The study also found that PACE appears to "delay, but not ultimately prevent, long-term NH stays." A separate study found that PACE enrollees were less likely to have a long NH stay than HCBS enrollees (Segelman et al. 2017). ■

Unless indicated otherwise, this section focuses on the experience with I–SNPs in nursing homes.[45] The survey is organized into six sections:

- key features of the I–SNP model,
- the insurers that offer I–SNPs,
- nursing home participation in I–SNPs,
- beneficiary enrollment in I–SNPs,
- the impact of I–SNPs on quality and outcomes, and
- I–SNP payment rates, rebates, and extra benefits.

For this work, we used several types of administrative data, including enrollment data, nursing home assessment data, MA quality data, and MA bid data. We also interviewed a variety of stakeholders who are knowledgeable about I–SNPs, such as NH operators, insurers that offer I–SNPs, consultants, and academic researchers.

Key features of the I–SNP model

The I–SNP model is based on the premise that plans can improve the quality of care for long-stay residents by delivering more care within the NH and reducing the use of expensive services such as inpatient care and emergency room visits. While there can be some variation across plans, our interviews suggest that I–SNPs largely appear to use the same basic approach to try to meet this goal. That approach has several features that distinguish I–SNPs from both FFS Medicare and conventional MA plans:

- *Use nurse practitioners (NPs) to deliver more care within the nursing home.* The NPs make regular visits to the NHs in the plan's provider network. (Our interviewees said NPs typically visit the NH two to three times each week.) The NP monitors the health of the plan's enrollees, coordinates their care with their physicians, communicates with family members, and works with the NH clinical staff to deliver on-site care. For example, the NP could direct the NH clinical staff to provide skilled care to an enrollee without a prior hospital stay, a practice known as "skilling in place."[46] The NPs for insurer-sponsored plans are typically employed by the plan; the NPs for provider-sponsored plans could be employed by either the plan or the NH or serve on a contracted basis.
- *Generate sufficient enrollment within the nursing home.* Scale plays an important role in the I–SNP care model. From the plan's perspective, the NPs are more cost-effective when they can see a large number of enrollees in the same NH instead of seeing a similar number spread across multiple facilities. According to our interviewees, I–SNPs aim to enroll somewhere between 40 percent and 70 percent of the long-stay residents in a NH, which for a medium-sized NH translates to roughly 20 to 40 enrollees.
- *Modify financial incentives for the nursing home.* In FFS Medicare, NHs have an incentive to send long-stay residents to the hospital so they can qualify for Medicare-covered, higher-payment skilled care. Once residents qualify for skilled care, NHs also have an incentive to continue providing them with skilled care because Medicare pays for that care using daily rates.[47] In MA, NHs can have similar incentives because many plans also appear to use daily rates for SNF care, although the incentives may be weaker than in FFS Medicare because plans often pay lower rates and may approve fewer days of care. In contrast, I–SNPs reimburse NHs using a variety of approaches (discussed in more detail later) that aim to reduce or eliminate these marginal incentives.
- *Minimize revenue losses for the nursing home.* If an I–SNP is successful at reducing hospitalizations for its enrollees, the NH might receive less revenue if fewer residents receive Medicare-covered skilled care. This potential loss of revenue could make NHs less willing to contract with I–SNPs. As a result, I–SNPs need to ensure that their payment arrangements with NHs, in aggregate, minimize or avoid these losses and make it attractive for NHs to contract with them.

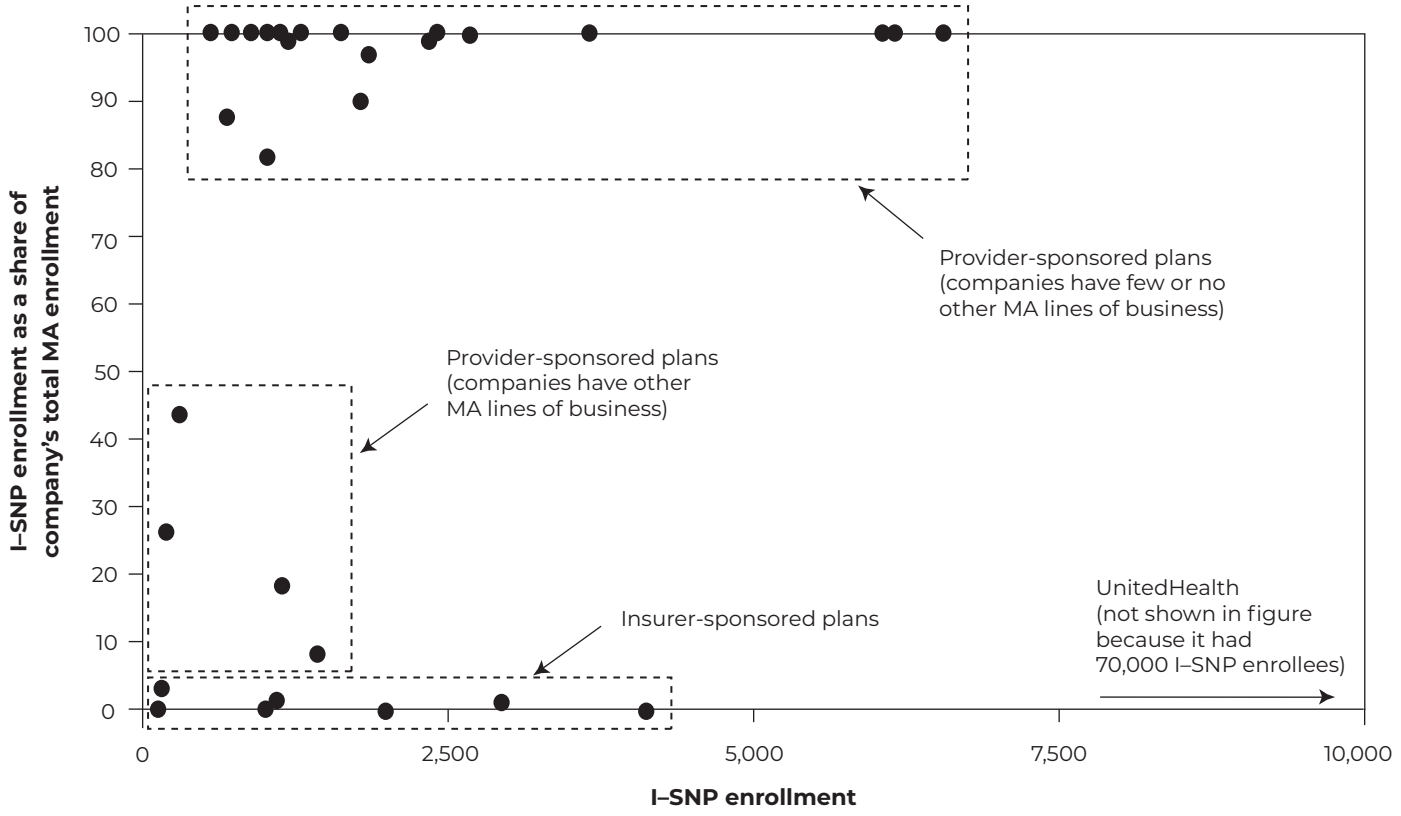
The insurers that offer I–SNPs

Figure 5-5 shows the insurers that offered I–SNPs in 2024. Each dot in the scatterplot is a different company. The horizontal axis shows the number of beneficiaries enrolled in the company's I–SNPs while the vertical axis shows its I–SNP enrollment as a share of its overall MA enrollment (across all types of MA plans, not just I–SNPs).

Most of these insurers have relatively few I–SNP enrollees—nearly all have fewer than 5,000 enrollees

FIGURE 5–5

An overview of the companies that offered I–SNPs in 2024



Note: I–SNP (institutional special-needs plan), MA (Medicare Advantage). Figures are based on July data.

Source: MedPAC analysis of Medicare plan enrollment data.

and most have fewer than 2,500. At the same time, there is wide variation in the importance of I–SNPs to their overall MA business. These insurers can be divided into three major groups:

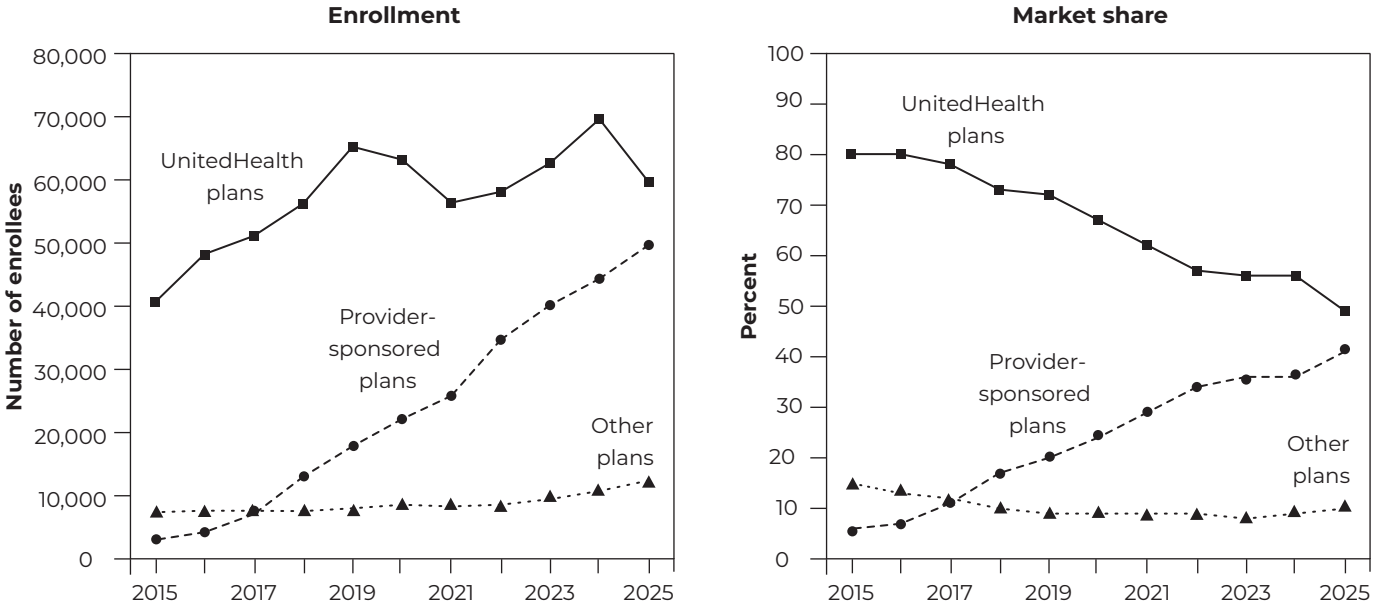
- *UnitedHealth*. This company was the only insurer that participated in the original Evercare demonstration, the predecessor for I–SNPs. Those Evercare plans were converted into I–SNPs in 2006 and UnitedHealth has been a major presence in the I–SNP market ever since. It has been the largest I–SNP insurer since 2012.[48]

  UnitedHealth's I–SNP enrollment—about 70,000 in 2024—is so much larger than other insurers' that the company does not appear in Figure 5-5 due to the scale we used. However, UnitedHealth is also the largest insurer in the MA program, and its I–SNP enrollment accounts for less than 1 percent of its overall MA enrollment.

- *Provider-sponsored plans*. Most of the companies (23 out of 31) that offered I–SNPs are "provider-sponsored" or "provider-led" plans, where the NHs in the plan's provider network have an equity or ownership stake in the insurer that sponsors the I–SNP. These insurers are largely clustered at the top of Figure 5-5; most have relatively few enrollees, and the I–SNP is often their only MA line of business. A few of these insurers, located in the middle box in Figure 5-5, are somewhat less reliant on I–SNPs (for example, they may also offer a conventional MA plan or D–SNP) but the I–SNP

FIGURE 5–6

Changes in I–SNP enrollment and market share, 2015–2025



Note: I–SNP (institutional special-needs plan). Figures for 2015–2024 are based on July data; figures for 2025 are based on March data.

Source: MedPAC analysis of Medicare plan enrollment data.

still accounts for between roughly 10 percent and 45 percent of their overall MA enrollment.

- *Insurer-sponsored plans*. The remaining insurers, located in the box running just above the horizontal axis in Figure 5-5, p. 265, are traditional health insurers that offer I–SNPs that both have relatively low enrollment and represent a very small share of their overall MA enrollment. This group includes companies such as Humana, Elevance Health, and CVS Health (Aetna).

The number of companies that offer I–SNPs more than doubled between 2015 and 2021, rising from 17 to 39 (Table 5-9, p. 260). This growth was largely driven by provider-sponsored plans, which accounted for 25 of the 35 companies that entered the market during this period; the overall change in the number of I–SNP insurers was smaller because 13 companies either left the market or were acquired by other insurers (data not shown). As a result, the enrollment and market share for provider-sponsored I–SNPs climbed rapidly (Figure 5-6). Between 2015 and 2021, their enrollment grew from about 3,000 to about 26,000, while enrollment in UnitedHealth's I–SNPs grew from 41,000 to 56,000. (During the pandemic, enrollment in provider-sponsored plans continued to grow because the entry of new plans more than offset the additional deaths due to COVID-19. The footprint for UnitedHealth's I–SNPs was more stable, so the effects of the pandemic on their enrollment are more apparent.) In terms of market share, provider-sponsored plans jumped from 6 percent to 29 percent, while UnitedHealth declined from 80 percent to 62 percent.

After peaking at 39 insurers in 2021 and 2022, the number of companies that offer I–SNPs has declined somewhat, falling to 32 in 2025 (Table 5-9, p. 260). The number of new entrants has fallen sharply: Only 4 companies have entered the market since 2021, while 11 companies have either closed their I–SNPs or

sold them to other insurers. However, enrollment in provider-sponsored plans has continued to grow, and the market shares for I–SNPs are currently around 50 percent for UnitedHealth, 40 percent for provider-sponsored plans, and 10 percent for other insurer-sponsored plans.[49]

Several interviewees said the decline in the launch of new provider-sponsored plans was at least partly due to the pandemic, which forced NHs to focus on more immediate, day-to-day challenges. Since the end of the pandemic, they have seen renewed interest in the concept and expected more provider-sponsored plans to enter the I–SNP market in the next few years.

Provider-sponsored plans can be structured in a variety of ways. In some cases, the I–SNP is a fully owned subsidiary of a NH chain, and the chain bears full financial risk for any losses that the plan might experience. This approach appears to be more common when the NH chain is relatively large; for example, Pruitt Health Premier is owned by a single chain that has over 100 NHs (ATI Advisory 2020). In these cases, the NH chain may contract with an outside company to perform some of the plan's insurance functions. In other cases, the I–SNP is a joint venture between one or more NH chains and an outside company that both handles some or all of the plan's insurance functions and has an ownership stake in the plan. Several interviewees said this approach is appealing to NHs that either do not want to bear full financial risk for an I–SNP or do not have enough capital to finance one on their own. For example, Perennial Advantage was formed by three NH chains, and Simpra Advantage is backed by 28 chains, many of them small chains with 10 or fewer NHs (ATI Advisory 2020, Flynn 2021, Silverstein 2019). Some provider-sponsored plans also allow NHs to participate in their provider network without taking an ownership stake (the traditional approach for insurer-sponsored plans), while one traditional insurer has formed a partnership in which a company that normally offers provider-sponsored plans operates some of the insurer's I–SNPs on a subcapitated basis (Grebbin 2023, McKnight's Long-Term Care News 2024).[50]

Several interviewees said that provider-sponsored plans need a minimum level of enrollment to be profitable. They noted that offering a plan entails a variety of relatively fixed costs (such as obtaining an insurance license, capital reserves, and regulatory compliance) that make a plan unprofitable unless the costs can be spread across a sufficiently large base of enrollees. When we asked how many enrollees these plans needed, their answers varied but had similar orders of magnitude: one interviewee said 1,000 enrollees by the end of the second or third year; a second interviewee said 500 enrollees in plans that are part of a joint venture and 2,000 to 3,000 enrollees in plans owned entirely by a NH chain; while a third interviewee said "in the thousands."

Nursing home participation in I–SNPs

Long-stay residents cannot enroll in an I–SNP unless their NH participates in the plan's provider network. As a result, NHs play a key role in determining how much of the long-stay population has access to an I–SNP. CMS requires that all I–SNPs that serve people in nursing homes (that is, the facility-based and hybrid plans) have at least one NH in their provider network in each county in their service area.

No publicly available data indicate which NHs participate in I–SNPs. To better understand these relationships, we used monthly enrollment data to identify the beneficiaries enrolled in I–SNPs and NH assessment data (from the MDS) for 2018 through 2023 to identify long-stay residents and the specific facilities in which they lived. We then calculated the number of long-stay residents in each NH as of July 1 of each year. We considered NHs to be participants in an I–SNP if two or more long-stay residents were enrolled in an I–SNP offered by the same insurer.[51]

In 2023, about a quarter of all NHs—more than 3,700 facilities—participated in I–SNPs (top panel of Table 5-11 (p. 268)). Between 2018 and 2023, the share of NHs that participated grew steadily, increasing by 12 percentage points, or almost 1,700 facilities. In our annual status report on the MA program, we measure access to I–SNPs by calculating the share of beneficiaries who live in counties where an I–SNP is offered, and we found that access grew from 46 percent in 2013 to 77 percent in 2023 (Figure 5-7, p. 269). However, for long-stay residents, access is better measured by the share of residents who live in NHs that participate in I–SNPs. Using this approach, the share of long-stay residents who have access to an I–SNP is much lower (about 33 percent in 2023) but has also been increasing over time (Figure 5-7 and the middle panel of Table 5-11).

TABLE 5–11

Between 2018 and 2023, nursing home participation in I–SNPs grew, but the share of eligible residents who enrolled declined somewhat

	2018	2019	2020	2021	2022	2023
Total nursing homes	15,186	15,121	15,018	14,905	14,806	14,643
NHs participating in I–SNPs	2,054	2,401	2,747	3,015	3,390	3,746
NHs not participating in I–SNPs	13,132	12,720	12,271	11,890	11,416	10,897
Share of NHs participating in I–SNPs	13.5%	15.9%	18.3%	20.2%	22.9%	25.6%
Total long-stay residents (in thousands)	915	908	857	762	793	815
Long-stay residents of NHs participating in I–SNPs	180	204	211	207	239	268
Long-stay residents of NHs not participating in I–SNPs	735	704	646	554	554	548
Share of long-stay residents eligible to enroll in I–SNPs	19.7%	22.5%	24.6%	27.2%	30.1%	32.8%
Total I–SNP enrollees in NHs (in thousands)	69	81	83	79	87	96
Share of eligible long-stay residents enrolled in I–SNPs	38.2%	39.7%	39.3%	38.3%	36.6%	35.7%

Note: I–SNP (institutional special-needs plan), NH (nursing home). We counted beneficiaries as long-stay residents if they had been in a nursing home for 90+ days. The total number of NHs is based on facilities with at least one long-stay resident. We counted NHs as participating in I–SNPs if they had two or more long-stay residents enrolled in I–SNPs offered by the same insurer. The figures for long-stay residents exclude residents who cannot enroll in an I–SNP because they do not have both Part A and Part B (about 3 percent of all residents). Figures are based on July data for each year. Components may not sum to totals due to rounding.

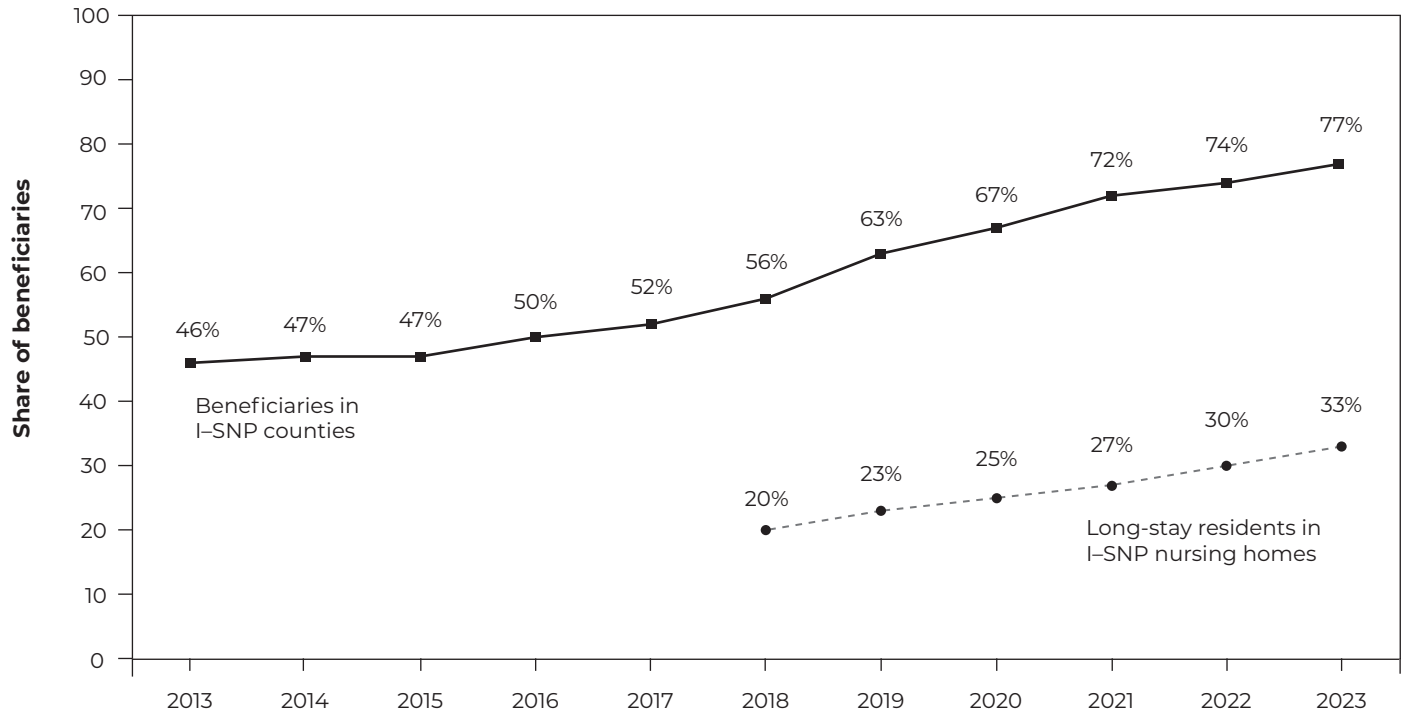
Source: MedPAC analysis of Medicare enrollment data and nursing home assessment data.

We also calculated the share of long-stay residents in the participating NHs that were enrolled in an I–SNP. As part of this calculation, we excluded beneficiaries that had Part A only or Part B only because they cannot enroll in an MA plan. Some interviewees also noted that, as a practical matter, some long-stay residents will not enroll in an I–SNP because they have retiree health coverage that requires them to enroll in FFS Medicare or an employer-sponsored MA plan, but we cannot identify these people with administrative data. Among long-stay residents with access to an I–SNP, we found that the share who actually enrolled in an I–SNP declined somewhat, from 38 percent in 2018 to 36 percent in 2023 (bottom panel of Table 5-11). In sum, Table 5-11 indicates that the growth in I–SNP enrollment between 2018 and 2023 was driven entirely by growth in the number of participating NHs rather than growth in the share of eligible beneficiaries who enroll.

Nearly all NHs (between 98 percent and 99 percent) that participated in I–SNPs worked with a single insurer. This arrangement means that when long-stay residents have access to an I–SNP, they typically have one plan available and are not choosing among I–SNPs offered by different insurers.[52] Our interviewees indicated that both insurers and NHs have strong incentives to prefer these one-to-one relationships. For insurers, having exclusive access to the NHs in its network makes it more likely that I–SNPs can generate the "critical mass" of enrollment needed to operate in a cost-effective manner. For NHs, working with a single insurer is preferable because their clinical staff need to become familiar with only one insurer's care model.

The NHs that participate in I–SNPs tend to keep working with the same insurer over time. On an annual basis, 93 percent of the NHs that participated in I–SNPs between 2018 and 2022 worked with the

FIGURE 5–7 The share of beneficiaries with access to an I–SNP increased from 2013 to 2023



Note: I–SNP (institutional special-needs plan). Figure is based on beneficiaries who have both Part A and Part B. Figures for the share of long-stay residents who live in I–SNP nursing homes are based on July data for each year.

Source: MedPAC analysis of MA plan bids, Medicare enrollment data, and MDS assessments.

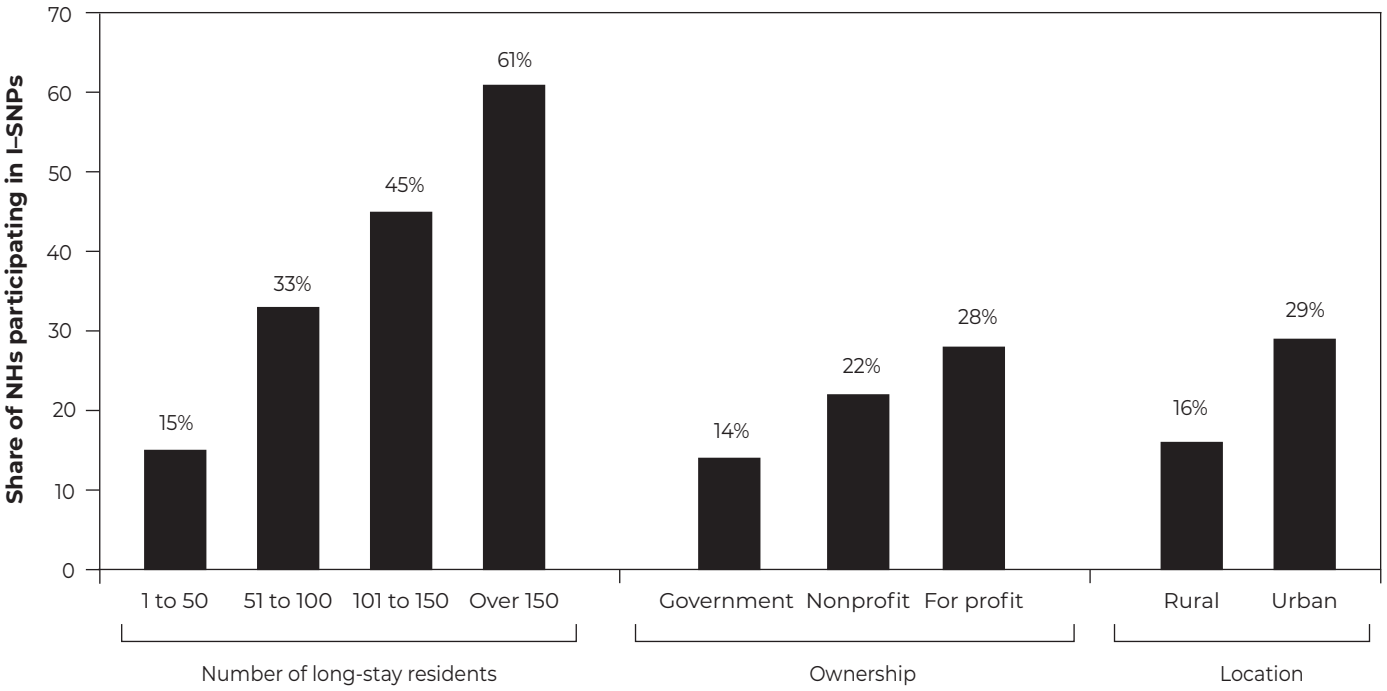
same insurer in the following year, 2 percent switched to another insurer, between 4 percent and 5 percent stopped participating in I–SNPs, and less than 1 percent closed. While these annual changes were relatively small, the cumulative effects were larger. We took the NHs that participated in an I–SNP in 2018 and looked at their status in 2023, five years later. We found that 73 percent of those NHs still worked with the same insurer, 9 percent had switched to another insurer, 15 percent did not participate in an I–SNP, and 3 percent had closed. The NHs that stopped participating tended to have fewer I–SNP enrollees than the NHs that continued to participate, underscoring the importance of adequate enrollment in the I–SNP model. (For example, the NHs that stopped participating between 2022 and 2023 had an average of 13 enrollees, while the NHs that continued participating had an average of 26 enrollees.)

Some types of NHs are more likely to participate in an I–SNP than others. Figure 5-8 (p. 270) shows how participation varies based on the number of long-stay residents, ownership type, and whether the NH is located in a rural or urban area. I–SNP participation was strongly associated with NH size: In 2023, about 15 percent of facilities with 50 or fewer residents participated, compared with about 60 percent of facilities with more than 150 residents. Given the importance of scale for I–SNPs, insurers may be less interested in smaller NHs because it is harder to generate enough enrollment to operate in a cost-effective manner.

In terms of ownership, for-profit NHs are more likely to participate than nonprofit NHs, but the difference in their participation rates is relatively small, about 5 percentage points in 2023. Government-owned

FIGURE 5–8

Variation in nursing home participation in I–SNPs, by selected facility characteristics, 2023



Note: I–SNP (institutional special-needs plan). We counted beneficiaries as long-stay residents if they had been in a nursing home for 90+ days. Figures are based on July data for each year.

Source: MedPAC analysis of Medicare enrollment data, nursing home assessment data, and provider of services file.

facilities have the lowest participation rates but account for less than 6 percent of all facilities. In terms of location, NHs in urban areas are almost twice as likely to participate as those in rural areas (in 2023, 29 percent vs. 16 percent). NHs in urban areas may be more attractive to insurers because they tend to be larger and the distances between them tend to be shorter, which may make the use of NPs more cost-effective.

The NHs that participate in I–SNPs differ from nonparticipating NHs in other respects as well (Table 5-12). Participating NHs have a larger share of patient days covered by Medicaid (60 percent vs. 54 percent) and lower total margins across all payers and sources of revenue (less than 0.1 percent vs. 0.7 percent). The participating NHs also tend to have lower staffing levels and lower overall quality ratings on the Care Compare website.

Our interviewees said that NHs participate in I–SNPs for a variety of reasons; many were tied to concerns about broader developments in Medicare that they considered unfavorable for the NH industry. For example, some NHs want to get ahead of the ongoing shift from traditional FFS payment to value-based payment but do not think the existing value-based models provide opportunities for NHs to receive shared-savings payments. Similarly, interviewees said the steady growth in MA enrollment puts financial pressure on NHs because plans tend to pay less for skilled care and approve fewer days of care. As a result, some NHs see I–SNPs as a way to generate additional revenue and gain more control over their reimbursement. One NH representative simply thought that an I–SNP would be a beneficial option for the facility's residents; they said their subsequent experience had been positive. Another interviewee said

TABLE 5–12 **Additional differences between nursing homes, by participation in I–SNPs, 2023**

Characteristic	Nursing homes participating in I–SNPs	Nursing homes not participating in I–SNPs
Share of days covered by:		
Medicaid	60%	54%
Fee-for-service Medicare	9	11
Other payers (includes MA plans)	31	35
Total margin (all payers, all lines of business)	<0.1	0.7
Median total nurse staffing (hours per resident day)	3.60	3.79
Average overall quality rating (low = 1 star, high = 5 stars)	2.68	2.86

Note: I–SNP (institutional special-needs plan), MA (Medicare Advantage). Figures for share of days covered by different payers and total margins are based on freestanding facilities.

Source: MedPAC analysis of Medicare enrollment, nursing home assessment, cost report, Bureau of Labor Statistics, U.S. Census, and Nursing Home Compare data.

NHs are more likely to participate when state Medicaid programs raise payment rates for long-stay care; the higher reimbursement makes NHs more willing to accept some uncertainty about the revenues they would receive from an I–SNP.

Several interviewees also mentioned reasons why NHs may not participate in I–SNPs:

- Two interviewees said that a subset of NHs think their most profitable strategy is to maximize the number of residents in FFS Medicare and limit their interactions with MA plans. One interviewee estimated that this group represents about 20 percent of all NHs.
- Some interviewees said that NHs in states that use case-mix systems to adjust their Medicaid payment rates for long-stay care are less likely to participate due to concerns that I–SNPs will lower their case mix and reduce their Medicaid revenues. However, they did not explain exactly how participation in an I–SNP might affect a facility's Medicaid case mix.
- One NH interviewee said that NHs need significant administrative capabilities (such as data analytics and ongoing staff training) to participate successfully in an I–SNP, and that many smaller NHs may be unsure about their ability to develop those capabilities.

How NHs are reimbursed by I–SNPs

We asked interviewees to describe how I–SNPs reimburse participating NHs for care. Their responses indicate that, while the methods used to reimburse NHs vary to some degree, the most common approach is a combination of capitated payments and incentive payments.

The capitated payment typically covers Part A skilled care and Part B therapy services (the primary types of services that NHs provide on-site) and is paid on a per member per month basis. The payment appears to rarely cover services provided outside the NH. The capitation rate is based on historical utilization rates for skilled care but also includes an allowance for the additional "skilling in place" that NHs are expected to provide to the plan's enrollees. Two interviewees said that some I–SNPs also use FFS payment amounts when developing their capitation rates, which can make participation in the I–SNP attractive since many MA plans use lower rates to pay for skilled care.

Two interviewees said I–SNPs may still pay NHs on a FFS basis in some situations. One NH representative said it was paid on a FFS basis during the first year that it participated in an I–SNP before switching to capitated payments in later years. One plan representative said it preferred to use capitation for its participating NHs but would also allow NHs to be paid using a FFS-based approach combined with larger incentive payments.

The use of capitated payments removes the financial incentive that NHs have in FFS Medicare to send long-stay residents to the hospital so they can receive higher-paid skilled care when they return. One representative of a NH chain said the use of capitation had also changed how its facilities deliver therapy services; the chain now tries to provide more therapy at an earlier stage while also providing less therapy overall.

The incentive payments can take a variety of forms, but interviewees said they are often tied to NH performance on certain quality metrics and/or the overall spending for plan enrollees. One representative of a NH chain said its quality-based incentive payments were tied to performance on three measures: the occurrence of falls resulting in major injury, the use of multiple medications (polypharmacy), and hospitalizations. Another interviewee said incentive payments are often tied to hospitalizations. The spending-based incentive payments are often structured as "shared savings" arrangements where NHs receive a portion of the savings that occur when total spending for enrollees is lower than a target amount. Both types of incentive payments for NHs are typically "upside only," meaning that the facility receives additional payments if it performs well but is not penalized if it performs poorly. (In provider-sponsored I–SNPs, the corporate owner of the NH may experience financial losses even if individual facilities are not penalized.) The incentive payments may be quite large compared with the incentives used in FFS payment systems: One NH interviewee said that incentive payments accounted for about half of the chain's I–SNP revenue, with capitated payments accounting for the other half. (For comparison, the value-based purchasing program for SNF care adjusts payment rates by between −2.0 and +1.8 percent.)

Like the capitated payments, these incentive payments aim to change the financial incentives that NHs face in FFS Medicare. The capitated payments help ensure that, at the margin, NHs do not receive additional revenue if they send an I–SNP enrollee to the hospital; the spending-based incentive payments go a step further by making it possible for NHs to receive lower incentive payments when their residents are hospitalized. At the same time, the quality-based incentives aim to ensure that NHs still provide adequate care. Plan representatives said that their payment methods, in combination, help ensure that the plan and its participating NHs have aligned incentives.

One interviewee said NHs need to evaluate the overall impact of an I–SNP's payment structure on their revenues before contracting with a plan. Another interviewee said this evaluation was challenging given the uncertainty about the amounts the NH would receive in incentive payments. Some interviewees said NHs can receive more revenue when residents are enrolled in an I–SNP than they would if those residents were enrolled in either FFS Medicare or another type of MA plan.

Beneficiary enrollment in I–SNPs

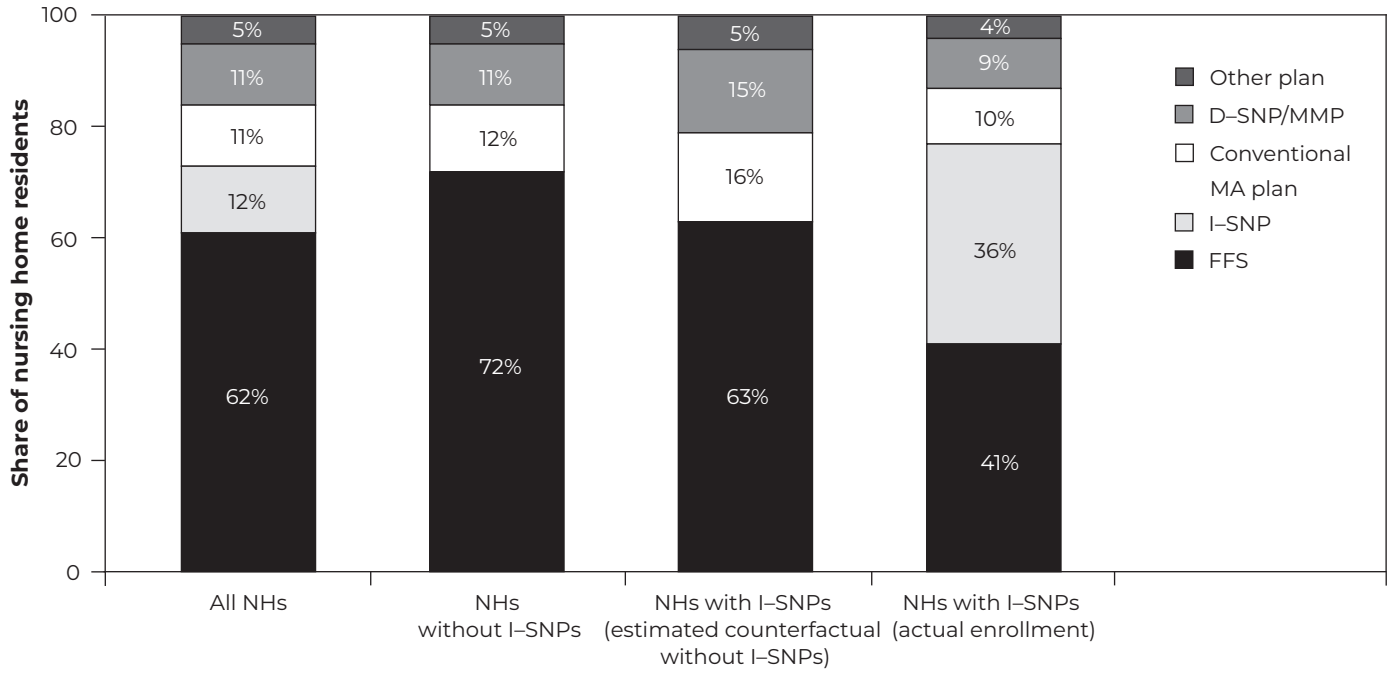
The limited availability of I–SNPs means that enrollment patterns for long-stay residents differ noticeably depending on whether their NH participates in an I–SNP (Figure 5-9). The first column in Figure 5-9 shows the overall enrollment pattern for all long-stay residents, with 62 percent enrolled in FFS Medicare and the other 38 percent enrolled in a private health plan, including 12 percent in I–SNPs. As a group, long-stay residents are more likely to be enrolled in FFS than other beneficiaries (in 2023, about 48 percent of all beneficiaries were in FFS).

The second column shows long-stay residents of NHs that do not participate in I–SNPs; a sizable majority (72 percent) of these beneficiaries were enrolled in FFS, and only 28 percent were in a health plan.

The third and fourth columns show long-stay residents of NHs with I–SNPs, presented in two ways. The third column estimates what the enrollment pattern for these NHs would look like if they did not participate in I–SNPs by assigning I–SNP enrollees to the coverage they had before joining the I–SNP. Without I–SNPs, we estimate that 37 percent of the residents in these NHs would be in MA plans, which is higher than the corresponding figure for NHs without I–SNPs (28

FIGURE 5–9

Share of long-stay nursing home residents enrolled in FFS Medicare versus private health plans, by type of nursing home, 2023



Note: FFS (fee-for-service), D–SNP (dual-eligible special-needs plan), MMP (Medicare–Medicaid Plan), MA (Medicare Advantage), I–SNP (institutional special-needs plan), NH (nursing home). The "other plan" category includes employer-sponsored MA plans, the Program of All-Inclusive Care for the Elderly, cost plans, and MA special-needs plans for beneficiaries with chronic conditions. The "counterfactual" column estimates what the enrollment pattern for NHs with I–SNPs would look like if I–SNPs were not available, based on the type of coverage that beneficiaries had before they enrolled in an I–SNP. We counted beneficiaries as long-stay residents if they had been in a nursing home for 90+ days. Figure does not include long-stay residents who cannot enroll in an MA plan because they do not have both Part A and Part B (about 3 percent of all residents). Figures are based on July data. Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare enrollment data and Minimum Data Set assessment data.

percent). The NHs that participate in I–SNPs thus face higher MA penetration than nonparticipating NHs. As noted earlier, our interviewees said that concerns about rising MA enrollment are one factor that leads NHs to participate in I–SNPs.

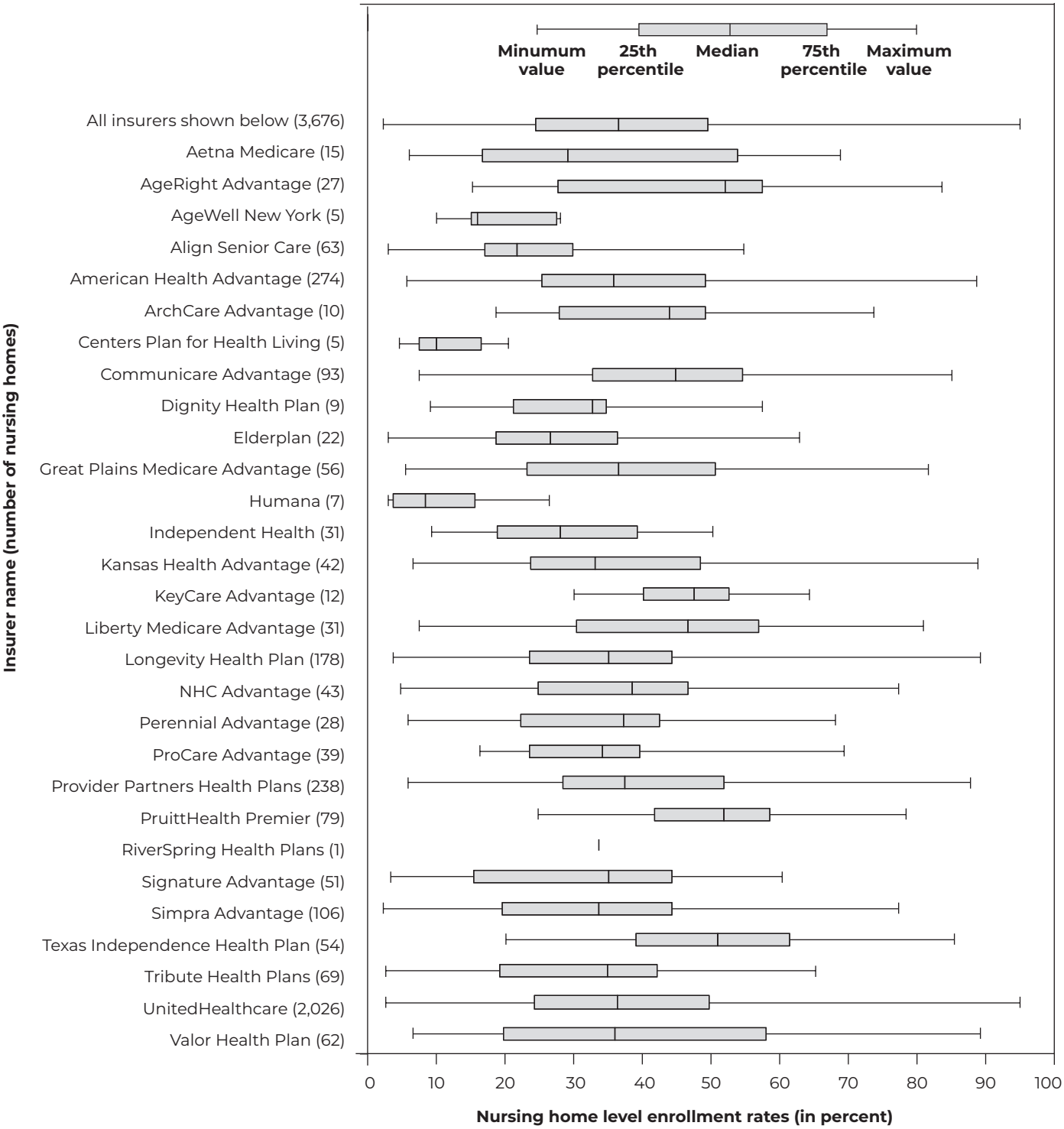
The fourth column shows the actual enrollment pattern in NHs with I–SNPs. Only 41 percent of residents were in FFS, followed by 36 percent in an I–SNP and 23 percent in another type of health plan. The figures in this column suggest that I–SNPs attract enrollment from both FFS and other MA plans. Our interviewees indicated that, from a financial standpoint, most NHs find enrollment in FFS or an I–SNP preferable to other types of health plans. (The Commission has long found that, in FFS, providers' average profit margins for skilled care have exceeded 10 percent; in I–SNPs, NHs can use their decision to participate in a plan's provider network to negotiate more favorable payment arrangements.) As a result, in aggregate, the share of residents with one of those forms of coverage is relatively similar across the two types of NHs: 72 percent and 77 percent, respectively.

The share of long-stay residents who enroll in I–SNPs varies across NHs

Among the NHs that participate in I–SNPs, the share of long-stay residents who enroll in I–SNPs varies widely (Figure 5-10, p. 274). Each row in the figure is an individual insurer, and the total number of NHs in

FIGURE 5–10

The share of long-stay residents who enroll in I–SNPs varies across both nursing homes and insurers



Note: I–SNP (institutional special-needs plan). We calculated enrollment rates for each nursing home based on long-stay residents (those who have been in the nursing home for 90+ days) who have both Part A and Part B. Enrollment rates are based on July 2023 data. This figure does not include five I–SNP insurers (Bright Health, Elevance Health, Florida Complete Care, SCAN Group, and UCare) that primarily enroll beneficiaries who live in the community. This figure uses the marketing name for each insurer; if an insurer used more than one marketing name for its I–SNPs, we used the most common marketing name.

Source: MedPAC analysis of Medicare enrollment data and nursing home assessment data.

its network is shown in parentheses after the insurer's name. The box plot for each insurer shows how enrollment rates vary at the NH level across its provider network, using the minimum value, 25th percentile, median, 75th percentile, and maximum value.

For example, the box plot for AgeRight Advantage summarizes the distribution of the enrollment rates for the 27 NHs in its network; the NH with the lowest enrollment rate had 15 percent of its long-stay residents enrolled in the I–SNP, while the NH with the highest enrollment rate had 83 percent enrolled.

Figure 5-10 shows that NH-level enrollment rates vary both within and across insurers. For many insurers, enrollment rates in the middle half of their distribution (between the 25th percentile and 75th percentile) ranged from roughly 20 percent to roughly 50 percent. At the same time, many insurers also had some NHs with relatively low rates (fewer than 20 percent of eligible residents enrolled) and some NHs with relatively high rates (more than 80 percent of eligible residents enrolled). Looking across insurers, among the 20 companies that had more than 25 NHs in their network, the median NH-level enrollment rate ranged from 21 percent to 52 percent.

Some interviewees specified the share of eligible long-stay residents that I–SNPs aimed to enroll in each NH, either among the facilities in their plan or across the market generally. Their estimates ranged from 40 percent to 70 percent. However, actual enrollment rates are often lower than this range, which suggests that I–SNPs may still be viable even if fewer residents enroll. (In absolute terms, in 2023, the median participating NH had only 21 I–SNP enrollees, and half of all participating NHs had between 13 and 33 enrollees.)

The length of time that NHs participate in I–SNPs appears to have relatively little effect, at least in aggregate, on the share of long-stay residents who enroll. For example, we identified 278 NHs that began participating in an I–SNP in 2019 and continued working with the same insurer through 2023. During this period, the overall share of long-stay residents in these NHs who were enrolled in an I–SNP ranged between 37 percent and 40 percent. The cohorts of NHs that began participating in 2020 and 2021 followed a similar pattern.

Demographic differences between I–SNP enrollees and other long-stay NH residents

The residents of NHs that participate in I–SNPs differ in some respects from the residents of NHs that do not participate (first two columns of Table 5-13 (p. 276)). Residents of participating NHs are more likely to be Black (19 percent vs. 13 percent), have Medicaid (86 percent vs. 80 percent), and live in an urban area (84 percent vs. 72 percent). However, the two groups were similar in terms of their median age, the share who were female versus male, median length of stay, and annual mortality rates.

The third and fourth columns of Table 5-13 (p. 276) compare long-stay residents who enrolled in I–SNPs with residents who had access to an I–SNP but did not enroll. The I–SNP enrollees had much longer lengths of stay (median of 42 months vs. 20 months) and much lower mortality rates (20 percent vs. 25 percent). They were also much more likely to have Medicaid (97 percent vs. 80 percent), but that difference is likely due to their longer length of stay. (Because of the high cost of NH care, the share of residents with Medicaid rises rapidly as length of stay increases.) The I–SNP enrollees were also younger and more likely to be female, Black, and live in a rural area, but these differences were small.

The longer lengths of stay and lower mortality rates suggest that some types of long-stay residents are more likely than others to enroll in I–SNPs. Although these differences could also indicate that I–SNPs reduce the mortality of their enrollees, the fact that lengths of stay and mortality rates look quite similar for participating and nonparticipating NHs suggests that the differences are more likely due to selection among the residents who have access to an I–SNP. It is unclear whether this selection is favorable or unfavorable for I–SNPs in the sense that we use "favorable selection" in our broader analyses of MA payments to describe how MA enrollees tend to have lower spending than their risk scores predict. More research would be needed to understand the relationship between differences in length of stay, beneficiary risk scores, and MA payments for long-stay residents.

This research would need to address several challenges. For example, our methodology for measuring favorable selection partly relies on a comparison of FFS beneficiaries who later switch

TABLE 5–13

Selected characteristics of long-stay nursing home residents, based on whether their nursing home participated in an I–SNP and whether they enrolled in an I–SNP, 2023

	Nursing home participated in an I–SNP		Among nursing homes that participated in an I–SNP	
Characteristic	**Yes**	**No**	**I–SNP enrollees**	**Non–I–SNP enrollees**
Beneficiaries (in thousands)	391	781	129	262
Median age (years)	80	81	79	80
Median length of stay (months)	26	26	42	20
Sex				
Female	63%	62%	64%	62%
Male	37	38	36	38
Race/ethnicity				
White, non-Hispanic	70	77	70	70
Black	19	13	21	19
Hispanic	7	6	7	7
Asian	2	2	1	2
Other/unknown	2	2	1	2
Eligible for full Medicaid benefits	86	80	97	80
Residence				
Urban area	84	72	83	85
Rural area	16	28	17	15
Died during the year	24	24	20	25

Note: I–SNP (institutional special-needs plan). We classified beneficiaries as long-stay residents if they had at least one month during the year in which they had been in a nursing home for more than 90 days.

Source: MedPAC analysis of Medicare administrative data and nursing home assessment data.

to MA with FFS beneficiaries who remain in FFS Medicare. That approach also adjusts for differences in the geographic distribution of the two groups. The number of beneficiaries who could be used in such an analysis would be limited. The number of long-stay NH residents with FFS coverage is relatively small and declining, and the share of these residents who switch directly to an I–SNP is even smaller. In addition, many residents live in NHs for a relatively short period of time, so partial-year spending may be a greater factor relative to the general Medicare population. Thus, any comparison of risk scores and spending might need to use monthly spending data to account for seasonality, instead of the annual data that are typically used. Finally, such an analysis would need to account for the coronavirus pandemic, most likely by using either prepandemic data (which would be older) or postpandemic data (which will still be relatively limited).

Some MA enrollment and marketing rules are particularly relevant for long-stay NH residents and I–SNPs

The MA program has rules that specify (1) when beneficiaries can enroll in or change their plan and (2) how insurers can market plans to beneficiaries. Three provisions are particularly relevant to I–SNPs because they apply specifically to nursing homes or are more likely to affect long-stay NH residents.

First, Medicare gives beneficiaries in NHs more flexibility to change their MA or Part D plan. Nursing home residents can change plans—such as switching from FFS Medicare to an MA plan, switching from MA to FFS, or changing their MA or stand-alone Part D plan—on a monthly basis, while other beneficiaries are largely limited to changing plans during the annual enrollment period. This provision recognizes that NH residents often have complex health needs and may need to change their enrollment in the middle of a plan year.

There have been concerns that some NHs may abuse this flexibility by disenrolling residents from various types of private Medicare health plans and switching them into FFS Medicare without their consent in order to avoid the lower payment rates for skilled care and utilization management that many plans employ. In 2015 and 2021, CMS sent memos to long-term care facilities that warned them about engaging in this "unacceptable practice" and reiterated the procedures that facilities need to follow to obtain a resident's consent to disenroll from a health plan (Centers for Medicare & Medicaid Services 2021, Centers for Medicare & Medicaid Services 2015).

Second, although Medicare generally requires that any decision to enroll or disenroll in a plan must be made by the beneficiary, another individual can make those decisions on a beneficiary's behalf if they are authorized to do so under state law (Centers for Medicare & Medicaid Services 2014). Our NH interviewees indicated that more than half of their long-stay residents had authorized representatives and that residents who still made their own decisions nonetheless consulted closely with family members.

Finally, MA's marketing rules prohibit agents and brokers from conducting door-to-door marketing. Since the NH is the residence for its long-stay beneficiaries, the agents and brokers for an I–SNP cannot enter the facility unless they have scheduled a sales meeting with a resident. In a provider-sponsored I–SNP, NH staff can provide information about the I–SNP to the facility's residents but cannot provide enrollment forms or have sales meetings with residents. If a resident expresses interest in enrolling in the I–SNP, the NH staff will pass their information on to an agent or broker for the plan, who will then schedule a sales meeting with the resident (or their authorized representative). One of our interviewees indicated that word of mouth plays an important role in marketing I–SNPs and that many residents in a NH will become interested in the plan if they hear that other residents have had a positive experience.

The impact of I–SNPs on quality and outcomes

In 2013, the Commission's recommendation to make I–SNPs a permanent part of the MA program was based on an assessment that "I–SNPs perform better than other SNPs and other MA plans on the majority of available quality measures" (Medicare Payment Advisory Commission 2013). In this section, we present an updated analysis of I–SNP performance that uses more recent data, includes more utilization measures, and draws on research literature that largely did not exist in 2013. We find once again that I–SNPs tend to perform somewhat better than other types of MA plans in caring for long-stay NH residents.

CMS requires MA plans to annually collect and report several types of quality data, including:

- the Healthcare Effectiveness and Data Information Set (HEDIS), a set of clinical quality measures developed by the National Committee for Quality Assurance (NCQA) to evaluate health plans;
- the Consumer Assessment of Healthcare Providers and Systems (CAHPS), a beneficiary survey developed by the Agency for Healthcare Research and Quality to assess patient experience; and
- the Health Outcomes Survey (HOS), a beneficiary survey developed by CMS to assess changes in beneficiaries' physical and mental functioning.

However, I–SNPs are exempt from the requirements to conduct the CAHPS and HOS surveys. Similarly, long-stay NH residents in other plans are also excluded from the surveys. As a result, our ability

to assess I–SNP performance using MA quality data is limited to HEDIS measures and does not address important aspects of quality, such as patient experience. (Other researchers, discussed below, have tried to evaluate I–SNP performance using quality measures based on MDS assessment data.) CMS also does not calculate HEDIS measures for beneficiaries in FFS Medicare, so we can only use the data to compare I–SNPs to other types of health plans. We analyzed two types of HEDIS measures: risk-adjusted utilization measures and clinical quality measures.

Risk-adjusted utilization measures

I–SNPs aim to reduce avoidable or unnecessary inpatient stays and ED visits by improving care coordination and providing more primary care within the NH setting. One way to assess the effectiveness of this approach is by using three measures of service use related to hospitals: acute hospital discharges, all-cause readmissions, and ED visits. When plans report these measures, they report both actual service use and an estimate of expected service use for enrollees who meet the measure's HEDIS specifications. Plans calculate the expected service use by applying a set of risk-adjustment models that are developed by NCQA and predict an enrollee's service use based on such factors as age, sex, and the presence of various clinical comorbidities. By itself, lower utilization is not necessarily indicative of better quality, but, as noted earlier, research suggests that a significant share of the hospital-related service use by NH residents is potentially avoidable. MA plans report a measure of hospitalizations for potentially preventable complications, but we could not use it in our analysis because its specifications exclude I–SNP enrollees and NH residents.

We calculated scores for these measures using person-level data for measurement year 2023, the most recent year available. We limited our analysis to long-stay NH residents, defined as beneficiaries who had at least one long-stay month during the year. Ideally, we would calculate separate scores for different plan types to compare their relative performance. However, we were concerned that the risk-adjustment models would not adequately account for underlying differences between I–SNP enrollees and nonenrollees, as discussed in the previous section. We therefore decided to calculate scores at a more aggregated level by dividing long-stay residents into two groups based on whether they lived in NHs that participated in an I–SNP. These more aggregated scores are less likely to be affected by limitations in the risk-adjustment models.

Table 5-14 shows the observed and risk-adjusted expected amounts for each measure plus the ratio of the two amounts, stratified by whether the NH participated in an I–SNP. An observed-to-expected ratio lower than 1 means NHs had lower utilization than expected given the demographics and clinical conditions of their long-stay residents, while a ratio greater than 1 means NHs had higher utilization than expected. The NHs that participated in I–SNPs performed better than the nonparticipating NHs on all three measures: They had fewer hospital discharges, all-cause readmissions, and ED visits.

These results should be treated with some caution for several reasons. First, NHs are not randomly assigned to participate in I–SNPs, and there could be unmeasured differences between the MA enrollees in the two groups of NHs that influence the differences we observe. Second, the risk-adjustment models are calibrated on a broad sample of MA enrollees—meaning that the observed-to-expected ratio across the entire sample should equal 1.0—and may not be as accurate for a small subset of MA enrollees like long-stay NH residents. For example, the overall ratio of 0.79 for ED visits across all long-stay residents in MA plans suggests that the expected utilization amounts for that service are overestimated for those beneficiaries. Third, the specifications for these measures may also exclude a significant amount of service use; for example, the Commission has found that, across all MA enrollees, the specifications for the all-cause readmission measure exclude 45 percent of index hospitalizations and 71 percent of readmissions (Medicare Payment Advisory Commission 2024a).[53] The specifications for all three measures also exclude beneficiaries with any hospice use during the year, a group that is more likely to live in NHs.

Clinical quality measures

In addition to the utilization measures, MA plans reported data for 33 other HEDIS measures for the 2023 measurement year. As with the utilization measures, we used data for long-stay NH residents to calculate scores for these measures. However,

TABLE 5–14

Nursing homes that participated in I–SNPs performed better on three HEDIS measures of service use related to hospitals, measurement year 2023

Type of service use	Observed amount	Risk-adjusted expected amount	Ratio of observed to expected amount
Acute hospital discharges			
NH participated in an I–SNP	35,483	39,786	0.89
NH did not participate in an I–SNP	58,501	52,381	1.12
Total	93,984	92,168	1.02
All-cause readmissions			
NH participated in an I–SNP	3,210	3,494	0.92
NH did not participate in an I–SNP	4,615	4,788	0.96
Total	7,825	8,282	0.94
Emergency department visits			
NH participated in an I–SNP	24,044	40,190	0.60
NH did not participate in an I–SNP	48,859	52,102	0.94
Total	72,903	92,293	0.79

Note: I–SNP (institutional special-needs plan), HEDIS (Healthcare Effectiveness Data and Information Set), NH (nursing home). Figures are based on beneficiaries who were long-stay nursing home residents (90+ days) for at least one month during the year. The specifications for these measures exclude beneficiaries who are considered outliers because of their high levels of service use (for example, having four or more hospital discharges during the year). Figures for acute hospital discharges and hospital readmission rates include observation stays. Table does not include beneficiaries in Puerto Rico. All differences between the observed-to-expected ratios for the two groups of NHs were statistically significant ($p < 0.05$).

Source: MedPAC analysis of HEDIS person-level data for measurement year 2023, enrollment data, and Minimum Data Set assessment data.

since these are largely process measures rather than outcomes measures, their scores are not risk adjusted and we do not have the same concerns about the effects of selection on the scores for different plan types. As a result, we stratified these results by plan type instead of NH participation in an I–SNP. We compared I–SNPs with the two other plan types that cover a significant number of long-stay NH residents: (1) conventional MA plans and (2) D–SNPs or MMPs (which are specialized plans for beneficiaries who have both Medicare and Medicaid).

We excluded 20 measures from our analysis because we determined that they could not be used to assess I–SNP performance. The specifications for 15 measures exclude elderly beneficiaries (usually age 66 or older) who were either long-stay NH residents or I–SNP enrollees at any time during the year. The rationale for the exclusion is that these measures may not be well suited for an institutionalized population. This exclusion applies to about 90 percent of I–SNP enrollees. We also excluded five measures because the scores for at least one plan type were based on fewer than 200 cases and thus apply to a relatively small number of enrollees.

Table 5-15 (p. 280) shows the scores for the remaining 13 measures. In most cases (which are noted with asterisks), the differences between the scores for conventional MA plans and D–SNPs/MMPs and the scores for I–SNPs were statistically significant. However, the differences between the scores on some measures are relatively small and may not be very meaningful to beneficiaries, even if they are statistically significant. CMS has addressed this challenge in some analyses of HEDIS scores by requiring that scores

TABLE 5–15

HEDIS scores for long-stay nursing home residents on selected measures, by plan type, measurement year 2023

Measure	Conventional MA plans	D–SNPs & MMPs	I–SNPs
Higher scores indicate better performance:			
Adults' access to preventive/ambulatory health services	99.2%*	99.6%*	>99.9%
Adult immunization status			
Influenza	34.6*	33.6*	37.8(+)
Herpes zoster	12.6*	11.4*	3.6(–)
Pneumococcal	53.4*	49.5*	30.0(–)
Tetanus, diphtheria, and acellular pertussis	28.0*	26.7*	9.6(–)
Antidepressant medication management			
Effective acute-phase treatment	83.8	82.6*	84.7
Effective continuation-phase treatment	76.0*	76.0*	78.3
Depression screening	3.9*	6.5*	15.9(+)
Follow-up after ED visit for people with multiple high-risk chronic conditions	39.3*	41.7*	44.6
Follow-up after hospitalization for mental illness			
7-day follow-up	8.1*	12.7*	3.6(–)
30-day follow-up	16.0*	24.9*	8.1(–)
Pharmacotherapy management of COPD exacerbation			
Bronchodilator	80.3*	85.1	86.8
Systemic corticosteroid	61.1	61.0	63.2
Use of spirometry testing in the assessment and diagnosis of COPD	8.9*	9.2*	3.0(–)
Lower scores indicate better performance:			
Nonrecommended PSA-based screening in older men	7.8	8.7*	7.6
Potentially harmful drug–disease interactions in older adults			
Chronic kidney disease	7.8	9.5*	6.8
Dementia	43.7*	43.9*	34.4(+)
History of falls	51.7	52.8*	49.4
Use of high-risk medications in older adults	30.6*	32.2*	25.0(+)
Use of opioids at high dosage	1.8*	3.1*	2.6
Use of opioids from multiple providers			
Multiple pharmacies	1.2*	2.0*	0.1
Multiple prescribers	19.7*	23.4*	21.8
Multiple prescribers and pharmacies	1.0*	1.7*	0.1

Note: HEDIS (Healthcare Effectiveness Data and Information Set), MA (Medicare Advantage), D–SNP (dual-eligible special-needs plan), MMP (Medicare–Medicaid Plan), I–SNP (institutional special-needs plan), ED (emergency department), COPD (chronic obstructive pulmonary disease), PSA (prostate-specific antigen). Figures are based on beneficiaries who were long-stay nursing home residents (90+ days) for at least one month during the year. This table does not include beneficiaries who were enrolled in other plan types, such as employer-sponsored MA plans or chronic condition special-needs plans. These other plan types collectively accounted for about 15 percent of the long-stay residents enrolled in health plans. Table does not include beneficiaries in Puerto Rico.
* The difference between this score and the I–SNP score is statistically significant ($p < 0.05$).
(+) I–SNPs performed better; the differences between their score and the scores for the other two plan types were both statistically significant (at the 5 percent level) and practically significant (a difference of at least 3 percentage points).
(–) I–SNPs performed worse; the differences between their score and the scores for the other two plan types were both statistically significant (at the 5 percent level) and practically significant (a difference of at least 3 percentage points).

Source: MedPAC analysis of HEDIS person-level data for measurement year 2023.

differ by at least 3 percentage points to have "practical significance" (Centers for Medicare & Medicaid Services 2023a, Centers for Medicare & Medicaid Services 2023b). Using this standard, the right column notes where I–SNPs performed better or worse than the other plan types and the differences were both statistically and practically significant. I–SNPs had mixed performance on adult immunization status, with a better score on influenza and lower scores for three other conditions. I–SNPs performed better on depression screening, limiting harmful drug–disease interactions in people with dementia, and limiting the use of high-risk medications. However, they performed worse on follow-up care after a hospitalization for mental illness and the use of spirometry testing.

Our finding that I–SNPs performed better on limiting harmful drug-disease interactions and limiting the use of high-risk medications differs from our 2013 analysis, which found that I–SNPs performed worse than other plans on those measures. However, it is unclear whether this change in findings reflects improvements in I–SNP performance or underlying differences in the methodologies we used for the two analyses. In particular, our previous analysis compared I–SNPs to all enrollees in other MA plans, regardless of whether they were NH residents, while our updated analysis is limited to NH residents.

The research literature on I–SNPs is limited but suggests they reduce the use of inpatient care

Relatively few studies have examined how I–SNPs affect service use and quality of care. Aside from the Commission's 2013 analysis, we are aware of only five studies that have looked specifically at this topic.

In 2002, researchers evaluated the Evercare demonstration, the predecessor for I–SNPs (Kane et al. 2002). The study compared Evercare enrollees with two groups of FFS beneficiaries: (1) those who lived in participating NHs but did not enroll and (2) those who lived in NHs that did not participate. The authors found that the hospitalization rate for Evercare enrollees was about 50 percent lower than the rates for both control groups. However, when "intensive service days" (instances when plans provided higher levels of care at the NH in lieu of inpatient care) were counted, admissions for the three groups were similar, suggesting that Evercare shifted some care to NHs but did not reduce the overall "incidence of events that traditionally required hospitalization." The authors also found that Evercare had mixed effects on various other quality metrics, like functioning levels and mortality.

In 2019, a study used data from 2014 to 2015 to compare enrollees in UnitedHealth's I–SNPs to long-stay NH residents with FFS Medicare (McGarry and Grabowski 2019). The study was limited to enrollees in NHs with "mature" I–SNPs, which were defined as having at least 12 months of experience, at least 30 enrollees, and at least 30 percent of long-stay residents enrolled. The study found that utilization rates for inpatient stays, 30-day readmissions, and emergency visits were about 50 percent lower for I–SNP enrollees than the FFS comparison group, while utilization rates for SNF stays were about two times higher, again suggesting that I–SNPs shift some care from hospitals to NHs.

Also in 2019, a different study used 2011 and 2013 data to examine whether NH participation in I–SNPs leads to lower use of hospice care (Dhingra et al. 2019). The study found that I–SNP participation was associated with lower hospice use in smaller NHs (50 beds or less) and higher hospice use in larger NHs (more than 100 beds), but the magnitude of the changes in hospice use was relatively small.

In 2024, another study examined the impact of I–SNPs on hospitalization rates and a set of MDS-based quality measures (Chen and Grabowski 2024). The study compared NHs with "mature" I–SNPs (in this case, defined as having 33.75 percent or more of long-stay residents enrolled) with NHs without I–SNPs. Within these two groups of NHs, the study's primary analysis focused on long-stay residents in MA plans and used a difference-in-differences methodology to estimate changes in hospitalization rates and quality measures once NHs with I–SNPs reached the maturity threshold. The study found that NHs with I–SNPs had hospitalization rates that were 4 percentage points lower than the rates for NHs without I–SNPs and that those reductions occurred in the three years after the I–SNP reached maturity. However, this finding was sensitive to the method used to define the start of a NH's participation in an I–SNP. The impact of I–SNPs on other quality measures was mixed, with decreases in urinary tract infections and pressure ulcers, increases in the number of residents who needed help with activities of daily living, and no effect on mortality rates.

In 2025, an industry-funded study used 2022 data to examine the association between I–SNP enrollment and a set of eight outcome measures (ATI Advisory 2025). The study focused on long-stay NH residents and compared I–SNP enrollees with FFS enrollees and enrollees in other types of MA plans. The study found that, relative to the other two groups, I–SNP enrollees had lower levels of functional impairment but higher levels of cognitive impairment. Compared with enrollees in other MA plans, I–SNP enrollment was associated with fewer ED visits, hospitalizations, and all-cause readmissions. The study also found that I–SNP enrollment was associated with better performance on two of four quality measures (occurrence of pressure ulcers and of falls resulting in a major injury) and higher spending on outpatient prescription drugs.

Overall, the research literature suggests that I–SNPs (1) reduce the use of inpatient care by their enrollees, although estimates of the size of the reduction vary, and (2) do not have a clearly positive or negative impact on various other quality measures. However, these studies likely overstate the impact of using I–SNPs on a broader scale because they focus on either a relatively small demonstration project or a subset of participating NHs with "mature" I–SNPs. (Evercare operated in five cities and, at its peak, had about 270 participating NHs and 10,000 enrollees. We estimate that, in 2023, only about a quarter of the NHs that participated in an I–SNP met the "mature" criteria from the McGarry study of at least 30 enrollees and at least 30 percent of long-stay residents enrolled; those facilities accounted for about half of I–SNP enrollment in NHs.) If I–SNPs were used on a broader scale, the additional insurers and NHs that participated may be less successful with the I–SNP model.

I–SNP payment rates, rebates, and extra benefits

Under the MA payment system, plans submit bids that reflect their estimate of the cost of providing the Part A and Part B benefit package. Each bid is compared with a benchmark that is based on local FFS costs in the plan's service area; the benchmarks are calculated at the county level and range from 95 percent to 115 percent of local FFS costs. Plans that have a quality rating of 4 stars or better (out of 5) qualify for more generous benchmarks (usually 5 percent higher). Plans that bid below their benchmark—which nearly all plans do—receive a portion of the difference between the two amounts as a "rebate" that is used to provide supplemental benefits to their enrollees; plans that bid above the benchmark must charge their enrollees a premium equal to the difference.

Table 5-16 shows the average benchmark, bid, rebate, and payment amount in 2025 for the three main types of MA plans that cover long-stay NH residents: conventional plans, D–SNPs, and I–SNPs. (Unlike Table 5-15 (p. 280), this table does not include MMPs because they have a different payment system.) In dollar terms, the figures for I–SNPs are much higher because these plans are available only to beneficiaries who need NH care, a group with very high average medical costs. In contrast, beneficiaries who need NH care represent a small share of enrollment in conventional plans and D–SNPs, so the figures for those two plan types largely reflect costs for beneficiaries in community settings, which are lower on average. However, the payment amount for a long-stay NH resident in a conventional plan or D–SNP will be much closer to the I–SNP average because the MA risk-adjustment system increases payments for beneficiaries who are expected to have high costs.

Relative to their benchmarks, I–SNPs have much higher bids, on average, than both conventional plans and D–SNPs (91 percent vs. 77 percent and 79 percent, respectively). The higher bids may indicate that I–SNPs have higher costs relative to their benchmarks or that I–SNPs face less competitive pressure than the other plan types, perhaps due to such factors as the practice of NHs contracting with a single insurer and the year-to-year continuity in insurer–NH relationships. The higher bids also mean that I–SNPs receive lower rebates (6 percent of their benchmarks vs. 15 percent for conventional plans and 14 percent for D–SNPs). Overall, the payment amounts for I–SNPs equal 97 percent of their benchmark, on average. None of our interviewees expressed concern about the adequacy of MA payments for I–SNPs.

When evaluating MA payment rates, the Commission has emphasized the importance of accounting for two key factors besides plan benchmarks and bids: coding intensity (MA's risk-adjustment system partly uses diagnosis codes to adjust payments to account for differences in enrollees' health status, which

TABLE 5–16

Differences in bids, rebates, and payment rates between I–SNPs and other types of MA plans, 2025

	Conventional MA plans	D–SNPs	I–SNPs
Average amount (per member per month):			
Benchmarks	$1,206	$1,819	$3,035
Bids	924	1,427	2,749
Rebates	187	258	190
Total payments	1,111	1,685	2,938
As a share of benchmarks:			
Bids	77%	79%	91%
Rebates	15	14	6
Total payments*	92	93	97
Average allocation of rebates			
Reduced Part A/Part B cost sharing	42%	4%	14%
Supplemental benefits	29	90	53
Enhanced drug coverage	15	<1	4
Reduction in Part D premium	8	4	26
Reduction in Part B premium	7	2	3

Note: I–SNP (institutional special-needs plan), MA (Medicare Advantage), D–SNP (dual-eligible special-needs plan). All dollar figures are risk adjusted. Benchmarks include quality bonuses. Estimates do not include beneficiaries with end-stage renal disease. Components may not sum to totals due to rounding.
* Figures for total payments do not account for the effects of coding intensity or selection.

Source: MedPAC analysis of MA bid data from CMS.

gives plans a financial incentive to submit more diagnosis codes) and favorable selection (beneficiaries who enroll in MA tend to have lower spending than their risk scores predict). Both factors increase MA spending and make plan enrollees appear more costly than they really are.

With respect to coding intensity, the Commission projects that, in 2025, the risk scores for MA enrollees are about 16 percent higher than they would have been if those beneficiaries were in FFS Medicare (Medicare Payment Advisory Commission 2025). CMS reduces MA risk scores to account for the higher coding intensity, but its adjustment eliminates only about 40 percent of the overall effect, and as a result MA risk scores (and payments) are still about 10 percent too high.

Although MA plans have an incentive to submit more diagnosis codes for all enrollees, the Commission has found that coding intensity varies across insurers, geographic regions, and types of enrollees. For long-stay NH residents, we estimated that the amount of coding intensity in 2023 was 12.7 percent, somewhat lower than the overall figure of 17.3 percent (Medicare Payment Advisory Commission 2025). After accounting for the CMS reduction in MA risk scores, the amount of coding intensity for long-stay NH residents was roughly 6 percent. The lower coding intensity for these enrollees could be at least partly due to their high mortality rates (when plans submit more diagnosis codes for an enrollee, they do not lead to higher payments for the enrollee until the following year). We did not estimate the amount of coding intensity for I–SNPs specifically, but they account for

about 30 percent of the long-stay residents in MA plans.

With respect to favorable selection, the Commission estimated that, in 2025, its effects will increase MA payments by about 11 percent (Medicare Payment Advisory Commission 2025). Favorable selection can occur due to unmeasured differences in health status but can also result from other factors such as differences in beneficiaries' propensity to seek care for reasons that are unrelated to their health. The Commission's methodology for measuring favorable selection is designed to produce a comprehensive estimate of its effects on MA spending, and we have not produced separate estimates for long-stay NH residents—who account for less than 1 percent of MA enrollment—or for I–SNP enrollees. Table 5-13 (p. 276) suggests that there is selection among I–SNP enrollees, but we do not have enough information to determine whether this selection affects MA payments for them.

As part of their bids, MA plans indicate how they plan to use their rebates to provide five types of extra benefits: reduced beneficiary cost sharing for Part A and Part B services, supplemental benefits that Medicare does not cover, enhanced Part D drug coverage, lower Part D premiums, and lower Part B premiums (bottom half of Table 5-16 (p. 283)). The three types of plans use their rebates in different ways. Conventional plans focus on reducing Part A and Part B cost sharing and providing supplemental benefits, while D–SNPs use almost all of their rebates to provide supplemental benefits. Most D–SNP enrollees already have their Part A, Part B, and Part D premiums and cost sharing covered by Medicaid and the Part D low-income subsidy (LIS).

By comparison, I–SNPs use about half of their rebates to provide supplemental benefits and use a relatively large share (26 percent) to lower their Part D premiums. These rebates lower the Part D premiums for I–SNPs to the point where the remainder is fully covered by the LIS, which more than 90 percent of I–SNP enrollees receive. (In 2025, only three I–SNPs, with a combined total of fewer than 200 enrollees, charge Part D premiums to LIS beneficiaries.) The fact that I–SNPs use a relatively large share of their rebates to lower their Part D premiums in this manner indicates that they have relatively high costs for prescription drugs, which is consistent with a recent study of I–SNPs (ATI Advisory 2025). As with D–SNPs, most I–SNP enrollees pay little or no cost sharing for Part D drugs because they are covered by the LIS.

In 2024, the actuarial firm Milliman examined the supplemental benefits that I–SNPs offered (Yeh and Yen 2024). The study found that all I–SNPs offered by national carriers (which, in this case, largely meant UnitedHealth plans) offered benefits such as dental, vision, and hearing benefits; podiatry services; over-the-counter items and services; and transportation. These benefits are also widely covered by conventional MA plans, although the extent of the coverage varies across plans. The I–SNPs offered by regional carriers (largely provider-sponsored plans) were less likely to offer those benefits (for example, only about half of the plans offered dental benefits) and were more likely to offer certain other benefits such as social-needs benefits, food and produce, and nonmedical transportation. The study also noted that I–SNPs faced growing competitive pressure from D–SNPs, which were increasingly offering so-called flex cards that enrollees can use for expenses such as food and utilities. Some of our interviewees expressed similar concerns about the extra benefits offered by D–SNPs.[54]

The MA star ratings provide limited insight into I–SNP performance

Under the MA quality-bonus program, plans receive star ratings that determine whether they qualify for an increase in their benchmark. Plans that receive a rating of 4 stars or more (out of 5) typically qualify for an increase of 5 percent.[55] However, plans that do not have enough data to calculate a star rating (because they are new or have low enrollment) receive an increase of 3.5 percent.

This year, a large majority of I–SNP enrollees (88 percent) are in plans that received some type of quality bonus—65 percent in plans that received the standard 5 percent bonus and 22 percent in plans that received the smaller 3.5 percent bonus (largely because they have low enrollment, not because they are new to the market).

The star ratings are based on 44 measures of clinical quality, patient experience, and plan performance. CMS calculates a rating for each MA contract rather

than each individual plan. (In MA, an insurer must sign a contract with CMS to participate in the program. An insurer can have multiple MA contracts and can offer multiple plans under each contract.) Some contracts may not have enough data to calculate scores for every measure. When they lack enough data, CMS does not calculate a star rating unless the contract can report scores for at least half of the measures related to MA and, if the contract includes plans that have drug coverage, half of the measures related to Part D. For contracts that have both SNP and non–SNP products, the threshold for getting a star rating is 15 of 29 MA measures and 6 of 11 Part D measures.

However, different requirements apply to contracts composed solely of I–SNPs. These contracts report fewer measures because I–SNPs do not administer the CAHPS and HOS beneficiary surveys (the sources for the patient-experience measures) and do not report some clinical quality measures. Their threshold for calculating a star rating is therefore lower: 9 of 17 MA measures and 5 of 9 Part D measures. In 2024, about three-quarters of all I–SNP enrollees were in these I–SNP-only contracts.

Regardless of the type of contract used, the star rating provides very limited insight into the performance of I–SNPs. When a contract includes both I–SNPs and non–I–SNP plans, the I–SNPs may account for a small share of the contract's total enrollment, and its star rating will largely reflect the performance of the non–I–SNP plans. When a contract has only I–SNPs, its star rating does not incorporate any patient-experience measures, and some of the clinical quality measures that are used may have limited value. (For example, the star ratings for these contracts are based on 11 HEDIS measures and 6 measures of plan administrative performance, but the specifications for 5 of those HEDIS measures exclude I–SNP enrollees over the age of 65, who account for about 90 percent of all I–SNP enrollees, because the measures are not considered clinically appropriate for those beneficiaries.) The star ratings also do not measure other important dimensions of care for NH residents such as quality of life.

Calculating star ratings for I–SNP–only contracts is also challenging because many have relatively low enrollment. Only about 20 percent of the I–SNP–only contracts with less than 1,000 enrollees have a star rating compared with about 70 percent of contracts with 1,000 to 2,000 enrollees and 100 percent of contracts with more than 2,000 enrollees. Nearly all of the I–SNPs that do not have a star rating due to low enrollment are provider-sponsored plans. Although some provider-sponsored plans do have star ratings, the ones without star ratings account for 63 percent of the overall enrollment in provider-sponsored plans.

Some provider-sponsored plans are structured in ways that make it unlikely they will receive a star rating for many years. In these cases, the I–SNP is part of a contract that also has at least one non-I–SNP plan, but the non–I–SNP plan has minimal enrollment (often fewer than 100 people), suggesting that the company may not actively market the product. The presence of the non–I–SNP plan ensures that the contract's star rating is not determined using the rules that apply to I–SNP–only contracts and effectively raises the threshold for calculating a star rating from 9 of 17 measures to 15 of 29 measures.

However, since the contract is almost entirely comprised of I–SNP enrollees, there will not be enough data to produce scores for many of the measures that are part of the higher threshold, such as the patient-experience measures. As a result, the star rating for the contract is still effectively based on the 17 measures used for I–SNP–only contracts, but the contract will not receive a star rating until it has enough I–SNP enrollees to produce scores for 15 of those measures. The number of I–SNP enrollees needed to produce scores for 15 measures appears to be much higher than the current enrollment in provider-sponsored plans. (As of the writing of this report, only two I–SNP–only contracts have scores for 15 or more measures. Both contracts belong to UnitedHealth, and the smaller of the two has about 9,000 enrollees. The next-largest contract, which is part of a provider-sponsored plan, has about 2,000 enrollees and reported scores for only 11 measures.) The presence of a small non-I–SNP plan thus extends the period of time in which a plan receives a guaranteed quality bonus of 3.5 percent and may appeal to plans that are concerned about receiving a low star rating. In 2024, as many as 10 provider-sponsored plans may have used this strategy in at least one of their contracts. Another possibility is that some provider-sponsored plans are interested in expanding their MA business beyond the NH setting (for example, by targeting beneficiaries in the non-NH

parts of a continuing-care retirement community) but have generated relatively little enrollment to date.

Potential future work

Private health plans have the potential to improve care for long-stay nursing home residents by providing more care in NHs and changing the financial incentives that NHs have in FFS Medicare to send long-stay residents to the hospital. However, the share of long-stay residents enrolled in I–SNPs is low. Future work could examine factors that limit the use of this model and could consider potential policy changes to reduce barriers to expansion. ■

Endnotes

1 A spell of illness ends when a beneficiary has not been an inpatient in a hospital or SNF for 60 days. At that point, a subsequent hospitalization starts a new spell of illness, and a beneficiary can receive another 100 days of SNF benefits following a 3-day hospital stay. Observation days and emergency room visits do not count toward the three-day hospital stay requirement. Copayments ($209.50 per day in 2025) begin on on the 21st day of the stay.

2 For example, therapy services must be ordered by a physician, require the skills of technical or professional personnel, and be furnished directly by or under the supervision of such personnel. Coverage ends when a skilled service is no longer needed (such as maintenance services performed by the patient with assistance from an unskilled caregiver).

3 We identified beneficiaries who had been in a NH for more than 90 days using the risk scores that CMS calculates for all beneficiaries to adjust payments to MA plans to account for differences in health status. These scores differ depending on whether a beneficiary lives in the community or a NH, and they include a monthly indicator that shows when a beneficiary has been in a NH for more than 90 days. CMS develops this indicator using information from the Minimum Data Set (MDS), a standardized assessment that NHs complete for every resident when they are admitted and at least quarterly after that. Since NHs are financed by a variety of payers, the MDS is especially useful because it can identify all long-stay residents, regardless of payer. Beneficiaries who reach the 90-day threshold are counted as long-stay residents until they die or have been discharged to the community for more than 14 days.

4 The long-stay population had been declining even before the coronavirus pandemic, from 1.4 million in 2012 to 1.3 million in 2019. During the pandemic, the long-stay population dropped sharply, to 1.1 million in 2021, but it has partially rebounded since then.

5 If the individual seeking NH care has a spouse who still lives in the community, Medicaid has provisions that reserve some of the couple's income and assets for the use of the community-dwelling spouse.

6 D–SNPs are part of the MA program, while MMPs are part of a separate demonstration project aimed at developing new models of care for dually eligible beneficiaries. MMPs have a high level of integration with Medicaid, while the level of integration for D–SNPs varies. We combine the two plan types here because (1) both plans serve dual-eligible beneficiaries and (2) we expect that most MMPs will be converted into D–SNPs when the MMP demonstration concludes at the end of 2025.

7 Beneficiaries who switch from MA to FFS Medicare may have difficulty purchasing a supplemental Medigap policy because they will typically be subject to insurance underwriting in most states. The availability of Medigap coverage will not be a concern for most NH residents who are dually eligible beneficiaries because Medicaid covers their Part A and Part B cost sharing.

8 Some nursing homes might not participate in either Medicaid or Medicare. We do not have information about them, though there are likely to be only a few.

9 PE firms invest in NHs because they are a steady source of income given the aging population, reliable government payers, and favorable tax treatment of earnings. PE firms acquire undervalued or underperforming NHs and then try to make them more valuable by increasing their volume, shifting to a more profitable payer mix, lowering their operating costs, and increasing the use of related third parties from which to buy services (such as staffing and therapy services). When purchasing a NH, a PE firm may separate the NH's operations from its real estate. The NH then becomes a tenant and assumes responsibility for the facility's operations. PE firms often require NHs to pay management and rental fees that also increase the PE firm's revenues (Medicare Payment Advisory Commission 2021).

10 Another study that made different assumptions in its estimates found higher shares of nursing homes with at least some REIT or PE ownership (13 percent and 16 percent, respectively) (Williams Jr. et al. 2024). Notably, these estimates may overstate the level of REIT and PE activity because they do not consider any subsequent divestments.

11 The Partnership for Long-Term Care Program began in the 1990s as a demonstration in California, Connecticut, Indiana, and New York. In 2005, the Congress gave all states the option of participating.

12 For example, the Health Insurance Portability and Accountability Act of 1996 allowed premiums to be considered a medical expense on federal tax returns.

13 Base payment amounts do not include supplemental payments that 23 states make to NHs and collectively account for 5 percent of Medicaid payments. Supplemental-payment data at the provider level are not reliable for nearly all states.

14 The relationship between staffing and the quality of NH care has been extensively studied. In general, studies find that higher levels of registered-nurse staffing are related to better outcomes but that total nurse staffing and staffing mix have mixed results (Clemens et al. 2021, Jutkowitz et al. 2023). Konetzka and colleagues found that, in facilities with known COVID-19 cases, higher staffing was associated with fewer deaths (Konetzka et al. 2021a).

15 Nursing homes must also meet state licensure requirements that are generally similar to the federal standards but may differ. For example, some states have minimum staffing requirements.

16 Nursing homes are separately inspected to follow up on resident or family complaints. Complaint investigation teams are not required to have a registered nurse. The timing of complaint-related surveys depends on the severity of the complaint. In addition, states must separately inspect 20 percent of homes each year for compliance with infection-control requirements, targeting homes with new COVID-19 cases or low staff vaccination rates.

17 Although nursing homes can be denied payment for all residents, in 2024 there were no such enforcement actions.

18 Until FY 2025, providers that did not comply with participation requirements were assessed either a per day or a per instance penalty based on the severity and scope of harm (or potential harm) to residents, and providers could not be assessed multiple instances (e.g., noncompliance on different days of the survey) for the same deficiency. Beginning in FY 2025, a facility that is out of compliance can be assessed both types of penalties and for multiple instances for the same deficiency (Centers for Medicare & Medicaid Services 2024c).

19 CMS identifies low-performing facilities using the results from the three most recent inspections. Facilities with the most deficiency points are eligible for the SFF Program.

20 An SFF graduates from the program when it has had two consecutive surveys that have 12 or fewer deficiencies with a rating of "E" or lower.

21 The measures included in the Quality Reporting Program include changes in skin integrity, share of residents experiencing falls with major injury (long-stay), discharge mobility score, discharge self-care score, drug regimen review, transfer of health information to the provider post-acute care, transfer of health information to the patient post-acute care, discharge function score, percentage of patients/residents who are up to date on their COVID-19 vaccine, Medicare spending per beneficiary, discharge to the community, potentially preventable 30-day postdischarge readmissions, SNF-care-associated infections requiring hospitalization, COVID-19 vaccination coverage among health care personnel, and influenza vaccination coverage among health care personnel.

22 The "scope" of a deficiency refers to whether it was isolated (a single instance) or widespread. The severity indicates whether the deficiency put residents at jeopardy of being harmed or were harmed (the highest severity) or there was no harm or the potential for only minimal harm (the lowest severity).

23 The nine long-stay measures include the percentage of long-stay residents whose need for help with activities of daily living increased; whose ability to move independently worsened; who have or had a catheter inserted and left in their bladder; who had a urinary tract infection; who experienced one or more falls with major injury; who got an antipsychotic medication; the percentage of high-risk residents with pressure ulcers; the number of hospitalizations per 1,000 long-stay residents; and the number of outpatient emergency department visits per 1,000 long-stay resident days. There are six short-stay measures: the percentage of short-stay residents whose ability to move independently improved; who had new or worsened pressure ulcers; who got antipsychotic medication for the first time; who were rehospitalized; who had an emergency department visit; and the rate of successful discharge home. All of the claims-based measures and four of the Minimum Data Set-based measures (moving independently for long-stay residents, improvement in short-stay residents' ability to move around on their own, presence of a catheter, and pressure ulcers in short-stay residents) are risk adjusted.

24 For example, the overall rating of a facility is raised by 1 star if it achieves 5 stars for its staffing rating; conversely, its rating is lowered by 1 star if the facility has 1 star for its staffing rating. A facility with 1 star on its inspection rating cannot have its overall rating increased by more than 1 star based on staffing and quality ratings.

25 One- and 2-star facilities treated 45 percent of residents, while 4- and 5-star facilities treated 35 percent of residents.

26 CMS will validate patient assessment information used in the Value-Based Purchasing Program (see p. 252).

27 Precursors to the QIO Program included the Professional Standards Review Organizations and the Peer Review Organization.

28 To account for the effects of COVID-19 on staffing and SNF admissions, the VBP suppressed performance results during the public health emergency. For FY 2022 and FY 2023, all

providers received 60 percent of the 2 percent withhold for a net reduction of 1.2 percent.

29 Because the performance period is lagged by two years and the baseline period is two years before that, results reported for FY 2019 through FY 2021 predate the COVID-19 public health emergency.

30 The MDS-based quality measures included catheter inserted and left in the bladder, antipsychotic medication use, one or more falls with major injury, self-reported moderate to severe pain, Stage II or higher pressure ulcers, decline in activities of daily living, urinary tract infections, and depressive symptoms.

31 The six conditions accounted for a large share of potentially avoidable hospitalizations and included pneumonia, congestive heart failure, chronic obstructive pulmonary disease/asthma, skin infection, fluid/electrolyte disorder or dehydration, and urinary tract infections.

32 The terms "earned savings" and "shared savings" are equivalent. In this section, we use the term "earned savings."

33 In some cases, visits furnished by certain specialties, such as cardiology and hematology, are included in the assignment. Primary care visits furnished in NHs are counted, but any SNF visits are excluded.

34 In some ACO models, providers can be paid a per member per month amount for primary care or all services. An ACO's benchmark is based on the historical spending on beneficiaries who would have been assigned to the ACO (based on the ACO's participating physicians) and the spending on assignable beneficiaries in the ACO's region. The benchmark is trended forward and adjusted to reflect the mix of beneficiaries assigned to the ACO.

35 In MSSP ACOs, at least one primary care visit has to be with a physician (i.e., visits by only nurse practitioners do not trigger assignment).

36 There is one NH-led ACO, Genesis, but we are not aware of any independent research on its performance.

37 A list of SNF affiliates must accompany a MSSP ACO's application to CMS. The SNF affiliates must have at least a 3-star rating from the CMS 5-star quality-rating system. In 2023, 45 percent of ACOs had a SNF waiver from CMS. A study of ACOs that had obtained SNF waivers between 2014 and 2019 found that the waivers were infrequently used. Less than 5 percent of ACO SNF stays were waiver stays, and the majority were for beneficiaries admitted from the community without a prior hospital stay (Centers for Medicare & Medicaid Services 2023c).

38 In the Medicare Shared Savings Program, the three-day waiver option is not available to long-stay residents.

39 Studies suggest that ACOs generally distribute earned savings to practices based on the number of beneficiaries assigned to their clinicians (Khullar et al. 2024, Schulz et al. 2015). As noted above, beneficiaries are assigned to the clinician who provides the plurality of primary care services.

40 There were initially 47 AIM ACOs, but by 2020 the participation had dwindled to 14. ACO administrators said they exited because they were not ready for the increased risk bearing that would accompany continued participation.

41 Insurers can also offer I–SNPs that target beneficiaries who live in certain other institutional settings—such as intermediate care facilities for individuals with intellectual disabilities, psychiatric hospitals, rehabilitation hospitals, or long-term care hospitals—but have never done so.

42 Starting in 2025, CMS allows certain I–SNPs to request an exception from the network-adequacy standards if they are unable to contract with some types of providers or provide sufficient access to Medicare benefits through additional telehealth coverage. However, we estimate that only about 15 percent of I–SNP enrollees are in plans that are eligible to apply for an exception.

43 The disenrollment of many long-stay residents from MMPs was one reason why CMS issued its 2015 memo to long-term care facilities warning them against trying to disenroll residents from health plans without their consent.

44 The evaluation of Ohio's demonstration, which has had much higher participation rates than other states, found that MMPs reduced the likelihood of a long NH stay.

45 The I–SNPs that serve people living in the community often appear to focus on assisted living facilities (ALFs), which provide a range of services—such as 24-hour supervision, medication management, meals, housekeeping, and transportation—but are not health care facilities like NHs. Some interviewees said ALFs have been a challenging setting for I–SNPs because they do not have the same clinical staff as NHs and because their residents tend to have higher incomes and are more interested in maintaining FFS coverage so that they have broad access to providers.

46 In FFS Medicare, beneficiaries cannot receive skilled care unless they have a prior inpatient stay that lasts three days or more. MA plans can waive this requirement, and nearly all plans (not just I–SNPs) do so. Skilled care services must be ordered by a physician, require the skills of technical or professional personnel (such as registered nurses, licensed

practical nurses, physical or occupational therapists, or speech-language pathologists), and be furnished directly by or under the supervision of skilled personnel.

47 Medicare's coverage of skilled care is limited to 100 days of care per spell of illness.

48 Prior to 2012, SCAN was the largest I–SNP insurer. At the time, special-needs plans simply had to ensure that enrollees who met the "special needs" requirement were a disproportionate share of their overall enrollment, which meant that they could also enroll beneficiaries who did not meet the special-needs requirement. SCAN's I–SNPs had their roots in another demonstration, the social HMO (S/HMO) demonstration, in which health plans provided some forms of long-term services and supports in addition to Medicare benefits. Beneficiaries could enroll in S/HMO plans if they simply had a high risk of needing NH care (Medicare Payment Advisory Commission 2003). Starting in 2012, special-needs plans had to limit their enrollment to beneficiaries who meet the special-needs requirement. Most enrollees in SCAN's I–SNPs did not meet this requirement and switched to other MA plans or traditional Medicare.

49 The 2025 decline in enrollment in UnitedHealth's plans is largely due to the company's decision to close 28 I–SNPs (out of a total of 67) at the end of 2024. The plans that were closed had relatively low enrollment. Most of the plans that were closed (23 of 28) were institutional-equivalent plans.

50 In a subcapitated arrangement, a health plan makes capitated payments to another company to provide certain services or care for certain enrollees.

51 There were a significant number of NHs (about 750 in 2023) that had a single I–SNP enrollee. For years in which we had data available, we looked at I–SNP enrollment in these NHs in both the prior year and the following year—for example, taking NHs that had a single enrollee in July 2022 and looking at their enrollment in July 2021 and July 2023. We found that the vast majority of these NHs had either zero or one I–SNP enrollee in both the prior year and the following year and concluded that they did not participate in an I–SNP in any meaningful fashion. For example, some of the one-enrollee cases involved beneficiaries who lived in a participating NH; had an inpatient stay; were discharged to a second, nonparticipating NH (where they were the only I–SNP enrollee); and then disenrolled from the I–SNP shortly thereafter.

52 In some cases, insurers offer multiple I–SNPs in the same county, including more than one I–SNP of the same type (for example, two facility-based plans). In these situations, the plans may differ in various respects, such as their coverage of supplemental benefits and premiums, and the beneficiaries who live in NHs that contract with these insurers do have some degree of choice among I–SNPs.

53 The underlying rationale for these exclusions is that the readmission measure should focus on instances in which service use is more likely to reflect the impact of a plan's care-management strategies. For example, the specifications exclude beneficiaries who had four or more inpatient stays during the year and require beneficiaries to be continuously enrolled in the plan for 12 months prior to an index hospitalization and the 30 days after an index hospitalization.

54 D–SNPs have offered the flex cards as part of a demonstration project (the Value-Based Insurance Design Model) that gives MA plans more flexibility to target their extra benefits to enrollees based on their health or socioeconomic status. CMS plans to end this demonstration at the end of 2025, and it is unclear whether D–SNPs will still be able to offer these cards in the future.

55 In certain counties, plans that earn a quality bonus receive a benchmark increase of 10 percent.

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