March 20, 2025

Michael Chernew, Ph.D.
Chairman
Medicare Payment Advisory Commission
425 I Street, NW, Suite 701
Washington, D.C. 20001

Subject: Public Comment on MedPAC's March 2025 Public Meeting

Dear Dr. Chernew:

On behalf of our 15,000 plus non-profit and proprietary skilled nursing centers, assisted living communities, and homes for individuals with intellectual and development disabilities, providing care to approximately 1.06 million residents and patients annually, the American Health Care Association and the National Center for Assisted Living (AHCA/NCAL) values the opportunity to offer comment on Medicare Payment Advisory Commission's (MedPAC) March 2025 meeting on Institutional Special Needs Plans (I-SNPs).

AHCA/NCAL members continue to seek opportunities to take a more active leadership role in the total care experience of their vulnerable residents and beneficiaries. In line with its mission to improve lives by delivering solutions for quality care, AHCA/NCAL established the Population Health Management (PHM) Council in 2019. The Council's goal is to strengthen provider-led PHM models through advocacy, education, and quality improvement data, ultimately improving the quality of care and life for beneficiaries in senior living settings. The Council includes AHCA/NCAL member providers with leadership in PHM models, such as provider-led Special Needs Plans (SNPs).

Our comments seek to address several questions raised by the MedPAC commissioners.

Beneficiary Enrollment and Selection Patterns

Residents in nursing homes are typically more medically complex and frailer than those living in the community. A recent ATI Advisory study found that enrollees in I-SNPs tend to be younger, more likely to be Black, dually eligible for Medicare and Medicaid, and experience mild to severe cognitive impairment. The I-SNP population experienced higher levels of cognitive impairment compared to both the Medicare fee-for-serve (FFS) and non-I-SNP Medicare Advantage (MA) populations. They were 30.6% more likely to have mild cognitive impairment than the Medicare FFS population and 20.4% more likely than the non-I-SNP MA population. Additionally, the I-SNP population was 20.9% more likely to experience severe cognitive impairment compared to the Medicare FFS population and 42.4% more likely than the non-I-SNP MA population.[1]

[1]ATI Advisory (2025). I-SNP Enrollment and Outcomes in Long-Term Care Settings https://atiadvisory.com/resources/i-snp-enrollment-outcomes-long-term-care/

An individual is eligible to enroll in an I-SNP, if they are Medicare Part A eligible, enrolled in Medicare Part B, in need of long term care for 90 days or greater and reside in a contracted facility with the I-SNP. Enrollment in I-SNPs is entirely voluntary, and it is essential that beneficiaries make informed decisions about their healthcare coverage based on their specific needs and circumstances. Given the high prevalence of cognitive impairment among long-term care residents, many individuals do not have the capacity to make decisions about their healthcare independently. As a result, most residents in nursing facilities have a medical power of attorney or an authorized representative who is legally designated to make enrollment and medical decisions on their behalf. These representatives play a critical role in ensuring that the resident's healthcare choices align with their best interests, values, and preferences.

Overall AHCA/NCAL member plans report low levels of disenrollment. If the beneficiary leaves the nursing facility and moves to another residential setting or community that is outside the Plan's network of participating providers, they would no longer meet the criteria for I-SNP enrollment, and would have the option to enroll in another type of MA plan or traditional Medicare fee for service (FFS).

Over the last couple of years, a factor contributing to increased disenrollments from I-SNPs is the growing appeal of supplemental benefits offered through debit cards in community-based SNP plans (Chronic Condition SNP and Dual Eligible SNP Plans). Our members strongly support whole-person healthcare, and the introduction of supplemental benefits and Special Supplemental Benefits for the Chronically Ill (SSBCI) presents MA plans with an opportunity to meet the needs of a vulnerable, medically complex population in a person-centered way. However, the appropriateness of SSBCI benefits depends on how well they are tailored to specific populations to ensure they provide real value to beneficiaries and don't serve as inducements or marketing opportunities. For instance, community-dwelling dual-eligible beneficiaries are likely to benefit from health-related social needs support provided by plans through flex cards, which can assist with rent, groceries, utilities, and other essential expenses. However, these benefits may not offer meaningful value to dual-eligible beneficiaries living in LTC facilities, as many of these expenses are already covered by Medicaid room and board rates, potentially making the additional benefits duplicative. Similarly, Dual Eligible SNP (D-SNP) plans that offer monetary healthy food benefits, designed for community-dwelling beneficiaries, may be less impactful for individuals in assisted living settings, where structured dietary services are typically already provided.

Additionally, SSBCI benefits can sometimes inadvertently serve the interests of family members rather than directly benefiting the enrollees themselves, which misaligns the intent of the benefit. For example, many beneficiaries in nursing facilities have a medical power of attorney or authorized representative due to the high prevalence of cognitive impairments. In such cases, SSBCI benefits like flex cards or healthy food stipends may attract the attention of the authorized representative, who might select a D-SNP over an I-SNP to secure these benefits for themselves rather than for the individual they represent. Our members have repeatedly voiced this is an ongoing and growing issue with families disenrolling long term care residents from I-SNPs to enroll them in a plan with one of the flexible spending cards. They elect to put their loved ones into a SNP with a model of care that doesn't suit their medically complex needs which is not in the

best interest of the beneficiary.

Comparative Outcomes and Model Efficacy

As noted by MedPAC staff, the strength and success of I-SNPs lie in their ability to integrate enhanced primary care and long-term services and supports directly on-site, where beneficiaries reside. The traditional physician clinic/practice model does not incent community physicians to come to nursing facilities on a daily/consistent basis, which limits the quality and consistency of care. In contrast, I-SNPs allocate more resources for on-site primary care physicians and advanced practice professionals such as nurse practitioners (NPs), providing a higher level of care than traditional MA plans.

This integration of primary care within the nursing facility environment fosters a more engaged, collaborative care experience. It not only improves the overall care provided to beneficiaries but also generates significant cost savings by reducing unnecessary hospitalizations. The increased time primary care professionals can spend with beneficiaries and their families also strengthens relationships, enhances communication, and facilitates discussions around goals of care and advance care planning. This enables beneficiaries and their families to make more informed, personalized decisions about end-of-life care, ensuring those decisions align with their values and preferences while minimizing unnecessary tests, procedures, and hospitalizations.

NPs who are not directly employed by the SNF often act as external care providers who bring additional expertise and support. They work closely with the facility's staff, including physicians, nurses, and other healthcare providers, to help manage residents' care more effectively. Most I-SNP models require the Advanced Practitioner to attend the interdisciplinary care team meeting, which is not required outside of the I-SNP model. If they collaborate well with the SNF team, they are generally seen as an asset in providing holistic care to residents. Building strong, collaborative relationships and maintaining clear communication channels are critical factors that contribute to the NP's effectiveness in improving care outcomes and ensuring the well-being of residents.

Not all I-SNP plans are the same. They vary significantly in terms of provider engagement in care model design, involvement in clinical decision-making, incentive and risk structures, and alignment of goals. Successful I-SNPs rely heavily on strong, collaborative partnerships between providers and the plan. Smaller, locally committed I-SNPs often engage providers in a more personalized and hands-on manner, fostering deeper relationships and greater flexibility. In contrast, larger I-SNPs may have more standardized processes but may lack the same level of tailored provider interaction. These differences highlight the importance of understanding how each plan is structured and how it fosters collaboration to achieve the best outcomes for beneficiaries.

D-SNPs and I-SNPs are both Medicare Advantage plans, but they are designed to serve different populations with unique healthcare needs. D-SNPs are intended for individuals who are eligible for both Medicare and Medicaid, while I-SNPs are focused on those who live in institutions like nursing homes irrespective of their Medicaid status. While D-SNPs may be effective for

community-dwelling dual eligible individuals, they face challenges in delivering better outcomes for long-term care residents for several reasons:

- **Limited Presence of Advanced Healthcare Practitioners in D-SNPs**: D-SNPs are typically structured to serve community-dwelling populations and often do not have the critical mass of members in long-term care facilities to justify the full-time presence of advanced healthcare practitioners. As a result, the care provided may lack the continuity and personalized attention needed to effectively manage the complex medical conditions of long-term care residents. In contrast, I-SNPs are specifically designed to focus on the healthcare needs of long-term care residents and generally have more resources to allocate advanced healthcare practitioners to these facilities, ensuring better care coordination and outcomes.
- **Clinical Model Mismatch**: The D-SNP model is optimized for individuals living in the community, not long-term care residents. Long-term care residents require specialized care that addresses their unique and often complex healthcare needs. Research has shown that I-SNPs, with their tailored model of care for institutionalized individuals, are more effective at addressing these needs. This makes I-SNPs a more appropriate model once individuals transition to a long-term care setting, as it focuses on the coordination of care for this specific population, leading to better health outcomes.
- **Lack of Focus on Long-Term Care Residents in D-SNPs**: As noted, the overall model for D-SNPs has not been designed with long-term care residents in mind. The limited focus on this population in D-SNPs means that they may not receive the specialized care in addition to access to benefits that meet their needs. On the other hand, I-SNPs are built around the needs of long-term care residents and have been shown to provide better outcomes, as evidenced by the ATI Advisory whitepaper. Transitioning to I-SNPs allows these individuals to receive care that is more aligned with their specific health needs, potentially leading to improved quality of life and better clinical outcomes.
- **Evidence Supporting I-SNP Benefits**: The ATI Advisory report looked at the relationship between I-SNPs and various outcome measures--utilization, quality, and spending-- compared to two groups: 1) Medicare Fee-For-Service (FFS) beneficiaries with both Part A and Part B or those solely enrolled in Part A, and 2) MA beneficiaries enrolled in non-I-SNP plans, including C-SNPs and D-SNPs.

  Key findings suggest that I-SNPs are associated with better quality outcomes, lower acute care utilization, and more efficient spending compared to both FFS beneficiaries and those in non-I-SNP MA plans. It found that I-SNP enrollees experienced better outcomes in areas such as pressure ulcers, fall injuries, and infections compared to both Medicare FFS and non-I-SNP MA beneficiaries. Furthermore, I-SNP enrollees had 57% lower inpatient admissions, with 53% less emergency department visits and were 29% less likely to experience a 30 day readmission compared to non-I-SNP MA.[1]

Our members report a spillover effect when there are residents in a facility who are enrolled in I-SNPs. The extent of this spillover effect is influenced by the penetration rate, or the percentage of residents enrolled in I-SNPs within a given facility or region. Higher I-SNP penetration means more resources, expertise, and specialized care dedicated to the I-SNP population, which in turn

increases the potential for positive effects on the non-I-SNP population. As more residents are enrolled in I-SNPs, the overall care environment can improve, leading to better outcomes for all residents, regardless of their plan affiliation.

On-Site Care and Staffing

Physician visit requirements differ for long-term residents and short-term patients of a SNF. Regulatory requirements mandate that **long-term residents** of a nursing facility must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. There is some variation based on state laws such that an NP who is not employed by the facility but works in collaboration with a licensed physician can conduct visits that meet the physician visit requirements, as long as they are within the state's scope of practice. NPs employed by the facility may perform medically necessary visits, but these do not replace the required physician visits and do not count toward the physician visit schedule. Visits by an I-SNP NP do not substitute for the mandatory physician visit.

Nursing facilities are required to report staffing data via Payroll-Based Journal (PBJ), a system created by the Centers for Medicare & Medicaid Services (CMS) to collect auditable and verifiable staffing information. PBJ ensures that CMS has accurate and reliable data on the staffing levels in nursing homes, including the number of hours worked by various categories of staff, such as registered nurses, certified nursing assistants, and other direct care workers.

However, it's important to note that I-SNP NPs who play a vital role in providing specialized care for residents in nursing facilities are not included in the PBJ staffing data. Despite the critical contributions of I-SNP NPs in managing resident care, improving outcomes, and supporting care coordination, their hours of service are not reflected in the staffing numbers submitted to CMS. As a result, facilities do not see an increase or decrease in their staffing levels based on the presence of I-SNP NPs. This can create a gap between the actual care provided and the staffing numbers that are publicly reported, potentially leading to a misunderstanding of the resources available at the facility.

AHCA/NCAL's analysis of member plan reported data obtained from claims for the period 2019-2021 demonstrated that 85% of total primary and specialty care is provided in the member facility primarily by advance practice professionals (NP/PAs) and 96% of all advance practice care offered to I-SNP beneficiaries are offered in the facility.

Barriers to Increased Participation

Certain challenges associated with I-SNPs such as the ability to meet general MA network adequacy standards, can vary based on the size of the plan and the additional plan products the I-SNP utilizes when contracting with providers to ensure network adequacy. However, there are also barriers that are consistent across all I-SNPs, regardless of their size. One such barrier is the misalignment of Star Ratings for I-SNPs, which can affect their overall performance evaluation. Additionally, the growing concern around flex cards has emerged as a recent challenge.

Network Adequacy

Network adequacy requirements are designed to ensure beneficiaries can access necessary services without undue burden. CMS' current standards for the number and type of specialties, as well as time and distance requirements, are suitable for traditional MA plans with a diverse, dispersed population. However, I-SNPs serve a more specific Medicare population limited to contracted institutional LTC facilities, where services are provided by relevant onsite physicians and primary care providers. Additionally, many I-SNPs offer mobile providers for services like podiatry, hearing, and dental care. Under current MA network adequacy standards, I-SNPs, which target a localized population, must contract enough primary care providers to cover beneficiaries countywide, not just those within the facility, despite most care being delivered onsite.

Residents of LTC facilities typically have specific needs due to the requirement for institutional-level care. They rarely require services from specialties such as plastic surgery, allergists, obstetricians, chiropractors, and endocrinologists. Of the over 1.4-million claims previously referenced, 26 out of 33 specialties are below 3% and nurse practitioner, internal medicine, family practice and physician assistants compromise 71% of all claims. Claims by specialties least often accessed include plastic surgery, 0.03%; allergy and immunology, 0.03%; Ob/gyn 0.06%; cardiothoracic surgery 0.01%; and chiropractors 0.3%. In addition, among the small percentage of I-SNP enrollees who seek care outside the facility, the average travel distance is 11 miles (urban) and 31 miles (rural). However, I-SNPs are held to network adequacy standards designed for a general Medicare population across an entire county. The challenge is that applying these broad standards to I-SNPs disadvantages smaller plans, which lack the leverage to secure provider contracts like larger MA or commercial plans. Many physician offices are unwilling to take on the administrative burden of contracts for patients they rarely or never see. In addition, small, locally committed I-SNPs have limited revenue impact on large health systems or hospitals given their smaller membership and utilization patterns. As these essential providers look to limit their own administrative burden and narrow the pool of contracting payers, smaller I-SNPs are at a significant disadvantage. This is a considerable issue in urban areas where consolidation of health systems has occurred and in rural areas where there is only one hospital or large market share by a provider. Smaller, locally committed I-SNPs have struggled with not securing a contract with a hospital even when offering above Medicare rates. The resulting lack of I-SNPs not meeting the blanket application of traditional MA network adequacy standards is plan preclusion in those counties, thereby reducing access and choice for eligible beneficiaries to these specialized, locally committed plans.

CMS recognized this distinction in the care utilization patterns of I-SNP beneficiaries and in the Contract Year 2025 Medicare Advantage and Part D Final Rule finalized a network adequacy exception process for Facility based I-SNPs that is in effect for 2026 applications (42 CFR 422.116 (f).[2] However, AHCA/NCAL member plans have reported challenges with the exception process,

[2] Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024 – Remaining Provisions and Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly, 89 Fed. Reg. 30,448 (April 23, 2024).

noting that navigating this process introduces additional administrative hurdles. There are opportunities to improve beneficiary access to I-SNPs, particularly in rural areas, while also reducing unnecessary administrative costs and burdens. This can be achieved by implementing targeted solutions that maintain the core principles of network adequacy standards—specifically access and avoiding undue burden, by the establishment of I-SNP-specific network adequacy requirements.

- Base the number of providers needed to meet network adequacy based on the eligible population within a facility (or each facility in a multi-facility plan), rather than using a sample of Medicare beneficiaries across the entire county.
- Base the required types of providers and facilities on the needs and utilization patterns of enrollees, excluding provider types where claims for services to beneficiaries residing in nursing facilities or assisted living represent 5% or less of total annual claims. Additionally, allow greater use of telehealth and other alternatives for low-utilization specialties and provider types to meet network adequacy.
- Reduce network adequacy time and distance standards for I-SNPs to a more realistic radius around a facility, reflecting actual care and utilization patterns.
- Include a hold harmless provision ensuring that, in the event an I-SNP enrollee needs to access an out-of-network provider, they incur no greater cost-sharing than if the services were in-network and are protected from any additional charges for out-of-network care.
- Apply an exception similar to the Essential Hospital designation for Regional PPOs to I-SNPs. If an I-SNP has made good-faith attempts to contract with the only hospital in a county (offering at least Medicare rates) and the hospital refuses, allow the I-SNP to use the hospital out-of-network without violating network adequacy standards, permitting continued operation in that county.

<u>Star Ratings</u>

The current quality system does not effectively capture high risk, medically complex populations. I-SNPs face many unique challenges when working towards providing the highest level of care for the beneficiaries they serve. The highly complex clinical care needed for these individuals can impact quality outcomes for these plans to achieve the rates needed to receive a Quality Bonus Payment for Star Ratings performance. Reaching these goals is often exacerbated by significantly smaller populations in each H-plan to reach the required denominator criteria to receive a rating.

CMS has an opportunity to adjust the Star Rating system for I-SNPs to provide a more meaningful and accurate system that reflects the quality of care provided by MA plans to this unique population and ensure more I-SNPs earn a rating. This would directly benefit I-SNP beneficiaries by allowing top-performing I-SNPs to grow and provide better care and benefits. Recommendations to modify or retain current I-SNP Star Ratings reporting requirements are identified below.

1. Retain, Adjust, Align or Expand I-SNP Measure Exclusions to Support the Complex Health Care Needs Addressed in the I-SNP Model of Care
   - Retain the I-SNP exclusion for beneficiaries 66 and older only

  - Colorectal Cancer Screening
  - Kidney Health Evaluation for Patients with Diabetes
- Adjust the I-SNP exclusion for current HEDIS measures with an I-SNP exclusion for beneficiaries 66 and older to exclude all or exclude none of the I-SNP beneficiaries
- Remove the I-SNP exclusion for beneficiaries 66 and older for the following measures:
  - Glycemic Status Assessment for Patients with Diabetes
  - Eye Exam for Patients with Diabetes
- Align the I-SNP exclusion for beneficiaries 66 and older for "like" measures across chronic conditions
  - Statin Use in Persons with Diabetes and Statin Therapy for Patients with Cardiovascular Disease
- Expand the I-SNP exclusion to all beneficiaries for the following measures:
  - Breast Cancer Screening – Currently 66 and older excluded
  - Controlling High Blood Pressure– Currently 66 and older excluded
  - Transitions of Care
  - Social Need Screening and Intervention
  - Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults
- Allow I-SNPs to stand alone for Star Ratings in the case that the CMS contract includes another type of SNP, because that increases the denominator minimums for the contract and doesn't allow an otherwise qualified I-SNP to qualify for a Star Rating.

2. Other Measure Logic Changes
   - Align the HEDIS Nonacute Inpatient Stay value set with the Inpatient Stay value set
   - Add typical follow up codes for I-SNP (99304-99310) to the follow up value sets
   - Adjust Members Choosing to Leave Plan logic based on unique I-SNP Membership Volatility
   - Address deprescribing in PDE Adherence Measure Logic

3. Additional Measure Considerations for I-SNP
   - Add Advance Care Planning as a measure for Medicare Star Ratings
   - Move Adult Immunization Status from Display to the Medicare Star Ratings and replace the CAHPS Annual Flu Vaccine measure
   - Move Antipsychotic Use in Persons with Dementia for LTC from Display to the Medicare Star Ratings
   - Move Depression Screening and Follow Up from Display to the Medicare Star Ratings
   - Address the gap resulting from retirement of the Care for Older Adults: Pain Assessment measure by NCQA (National Committee for Quality Assurance)

Conclusion:
AHCA/NCAL and its PHM Council are dedicated to enhancing the quality of care and the quality of life of individuals through solutions that enable providers to assume greater leadership for and meaningfully participate in the full care experience of their residents and patients. We appreciate MedPAC's deliberate exploration of I-SNPs and their recognition of these plans as a valuable solution for the long-term care beneficiary population. I-SNPs play a crucial role in providing

tailored healthcare services to individuals in institutional settings, ensuring they receive specialized care that meets their unique needs. We support further efforts to improve the effectiveness and accessibility of I-SNPs. We would be glad to provide additional feedback or suggestions on how these plans can be expanded to better serve this population, ensuring improved outcomes and greater access to care for those who rely on long-term care services.

Please contact Martin Allen at mallen@ahca.org or Nisha Hammel at nhammel@ahca.org or 202-898-6305 with any questions or requests to discuss our comments.

Sincerely,

[Transmitted Electronically]
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Cc: Director Paul Masi, M.P.P.
MedPAC Commissioners