Center for Medicare Advocacy
Advancing Access to Medicare and Health Care

March 20, 2025
Submitted at meetingcomments@medpac.gov

Dear MedPAC:

I am submitting the following comments on Institutional Special Needs Plans (I-SNPs), discussed at MedPAC's meeting on March 7, 2025. The comments are based solely on the PowerPoint and oral presentation. I understand that additional points about I-SNPs may be included in the final chapter that MedPAC releases later this Spring.

The Center for Medicare Advocacy (Center) is a national, private, non-profit law organization, founded in 1986, that provides education, analysis, advocacy, and legal assistance to assist people nationwide, primarily the elderly and people with disabilities, to obtain necessary health care, therapy, and Medicare. The Center focuses on the needs of Medicare beneficiaries, people with chronic conditions, and those in need of long-term care and provides training regarding Medicare and health care rights throughout the country. It advocates on behalf of beneficiaries in administrative and legislative forums and serves as legal counsel in litigation of importance to Medicare beneficiaries and others seeking health coverage. These comments are based on the Center's experiences talking with and representing Medicare beneficiaries and their families and advocates.

Summary of Concerns

1. MedPAC should analyze the effects of I-SNPs on quality of care for nursing home residents.

2. I-SNPs operated by nursing facilities have a conflict of interest with the nursing facility residents they cover.

3. Nursing facilities' interest in operating I-SNPs is primarily financial.

4. MedPAC should seek out residents in I-SNPs and their advocates to better understand their experiences.

Background

The nursing home industry has strongly disfavored the Medicare Advantage (MA) program for a long time because it opposes MA's prior authorization practices, residents' reduced lengths of stay, and lower reimbursement rates, compared to their experiences with the traditional Medicare program. Although the industry has recently become increasingly public about its dissatisfaction with MA, nursing facilities have quietly and largely under the radar become MA providers on their own through the Institutional Special Needs Plans (I-SNPs) program. I-SNPs are MA plans that are limited to beneficiaries who require, or are expected to need, institutional long-term care for 90 days or more. These MA plans are now, more specifically, called facility-based institutional Special Needs Plans, FI-SNPs.

MedPAC reported on March 7, 2025 that 125,000 nursing home residents were enrolled in I-SNPs in 2024, covering about 12% of long-stay nursing home residents.

Nursing homes themselves control a large and increasing number of FI-SNPs and covered residents. Between 2016 and 2018, the number of provider-led I-SNPs doubled from 12 to 24 and the number of enrollees in provider-led I-SNPs more than doubled, from 5,014 to 12,488.[1] In 2019, there were 60 provider-led I-SNPs, covering 18,320 beneficiaries.[2] MedPAC reported on March 7, 2025 that 35% of 125,000 I-SNP nursing home residents in 2024 are enrolled in provider-controlled I-SNPs – 43,750 residents. Nursing homes' control of FI-SNPs is an important issue because, as discussed below, they have an inherent conflict of interest with their residents and their interest in operating an FI-SNP for residents is financial.

Concerns

1. MedPAC should analyze the effects of FI-SNPs on quality of care for nursing home residents.

In 2013, MedPAC found that I-SNPs "have higher rates than regular MA plans for the use of potentially harmful drugs among the elderly and the use of drug combinations with potentially harmful interactions."[3] MedPAC excused these higher rates of inappropriate drugs and drug combinations by noting I-SNPs' "higher rates of monitoring of persistently used drugs suggest that drugs with potential interactions or adverse effects are also being closely monitored."[4] MedPAC did not provide any evidence that I-SNPs' "close monitoring" of high drug use among covered residents was successful in actually reducing the high use of inappropriate drugs or their adverse effects on residents.

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[1] Anne Tumlinson and Elizabeth Walsh, "Long-Term Care Providers Drive Growth in Special Medicare Advantage Plans," *Skilled Nursing News* (Dec. 18, 2018), https://skillednursingnews.com/2018/12/long-term-care-providers-drive-growth-special-medicare-advantage-plans/

[2] Alex Spanko, "I-SNP Case Studies Show Promise in Era Where Fee-for-Service Medicare Looks Unsustainable," Skilled Nursing News (Oct. 28, 2019), https://skillednursingnews.com/2019/10/i-snp-case-studies-show-promise-in-era-where-fee-for-service-medicare-looks-unsustainable/.

[3] MedPAC, Report to the Congress: Medicare Payment Policy, "Medicare Advantage special needs plans" (Chapter 14, p. 322) (Mar. 2013), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/chapter-14-medicare-advantage-special-needs-plans-march-2013-report-.pdf.

[4] *Id*.

In fact, high rates of drug use appear to continue to be a problem. In February 2025, ATI Advisory released "*Institutional Special Needs Plan (I-SNP Enrollment and Outcomes in Long-Term Care Settings*"[5] (Issue Brief), which found 26% higher Part D spending for residents in I-SNPs.

MedPAC's second observation in 2013 was that I-SNPs have "fewer hospital readmissions than would be expected given the clinical severity of their enrollees."[6] MedPAC then leapt to the conclusion that "I-SNPs' performance in hospital readmissions rates is an important measure of whether they provide a more integrated delivery system."[7] That conclusion is not necessarily true. I-SNPs may simply be denying hospitalization for residents who need to be hospitalized or they may not be paying for hospital care that is medically necessary. MedPAC's only support for its 2013 conclusion is the statement that "I-SNPs attempt to reduce hospital and emergency department utilization through care management and by emphasizing the provision of primary care."[8] MedPAC provided no evidence of "a more integrated delivery system" in facilities with I-SNPs. Citing I-SNPs' use of nurse practitioners, MedPAC then ended its brief analysis with the statement, "Achieving readmission rates that are lower than expected demonstrates that I-SNPs are meeting their goal to reduce hospitalization for beneficiaries who are institutionalized."[9] From our perspective, MedPAC's 2013 report defended I-SNPs' lower rates of hospitalization (even for residents whose clinical severity may suggest a medical need for hospital care) solely because these lower rates achieved I-SNPs' goal of reducing hospitalization. That statement was circular and conclusory and not persuasive.

Although concerns about nursing home quality may be included in the final chapter later this Spring, MedPAC did not revisit either of these concerns at the March 10 meeting or in the PowerPoint. MedPAC did not mention high drug use among nursing home residents receiving their Medicare coverage through I-SNPs or the lower rates of hospital care than expected (based on clinical condition) among residents in I-SNPs. MedPAC provided no information about the quality of care received by residents in I-SNPs. The focus in March was almost entirely on the reduced use of acute care hospitals and emergency departments and reduced hospital readmissions in the I-SNP model and the model's practice of sending nurse practitioners to nursing facilities to supplement facilities' regular staff. More information about both issues is needed.

Since hospitalization is the most expensive form of health care, the avoidance of all hospitalizations is uniformly positive for the payer, here, I-SNPs. But that does not mean the avoidance of all hospitalization is uniformly positive for all patients. Not all hospital avoidance is appropriate. Sometimes, nursing home residents experience an acute episode that requires inpatient hospital care, or at least an emergency department visit. MedPAC should evaluate whether the I-SNP model avoids only hospitalizations that can appropriately be avoided with additional care provided in the SNF.

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[5] Full report is accessed through a link at https://atiadvisory.com/resources/i-snp-enrollment-outcomes-long-term-care/.

[6] MedPAC, Report to the Congress: Medicare Payment Policy, "Medicare Advantage special needs plans" (Chapter 14, p. 322) (Mar. 2013), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/chapter-14-medicare-advantage-special-needs-plans-march-2013-report-.pdf.

[7] *Id.*

[8] *Id.*

[9] *Id*. 322-323.

MedPAC views I-SNPs' avoiding hospitalization as positive because I-SNPs place nurse practitioners in nursing homes. But MedPAC provided no information at the March meeting about how the model works in practice – for example, how many nurse practitioners are typically placed in each facility, whether nurse practitioners work full-time in the facilities, whether nurse practitioners are assigned to specific residents to promote continuity of care, how nurse practitioners interact with nursing homes' permanent staff, and more. Commissioner R. Tamara Konetzka raised many of these issues. MedPAC should evaluate which specific models work most effectively to promote high-quality care for residents.

One specific concern about the model is whether nurse practitioners are assigned to nursing homes only during daytime shifts. If nurse practitioners are not expanding nurse coverage during the other 16 hours of a day, they are not available during evening shifts, when residents may also experience medical crises.

2. I-SNPs operated by nursing facilities have a conflict of interest with the nursing facility residents they cover.

Although MedPAC acknowledges that I-SNPs are operated by both nursing homes and insurance companies, it does not analyze possible differences or issues raised by the two models.

The Center is concerned about MA plans in general. However, nursing home companies that operate I-SNPs, in addition, have an inherent conflict of interest with their enrollee residents. They save money (and therefore make more profit from the I-SNP) by not covering certain care – specifically, hospital care (which is the express goal of the I-SNP model) and even some nursing home care.

In July 2017, Jordan Rau of *Kaiser Health News* described in *U.S. New & World Report* the experience of Faith Daiak, who lived in an Erickson Living continuing care retirement community (CCRC) in Silver Spring, Maryland. In "Nursing Homes Move Into The Insurance Business,"[10] he wrote about what happened to Mrs. Daiak, who had been sold an I-SNP, an Erickson Advantage Plan, by an Erickson nurse. After experiencing the flu, Mrs. Daiak was hospitalized for ten days and then sent to the skilled nursing facility (SNF) part of her CCRC. The Erickson Advantage Plan repeatedly tried to stop paying for her SNF care – first saying she was not improving. As Mrs. Daiak appealed the lack of coverage on this illegal basis,[11] she was rehospitalized. This time, Mrs. Daiak returned to the SNF with a feeding tube in her stomach, a medical need that automatically made her eligible for Medicare coverage at the SNF.[12] The Plan nevertheless denied coverage again and relented only when Rau of *Kaiser Health News* called the facility.

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[10] Jordan Rau, "Nursing Homes Get Into the Insurance Business," *U.S. News & World Report* (Jul. 12, 2017), https://www.usnews.com/news/healthcare-of-tomorrow/articles/2017-07-12/nursing-homes-get-into-the-insurance-business.

[11] Medicare covers care in a SNF for a resident who needs professional nursing or professional rehabilitation services to maintain function or to prevent or slow decline or deterioration, not just if the resident is expected to improve. *Jimmo v. Sebelius*, Civil Action No. 5:11-CV-17-CR (D. Vt. Jan. 24, 2023), https://www.cms.gov/medicare/settlements/jimmo.

[12] 42 C.F.R. §409.33(b); Medicare Benefit Policy Manual, Chapter 8, §30.3.

Rau described residents of other Erickson communities who similarly experienced denials of coverage of their nursing home stay when they had an Erickson I-SNP policy. Rau described a Massachusetts Erickson community, where a resident returning from the hospital was, like Mrs. Daiak, similarly placed in the CCRC's SNF. After 11 days, Erickson Advantage advised the resident's daughter that her mother no longer needed daily therapy and, as a result, that the plan would no longer cover her stay at the SNF. The SNF billed the resident a daily rate of $463, later raised to $483. The daughter appealed the denial of coverage for the SNF stay, but eventually lost her appeal before an Administrative Law Judge (ALJ). Relying on testimony from the SNF staff, the ALJ ruled that the mother's stay in the SNF was not covered by Erickson Advantage. Her bill for the SNF was $30,000 and counting at the time of the *Kaiser* report.

Other nursing home companies also have their own I-SNPs. One example is PruittHealth, whose I-SNP is called PruittHealth Premier Advantage (HMO I-SNP).[13] Other nursing home companies are joining with each other to form provider-owned I-SNPs.[14]

3. Nursing facilities' interest in operating I-SNPs is financial.

I-SNPs are insurance plans, which means that SNFs that operate them are responsible for all health care costs of plan members. By operating its own I-SNP, a SNF directly receives the full Medicare payment for plan enrollees, controlling whether and how Medicare dollars are spent.

An observational analysis,[15] comparing 8,052 United Healthcare I-SNP members with 12,982 beneficiaries in traditional Medicare in 13 states[16] in 2014-2015, found significant differences (when differences in the demographics of the two groups of residents were adjusted) in the settings where I-SNP enrollees received care:

Care setting	**I-SNP nursing home residents**	**Traditional Medicare residents**
Inpatient hospital stays	310 per 1000 beneficiaries	500 per 1000 beneficiaries
Emergency department visits	217 per 1000 beneficiaries	441 per 1000 beneficiaries
30-day hospital readmissions	175 per 1000 beneficiaries	318 per 1000 beneficiaries
SNF utilization	514 per 1000 beneficiaries	242 per 1000 beneficiaries

[13] https://pruitthealthpremier.com/wp-content/uploads/2023/09/2024_SB_H3291_003_Eng-v2-1.pdf.
[14] Amy Stulick, "Brickyard CEO: Large Provider-Owned I-SNP for Nursing Homes Poised to Launch, Medicare Advantage Still Inflicting Pain," Skilled Nursing News (Jul. 1, 2024), https://skillednursingnews.com/2024/07/inside-brickyards-focus-on-bringing-largest-provider-owned-i-snp-to-nursing-home-residents/.
[15] Brian E. McGarry, David C. Grabowski, "Managed Care for Long-Stay Nursing Home Residents: An Evaluation of Institutional Special Needs Plans," *American Journal of Managed Care*, 2019;25(9):438-443, https://www.ajmc.com/journals/issue/2019/2019-vol25-n9/managed-care-for-long-stay-nursing-home-residents-an-evaluation-of-institutional-special-needs-plans.
[16] The states are Arizona, Colorado, Connecticut, Florida, Georgia, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Washington, and Wisconsin.

In summary, the researchers found that I-SNP enrollees' utilization of inpatient hospitals was 38% lower than beneficiaries in traditional Medicare; utilization of emergency departments, 51% lower; and 30-day hospital readmissions, 45% lower. However, use of SNF care was 112% higher.[17]

The analysis did not review the quality of care that I-SNP enrollees received in their SNFs and whether enrollees who should have been hospitalized based on their clinical conditions were inappropriately denied hospital care.

I-SNPs are profitable. MedPAC reported in March 2019 that I-SNPs in 2017 had average margins of 9.0% (and 14.1% in 2016), compared to MA plans' average margins of 2.7%.[18] In March 2024, MedPAC reported that in 2022, I-SNPs had margins of 4.0%, compared to 3.6% for all MA plans.[19]

The American Health Care Association, the large nursing home trade association, created a Population Health Management (PHM) Council in 2019 in order "to convene and support long LTC providers who are leading in PHM initiatives through advocacy, education, and quality improvement data."[20] AHCA describes provider-led special needs plans as "one PHM growing solution." AHCA identifies four Council Partners: AllyAlign Health, American Health Plans, Longevity Health Plan, PPHP Provider Partners Health Plans.

Comments posted on AHCA's website by companies promoting I-SNPs *stress the profits that can be made*. American Health Plans writes on AHCA's website:

> American Health Plans' provider-owned I-SNPs allow nursing home owners and operators to take control of the LTC residents and realize 100 percent of the shared savings associated with execution of the model of care.
>
> **Facility level financial returns: 100 percent shared savings.**
> For too long, the concept of risk-based reimbursement meant an upside to other providers and a downside for nursing home owners and operators. American Health Plans has changed that dynamic. Their members are your residents and 100 percent of the shared savings generated through great clinical results is paid to the nursing facilities. These are savings your facility has earned. American Health Plans ensures you keep them within the facility.
>
> **American Health Plans: control your future by controlling the Medicare premium**
> As nursing home owners themselves, American Health Partners appreciates the challenges of clinical resources and cash flow. However, their experience owning and operating Medicare Advantage Plans since the inception of the program in 2004 has allowed them to

[17] Brian E. McGarry, David C. Grabowski, "Managed Care for Long-Stay Nursing Home Residents: An Evaluation of Institutional Special Needs Plans," *American Journal of Managed Care*, 2019;25(9):438-443.
[18] Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy (Chapter 13, pages 358, 357, respectively) (Mar. 2019), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar19_medpac_ch13_sec.pdf.
[19] Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy (Chapter 12, page 392), https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC-3.pdf.
[20] AHCA, "Population Health Management (PHM)," https://www.ahcancal.org/Reimbursement/Pages/Population-Health-Management.aspx.

realize the clinical and financial power of controlling the Medicare premium for their nursing home residents. They want to partner with you to bring the clinical program and financial upside to your facilities as well.[21]

An early article in *Skilled Nursing News* described nursing homes creating and controlling I-SNPs.[22] The CEO of AllyAlign, a company listed on AHCA's website that helps providers, including SNFs, implement provider-sponsored managed care plans, described the model: "The construct is to grab the [Medicare] premium dollar directly if you're an LTC provider, and then manage in the best interests of the patient."[23]

Financial calculations are a key consideration for facilities considering starting or joining an I-SNP.[24]

4. MedPAC should seek out residents in I-SNPs and their advocates to better understand their experiences.

As Commission Member Dr. Brian Miller observed at the meeting, MedPAC needs to learn about the perspectives of beneficiaries and their advocates concerning I-SNPs. The PowerPoint and presentation were based solely on communications with I-SNPs and nursing homes. MedPAC should seek to understand

- marketing practices of I-SNPs (how does the provider inform residents of its I-SNP? What kinds of materials are provided to residents?)
- when and how often residents interact with nurse practitioners; how much care is provided by an I-SNP's nurse practitioner; whether regular facility staff provide less care to residents enrolled in I-SNPs because those residents are receiving care from the I-SNP's nurse practitioners; whether residents have a choice of nurse practitioner
- whether residents are adequately informed about the I-SNPs' provider networks and their ability to see health care professionals outside the network, as provided by 42 C.F.R. §422.116(f)(iv)(B) (see discussion of new special exceptions process for FI-SNPs from network adequacy requirements, below)
- what differences exist for residents in I-SNPs run by insurance companies, compared to I-SNPs run by nursing homes.

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[21] American Health Plans, "An Opportunity to Transform Long Term Care," https://www.ahcancal.org/Reimbursement/Documents/PHM/American%20Health%20Plans%20Overview.pdf#search=American%20Health%20Plans.

[22] Maggie Flynn, "Ally Align CEO: I-SNPs Will Form 'Permanent Pillar' in Changing Skilled Nursing World," *Skilled Nursing News* (Jan. 27, 2019), https://skillednursingnews.com/2019/01/allyalign-ceo-i-snps-will-form-permanent-pillar-in-changing-skilled-nursing-world/.

[23] *Id.*

[24] Amy Stulick, "Why the Dynamic Between Medicare Part B and I-SNPs could Affect the Nursing Home Bottom Line," *Skilled Nursing News* (Sep. 8, 2023), https://skillednursingnews.com/2023/09/why-the-dynamic-between-medicare-part-b-and-i-snps-could-affect-the-nursing-home-bottom-line/. *See Skilled Nursing News* articles discussing I-SNPs, https://skillednursingnews.com/?s=I-SNP.

A final point

In final Medicare Advantage rules published in April 2024,[25] CMS revised network adequacy rules for FI-SNPs, in response to comments from the I-SNP provider community. CMS wrote:

> The I–SNP industry has indicated through public comments and in prior correspondence to CMS that many FI–SNPs have difficulty contracting with providers outside their facilities, due to their model of care. This is because these providers know that enrollees of the I–SNP will not routinely seek care with these providers since they generally do not travel away from the facility for care.
>
> The MA organizations offering and those that are interested in offering FI–SNPs have raised questions about whether our network standards are appropriate considering the nature of the FI–SNP coverage model. The residential nature of this model creates inherent differences in patterns of care for FI–SNP enrollees as compared to the prevailing patterns of community health care delivery in other MA plan types. For example, most residents of a facility receive their care from a provider at the facility rather than traveling to a provider outside the facility whereas individuals who live at home in the community will need to travel to a provider to receive health care services. [26]

In response to industry concerns, CMS proposed, and in April 2024, made final, "a new exception for FI-SNP plans from the network evaluation requirements."[27] CMS decided "to broaden our acceptable rationales for facility-based I–SNPs when submitting a network exception under §422.116(f)."[28] Section 422.116(f)(ii)(A) and (B), (iv)(A),(B) now authorizes a new Exception request solely for FI-SNPs. FI-SNPs providing evidence that they are "unable to contract with certain specialty types" are exempted from network adequacy requirements if they provide "additional telehealth benefits."

CMS responded to the nursing home industry request for an exemption from network adequacy requirements. Whether this exemption actually ensures that residents receive the medically necessary care they need also needs to be evaluated.

Conclusion

Although residents who receive appropriate care in the nursing facility where they live may need less hospital care, more analysis is needed to determine whether residents are, in fact, receiving appropriate care in their nursing facilities. Reviewing and documenting the reduced use of hospitals is not sufficient and does not support the I-SNP model, especially when MedPAC in 2013

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[25] CMS, "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 (PACE)," 89 Fed. Reg. 30448 (Apr. 23, 2024), https://www.govinfo.gov/content/pkg/FR-2024-04-23/pdf/2024-07105.pdf.

[26] Id. 89 Fed. Reg., 30673.

[27] *Id*.

[28] *Id.* 30784.

documented higher drug use and less hospitalization than would have been anticipated (based on clinical condition) for nursing home residents in I-SNPs.

Thank you for the opportunity to submit comments. I look forward to reading the final report.

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