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Advising the Congress on Medicare issues

Institutional special-needs plans: Provision of services, network-adequacy requirements, and star ratings

Eric Rollins

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Institutional special-needs plans (I-SNPs)

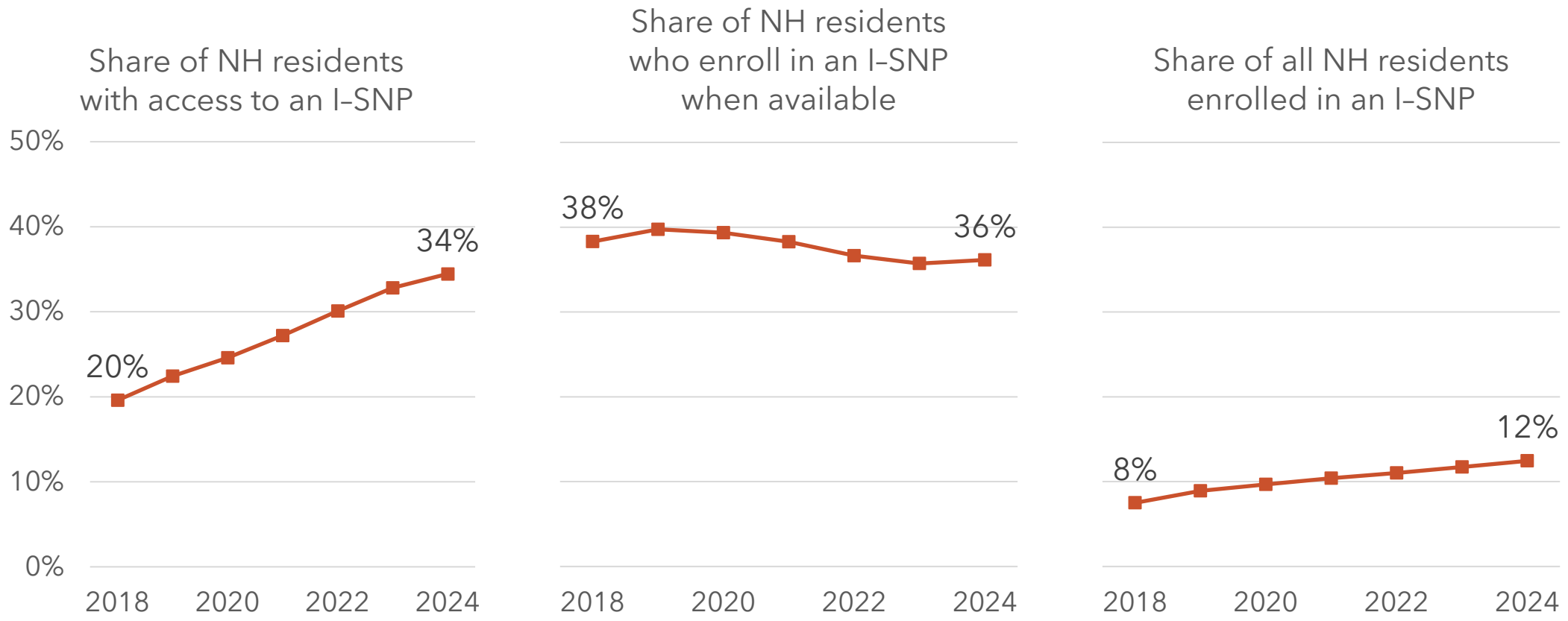
- The Commission discussed I-SNPs as part of our broader work on beneficiaries in nursing homes (NHs) that appeared in the June 2025 report
- Commissioners were generally supportive of I-SNPs and expressed interest in doing more work on them, particularly:
  - Getting more information on the I-SNP model of care
  - Identifying areas where Medicare Advantage's regulatory requirements may be a poor fit for I-SNPs

Key points from last year's work

- I–SNPs are specialized MA plans for beneficiaries who need the level of care provided in a NH:
  - Roughly 85% of enrollees live in NHs
  - Plans use nurse practitioners to deliver more care within the NH
  - NHs have incentives to provide more care onsite
  - NH residents cannot enroll unless their facility participates in a plan's network
- The I–SNP market is relatively small
  - About 129,000 enrollees (including those in the community)
  - Many insurers that offer I–SNPs are relatively small and have little or no enrollment in other types of MA plans

Note: I–SNP (institutional special-needs plan), MA (Medicare Advantage), NH (nursing home).

I–SNP penetration in nursing homes is low due to limited access and modest enrollment rates



Note: I–SNP (institutional special-needs plan), NH (nursing home).
Source: MedPAC analysis of Medicare enrollment data and NH assessment data.

Key points from last year's work (continued)

- Among participating NHs, residents who enroll in I–SNPs differ in some respects from other residents (longer lengths of stay, lower mortality rates)
- We found that NHs with I–SNPs performed better than NHs without I–SNPs on some metrics (fewer hospital discharges, readmissions, and emergency department visits)
- Outside researchers have found that I–SNPs reduce the use of inpatient care but do not have a clear effect on various other quality measures

Note: NH (nursing home), I–SNP (institutional special-needs plan).

Quantifying the role that NPs play in providing care to I–SNP enrollees

- NPs play a key role in the I–SNP model of care, but there is little information about the care they deliver
- We examined use of E&M services by long-stay residents with four different types of coverage: fee-for-service, conventional MA plan, D–SNP/MMP, and I–SNP
- One limitation of our analysis is that we did not adjust for a potential lack of completeness in encounter data

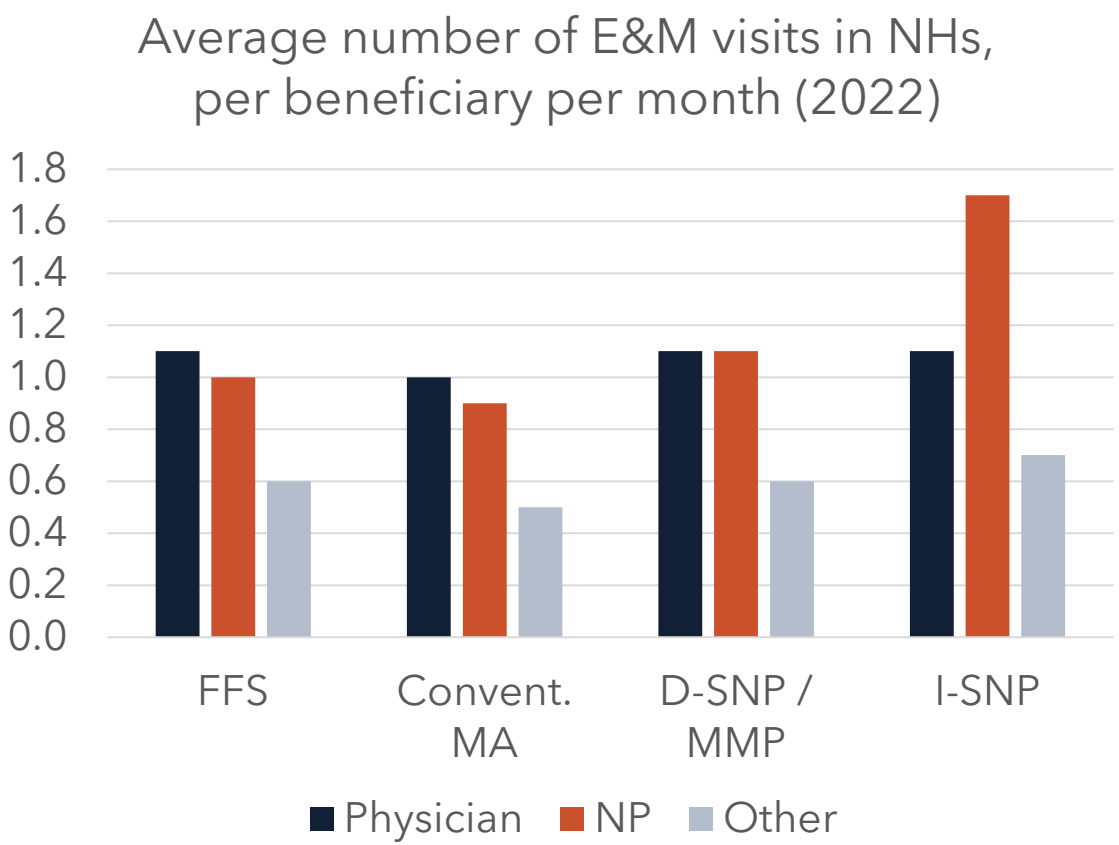
Note: NP (nurse practitioner), I–SNP (institutional special-needs plan), E&M (evaluation and management), MA (Medicare Advantage), D–SNP (dual-eligible special-needs plan), MMP (Medicare–Medicaid Plan).

Overall, long-stay NH residents had high rates of E&M service use

- Overall average of 3.9 visits per beneficiary per month in 2022
  - No difference between overall FFS and MA averages
  - Within MA, NH residents in conventional plans had fewer visits (3.6) than those in D–SNPs/MMPs (4.3) or I–SNPs (4.2)
- Across all types of coverage, residents received over 90% of their E&M care in the NH or hospital

Note: NH (nursing home), E&M (evaluation & management), FFS (fee-for-service), MA (Medicare Advantage), D–SNP (dual-eligible special-needs plan), MMP (Medicare–Medicaid Plan), I–SNP (institutional special-needs plan).

I–SNP enrollees had more E&M visits within the NH than residents enrolled in FFS or other MA plans



- I–SNP enrollees had 3.4 total visits versus 2.4 to 2.8 for residents with other types of coverage
- NPs accounted for most of the additional visits
- Our findings were directionally consistent with what we heard in interviews with I–SNP stakeholders

Note: I–SNP (institutional special-needs plan), E&M (evaluation and management), NH (nursing home), FFS (fee-for-service), MA (Medicare Advantage), D–SNP (dual-eligible special-needs plan), MMP (Medicare–Medicaid Plan), NP (nurse practitioner).

Source: MedPAC analysis of Medicare enrollment data, NH assessment data, FFS claims data, and MA encounter data.

MA's network-adequacy requirements may not be appropriate for some I–SNPs

- Requirements aim to ensure that enrollees have adequate access (minimum number of providers, time/distance standards)
- I–SNP representatives have said that the adequacy requirements:
  - Are designed for beneficiaries who live in the community
  - Have been a barrier to I–SNP expansion
- Starting in 2025, CMS made it easier for certain facility-based I–SNPs to get an exception from the requirements
  - Only ~10% of I–SNPs are potentially eligible
  - We do not yet have information on how the I–SNP exception is being used

Note: MA (Medicare Advantage), I–SNP (institutional special-needs plan), NH (nursing home).

Commissioners could consider additional options to give facility-based I–SNPs more flexibility

- Assess network adequacy at the plan level
  - Would make more plans eligible to use the new exception
- Reduce the required minimum number of providers
- Reduce the number of provider types for which I–SNPs must meet adequacy standards
- Allow I–SNPs to operate without a provider network if enrollees have appropriate protections to ensure adequate access

→ It is unclear how much these options would improve the availability of I–SNPs

Note: I–SNP (institutional special-needs plan).

The MA star ratings are a poor fit for I–SNPs

- Plans that receive a rating of 4+ stars get a quality bonus (a 5% increase in their benchmark)
  - Ratings are based on 41 quality measures and use a variety of data sources
  - Plans that are too new/small to calculate a rating get a 3.5% increase
- Ratings provide limited insight into I–SNP performance
  - I–SNPs do not conduct the CAHPS survey (on patient experience) or the HOS (survey of changes in physical/mental functioning)
  - Most HEDIS measures used in the ratings (9 of 14) exclude I–SNP enrollees over age 65

Note: MA (Medicare Advantage), I–SNP (institutional special-needs plan), CAHPS (Consumer Assessment of Healthcare Providers and Systems), HOS (Health Outcomes Survey), HEDIS (Healthcare Effectiveness Data and Information Set).

Despite the limitations of the star ratings, most I–SNPs still receive a quality bonus

- This year, 84% of I–SNP enrollees are in plans that received some type of quality bonus
  - Higher than conventional plans (69%) and D–SNPs (58%)
  - However, I–SNPs (particularly provider-sponsored I–SNPs) are much more likely to receive the automatic 3.5% bonus for new/small plans than other types of plans
- Overall, the star ratings do not appear to pose a major financial disadvantage for I–SNPs but are nonetheless a poor fit in terms of promoting better quality

Note: I–SNP (institutional special-needs plan), D–SNP (dual-eligible special-needs plan).

Commissioners could consider various options to improve quality incentives for I–SNPs

- Revise current methodology
  - Determine ratings at plan level; modify which measures are used
- Explore the use of separate star ratings for I–SNPs:
  - Could provide an opportunity to use more patient-experience measures and/or measures based on NH assessment data
  - Could generate confusion for beneficiaries
  - Calculating ratings for small plans would still be a challenge
- Potential impact of separate ratings on I–SNP availability and quality is difficult to assess

Note: I–SNP (institutional special-needs plan), NH (nursing home).

Discussion

- Questions about today's presentation
- Potential additional analyses related to I–SNPs

- We do not plan to publish this material in our June 2026 report; if there is commissioner interest, we could conduct additional work on I–SNPs in the next meeting cycle and include a chapter on them in our June 2027 report

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