Medicare Advantage: I-SNPs

THE BETTER WAY

REAFFIRMING THE PROMISE OF MEDICARE ADVANTAGE FOR NURSING HOME CARE: INSTITUTIONAL SPECIAL NEEDS PLAN NETWORK ADEQUACY

As more seniors age into Medicare eligibility, the growth of Medicare Advantage plans continues to rise. These plans offer many perks that appeal to seniors, which is contributing to their skyrocketing popularity: in 2007, just 19 percent of Medicare-eligible seniors were enrolled in MA plans, but by 2025, more than half (54 percent) of eligible seniors opted for MA over traditional Medicare.

Institutional Special Needs Plan (I-SNPs) are a type of Medicare Advantage Special Needs Plan designed for individuals who require an institutional-level care (community-based) or who live or are expected to live in a long term care facility for at least 90 consecutive days. These plans focus on beneficiaries with complex health needs, ensuring they receive highly coordinated, personalized care.

Personalized Bedside Care

What makes I-SNPs valuable is their unique model of care; they align financial and clinical incentives to improve health outcomes. Beneficiaries benefit from dedicated, on-site primary care teams who proactively manage chronic conditions, reduce avoidable hospitalizations, and enhance quality of life. Unlike models that rely on AI-driven or third-party decision-making, provider-led I-SNPs deliver true bedside care, where clinical decisions are made by the care team who knows the resident best. This approach delivers care where the patient lives, fostering integrated care, continuity, convenience, and better overall health.

Highly Localized Care Networks

AHCA/NCAL has long advocated for updating network adequacy standards for I-SNPs, recognizing their distinct patterns of care compared to larger MA plans. Currently, I-SNPs, including small, provider-led plans, are held to the same blanket requirements as traditional MA plans, which serve diverse and geographically dispersed populations.

By design, provider-led I-SNPs are highly localized. Beneficiaries reside in long-term care facilities or assisted living, where 85 percent of care is delivered onsite, and when travel is needed, the average distance is approximately 15 miles. Despite this data, campus-based SNPs are still must meet the same network adequacy standards as large, generalized MA plans, creating a significant disadvantage especially for smaller, localized provider-led I-SNPs.

Medicare Advantage: I-SNPs

THE BETTER WAY

Smaller, locally committed provider-led I-SNPs often lack the negotiating power of large insurers to secure external provider contracts. Physician offices may be reluctant to contract with plans for patients they rarely, if ever, see. In urban areas dominated by consolidated health systems and rural areas with limited provider options, LTC provider-led I-SNPs face significant barriers—even when offering above-Medicare rates.

As a result, when these plans cannot meet misaligned network adequacy standards, they are precluded from offering coverage. This means beneficiaries do not have access to a care model specifically designed for their needs—unlike traditional MA plans built for a broader community population.

THE BETTER WAY

AHCA/NCAL recommends that campus-based SNPs be treated as a distinct regulatory category for network adequacy, with simplified pathways that reflect their integrated, facility-based care model. I-SNP network adequacy standards should be tailored to the care needs of its specific beneficiary group rather than the broader Medicare population. To maintain flexibility while protecting beneficiary access, AHCA/NCAL supports allowing telehealth to satisfy requirements for low-utilization specialties and implementing hold-harmless provisions for beneficiaries who receive care from out-of-network providers. These data-driven changes would strengthen the viability of locally committed, provider-led I-SNPs, increase choice and competition, and expand access to high-quality, coordinated care for eligible seniors.

Sources:

- 42 CFR § 422.116 which are updated annually in the Health Services Delivery (HSD) Reference File.
- AHCA analysis of AHCA member plan claims, 2019-2021