Destiny in hand

Provider-owned Institutional Special Needs Plans (I-SNPs) are one of the newest waves in long-term care. Designed to take control of insurance funding for a special class of residents, I-SNPs have soared from just three a few years ago to 22 or more today. Earlier this year, the American Health Care Association formed a special council to promote their creation, growth and related lobbying efforts. As one of the approach's pioneers, Marquis Companies CFO Steve Fogg recently spoke with *McKnight's* Editor James M. Berklan about how his company's I-SNP, Age Right Advantage, came to fruition, its challenges and what others can expect if they explore a similar route.

Photos: Gary Tetz

Q: How did Marquis get started with its I-SNP?

A: We went live with an active plan January 1, 2017, but our journey began about 18 months prior. We wanted to significantly improve clinical services in our facilities. By having the I-SNP, that provided some of the funding to help pay for the people to make that happen. Being in control of the healthcare dollar and having control of your own destiny are absolutely two of the reasons to do this.

Without having the I-SNP and having "long-term livers" in our facility as part of it, we wouldn't get the funds to help pay for all the things or physicians we wanted.

All of the moves to value-based pay, whether through Medicare or managed care, have led us to upgrade clinical services and drive better outcomes, as well as overall resident experiences.

We also saw that having this I-SNP and providing these services to our long-term living population were potentially the best things we could do to maintain or improve our long-term liver occupancy rate. The I-SNP and the clinical services that come with it are important in terms of the supply-and-demand equation.

Q: How has this changed clinical offerings?

A: The percentage of nurse practitioners physically in a facility was fairly minimal to

nothing. Generally, we had medical director relationships, which by regulation have responsibility, but maybe meant they were in once or twice a month.

Now, we employ about 15 physicians and nurse practitioners, and they're actually in our facilities, for our long-term livers who are in the I-SNP, but they're also providing services to our short-term residents.

The biggest change is they're there, visible and seeing residents on an everyday basis. It upgrades the experience and minimizes return hospital visits.

It's a huge transition. Having that level of professional in the building has been phenomenally helpful in terms of the outcomes we reach in all Quality Measures, as well as our readmission rates.

Q: How big is this operation?

A: The I-SNP serves about 30 buildings. [We have] about 15 buildings within 40 miles of each other, all in the Portland [Oregon] area. So we have huge efficiencies and economies with them so close. CMS approves these by county; we're in five.

We also serve one non-Marquis provider, so there are additional facilities. We're definitely looking to long-term growth offering services to non-Marquis facilities.

Currently, there are just fewer than 500 members in the I-SNP plan. Any resident who meets the definition of needing 90 days or longer of skilled nursing service is eligible. We're also marketing it in our assisted living facilities. They're eligible in our state.

Residents don't have to enroll in our I-SNP. It becomes their decision once they're eligible.

Q: How do residents react?

A: Generally speaking, many of the residents and their families are very excited about our plan because they gain access to our nurse practitioners and physicians.

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We have about a 65% penetration rate for potential residents who could be members. If they have a long-existing relationship with their own doctor, they might not be interested in our network. Or, very infrequently, there will be spouses with different coverage and they don't want to split.

I should note that the other clinicians in our buildings — like the RNs and LPNs — all provide their same coverage as usual.

Q: What's most difficult about running an I-SNP?

A: Managing the clinical services, whether starting or recruiting them, is extremely challenging. Just like with nurses, there's a shortage of nurse practitioners, and many physicians haven't necessarily migrated to geriatrics.

We were deeply fortunate because we have pretty active I-SNPs in our market. Not provider-owned, but we had a nurse practitioner workforce we were able to leverage and have come work with us.

We're finding it a little easier to get physicians right now. It feels like a consistent theme: They're getting burned out in the clinical environment and they're attracted to this concept of providing skills in an aging facility. They see it as something new and exciting.

Q: How do you frame the start-up stage?

A: Most of us have underestimated the immense time and effort to deal with the regulatory matters, application filings and building out the network.

Also, it's important to know that there should be little expectation of financial return. It doesn't matter if you're for-profit or nonprofit. The economics can be challenging. Looking at the I-SNP on its own, you're not going to see huge returns.

We've done it because it provides value to our facility operators by driving better outcomes. That leads to being better on the value-based pay piece.

Q: How do the administrative tasks get covered?

A: Our equity partner is Ally Align. They're off-site but provide all the day-to-day operations, processes and systems for the insurance plan. They do it for other provider-owned plans across the country as well. Things like the member enrollment process and claims processing system. They also manage all the regulatory filings to CMS.

Q: Any other keys?

A: Know that starting and implementing an I-SNP is not just another program that goes into a facility. It's a huge culture change. It requires support from leadership, and understanding what it takes to be successful.

If an organization doesn't thrive in that arena and just considers it another program, it's not going to be successful in terms of enrollment, penetration rate or managing economics of the plan.

Q: What's the outlook?

A: I'm very bullish on these, for the right providers. You need dense market penetration, a history of providing good quality care, and good quality outcomes. Density means facilities in proximity but also in size. You really need a minimum of about 500 members for economies of scale for this to work. That kind of precludes a two- or three-facility plan, though there are examples of unrelated providers who have come together to start their own I-SNP. ■