Nursing Home Surprise: Advantage Plans May Shorten Stays to Less Time Than Medicare Covers

By **Susan Jaffe** OCTOBER 4, 2022
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After 11 days in a St. Paul, Minnesota, skilled nursing facility recuperating from a fall, Paula Christopherson, 97, was told by her insurer that she should return home.

But instead of being relieved, Christopherson and her daughter were worried because her medical team said she wasn't well enough to leave.

"This seems unethical," said daughter Amy Loomis, who feared what would happen if the Medicare Advantage plan, run by UnitedHealthcare, ended coverage for her mother's nursing home care. The facility gave Christopherson a choice: pay several thousand dollars to stay, appeal the company's decision, or go home.

Health care providers, nursing home representatives, and advocates for residents say Medicare Advantage plans are increasingly ending members' coverage for nursing home and rehabilitation services before patients are healthy enough to go home.

Half of the nearly 65 million people with Medicare are enrolled in the private health plans called Medicare Advantage, an alternative to the traditional government program. The plans must cover — at a minimum — the same benefits as traditional Medicare, including up to 100 days of skilled nursing home care every year.

But the private plans have leeway when deciding how much nursing home care a patient needs.

"In traditional Medicare, the medical professionals at the facility decide when someone is safe to go home," said Eric Krupa, an attorney at the Center for Medicare Advocacy, a nonprofit law group that advises beneficiaries. "In Medicare Advantage, the plan decides."

Mairead Painter, a vice president of the National Association of State Long-Term Care Ombudsman Programs who directs Connecticut's office, said, "People are going to the nursing home, and then very quickly getting a denial, and then told to appeal, which adds to their stress when they're already trying to recuperate."

The federal government pays Medicare Advantage plans a monthly amount for each enrollee, regardless of how much care that person needs. This raises "the potential incentive for insurers to deny access to services and payment in an attempt to increase profits," according to an April analysis by the Department of Health and Human Services' inspector general. Investigators found that nursing home coverage was among the most frequently denied services by the private plans and often would have been covered under traditional Medicare.

The federal Centers for Medicare & Medicaid Services recently signaled its interest in cracking down on unwarranted denials of members' coverage. In August, it asked for public feedback on how to prevent Advantage plans from limiting "access to medically necessary care."

The limits on nursing home coverage come after several decades of efforts by insurers to reduce hospitalizations, initiatives designed to help drive down costs and reduce the risk of infections.

Charlene Harrington, a professor emerita at the University of California-San Francisco's School of Nursing and an expert on nursing home reimbursement and regulation, said nursing homes have an incentive to extend residents' stays. "Length of stay and occupancy are the main predictor of profitability, so they want to keep people as long as possible," she said. Many facilities still have empty beds, a lingering effect of the covid-19 pandemic.

When to leave a nursing home "is a complicated decision because you have two groups that have reverse incentives," she said. "People are probably better off at home," she said, if they are healthy enough and have family members or other sources of support and secure housing. "The resident ought to have some say about it."

Jill Sumner, a vice president for the American Health Care Association, which represents nursing homes, said her group has "significant concerns" about large Advantage plans cutting off coverage. "The health plan can determine how long someone is in a nursing home typically without laying eyes on the person," she said.

The problem has become "more widespread and more frequent," said Dr. Rajeev Kumar, vice president of the Society for Post-Acute and Long-Term Care Medicine, which represents long-term care practitioners. "It's not just one plan," he said. "It's pretty much all of them."

As Medicare Advantage enrollment has spiked in recent years, Kumar said, disagreements between insurers and nursing home medical teams have increased. In addition, he said, insurers have hired companies, such as Tennessee-based naviHealth, that use data about other patients to help predict how much care an individual needs in a skilled nursing facility based on her health condition. Those calculations can conflict with what medical teams recommend, he said.

UnitedHealthcare, which is the largest provider of Medicare Advantage plans, bought naviHealth in 2020.

Sumner said nursing homes are feeling the impact. "Since the advent of these companies, we've seen shorter lengths of stays," she said.

In a recent news release, naviHealth said its "predictive technology" helps patients "enjoy more days at home, and health care providers and health plans can significantly reduce costs."

UnitedHealthcare spokesperson Heather Soule would not explain why the company limited coverage for the members mentioned in this article. But, in a statement, she said such decisions are based on Medicare's criteria for medically necessary care and involve a review of members' medical records and clinical conditions. If members disagree, she said, they can appeal.

When the patient no longer meets the criteria for coverage in a skilled nursing facility, "that does not mean the member no longer requires care," Soule said. "That is why our care coordinators proactively engage with members, caregivers, and providers to help guide them through an individualized care plan focused on the member's unique needs."

She noted that many Advantage plan members prefer receiving care at home. But some members and their advocates say that option is not

always practical or safe.

Patricia Maynard, 80, a retired Connecticut school cafeteria employee, was in a nursing home recovering from a hip replacement in December when her UnitedHealthcare Medicare Advantage plan notified her it was ending coverage. Her doctors disagreed with the decision.

"If I stayed, I would have to pay," Maynard said. "Or I could go home and not worry about a bill." Without insurance, the average daily cost of a semiprivate room at her nursing home was $415, according to a 2020 state survey of facility charges. But going home was also impractical: "I couldn't walk because of the pain," she said.

Maynard appealed, and the company reversed its decision. But a few days later, she received another notice saying the plan had decided to stop payment, again over the objections of her medical team.

The cycle continued 10 more times, Krupa said.

Maynard's repeated appeals are part of the usual Medicare Advantage appeals process, said Beth Lynk, a CMS spokesperson, in a statement.

When a request to the Advantage plan is not successful, members can appeal to an independent "quality improvement organization," or QIO, that handles Medicare complaints, Lynk said. "If an enrollee receives a favorable decision from the QIO, the plan is required to continue to pay for the nursing home stay until the plan or facility decides the member or patient no longer needs it," she explained. Residents who disagree can file another appeal.

CMS could not provide data on how many beneficiaries had their nursing home care cut off by their Advantage plans or on how many succeeded in getting the decision reversed.

While recuperating from a fall, Paula Christopherson was told by her Medicare Advantage plan that she should leave the skilled nursing facility and return home even though her medical team said she wasn't well enough to leave. Amy Loomis (left), her daughter, says the plan's decision to no longer cover the nursing home stay "mystified" the family.
(CHARLES CHRISTOPHERSON)

To make fighting the denials easier, the Center for Medicare Advocacy created a form to help Medicare Advantage members file a grievance with their plan.

When UnitedHealthcare decided it wouldn't pay for an additional five days in the nursing home for Christopherson, she stayed at the facility and appealed. When she returned to her apartment, the facility billed her nearly $2,500 for that period.

After Christopherson made repeated appeals, UnitedHealthcare reversed its decision and paid for her entire stay.

Loomis said her family remains "mystified" by her mother's ordeal.

"How can the insurance company deny coverage recommended by her medical care team?" Loomis asked. "They're the experts, and they deal with people like my mother every day."

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