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Medicare Advantage Control of Postacute Costs:Perspectives From Stakeholders

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Abstract

OBJECTIVES: Medicare Advantage (MA) plans have strong incentives to control costs, including postacute spending; however, to our knowledge, no research has examined the methods that MA plans use to control or reduce postacute costs. This study aimed to understand such MA plan efforts and the possible unintended consequences.

STUDY DESIGN: A multiple case study method was used.

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METHODS: We conducted 154 interviews with administrative and clinical staff working in 10 MA plans, 16 hospitals, and 25 skilled nursing facilities (SNFs) in 8 geographically diverse markets across the United States.

RESULTS: Participants discussed how MA plans attempted to reduce postacute care spending by controlling the SNF to which patients are discharged and SNF length of stay (LOS). Plans typically influenced SNF selection by providing patients with a list of facilities in which their care would be covered. To influence LOS, MA plans most commonly authorized patient stays in SNFs for a certain number of days and required that SNFs adhere to this limitation, but they did not provide guidance or assistance in ensuring that the LOS goals were met. Hospital and SNF responses to the largely authorization-based system were frequently negative, and participants expressed concerns about potential unintended consequences.

CONCLUSIONS: In their interactions with hospitals and SNFs, MA plans attempted to influence the choice of SNF and LOS to control postacute spending. However, exerting too much influence over hospitals and SNFs, as these results seem to indicate, may have the negative consequences of delayed hospital discharge and SNFs' avoidance of burdensome plans.

Medicare Advantage (MA) offers Medicare beneficiaries the option of receiving healthcare benefits through private insurance plans rather than through traditional fee-for-service Medicare. In 2017, MA beneficiaries made up 33% of the Medicare population, and Medicare's capitated payments to MA plans comprised 30% of total Medicare spending.[1] Following hospitalizations, one-fifth of Medicare beneficiaries, both fee-for-service and MA, are discharged to skilled nursing facilities (SNFs) for postacute care (PAC).[2] The growth in SNF utilization and spending[3] has placed pressure on payers to identify effective strategies to reduce postacute spending.[4]

Because MA plans receive capitated payments in exchange for bearing the risk of providing Medicare-covered services, plans may attempt to control PAC spending by requiring prior authorization for each PAC stay and for specific length of stay (LOS) durations or by limiting the network of SNFs in which patients' care is covered.[2] Health plans employ prior authorization to determine whether they will pay for a SNF stay and, if so, the duration of the stay that will be covered. Restricting the network of SNFs may reduce administrative costs associated with working with a larger number of SNFs and preferentially direct patients to SNFs with more efficient practice patterns. Additionally, because MA patients can go directly to a SNF without an acute stay, plans may be further motivated to narrow their SNF networks. These cost-containment strategies are unavailable in traditional Medicare because the program does not selectively contract with providers and does not use prior authorization for SNF care beyond requiring a 3-day qualifying hospital stay.

Prior research comparing PAC in traditional Medicare versus MA has reported that MA patients use less PAC, have a shorter LOS, experi-ence fewer readmissions, and are more likely to be discharged to the community.[5] However, MA patients are more likely to receive care in low-quality SNFs and have high rates of switching to traditional Medicare following a SNF stay.[6,7] Of note, there is little empirical study of the specific strategies that MA plans use to reduce PAC spending and manage/coordinate care for their enrollees. This lack of prior research raises a critical gap for 3 reasons. First, there is a pressing need to identify

effective approaches, including those used by MA, to improve the value of PAC.[8] Second, federal policy has stimulated enrollment in MA under the theory that capitated payments to private plans will improve quality and lower costs, but the specific strategies that these plans use to achieve these objectives are unknown. Third, MA strategies to reduce the use of PAC may have adverse unintended consequences, and PAC providers that contract with MA plans and serve MA patients may be well positioned to identify and report these consequences.

The present study aimed to explore these mechanisms and potential consequences and sought to describe perceptions from plans, hospitals, and SNFs. Whereas quantitative analysis of secondary data may shed light on patient outcomes, LOS, or other utilization trends, these data are often out-of-date and do not give information on actual mechanisms at work. This study required a qualitative approach, as such data can help uncover and examine these dynamics in detail and lead to the development of further hypotheses that can be tested in future quantitative work.

METHODS

Design and Sample

We conducted a qualitative study of 154 participants from 10 MA plans, 16 hospitals, and 25 SNFs in 8 markets across the country. We selected markets that varied based on region of the country, county size, MA penetration rates, and the absence or presence of accountable care organizations. For further information on market selection, see McHugh et al.[9]

Procedures

We first recruited the 1 or 2 largest MA plans in each of the 8 markets, then recruited from each of those markets 1 hospital with a low readmission rate and 1 with a higher rate. Using Medicare claims data, we then selected at least 3 SNFs to which the 2 hospitals discharged patients. During in-person facility visits, we conducted 154 interviews, representing 10 MA plans, 16 hospitals, and 25 SNFs. We interviewed the chief medical officer (CMO) and a care manager for each MA plan; the vice president of strategy, the CMO, a discharge planner, and a hospitalist in each hospital; and the administrator, director of nursing, and admissions coordinator, among other staff, for each SNF. These interviews were designed, in part, to understand relationships among MA plans, hospitals, and SNFs. Participants were asked about hospital discharge planning, SNF placement and LOS, and the role that different actors, including MA plans, play in placement and LOS decisions. Sample questions from different interview participant roles are included in Table 1. These interviews took place in participants' offices or, in the case of many of the MA plan interviews, on the phone, and they lasted approximately 40 minutes each. All interviews were audio recorded and transcribed for analysis.

Analysis

Interviews were qualitatively analyzed to identify overarching themes and patterns of responses.[10–13] First, we developed a preliminary coding scheme based on the questions included in our interview protocols. We then adjusted the scheme in an iterative fashion to add codes and refine code definitions; additional codes were added depending on the

material that emerged from the interviews. The scheme was then applied to each transcript and analyzed by members of the research team. For detailed information regarding data analysis, see Tyler et al.[14]

During analysis, an audit trail was kept to record ongoing team decisions, including selection and definitions of codes and discussion of emerging themes and competing interpretations.[11,15–18] Coded data were entered into the qualitative software package NVivo (QSR International Pty Ltd; Melbourne, Australia) for data management. The research protocol and associated materials were approved by Brown University's institutional review board, and informed consent was obtained from all participants.

RESULTS

Qualitative analysis yielded several themes. Participants discussed relationships among MA plans, hospitals, and SNFs, including the ways that these 3 types of organizations typically interact. MA plans described efforts to influence PAC costs by directing patients to specific SNFs and limiting SNF LOS, whereas hospital and SNF participants discussed their perspectives about these aspects of the interorganizational relationships. Somewhat unexpectedly, MA plans did not report attempting to influence the initial posthospital discharge setting (eg, SNF, independent rehabilitation facility, home healthcare, home without PAC), nor did hospital or SNF interview participants describe MA plan staff trying to influence the type of postacute setting.

MA Plans Reduce PAC Costs by Influencing SNF Selection and LOS

MA plan participants discussed 2 methods for reducing PAC costs: controlling the SNF to which MA patients are discharged following hospitalization and limiting the LOS in the SNF. A CMO at one plan in the Northeast described this focus on the appropriate discharge destination: "We're, as a plan, very highly focused on right care, right place, right reason" (site 6, plan 1, interview 1). A chief operating officer at a Southern MA plan seconded this: "We wanna make sure that that member always has the right level of service. And that's one of the things that we do push very hard to our staff, is we gotta make sure the member gets the right service at the right time" (site 7, plan 2, interview 1).

Of note, this focus on the right care at the right time was limited to helping hospitals and patients select a facility once the discharge setting had already been determined and then limiting LOS once the patient was in that facility. MA plan interview participants did not describe involvement in determining the posthospital discharge setting. Those participants instead reported that hospitals were responsible for deciding the site of PAC, and the MA plans would then authorize the hospitals' decisions based on patients' clinical requirements. Then, once the SNF was selected as the discharge setting, MA plans were involved in choosing which specific SNF. A CMO at a plan in the Midwest described the overall cost of PAC and highlighted the need to balance patient and plan priorities:

> *[PAC] is a huge cost growth area for our plan and for the enterprise as a whole. I mean, the challenges are the expense line, also the nature of PAC and a lack of energy on the part of the PAC providers to move along or expedite the progression*

of the clinical course for our members that are patients...so it requires constant scrutiny, um, advocacy for the member, and also advocacy for us as a payer.… [SNFs] have no incentive to, in fact a negative incentive, to discharge our members (site 4, plan 1, interview 1).

MA Plan Influence of SNF Selection

As illustrated in Table 2, MA plan interview participants discussed their efforts to influence the SNF to which their beneficiaries would be discharged following hospitalizations. These efforts were frequently authorization based and limited to providing beneficiaries with a list of SNFs in which care would be covered. Participants reported that patients were encouraged to select from a network of approved SNFs and would frequently be responsible for costs if they did not. Hospital participants described this authorization-based system of MA plan involvement in SNF decision making as a potential barrier to timely care, frequently reporting a delay in the placement of MA patients. This delay may complicate relationships between hospitals and SNFs; because it is relatively easier to place traditional Medicare beneficiaries than MA beneficiaries, SNFs may be less willing to take MA patients. (See Table 2 for example quotes.)

A few MA plans were reported to use a more hands-on approach that included sharing of staff and active involvement in discharge planning in the hospital. This took the form of care managers who worked with (1) hospital staff to provide the range of covered options and (2) patients and their families to provide further information about these options, as needed. Although MA plans described these efforts as collaborative, hospital interview participants did not tend to differentiate between these efforts and those that were strictly authorization based. Hospital participants indicated that MA plans were not particularly involved in the SNF selection process. They also stated that any MA involvement causes delays in SNF placement. (See Table 2 for example quotes.)

MA Plan Influence of SNF LOS

As illustrated in Table 3, to influence LOS, interview participants expressed that most frequently, MA plans authorized patient stays in SNFs for a certain number of days and required that SNFs adhere to this limitation. However, the MA plans did not provide guidance or assistance in ensuring that the LOS goals were met. SNF responses to this authorization-based system were frequently negative, and participants described MA plans as “dictat[ing]” the LOS, that they felt they were “working against managed care,” and that working with MA plans was “not worth it.” SNF participants also expressed that MA plans were especially difficult to deal with when it came to balancing restrictive authorization requirements with relatively low reimbursement. Specific areas of frustration that SNF participants discussed included low reimbursement and a burdensome process of appealing for longer LOS. One participant also described that SNFs sometimes stop taking beneficiaries from plans that are deemed “high maintenance.” (See Table 3 for example quotes.)

A few participants reported that MA plans took a more collaborative approach when it came to controlling SNF LOS. Some plans placed their own staff in SNFs to assist with the

paperwork required to determine LOS. Other plans engaged directly with patients and family members in an effort to control LOS. SNF interview participants described nuanced responses to this more engaged MA approach: Such participants described the added value of working with MA plans despite the burden of additional paperwork required through contracting with MA plans. These participants also described the benefit of building relationships with MA plan staff—having connections with MA staff made the contracting and authorization process smoother and made plans more amenable to appeals for longer LOS. (See Table 3 for example quotes.)

DISCUSSION

Interview participants from MA plans noted that the plans were interested in reducing postacute spending by ensuring that patients received the right care at the right time by influencing SNF selection and LOS. Plans typically influenced SNF selection by providing patients with a list of facilities in which their care would be covered. Sometimes, however, MA plans were more engaged in the process, working with hospital staff to place their beneficiaries. Hospital participants tended to describe MA plan involvement in SNF decision making as a challenge because any form of MA plan involvement seemed to be associated with a delay in placement of MA patients. To reduce LOS, MA plans most commonly authorized and capped the number of days they would pay for their patients to receive care in SNFs, and SNFs then had to ensure that these caps were not surpassed. Less commonly, MA plans were reported to take a more hands-on approach and engaged with SNFs and patients to actively reduce SNF LOS by monitoring care and improving communication among the plan, the SNF, and the patient.

Several hospital participants suggested that hospital LOS was sometimes prolonged if there were delays in identifying a SNF. Although this practice could increase total costs of care because hospital days are more expensive than SNF days, the costs of prolonged hospital stays are likely borne by hospitals rather than MA plans, under the assumption that MA plans use the same prospective payment approach used in traditional Medicare. This additional cost to hospitals that may result from working with more restrictive MA plans may place significant strain on interorganizational interactions. However, it is also important to note that hospitals have incentives to reduce LOS, perhaps unduly, under the diagnosis-related group system, so some increase in hospital LOS may be appropriate.

SNF responses to the MA plans' largely authorization-based LOS system were frequently negative, with adverse consequences related to LOS reduction including unwillingness of SNFs to take on patients from specific plans that were perceived to be too authoritative and whose practices were deemed too burdensome. SNF unwillingness to accept patients from certain plans could have serious implications. In their interactions with hospitals and SNFs, MA plans have the power to affect the type and intensity of PAC. However, exerting too much power over hospitals and SNFs, as these results seem to indicate, can influence SNFs to avoid working with certain plans. Even if SNFs continue to accept patients from these plans, these MA plan strategies may create pushback from SNFs, which could adversely affect patients.

It is possible that the SNFs that are able to turn down MA patients are those that are of higher quality and are able to attract patients with other sources of coverage. This could mean that when MA plans are behaving authoritatively, their patients might have reduced access to SNFs of higher quality. This is consistent with recent research, which found that inequities in SNF payment are promoting patient selection and advantages for some providers over others and that, compared with traditional Medicare patients, MA patients receive care in SNFs of lower quality.[5,19] Alternatively, it is important to note that although we have reported on the MA plan motivation to reduce spending and the associated SNF frustrations, SNFs have a contrary motivation. Whereas SNF participants discussed MA plans as "pushing" patients out, because SNFs get paid by the day, they have an incentive to keep patients longer even though the "extra" days are not necessarily better for patient outcomes.

Of note, this paper reported findings related to MA plan influence of SNF selection and LOS after the posthospital discharge setting had already been determined. It would be reasonable to expect that plans might attempt to influence the choice of PAC site (eg, SNF, home healthcare, home without PAC) in an attempt to reduce PAC spending. Given that SNF care is more expensive than other postacute options, it might be expected that MA plans would want to deflect patients away from SNFs by approving patients for lowerintensity settings of care. However, despite asking our diverse group of participants about strategies used to ensure appropriate use of PAC, we found no evidence of plans deflecting admissions away from SNFs or denying postacute services based on cost. Interview participants noted that hospitals and patients determined the posthospital setting, and MA plans reviewed and decided whether to authorize hospitals' choices. Participants always described this MA plan authorization process as based on clinical need. Plans did not seem to overrule hospitals' decisions about the need for SNF care and limited their influence to control of SNF selection and LOS.

Although it did not come up in these interviews, another potential implication of MA plan strategies regarding PAC spending is the additional complication of a possible lack of alignment between the SNFs that hospitals versus MA plans choose to work with. Hospitals sometimes own and frequently contract with SNFs to which they discharge patients, and it is possible that MA plans may have preferences for SNFs that are outside these contracting networks. If hospitals must then send patients outside their networks, there may be less coordination of care between the acute and postacute settings. Future research should further investigate this and other aspects of these complicated interorganizational relationships.

Limitations

Our results are not intended to be generalizable, and these plans, hospitals, and SNFs that agreed to participate may be different from others that did not participate. Nevertheless, our study included a substantial amount of data by the standards of qualitative research: Interviews with 154 staff in MA plans, hospitals, and SNFs provided insight into emerging patterns of these organizations' behaviors.

CONCLUSIONS

This paper is the first examination, to our knowledge, of MA plan methods of influencing and reducing postacute spending and presents perspectives from 3 critical types of stakeholders. In their interactions with hospitals and SNFs, MA plans attempted to influence the choice of SNF and LOS to control postacute spending. However, when plans exert what is perceived to be too much control over hospitals and SNFs, as our results seem to indicate, delays in hospital discharge and SNF avoidance of burdensome MA plans may result. SNFs' unwillingness to accept patients from specific plans may restrict access to higher-quality SNFs by patients in MA plans.

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TAKEAWAY POINTS

We examined the methods that Medicare Advantage (MA) plans use to control or reduce postacute spending, as well as their possible unintended consequences. Plans attempted to reduce spending by controlling the skilled nursing facility (SNF) to which patients are discharged and the SNF length of stay:

- Some plans used a more hands-on approach by engaging with SNFs and patients.
- Most plans used authorization processes.
- SNFs and hospitals reported negative consequences of these authorization processes, including longer hospital lengths of stay and SNF avoidance of some plans.
- These negative consequences could result in MA patients being sent to lower-quality SNFs.

TABLE 1.

Examples of Relevant Interview Protocol Questions

Participant Role	Example Questions
MA CMO	What are some challenges you face paying for PAC? • Is this an area of cost growth for your plan? • If so, what do you think are the primary cost drivers of PAC for your population? • Please tell me about the use of PAC in your beneficiary population. Is addressing the use of PAC a focus for you? What strategies do you use to ensure the appropriate use of PAC? • How do clinical characteristics and patient preferences impact the site of PAC? • What strategies do you use in terms of intensity of care (ie, discharge setting, number of days in SNF or home healthcare, therapy frequency, length of therapy sessions)? • How do you think these strategies have helped the appropriate placement of patients?
MA care manager	How do you identify plan members who may need PAC? • Are hospitals required to notify the plan when a PAC stay is anticipated? • Do members themselves alert the plan? • Do you have care managers present at all member hospitals? • Do care managers visit SNFs? What are their goals and how does that work? • How do you communicate with plan members, hospital staff, and/or PAC providers about care planning? Example case: To better understand how discharges are done in practice, I would like you to consider the following patient. *Ms Jones is a 78-year-old woman who had a fall at home, which resulted in a hip fracture. Except for some hypertension, she was relatively healthy and active, often going to the senior center. Medically, she is stable. She is being discharged for rehabilitation.* • Please walk me through how you would approach managing PAC placement for this patient. › What options would you present to the patient and family? › Please tell me about how you decide where to send this patient for PAC. › How do you approach the topic of which facility to recommend? › How would you decide how long she'd need to stay in PAC? › What other factors might alter the PAC arrangements for Ms Jones?
Hospital VP of strategy	How are decisions made about where to discharge patients needing PAC? • Please tell me about any procedures or guidelines you have regarding the discharge of patients to SNFs. • How are these guidelines communicated to discharge planners?

Participant Role	Example Questions
	• Are there any specific written policies to describe this? • How do managed care plans influence the choice of postacute provider? • Can you give me an example?
Hospital discharge planner	Example case: To better understand how discharges are done in practice, I would like you to consider the following patient. *Ms Jones is a 78-year-old woman who had a fall at home, which resulted in a hip fracture. Except for some hypertension, she was relatively healthy and active, often going to the senior center. Medically, she is stable. She is being discharged for rehabilitation.* • Can you describe whether the discharge planning process would differ if Ms Jones were enrolled in a Medicare managed care plan? › What influence does the plan have? › Are there differences in this by plan?
SNF administrator	Can you describe your contracting experience with Medicare managed care plans? Can you walk me through how Medicare managed care plans influence the use of postacute services provided to your patients? • What oversight do they provide? • Are co-payments or preauthorization involved? • Are some managed care patients admitted to SNF without a prior 3-day hospital stay? Please share any additional perspectives you may have about your relationships with Medicare managed care plans.
SNF admissions coordinator	What factors do you think influence the decision of where patients are sent for PAC? • What is the role of the case manager at the hospital? • Tell me how managed care plans might influence choice (and if this has changed). • Please tell me how patients and their families may be engaged in the selection process.
SNF director of nursing	Based on our data, we've noticed decreasing lengths of SNF stay. Potential factors in this could include changes in the market, such as increased use of managed care, new accountable care organizations, and focus on quality and costs, among other things. • What has been your facility's experience with length of stay? • What would you attribute that to? • How has changing length of stay affected the facility or how you provide care?

CMO indicates chief medical officer; MA, Medicare Advantage; PAC, postacute care; SNF, skilled nursing facility; VP, vice president.

TABLE 2.

MA Influence of SNF Selection

Theme	Participant	Quote
Authorization-based approach	Care manager, Southwest (site 1, plan 2, interview 1)	We don't get involved in discharge planning in the hospital.… We allow choice, as long as it's in network we provide a list or a selection.
	CMO, Northeast (site 6, plan 1, interview 1)	We say to them, "As per your contract, if you go out of network, then," you know depending on what their network benefit is, their responsibility is just based on the contract. If they have no out-of-network benefit then we make them aware that "this is on your dime."
Hospital response	VP of strategy, Midwest (site 4, hospital 2, interview 1)	One of the biggest impediments we have with Medicare Advantage products…these commercial insurance companies don't tend to work on weekends and the last I checked hospitals do. It's a huge impediment to patients getting access to care when they're ready to go on a Saturday morning and we can't get approval, preauthorization until Monday which often turns into Tuesday.
	VP of strategy, Southwest (site 1, hospital 1, interview 2)	So we have lately started seeing…a delay in acceptance of managed care patients…while the Medicare patients [snaps fingers] get placed like this, you know? So I think there is this expectation that we will take your managed care now if you give us Medicare.
	Discharge planner, South (site 7, hospital 1, interview 3)	It's dictating that they not be able to go because we're not able to get the authorization and so it's kind of a game right now with those Medicare Advantage plans. They're a frustrator in this process, a significant frustrator.
Engaged approach	CMO, Southeast (site 2, plan 2, interview 1)	We have an on-site presence.… From the moment they get into the hospital we are having conversations with physicians, with family, with whomever, to say, "Gosh, it looks like Mom or Dad would benefit from this service, how do you feel about that?" And then we advocate with the providers also for that to be the plan of care.
	Care manager, Northwest (site 5, plan 2, interview 2)	I call the case manager and say, "I'm from the insurance plan, my job is to help this patient discharge back to the community. How can I help you follow up on that?" And together we form a plan. And obviously going to a postacute facility is assessed and decided upon by the inpatient team, and then once it's decided that that is the plan, we work with the patients to help them understand what that means and help them decide whether that's something that they want to do. And then we work with our field nursing authorization team to help facilitate the authorization. And then the discharge planner works with the family to select a facility for discharge.
Hospital response	Discharge planner, Northwest (site 5, hospital 1, interview 3)	If they need to transition to [SNF], we always try to arrange, especially with those payers that we know have a care manager assigned, we provide [the patient] with that contact number to reach out to that care manager, should they have questions, and let them understand the limitations of their skilled care.
	Discharge planner, Midwest (site 3, hospital 1, interview 3)	If they had a case manager I'd probably be talking to the case manager, but other than that… It might change [a patient's] choices because sometimes the managed care is like, "No, we don't go here" or "We don't have a contract with here" type of thing but other than that, it's not a big change.
	VP of strategy, Northwest (site 5, hospital 2, interview 2)	I don't get the impression that the plans are really stepping in a lot, and trying to put their people on the ground, or whatever, but what does become a barrier, is, you know, say we have a [plan] person and they want to stay in the [plan] network, but [plan] network is so small they don't have a bed. Then here we are, we're all stuck, 'cause understandably the person doesn't want to go outside of network and [plan] is not paying for it, and it's the hospital who usually takes the short end of it there. So [the patient] stays.

CMO indicates chief medical officer; MA, Medicare Advantage; SNF, skilled nursing facility; VP, vice president.

TABLE 3.

MA Influence of SNF Length of Stay

Theme	Participant	Quote
Authorization-based approach	Administrator, Northeast (site 6, SNF 3, interview 1)	Managed care dictates the wow, okay, let me rephrase that, be careful, okay when we are confidential, um, they strongly suggest the discharge date based on diagnosis, and so if we think they need 3 weeks, they might only authorize 7 days at a time.
	Admissions coordinator, Southwest (site 1, SNF 2, interview 3)	Usually they have an estimated amount of time and then as we weekly, or whatever, send them all the faxes of the updates, how the patient's doing in therapy, sometimes they'll change that. They'll authorize a certain amount of time and then say they authorize 2 weeks —and then, as it gets closer to that 2-week mark, they may extend that if they feel. But it's all their decision. The managed cares [sic] decide when the patient is ready to go.
SNF response	Director of nursing, Northwest (site 5, SNF 4, interview 2)	My difficulties with managed care is [sic] they want the person out and they don't want them better.... So even if we say, like we need more time, we need another 5 days, they're pushing, pushing, pushing to get them out, because they're getting reimbursed from Medicare so they want them out as fast as possible… I kind of feel like I'm working against managed care, where [with] people that just have basic Medicare, we don't have that issue.
	Administrator, Northwest (site 5, SNF 4, interview 1)	There's a lot of up-front requirements that are honestly set up so that if we fail to meet one of those requirements, they don't have to pay. I mean essentially, it's very strict on the up front trying to get authorization and then if you're late by 1 day, they're not paying the entire stay.
	Administrator, Southwest (site 1, SNF 3, interview 4)	They're one of [the] lowest payers. So even if everything works great, quite honestly, we learned it's not profitable. But when it's only [a] 3-to-6-day length of stay, there's so much work we actually do up front between admission and everything else associated with it, and then all of a sudden, you're turning around and discharging them and then my guess is we've had 20, 25 percent of the families appeal [for a longer stay]. So then we're having to put in a lot of hours just collecting all the paperwork to address the appeals. But at some point, it just becomes, you know, it's not worth it.
	Administrator, Midwest (site 3, SNF 1, interview 3)	[Plan A] entered the market and is extremely unliked in [state] because they were auditing every single claim initially, which is ridiculous. Now they've agreed to reduce the amount of audits, but they are very challenging to work with in that they cut the people off really quickly. And we are often appealing on behalf of the patient.… So they're a very high-maintenance [plan] and some [SNFs] won't take 'em anymore because of that.
Engaged approach	Admissions coordinator, Southeast (site 2, SNF 2, interview 2)	In the [SNF] they have nurses. Each managed care hires their own. And they come in and visit with the patients and our nursing staff…I think they're here probably at least 2 to 3 times a week, you know depending on what your caseload is.
	CMO, Southwest (site 1, plan 1, interview 1)	What we do is we meet and greet patients, explain our role, which is mainly we assist the case manager in the facility.... I go over benefits with families, basically explain the plan of care and the anticipated length of stay at the facility. I'm there for any questions that my case managers might have.
SNF response	Administrator, Northwest (site 5, SNF 2, interview 1)	The contract process isn't bad, and then once we're in, we're finding obviously that they want shorter lengths of stay.… We have some that we call the same person every week to give them updates, and things happen and say somebody changes their insurance midway through their stay and they don't tell us? It's nice to have that person that we can call and trust and say here's what happened, can you help us out? And usually they can.… But it's a headache to every week send in all the paperwork and get it approved. It's just the nature of the game.
	Administrator, South (site 7, SNF 1, interview 1)	We have a managed care coordinator who actually spends most of her day talking to the managed care companies directly and she's built a really great rapport with most of them…because sometimes it's difficult to actually get a person when you're dealing with managed care companies [laughing]. You get a number, a line, but she's developed those direct contacts which makes this a lot easier to negotiate contracts and get authorizations approved as well.
	Director of nursing, Northwest (site 5, SNF 4, interview 2)	We have an HMO coordinator here. She does the updates. She kind of organizes, faxes, you know. Kind of does that communication between.… A lot of times if the family doesn't agree [with the plan's length of stay determination] or we don't agree, we can give them

Theme	Participant	Quote
		the option of an appeal. Sometimes they win, sometimes they don't. And there's with one company we usually win all the time. And then with [other plan] we don't. So they are very tight. I understand their points, but they don't take our points into consideration.

CMO indicates chief medical officer; HMO, health maintenance organization; MA, Medicare Advantage; SNF, skilled nursing facility.