MEDICARE ADVANTAGE

THE SOLUTION:

Take measures to ensure Medicare Advantage processes and practices are putting patient care first.

Medicare Advantage programs regularly overpromise and under deliver for seniors. Oftentimes, patients are surprised to learn the physicians they rely on, or procedures previously covered, are no longer part of the plan they have chosen.

CONFUSION AND FRUSTRATION FOR ALL

Over the last several years as some Kansans have switched from traditional Medicare to a variety of Medicare Advantage plans, many have come to realize the disparity between the two in the services they cover. Often, these patients do not realize they have forfeited their traditional Medicare benefits, so they present their traditional Medicare card during hospital visits. This is especially challenging for hospitals right after Medicare Advantage Open Enrollment periods.

Most traditional Medicare services do not require prior authorizations, therefore hospitals operate on the assumption that their expert decisions on levels of care will be followed. However, Medicare Advantage plans may deny an inpatient stay even after treatment is completed because no prior authorization was on file. The result of these denials is increased costs for the beneficiaries or increased uncompensated care costs. Kansas hospitals support the Centers for Medicaid and Medicare Services proposed rule for technical and policy changes related to Medicare Advantage plans to ensure equal access to care for all Medicare beneficiaries and reduce cost-shifting to vulnerable Kansans.

EXAMPLE #1

A hospital cared for a patient who suffered a stroke. The patient had a pre-existing urinary tract infection with E. coli and had developed acute metabolic encephalopathy.

The managed care plan denied any inpatient rehabilitation services. Because the hospital did not have a safe dismissal plan of care, the patient remained in the hospital for 20 days (unpaid) before being discharged home to the care of a neighbor.

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EXAMPLE #2

A patient with a persistent and severe back pain needed an MRI. There was clear evidence-based clinical documentation on the necessity of a MRI. The managed care plan would not approve the MRI until the patient tried physical therapy for six weeks thus delaying the correct diagnosis. The patient attended six weeks of physical therapy with no pain relief. A new request for an MRI was sent and 14 days later an approval was given. Nearly three months after presenting to the hospital with severe back pain, the MRI was performed and proper treatment was ordered.

A CONGRESSIONAL SOLUTION

Support policies that protect patients and align Medicare Advantage plans more closely with traditional Medicare.

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