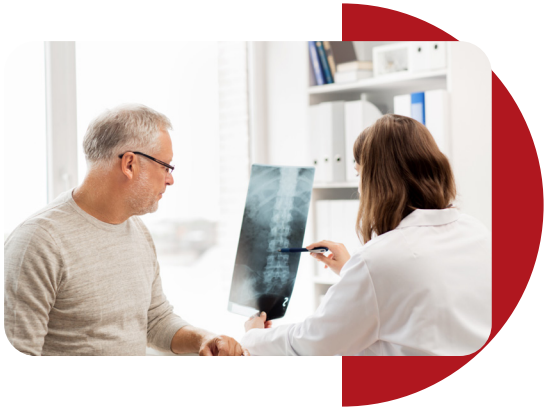
FEDERAL

MEDICARE ADVANTAGE

THE SOLUTION

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

CONFUSION, FRUSTRATION AND MYTHS



Over the last several years as some Kansans have switched from Original Medicare to a variety of Medicare Advantage plans often under assumptions that it is more affordable than Original Medicare, 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 Original Medicare benefits, so they present their Original Medicare card during hospital visits not aware that Medicare Advantage has networks that are more restrictive than Original Medicare.

Most Original Medicare services do not require prior authorizations; therefore hospitals operate on the assumption that their physicians' 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 borne by hospitals. Medicare Advantage plans may sound like a good deal, but there are often serious consequences when patients face serious illness and need comprehensive care.

Kansas hospitals support the Centers for Medicare and Medicaid Services rulemaking in recent years to strengthen oversight of Medicare Advantage plans to ensure equal access to care for all Medicare beneficiaries and reduce cost-shifting to vulnerable Kansans, but more must be done to fix the serious problems in the program.

MEDICARE ADVANTAGE PLANS EXPANDING WITHOUT OVERSIGHT

1. Oversight and enforcement of the program is very lax and there are few protections, particularly when patients are denied care or diverted to inferior sites of care.
2. Medicare Advantage plans are overpaid by CMS and can cost more than Original Medicare, while also often not reimbursing Critical Access Hospitals cost-based reimbursement that Original Medicare mandates.
3. The remedy of beneficiaries simply disenrolling from a Medicare Advantage plan and returning to Original Medicare has several hurdles that can make it prohibitive to regain Original Medicare coverage.

FEDERAL: MEDICARE ADVANTAGE CONTINUED ...

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THE SOLUTION:

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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.

EXAMPLE 2

A patient with 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 provide greater oversight of Medicare Advantage plans, protect patients and align Medicare Advantage plans more closely with Original Medicare, including:

1. Legislation like the Senior's Timely Access to Care Act to ensure unnecessary encumbrances do not keep anyone from receiving the care they need in a timely manner.
2. Pass Medicare Advantage Payer Reform for Critical Access Hospitals that would require Medicare Advantage plans to pay cost-based reimbursement.
3. Institute reforms that allows MA beneficiaries to switch back to Original Medicare without being denied Medicare supplemental coverage due to pre-existing conditions.

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