MEDICARE "ADVANTAGE" DELAY TACTICS –A GROWING CAUSE OF EMERGENCY DEPARTMENT BOARDING

Drs. Smith, Vieth, et al

https://vtdigger.org/2024/02/08/ben-smith-julie-vieth-matthew-siket-ryan-sexton-a-crisis-in-our-emergency-departments/

as well as Sydnee Boucher, RN

https://vtdigger.org/2024/02/13/letter-to-the-editor-boarding-in-the-emergency-department/

do well to alert us to the problem of ER boarding. Holding patients for hours or days in emergency departments leads to inefficiency within the emergency department, contributes to burnout of ER physicians and other staff, and delays proper treatment of patients, in a noisy and uncomfortable setting. An insufficient number of staffed rehab beds contributes to this problem as does a worsening nursing shortage. Both of these need to be addressed. But even when staff and beds are available, we are often unable to discharge patients whose acute medical issues have resolved: A growing number of Vermonters have signed their Medicare benefit to a Medicare "Advantage" company—now up to 35 – 40%. And the practices of these companies regularly delay our ability to discharge our patients to rehab facilities.

When hospitalized patients show steady improvement, the goal is to get them home as soon as possible. But after several days of hospitalization for a stroke or serious illness, many frail, elderly Vermonters are too weak and unsteady to go directly home. Generally, such individuals are identified early in the hospitalization, doctors and care management team have already spoken with patient and family about the optimal discharge destination and contacted local rehab centers. And most of the time—barring a COVID outbreak—rehab facilities are able to accept the patient

promptly: If these patients are covered through Medicaid or traditional Medicare, they are almost always transferred to rehab that day or the following day. This opens up an acute care bed for patients who have been waiting in the Emergency Department,

But the process for Medicare “Advantage” (MA) patients is different--and longer: Post-hospitalization rehab care is one of the benefits Medicare covers, and MA plans are legally obliged to fund this type of care, so long as it’s medically necessary. However, a nearly invariant part of the MA business model is to draw out the process of determining the medical necessity of rehab care. The MA plan will almost always approve rehab, but not before 3 – 4 days pass by. Our discharge planners leave voicemail message—these aren’t returned for at least 24 hours. We fax over Physical Therapy notes. These mysteriously disappear. When appropriate MA staff have been identified and are finally admitting they have all the required records, we then have to find out which rehab centers are in the MA plan’s network. Networks change frequently, so this can be problematic, especially when the patient and family prefer a rehab center that is not in the plan’s network. Once that’s settled, we enter the final phase: Approval by the MA plan’s Medical Director. Based on how difficult they are to locate, these doctors seem to work maximum 3 hour workdays and take vacations over half the time. The MA plan puts a hold on the entire process when a weekend arrives. Over the last few years, extensive documentation has come to light demonstrating that MA-induced delays and denials of care are an intentional practice of these plans. Meanwhile, patients boarded in the ER continue to wait.

Accurate studies are lacking, but in my experience, the average MA related delay is 3 - 4 days.

Though we hear that the private sector operates more efficiently than the public sector, this MA-induced bottleneck **is** anything but efficient for both the patient and

the hospital. The hospital staff has to provide physical therapy and attend to all the patient's needs. Many of these patients cannot safely get out of bed, and may not remember that in time. And if dementia is also an issue, then the patient may require a great deal of staff time. But **for** the Medicare "Advantage" plan, these delays are desirable: During those 3 -4 day delays, the MA plan is paying nothing. And if the patient becomes frustrated awaiting the transfer to rehab and decides to take a chance on going home early, all the better for the MA plan's bottom line.

This entire process entails many harms to the hospital: Patients' morale is often affected, the hospital is not being paid for care it's providing, the hospital is deprived of revenue for patients lingering in the ER who require admission, and the quality of care is compromised. But for the MA plan's management and investors, there is simply no problem at all: What may be happening at some financially struggling rural hospital thousands of miles away isn't even on their radar.

The legislature should not ignore this crisis: In addition to the policy changes Drs Smith, Vieth et al recommend, Vermont's legislature should prohibit private plans from imposing approval processes for rehab: Instead, they should require MA plans to universally approve rehab stays when the front line staff, physicians, physical therapists, etc clearly document the need. Every Medicare-approved rehab facility should be covered, without regard to the MA plan's often narrow network. And the legislature should take additional steps so that every Vermont Medicare beneficiary is aware of all the maneuvers that MA plans employ – delays, denials of payment, constricted provider networks, high copays for expensive medications, etc-- so that signing their care over to Medicare "Advantage" corporations can become a fully informed decision.

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