When Advantage is not an Advantage: Benefits and Limitations of Traditional Medicare vs Managed Medicare

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Mount Sinai

Presentation Overview

Mount Sinai

Background	Review of Medicare	Comparison MA vs TM	Comparison MA vs TM at EOL	Key Take Aways
▪ Historical timeline and enrollment	▪ Review of Medicare programs and their benefits	▪ Variances of the two programs ▪ Case studies	▪ Variances and considerations ▪ Disenrollment	▪ Patient guidance ▪ Evidence-based review of benefits and limitations

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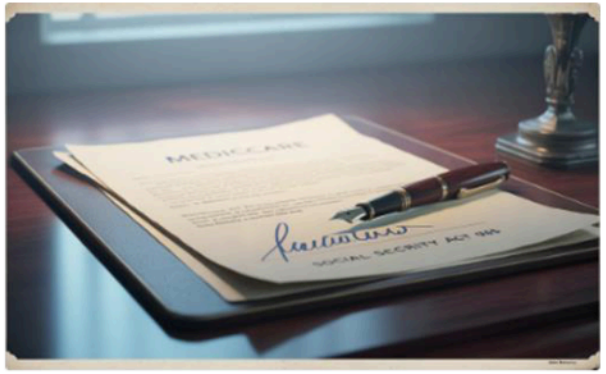
The Evolution of Medicare Advantage

Medicare Advantage, also known as Part C, allows enrollees to receive Medicare benefits through private insurance plans. This option was added in 1996, though health plans have played a role in Medicare since its inception.



1965-1972

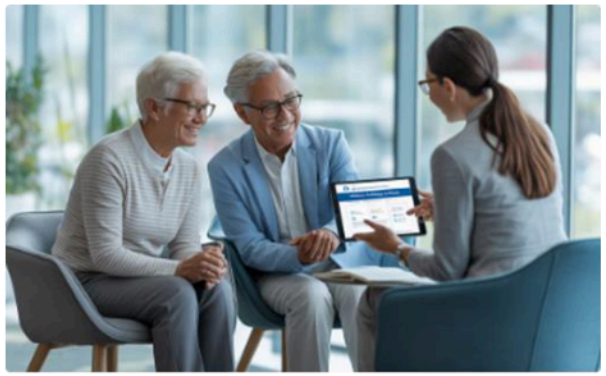
Medicare established in 1965 under the Social Security Act, creating Original Medicare Parts A and B. The 1972 Social Security Amendments authorized the first Medicare HMO contracts, allowing private insurers limited participation.

1982-1997

Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 formalized Medicare managed care with risk contracts. Balanced Budget Act of 1997 created Medicare+Choice (Part C) with expanded plan options and new payment methodology.

2003-2010

Medicare Modernization Act of 2003 renamed program to Medicare Advantage and increased plan payments by 12%, spurring enrollment growth. Affordable Care Act of 2010 implemented quality bonus payments while gradually reducing base payments to align closer with Original Medicare costs. (Medicare Rights Center, 2023)



2018-Present

Bipartisan Budget Act of 2018 expanded supplemental benefits to include non-medical services addressing social determinants of health. Medicare Advantage (MA) enrollment surpassed 48% of all Medicare beneficiaries in 2023 and 22 states reached rates of 50% or higher for MA enrollment, according to the corrected data set CMS released in March 2023 (Chartis, 2023).

Medicare Basics: What is Medicare?

Federal Health Insurance Program

Medicare is a federal health insurance program primarily for people age 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease.

Established in 1965

Created as part of the Social Security Amendments, Medicare has evolved over decades to provide comprehensive healthcare coverage for millions of Americans.

Administered by CMS

The Centers for Medicare & Medicaid Services (CMS) oversees the Medicare program, establishing regulations and payment policies.

Medicare serves as the primary health insurance coverage for over 65 million Americans. It provides essential healthcare benefits that help beneficiaries access necessary medical services while protecting them from excessive healthcare costs in retirement and during periods of disability.

Medicare Part A: Hospital Insurance

Inpatient Hospital Care

Covers semi-private rooms, meals, general nursing, and other hospital services and supplies during inpatient stays.

Subacute Rehabilitation

Provides coverage for semi-private rooms, meals, skilled nursing and rehabilitative services, and other services in a skilled nursing facility following a qualifying hospital stay.

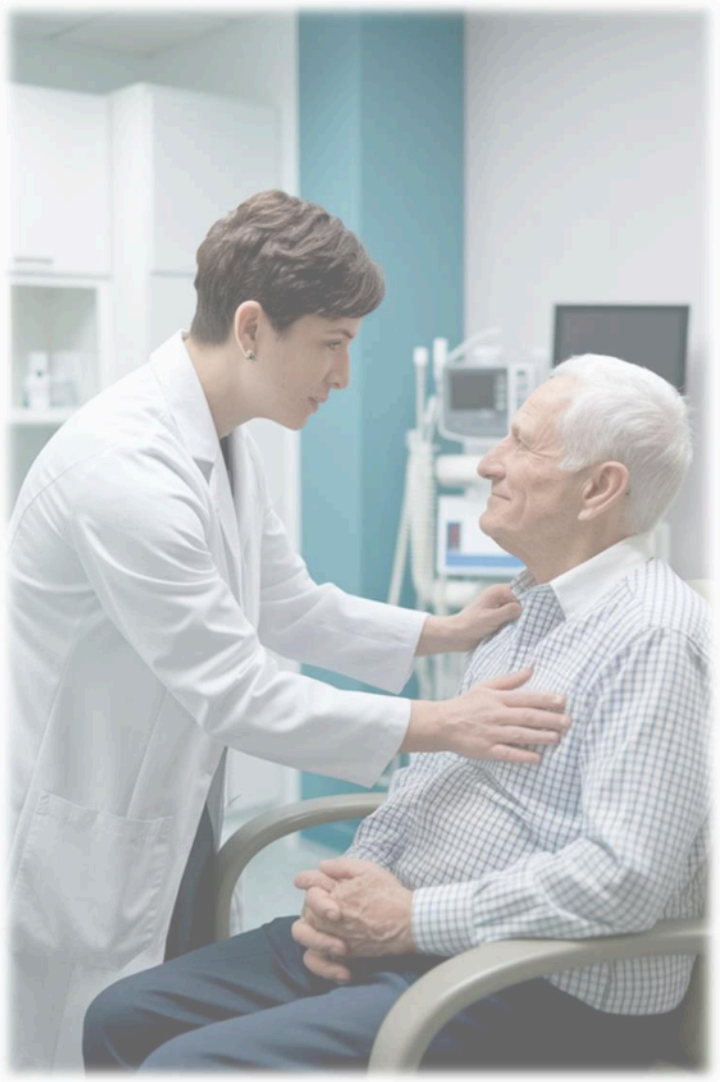
Home Health Services

Covers medically necessary part-time skilled nursing care, physical therapy, speech-language pathology, and continued occupational services at home.

Hospice Care

Provides comfort care and symptom management for terminally ill patients who choose palliative care instead of curative treatments.

Medicare Part B: Medical Insurance



Doctor Services

Covers medically necessary services from doctors and other healthcare providers, including office visits, consultations, and services received while a hospital inpatient or outpatient.

Outpatient Care

Provides coverage for outpatient care including diagnostic tests, emergency department visits, outpatient surgeries, and certain preventive services.

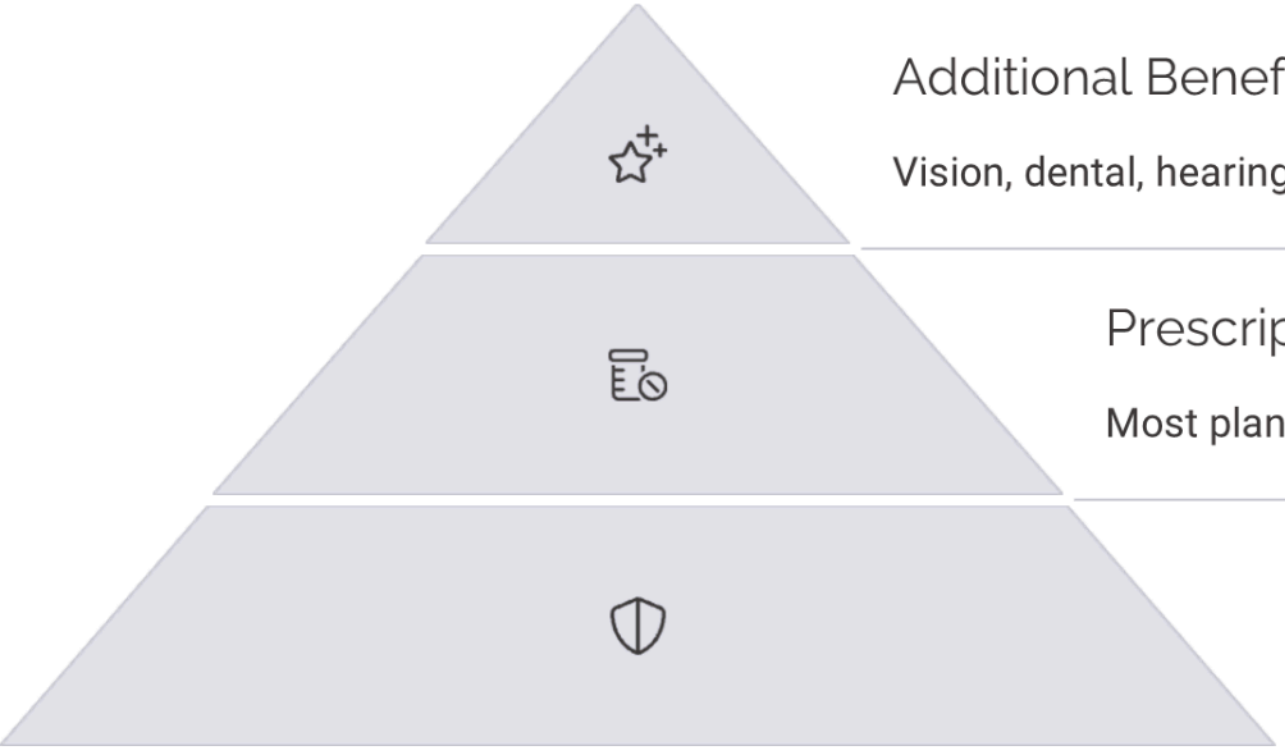
Preventive Services

Covers many preventive services at no cost, including annual wellness visits, vaccinations, cancer screenings, and other preventive care to detect and prevent illness.

Durable Medical Equipment

Covers medically necessary equipment like wheelchairs, walkers, hospital beds, and other equipment prescribed by healthcare providers for home use.

Medicare Part C: Medicare Advantage



Additional Benefits

Vision, dental, hearing, fitness programs

Prescription Drug Coverage

Most plans include Part D benefits

Parts A & B Coverage

All Original Medicare benefits

Medicare Part C, also known as Medicare Advantage, offers an alternative way to receive Medicare benefits through private insurance companies approved by Medicare. These plans must cover all services that Original Medicare covers and often include additional benefits.

Medicare Advantage plans typically operate as managed care plans (like HMOs or PPOs) with provider networks, coordination requirements, and different cost-sharing structures than Original Medicare.

Medicare Part D: Prescription Drug Coverage

Prescription Medications

Coverage for outpatient prescription drugs

Pharmacy Networks

Specific pharmacies with preferred pricing

Formularies

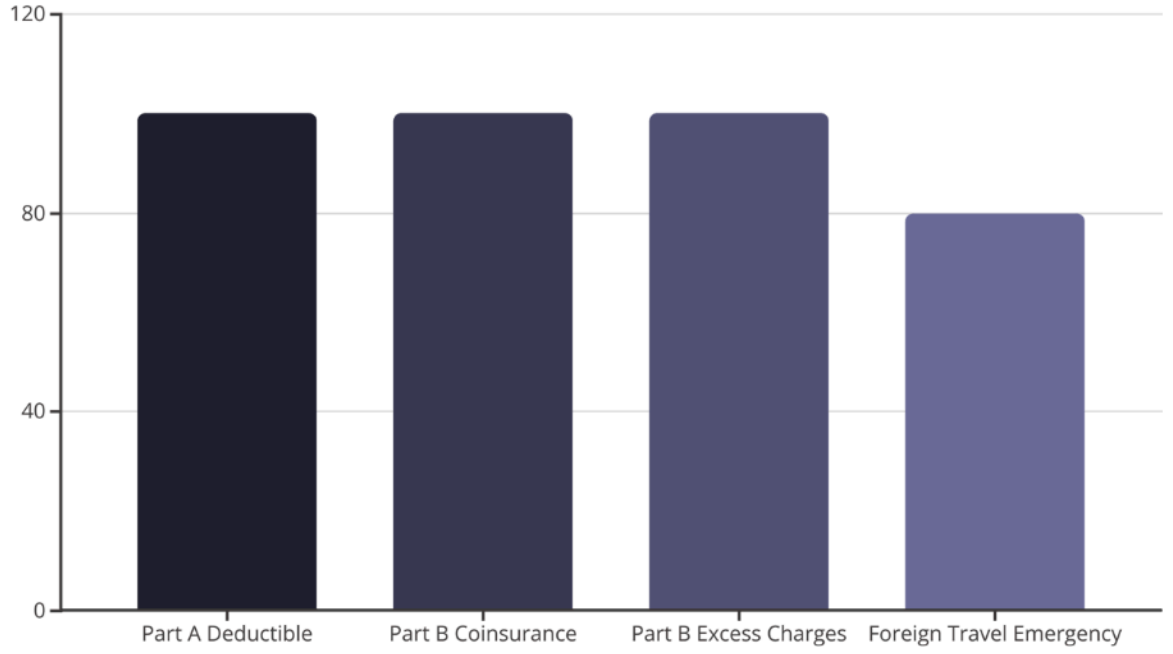
Plan-specific lists of covered medications

Tiered Copayments

Different cost levels based on drug categories

Medicare Part D provides prescription drug coverage through private insurance companies approved by Medicare. Beneficiaries can get Part D coverage either through a standalone Prescription Drug Plan (for those with Original Medicare) or as part of a Medicare Advantage plan that includes drug coverage.

Medicare Supplement Insurance (Medigap)



(KFF, 2025)

Medicare Supplement Insurance, also called Medigap, is private insurance designed to help pay some of the healthcare costs that Original Medicare doesn't cover, such as copayments, coinsurance, and deductibles. These policies are standardized and identified by letters (Plans A through N).

Medigap policies work alongside Original Medicare but cannot be used with Medicare Advantage plans. They help provide financial protection against high out-of-pocket costs but require additional monthly premiums beyond the Part B premium.

Medicare Eligibility

Age-based

65

Standard Eligibility Age

Primary age when most Americans become eligible for Medicare benefits

7

Initial Enrollment Period

Months surrounding 65th birthday (3 before, month of, 3 after)

40

Work Credits

Quarters of work typically needed for premium-free Part A

Disability-based

24 Months

Receive Social Security Disability Insurance benefits for 24 months

Medicare Eligibility

Automatically enrolled in Medicare Parts A and B

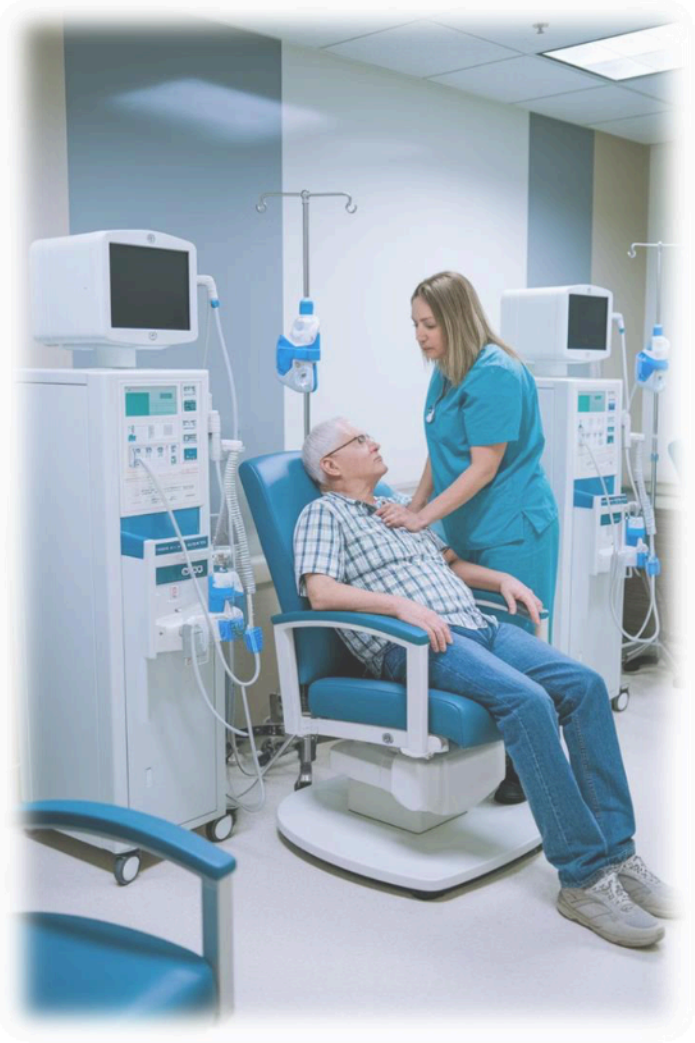
Coverage Choices

Option to keep Original Medicare or choose Medicare Advantage

Prescription Coverage

Opportunity to enroll in Part D drug coverage

Medicare Eligibility: Special Conditions



End-Stage Renal Disease (ESRD)

Individuals of any age with permanent kidney failure requiring dialysis or transplant qualify for Medicare coverage. Eligibility typically begins three months after dialysis starts or immediately following a kidney transplant.

Amyotrophic Lateral Sclerosis (ALS)

People diagnosed with ALS (Lou Gehrig's disease) automatically qualify for Medicare in the same month they begin receiving Social Security Disability benefits, with no 24-month waiting period.

Railroad Retirement Board Benefits

Individuals receiving Railroad Retirement Board benefits qualify for Medicare under similar rules as Social Security recipients, with automatic enrollment at age 65 or after disability qualification.

Medicare Enrollment Periods: Annual Election

Oct 15

Start Date

Annual Election Period begins each year

Dec 7

End Date

Final day to make Medicare coverage changes

Jan 1

Effective Date

New coverage begins following year

The Annual Election Period (AEP), sometimes called the Open Enrollment Period, runs from October 15 to December 7 each year. During this time, Medicare beneficiaries can review and change their coverage options for the following year, including switching between Original Medicare and Medicare Advantage or changing Part D prescription drug plans.

This annual opportunity allows beneficiaries to adjust their coverage based on changing health needs, new plan offerings, or changes to existing plans' costs, benefits, or provider networks.

Medicare Enrollment Periods: Medicare Advantage Open Enrollment

January 1 - March 31

Annual opportunity for MA plan changes

Switch MA Plans

Change from one MA plan to another

Return to Original Medicare

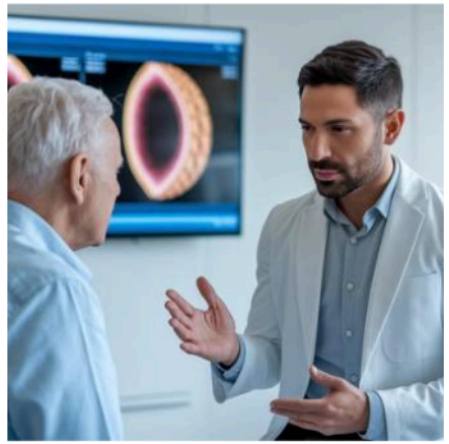
Option to leave MA and return to Traditional Medicare

The Medicare Advantage Open Enrollment Period (MA OEP) runs from January 1 to March 31 each year. This period provides Medicare Advantage enrollees an additional opportunity to make a one-time change to their coverage after the Annual Election Period has ended.

During this period, beneficiaries can switch to a different Medicare Advantage plan or return to Original Medicare (with or without joining a Part D plan). However, this period does not allow those in Original Medicare to join a Medicare Advantage plan.

Medicare Coverage: Preventive Services

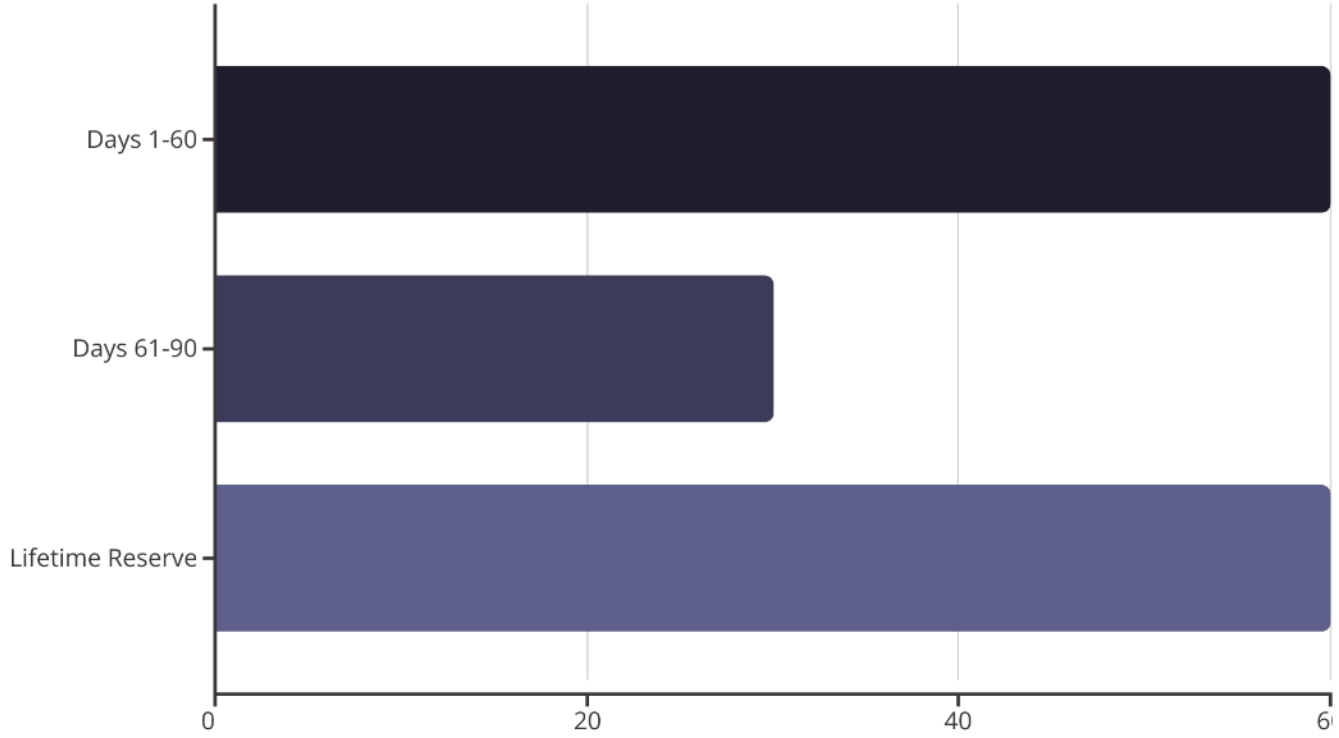



Medicare covers a wide range of preventive services at no cost to beneficiaries when provided by qualifying providers. These services include annual wellness visits, vaccinations (flu, pneumonia, COVID-19, hepatitis B), cancer screenings (mammograms, colonoscopies, prostate exams), cardiovascular screenings, diabetes screenings, bone mass measurements, and depression screenings.

These preventive services are covered under both Traditional Medicare and Medicare Advantage plans, though MA plans may offer additional preventive benefits beyond the standard Medicare-covered services.

Medicare Coverage: Hospital Services



Medicare Part A covers inpatient hospital care based on benefit periods. A benefit period begins when you're admitted to a hospital and ends when you haven't received inpatient care for 60 consecutive days. For each benefit period, Medicare covers the first 60 days after the deductible, then days 61-90 with a daily coinsurance.

Medicare also provides 60 "lifetime reserve days" that can be used once the standard 90 days in a benefit period are exhausted. These reserve days come with a higher daily coinsurance and once used, are not renewed. Both Traditional Medicare and Medicare Advantage cover inpatient hospital care, though cost-sharing structures may differ in MA plans.

Medicare Coverage: Sub-acute Rehabilitation

Qualifying Hospital Stay

3-day inpatient hospital stay required before SNF coverage

2

Days 1-20

Medicare covers 100% of approved costs

Days 21-100

Daily coinsurance required ($200.00 in 2023)

Beyond Day 100

No Medicare coverage for extended SNF stays

Medicare covers skilled nursing facility for short term rehab or medical needs care when medically necessary following a qualifying 3-day inpatient hospital stay. Coverage includes semi-private rooms, meals, skilled nursing care, therapy services, medications, and medical equipment used in the facility.

Medicare Coverage: Home Health Services

Homebound Requirement

Patient must be confined to home due to illness or injury, with significant difficulty leaving without assistance.

Doctor Certification

A doctor must certify that the patient needs skilled care and establish a care plan for home health services.

Skilled Care Needed

Services must include skilled nursing care, physical therapy, speech therapy, or continued occupational therapy.

Medicare-Certified Agency

Services must be provided by a home health agency that is Medicare-certified to qualify for coverage.

Medicare covers home health services when all qualifying criteria are met. Covered services include part-time skilled nursing care, physical therapy, speech-language pathology, occupational therapy, medical social services, and home health aide services. Medicare also covers medical supplies and durable medical equipment when part of the care plan.

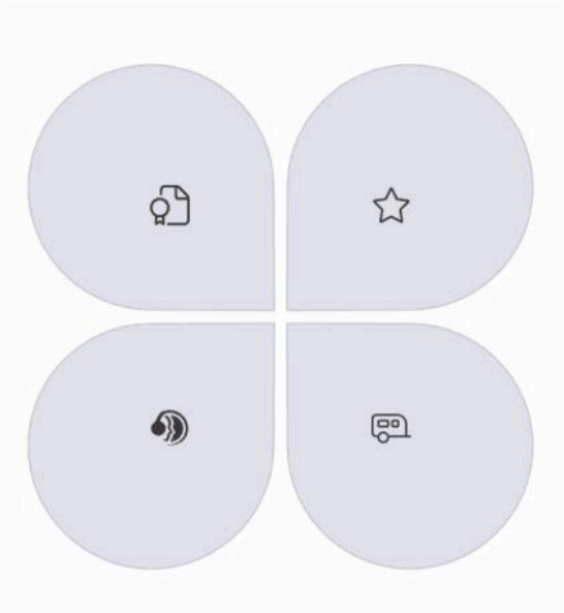
Medicare Coverage: Hospice Care

Terminal Illness

Life expectancy of 6 months or less certified by doctor

Interdisciplinary Team

Doctors, nurses, counselors, and other professionals



Comfort Care

Focus on pain relief and symptom management

Care Location

Services provided at home or inpatient facility

Medicare provides comprehensive hospice benefits for beneficiaries with terminal illnesses who choose palliative care (comfort care) rather than curative treatment. Covered services include doctor and nursing care, medical equipment and supplies, prescription drugs for symptom control and pain relief, hospice aide services, physical and occupational therapy, speech-language pathology, social worker services, dietary counseling, and grief counseling.

Medicare Coverage: Prescription Drugs

Annual Deductible

Part D plans typically have an annual deductible (up to $505 in 2023) that must be paid before coverage begins. Some plans waive the deductible for certain tiers of medications.

Initial Coverage Phase

After meeting the deductible, beneficiaries pay copayments or coinsurance for covered drugs until reaching the initial coverage limit ($4,660 in total drug costs for 2023).

Coverage Gap (Donut Hole)

In this phase, beneficiaries pay 25% of costs for both brand-name and generic drugs until reaching the catastrophic coverage threshold ($7,400 in out-of-pocket costs for 2023).

Catastrophic Coverage

Once in catastrophic coverage, beneficiaries pay a small coinsurance (5%) or copayment for covered drugs for the remainder of the year.

Medicare Coverage Gaps: What's Not Covered

Dental Care

Traditional Medicare doesn't cover routine dental care including cleanings, fillings, tooth extractions, dentures, dental plates, or other dental devices. Some Medicare Advantage plans offer dental coverage as an additional benefit.

Vision Services

Routine eye exams, glasses, and contact lenses aren't covered by Traditional Medicare (except after cataract surgery). Many Medicare Advantage plans include vision benefits as part of their coverage.

Hearing Aids

Traditional Medicare doesn't cover hearing aids or exams for fitting hearing aids. Some Medicare Advantage plans offer hearing benefits that may include coverage for hearing aids and related services.

Long-Term Care

Neither Traditional Medicare nor Medicare Advantage covers long-term custodial care in nursing homes or assisted living facilities when that's the only care needed. This represents one of the most significant coverage gaps in Medicare.

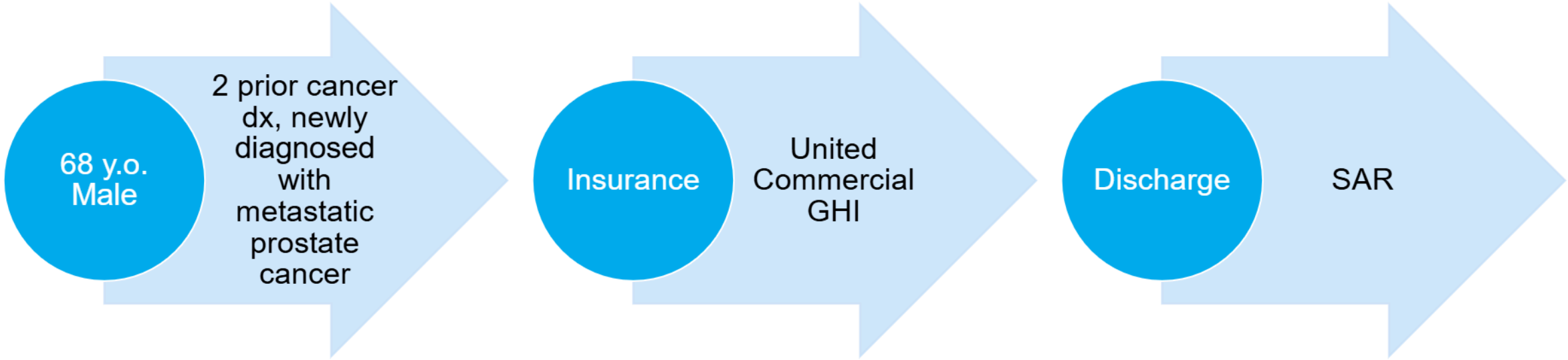
Medicare Cost-Sharing: Deductibles and Coinsurance

Medicare beneficiaries face various cost-sharing requirements beyond premiums. Part A includes a deductible for each benefit period and daily coinsurance for extended hospital and skilled nursing facility stays. Part B generally requires beneficiaries to pay 20% of the Medicare-approved amount for most doctor services, outpatient therapy, and durable medical equipment after meeting the annual deductible.

Medicare Advantage plans may have different cost-sharing structures but must provide benefits at least as good as Original Medicare. Many MA plans replace the Original Medicare cost-sharing with copayments for specific services.

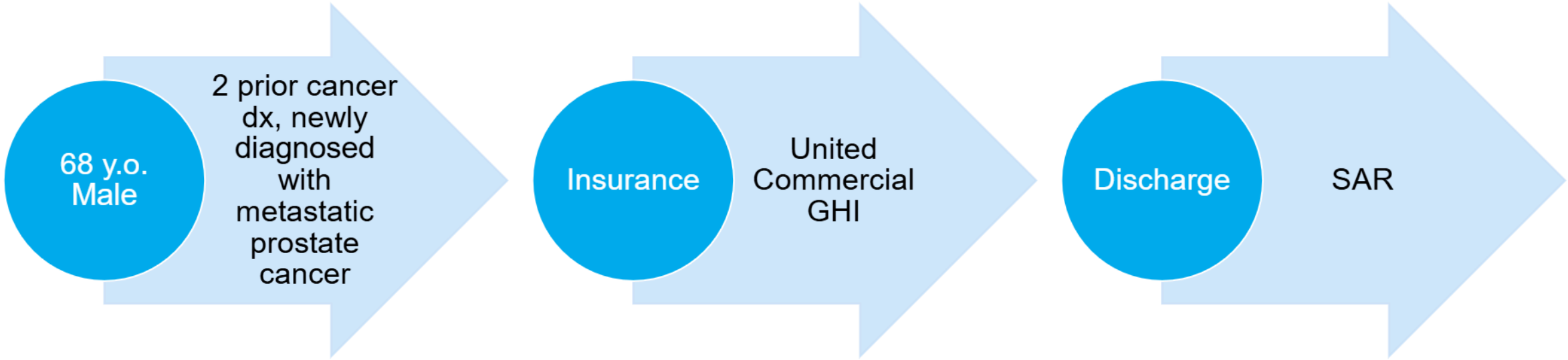
Comparison: Traditional Medicare vs Managed Medicare

Case Study



Patient was admitted for new compression fracture and found to have elevated PSA with 2 weeks of hematuria in the community and SOB. CR revealed lung lesions concerned to be malignant. Bone biopsy confirmed metastatic prostate carcinoma. Patient has a history of 2 other cancer diagnosis and has a history of exposure from the world trade center as a volunteer firefighter. Patient is found to be aspirating and declined NG tube. Patient remains actively employed full time as a lawyer. Patient is divorced and has adult children. He rents a room in a home upstate where he lives with a roommate/friend. Patient is recommended for SAR.

Case Study



What information might be helpful when advance care planning?

Case Study

Advance Care Planning considerations:

1. Understanding patient's goals and values
2. Available caregiver in the community
3. HCP awareness of patient's wishes
4. Plans for retirement/likely need to stop working
5. Insurance changes/ Medicare
6. Long term care planning

Patient's goal was to remain independent and at home. SW provided eligibility and registration process for enrollment in world trade center programs in order to access additional benefits. SW provided education related to Medicare vs managed Medicare and the impact on continuity of care when patient retires and transitions to Medicare from his commercial plan. SW provided information about Medicaid eligibility and MLTC in order to obtain coverage for long term care in the community to keep the patient home. A family meeting was held to review patient's goals and wishes with his HCP/son.

Program Structure

Traditional Medicare

Fee-for-Service Model

Traditional Medicare operates on a fee-for-service basis, where providers are paid for each service performed rather than a capitated rate.

Broader Provider Networks

Patients have access to nearly all Medicare-participating providers nationwide with minimal restrictions on choice.

Component Structure

Consists of Parts A (hospital), B (medical), and optional D (prescription), requiring separate enrollment in each component.

Supplemental Coverage

Requires additional Medigap policies to limit out-of-pocket costs, as Traditional Medicare has no spending cap.

Medicare Advantage

Managed Care Model

Medicare Advantage operates through private insurance companies that contract with Medicare to provide benefits, using managed care approaches to control costs and coordinate services.

Restricted Provider Networks

Plans typically limit coverage to specific networks of providers, requiring patients to use in-network doctors and facilities to maximize benefits and minimize costs.

All-in-One Coverage

Combines Parts A, B, and typically D into a single comprehensive plan, simplifying enrollment and billing for beneficiaries seeking integrated coverage.

Spending Protection

Features annual out-of-pocket spending caps that protect beneficiaries from catastrophic healthcare expenses, unlike Traditional Medicare's unlimited liability.

Patient Costs: Traditional Medicare

20%

Part B Coinsurance

Standard coinsurance rate for most outpatient services under Traditional Medicare

$0

Maximum Limit

No cap on annual out-of-pocket expenses without supplemental coverage

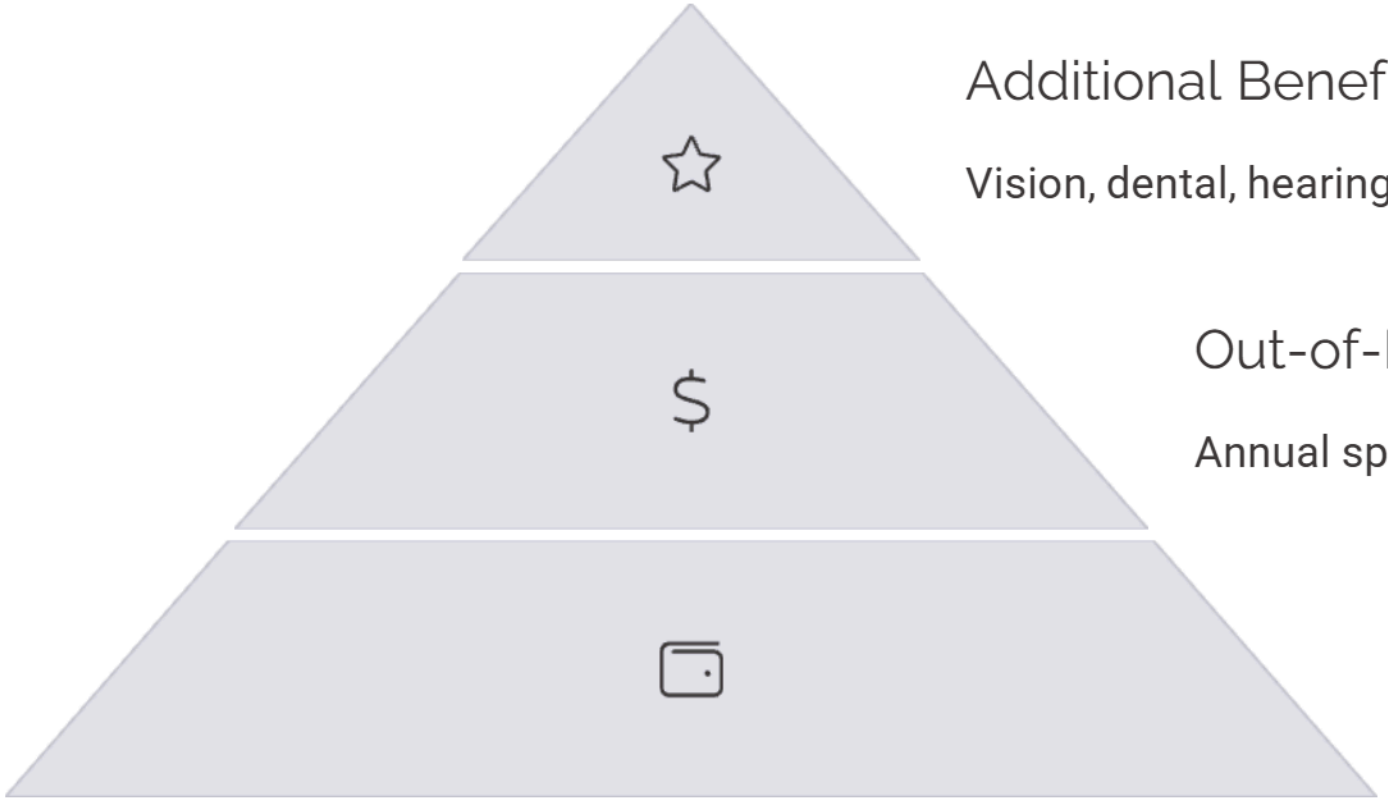
$164.90

Part B Premium

Standard monthly premium for 2023 (may be higher based on income)

Traditional Medicare offers predictable premiums and cost-sharing arrangements but lacks an out-of-pocket maximum. Coverage for vision, dental, and hearing services is limited, resulting in generally higher costs for beneficiaries who don't have supplemental Medigap coverage.

Patient Costs: Medicare Advantage



Additional Benefits

Vision, dental, hearing coverage

Out-of-Pocket Caps

Annual spending limits

Lower Premiums

Often less than TM + Medigap

Medicare Advantage plans typically offer lower premiums compared to the combined cost of Traditional Medicare plus Medigap. They include out-of-pocket spending caps and additional benefits like vision, dental, hearing, and prescription coverage that Traditional Medicare doesn't provide.

However, patients with serious illnesses may face higher costs due to network restrictions and service limitations, especially when specialized care is needed.

Prior Authorization: Traditional Medicare

Minimal Requirements

Traditional Medicare has significantly fewer services requiring prior authorization compared to Medicare Advantage plans.

Low Frequency

Approximately 0.01 prior authorizations per beneficiary, or roughly 1 per 100 beneficiaries, far less than MA's 2 per enrollee. (CMS, 2023; KFF, 2025)

Direct Specialist Access

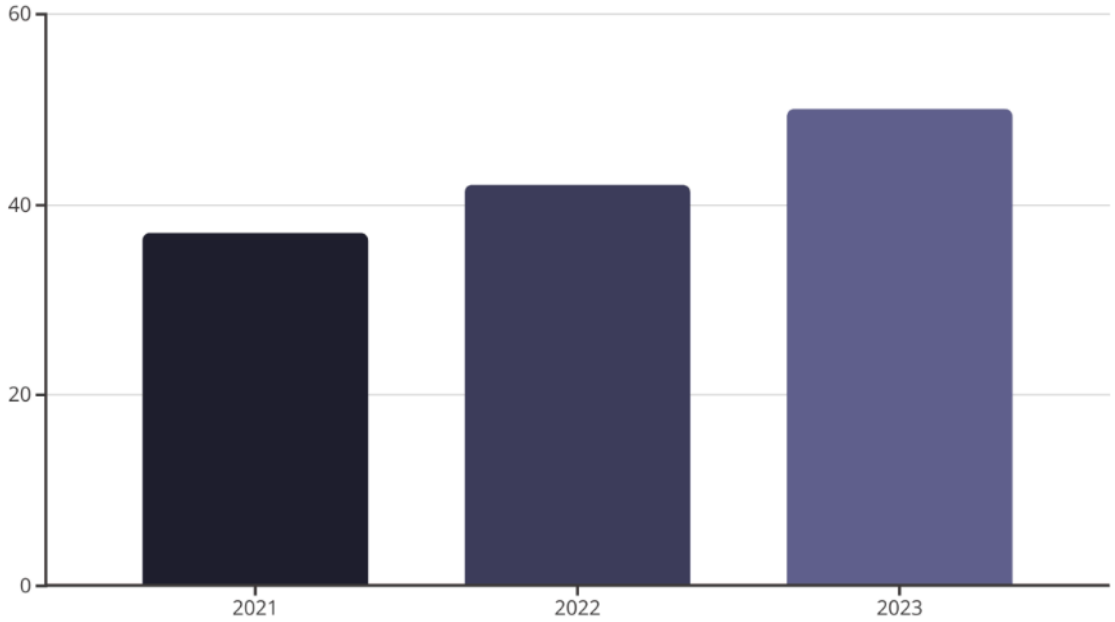
Patients can access specialists without referral requirements, reducing barriers to specialized care.

Traditional Medicare features fewer service categories requiring prior authorization and less restrictive access to post-acute care facilities. However, it does have a lower appeal overturn rate (29% in 2022) compared to Medicare Advantage's 81.7%. (CMS, 2023; KFF, 2025).

Prior Authorization: Medicare Advantage

Medicare Advantage plans have significantly higher utilization of prior authorization requirements, with nearly 50 million determinations in 2023, showing steady increases from 37 million in 2021 to 42 million in 2022. This averages to approximately 2 prior authorization determinations per enrollee annually. (CMS, 2023; Biniek, Sroczynski, Freed & Neuman , 2025)

The denial rate was 6.4% in 2023, slightly improved from 7.4% in 2022. Notably, only 11.7% of denied requests were appealed in 2023, but 81.7% of those appeals were partially or fully overturned, suggesting potential issues with initial denial decisions. (CMS, 2023; Biniek, Sroczynski, Freed & Neuman , 2025)



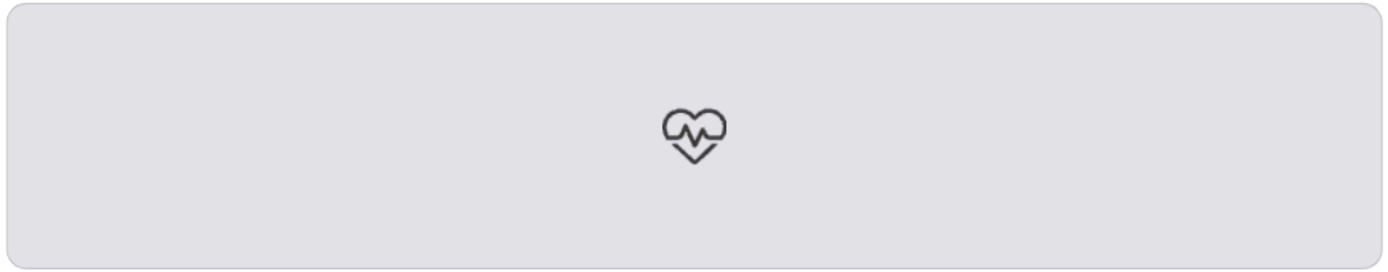
Clinical Implications of Prior Authorization

Care Delays

Waiting periods during appeals process

Administrative Burden

Time spent managing authorizations



Health Impacts

Potential negative effects from delays

Overturned denials represent medically necessary care that was initially denied, highlighting a significant concern for patient care. The high overturn rate (81.7%) in Medicare Advantage appeals suggests many initial denials may be inappropriate. (CMS, 2023; Biniek, Sroczynski, Freed & Neuman , 2025)

Providers must consider how coverage restrictions might influence clinical decision-making, potentially leading to suboptimal treatment choices based on coverage rather than best medical practice.

Care Coordination Differences

Medicare Advantage Approach

Medicare Advantage plans emphasize structured care coordination through primary care providers who serve as gatekeepers to the healthcare system. This approach includes:

- Designated care managers for high-risk patients
- Integrated electronic health records within networks
- Standardized care pathways for common conditions
- Financial incentives for providers to coordinate care

Traditional Medicare Approach

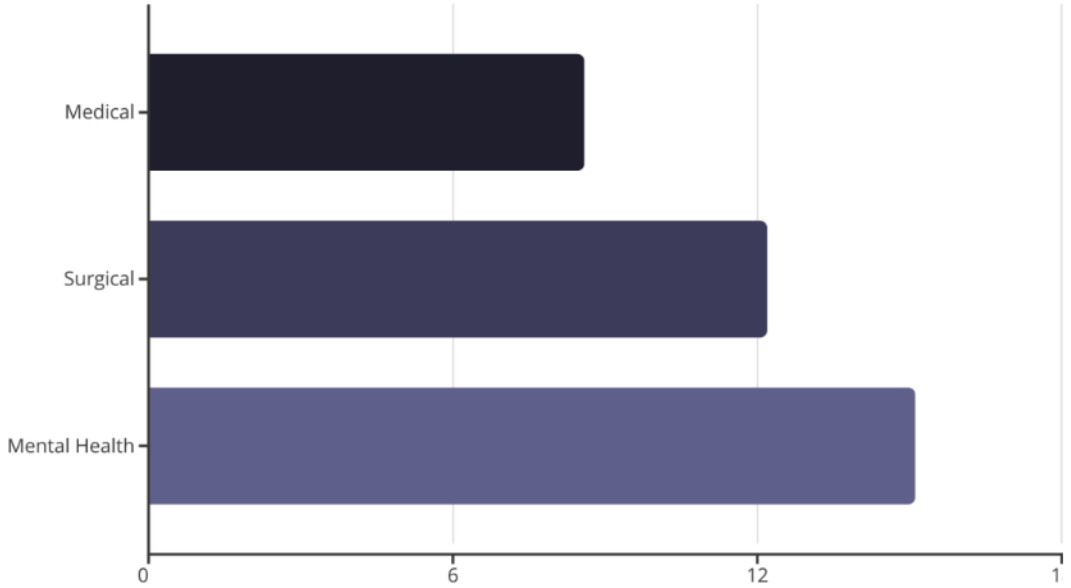
Traditional Medicare offers broader access but less structured coordination mechanisms. Key features include:

- Direct access to specialists without referrals
- Patient-directed care pathways
- Optional care coordination through ACOs
- Less integration between different providers

Hospital Utilization Comparison

According to CMS data from 2015, Medicare Advantage patients consistently experienced shorter hospital stays across all service categories compared to Traditional Medicare beneficiaries. Mental health stays show the most significant difference, with MA patients being discharged 15.1% sooner. (HCUP, 2015).

As of 2023, Medicare Advantage patients were 2.6% less likely to have an avoidable hospital admission and shorter rehab stays. (Xu, Anderson, Liu & et al., 2023).



Several factors contribute to these shorter stays, including care coordination programs, financial incentives for efficient care, narrower provider networks with standardized protocols, and a focus on preventing unnecessary admissions through primary care.

Patient Satisfaction Comparison

Medicare Advantage Strengths

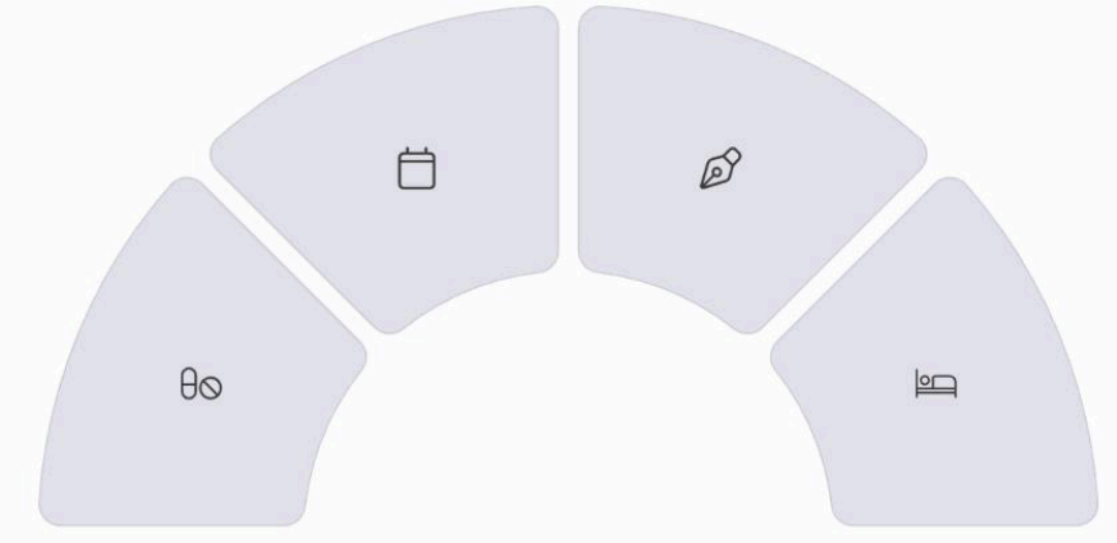
Higher satisfaction with preventive services and routine care coordination

Traditional Medicare Strengths

Higher-rated hospitals and inpatient care experiences

Medicare Advantage Strengths

Better experiences with prescription drugs and medication management

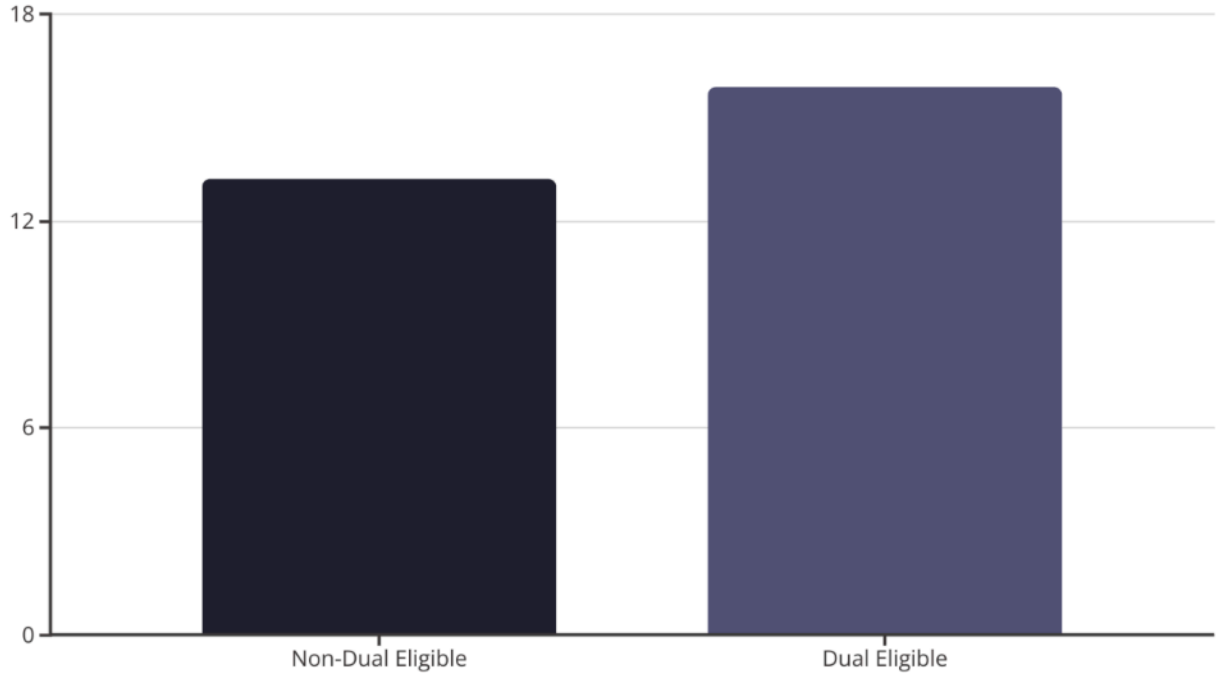


Traditional Medicare Strengths

Better-rated skilled nursing facilities and post-acute care

Both Medicare programs show comparable overall satisfaction rates among beneficiaries but excel in different areas. The differences in satisfaction align with the structural strengths of each program - MA's coordination and TM's provider quality.

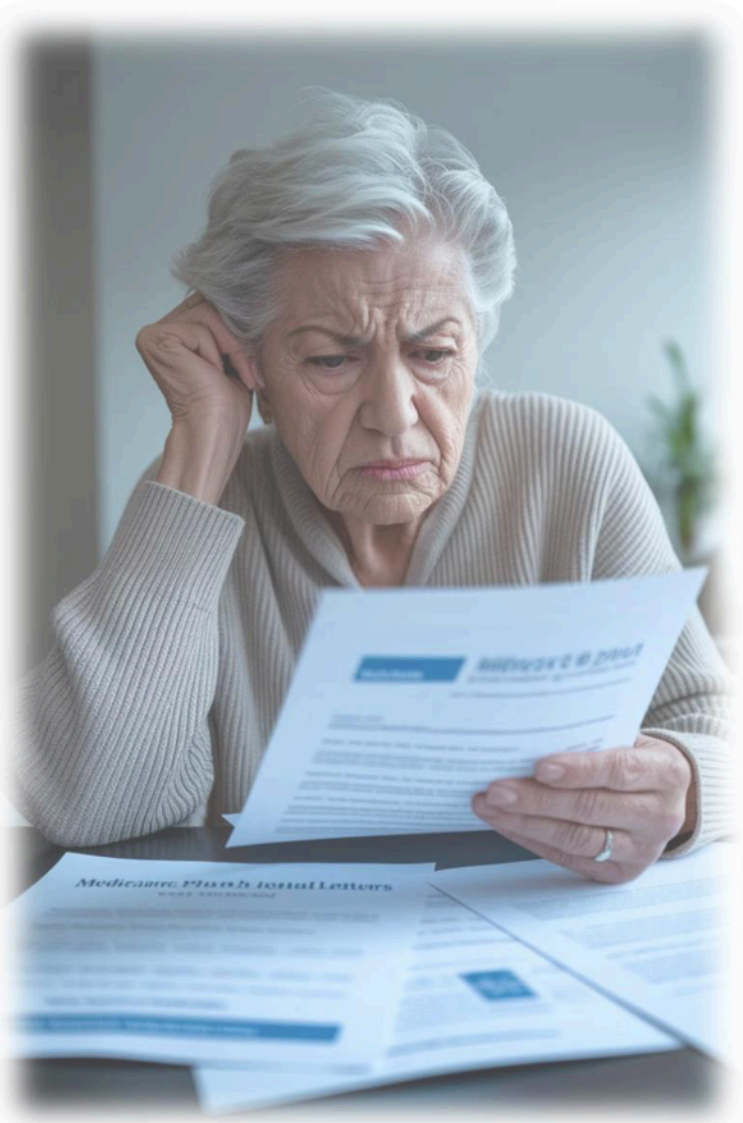
Disenrollment Rates: Short-Term



Medicare Advantage plans experience significant short-term disenrollment within the first year. **Dual-eligible beneficiaries (those qualifying for both Medicare and Medicaid)** show higher disenrollment rates at 15.9% compared to 13.2% for non-dual eligible enrollees. (Meyers, Ryan & Trivedi, 2023)

These rates indicate that a substantial portion of beneficiaries find their Medicare Advantage plans unsatisfactory within the first year, with vulnerable populations more likely to switch. Common reasons include provider access problems, unexpected out-of-pocket costs, coverage denials, and changes in healthcare needs.

Disenrollment Rates: Long-Term



48.3%

Non-Dual Eligible

Five-year disenrollment rate from Medicare Advantage plans

53.4%

Dual Eligible

Five-year disenrollment rate for those eligible for both Medicare and Medicaid

The long-term retention picture for Medicare Advantage plans shows concerning trends, with nearly half of all enrollees leaving their plans within five years. Dual-eligible beneficiaries, who often have more complex healthcare needs, show even higher disenrollment rates at 53.4% over five years. (Meyers, Ryan & Trivedi, 2023)

These substantial disenrollment figures suggest ongoing challenges with member satisfaction and retention in Medicare Advantage programs, particularly for vulnerable populations with complex care needs.

Hospice and End of Life Care: Traditional Medicare vs Managed Medicare

Hospice Utilization Comparison

In 2019, Medicare Advantage enrollees have historically shown higher hospice enrollment rates (53.2%) compared to Traditional Medicare beneficiaries (47.2%). However, in 2021 both MA and TM rates were 47.4%. (MedPAC, 2023)

The key difference is MA enrollees are more likely to enroll in hospice from the community versus SNFs or the hospital. Length of enrollment is nearly identical (Ankuda, Belanger, Bunker, et al, 2023)

A key factor in this difference is the financial incentive structure - hospice costs are "carved out" of MA plans and paid by Traditional Medicare, potentially encouraging MA plans to refer eligible patients to hospice services more readily. Home hospice is the primary level of care utilized under MA plans.

End-of-Life Care Quality Considerations

Provider Quality

Traditional Medicare beneficiaries typically access higher-rated hospice providers, suggesting potential quality differences in end-of-life care between the programs.

Referral Timing

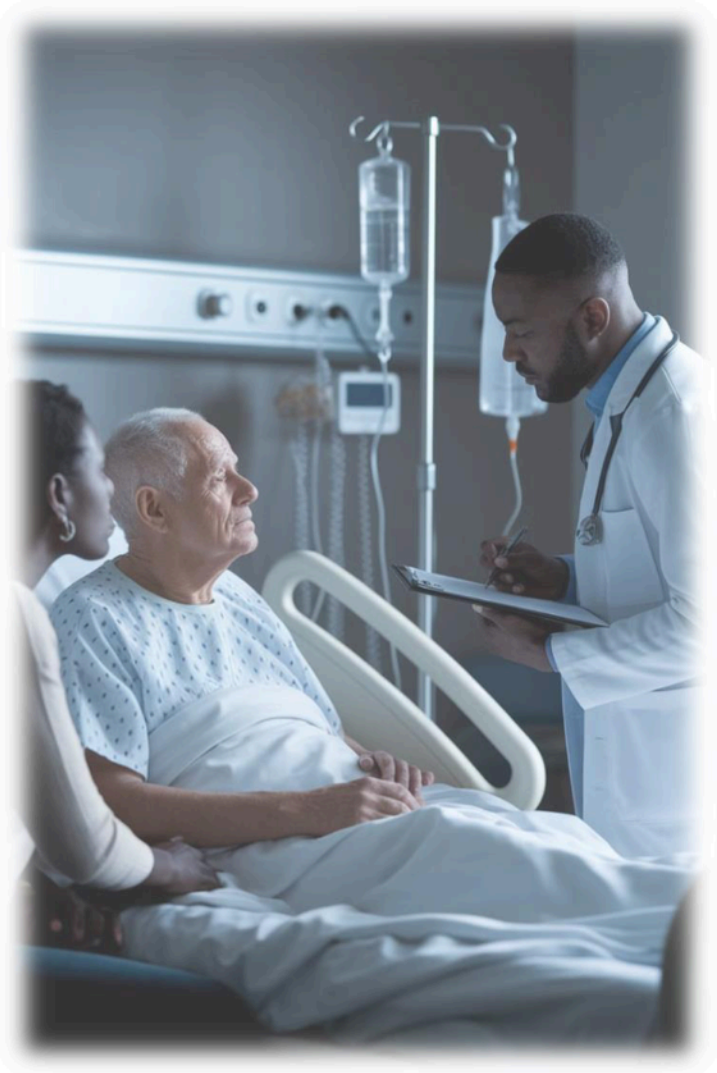
Medicare Advantage emphasizes cost containment through earlier hospice referrals, which may benefit some patients but could be premature for others.

Care Continuity

The transition from MA to hospice can disrupt care continuity as financial responsibility shifts to Traditional Medicare, potentially affecting coordination.

While Medicare Advantage shows higher hospice utilization rates, questions remain about the quality and appropriateness of these referrals. The financial incentive to transfer cost responsibility to Traditional Medicare may influence decision-making in ways that don't always prioritize patient-centered care.

End-of-Life Disenrollment Patterns



Higher Rate

MA beneficiaries in their last year of life disenroll at twice the rate of other beneficiaries

Primary Reason

Limitations accessing specialized care under MA plans

Financial Impact

Medicare spent $422M more in 2016 and $490M more in 2017 on these switchers

According to a 2021 Government Accountability Office (GAO) study, Medicare Advantage beneficiaries in their last year of life disenroll to fee-for-service Medicare at **more than twice** the rate of all other MA beneficiaries. This disproportionate disenrollment pattern raises significant concerns about care access for seriously ill patients in MA plans.

End-of-Life Care Considerations for Providers

Discuss Medicare Options

Consider initiating conversations about Medicare coverage options when patients receive serious diagnoses that may require specialized care.

Monitor Coverage Limitations

Be aware of potential coverage limitations for complex or specialized treatments in Medicare Advantage plans that might affect treatment options.

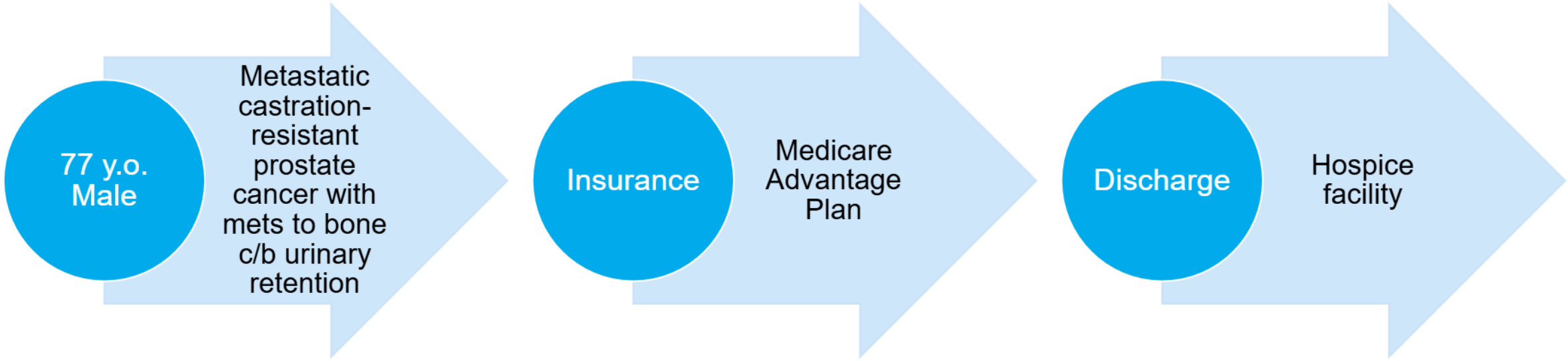
Assess Specialty Access

Evaluate whether patients have adequate access to needed specialists and consider implications of plan type on continuity of care.

Plan for Transitions

Understand enrollment periods and help patients anticipate potential needs for plan changes as health status evolves.

Case Study



Barriers to discharge:

1. Decreased PO intake requiring IV medication including IV opioids for end-of-life symptom management
2. Insufficient caregiver in the community
3. No Medicaid eligibility
4. Managed Medicare did not cover the level of hospice care he required

Case Study

Patient was referred to Goodman Brown Hospice Residence and was not financially accepted as patient did not have Medicaid. Patient and family interested in applying for Medicaid with possible eligibility with spend down. Patient decompensated and required a higher level of care. Patient's managed plan does not provide coverage for Calvary Hospital which the patient required. Social work counseled family about disenrollment from managed Medicare plan as it was approaching the end of the month. Family in agreement and opted to dis-enroll and transition to traditional Medicare.

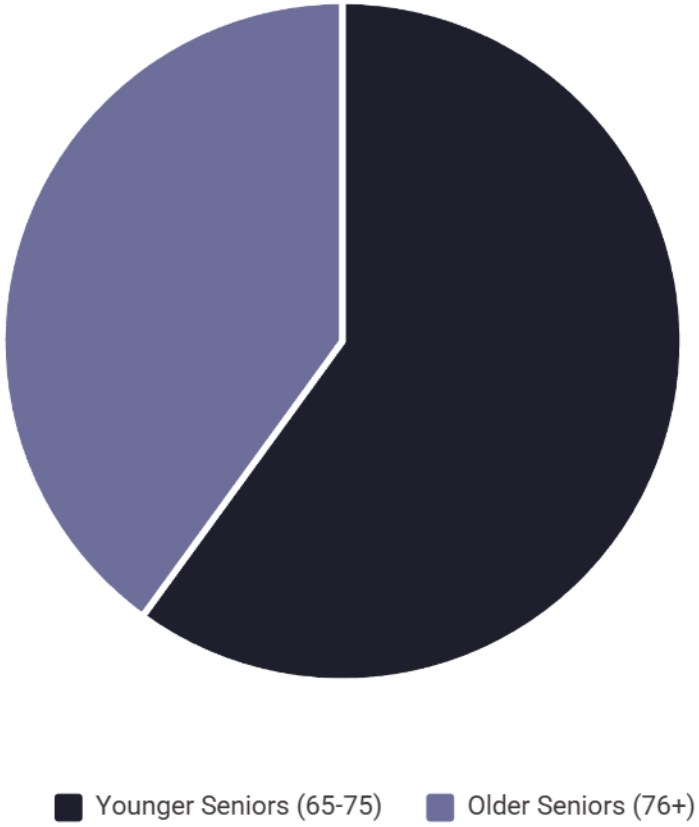
With traditional Medicare patient was able to be referred to Calvary. Patient acutely decompensated and died prior to completion of the dis-enrollment process.

Patient Guidance: Traditional Medicare vs Managed Medicare

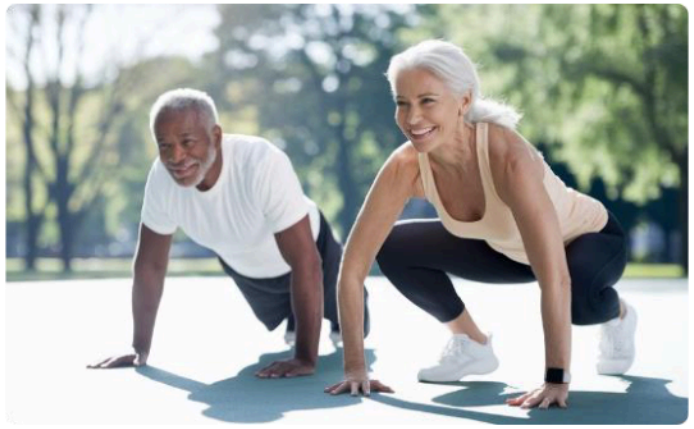
Patient Population Differences

Medicare Advantage plans tend to attract a different beneficiary population than Traditional Medicare. MA enrollees are generally younger, healthier, and have fewer complex medical conditions. They often prioritize lower premiums and additional benefits like dental and vision coverage.

Traditional Medicare, particularly when combined with Medigap, tends to serve a higher proportion of patients with complex healthcare needs, multiple chronic conditions, and those requiring specialized care. Understanding these population differences is crucial for providers managing care across both programs.



Patient Guidance: Who Benefits from Medicare Advantage?



Healthy, Active Seniors

Patients with stable, manageable health conditions who primarily need preventive care and routine services may benefit from Medicare Advantage's lower premiums and additional wellness benefits.

Those Valuing Additional Benefits

Beneficiaries who prioritize coverage for vision, dental, hearing, and fitness programs often find Medicare Advantage plans more comprehensive for these routine needs.

Patients Preferring Coordinated Care

Those who value having a primary care physician coordinate all aspects of their care and appreciate structured healthcare delivery may prefer the integrated approach of Medicare Advantage.

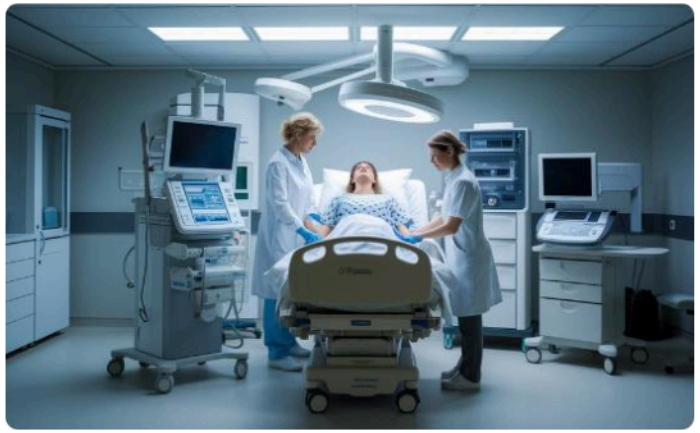
Patient Guidance: Who Benefits from Traditional Medicare?

Patients with Complex Needs

Those with multiple chronic conditions, rare diseases, or complex healthcare needs often benefit from Traditional Medicare's broader access to specialists and facilities nationwide.

Frequent Travelers

Beneficiaries who travel frequently or split time between multiple residences benefit from Traditional Medicare's nationwide coverage without network restrictions.



Those Anticipating Specialized Care

Patients with serious diagnoses or expecting to need specific high-cost treatments may find Traditional Medicare offers more direct access to specialized care centers and treatments.

Take aways: Traditional Medicare vs Managed Medicare

Key Evidence-Based Insights: Program Strengths

Medicare Advantage Strengths

- Excels in preventive care delivery and coordination
- Provides additional benefits not covered by Traditional Medicare
- Offers out-of-pocket spending caps for financial protection
- Often features lower premium costs than TM + Medigap
- Shows higher hospice utilization and earlier referrals

Traditional Medicare Strengths

- Provides unrestricted provider choice nationwide
- Offers direct access to specialists without referrals
- Shows better retention among beneficiaries with serious illness
- Features minimal prior authorization requirements
- Provides access to higher-rated hospitals and skilled nursing facilities

Key Evidence-Based Insights: Program Limitations

Medicare Advantage Limitations

- Imposes network restrictions limiting provider choice
- Features high prior authorization requirements (2 per enrollee)
- Shows high disenrollment rates (nearly 50% after five years)
- Demonstrates twice the disenrollment rate for end-of-life patients
- May create barriers to specialized care for complex conditions

Traditional Medicare Limitations

- Lacks integrated care management structures
- Requires supplemental coverage to limit out-of-pocket costs
- Provides limited coverage for dental, vision, and hearing
- Features higher combined premiums with Medigap
- Offers fewer structured preventive care programs

Key Takeaways for Providers

Understand Both Programs

Recognize that both Medicare Advantage and Traditional Medicare have strengths and limitations that may affect different patients differently.

2

Consider Patient Needs

Assess individual patient circumstances, including health status, provider preferences, financial situation, and anticipated care needs.

Monitor Access Issues

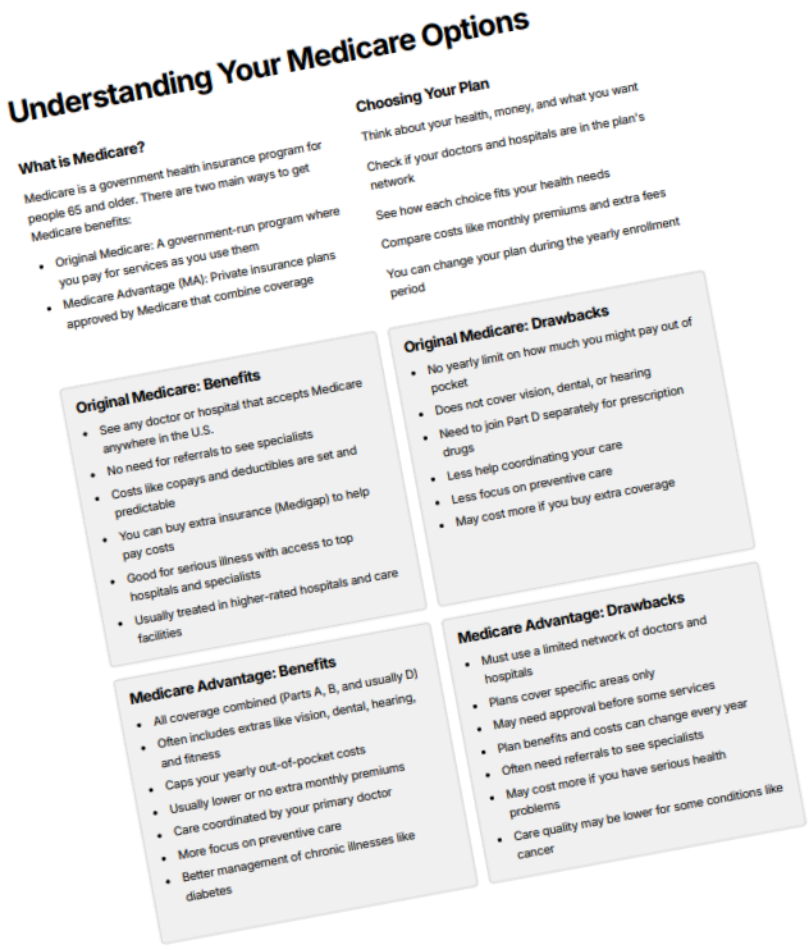
Be alert to potential care access barriers, especially for patients with complex conditions or those needing specialized services.

Facilitate Informed Choices

Help patients understand their Medicare options, particularly when facing serious diagnoses or changing health needs.

As a healthcare provider, your understanding of Medicare options can significantly impact your patients' healthcare experiences. By recognizing the differences between Medicare Advantage and Traditional Medicare, you can help guide patients toward coverage that best meets their individual healthcare needs and preferences.

Handouts



Understanding Your Medicare Options

What is Medicare?

Medicare is a government health insurance program for people 65 and older. There are two main ways to get Medicare benefits:

- Original Medicare: A government-run program where you pay for services as you use them
- Medicare Advantage (MA): Private insurance plans approved by Medicare that combine coverage

Choosing Your Plan

Think about your health, money, and what you want

Check if your doctors and hospitals are in the plan's network

See how each choice fits your health needs

Compare costs like monthly premiums and extra fees

You can change your plan during the yearly enrollment period

Original Medicare: Benefits

- See any doctor or hospital that accepts Medicare anywhere in the U.S.
- No need for referrals to see specialists
- Costs like copays and deductibles are set and predictable
- You can buy extra insurance (Medigap) to help pay costs
- Good for serious illness with access to top hospitals and specialists
- Usually treated in higher-rated hospitals and care facilities

Original Medicare: Drawbacks

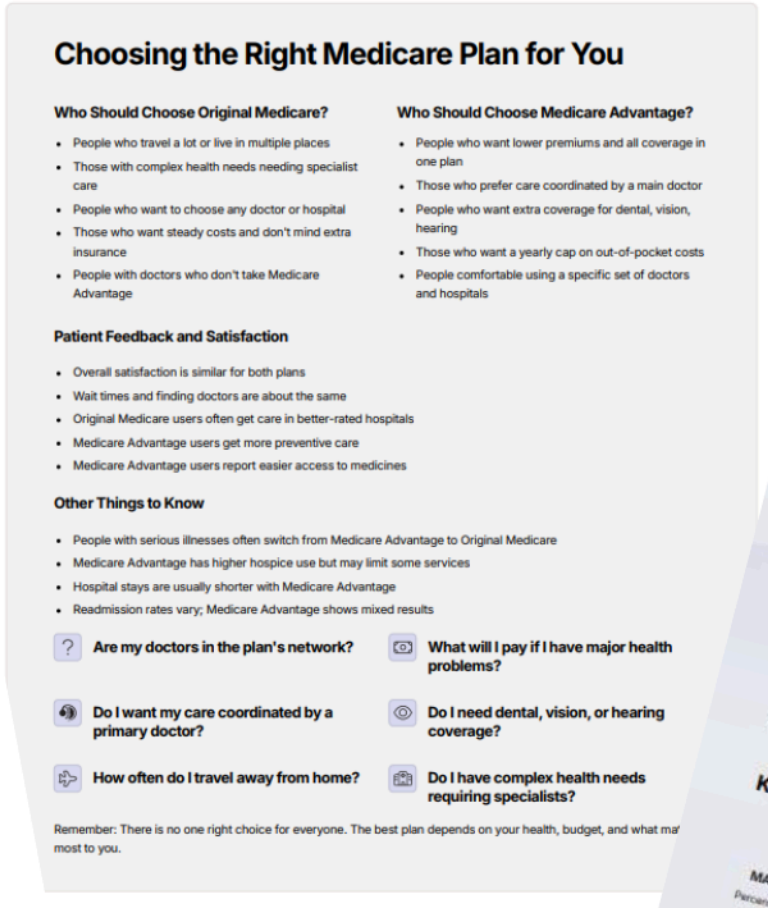
- No yearly limit on how much you might pay out of pocket
- Does not cover vision, dental, or hearing
- Need to join Part D separately for prescription drugs
- Less help coordinating your care
- Less focus on preventive care
- May cost more if you buy extra coverage

Medicare Advantage: Benefits

- All coverage combined (Parts A, B, and usually D)
- Often includes extras like vision, dental, hearing, and fitness
- Caps your yearly out-of-pocket costs
- Usually lower or no extra monthly premiums
- Care coordinated by your primary doctor
- More focus on preventive care
- Better management of chronic illnesses like diabetes

Medicare Advantage: Drawbacks

- Must use a limited network of doctors and hospitals
- Plans cover specific areas only
- May need approval before some services
- Plan benefits and costs can change every year
- Often need referrals to see specialists
- May cost more if you have serious health problems
- Care quality may be lower for some conditions like cancer



Choosing the Right Medicare Plan for You

Who Should Choose Original Medicare?

- People who travel a lot or live in multiple places
- Those with complex health needs needing specialist care
- People who want to choose any doctor or hospital
- Those who want steady costs and don't mind extra insurance
- People with doctors who don't take Medicare Advantage

Who Should Choose Medicare Advantage?

- People who want lower premiums and all coverage in one plan
- Those who prefer care coordinated by a main doctor
- People who want extra coverage for dental, vision, hearing
- Those who want a yearly cap on out-of-pocket costs
- People comfortable using a specific set of doctors and hospitals

Patient Feedback and Satisfaction

- Overall satisfaction is similar for both plans
- Wait times and finding doctors are about the same
- Original Medicare users often get care in better-rated hospitals
- Medicare Advantage users get more preventive care
- Medicare Advantage users report easier access to medicines

Other Things to Know

- People with serious illnesses often switch from Medicare Advantage to Original Medicare
- Medicare Advantage has higher hospice use but may limit some services
- Hospital stays are usually shorter with Medicare Advantage
- Readmission rates vary; Medicare Advantage shows mixed results

Are my doctors in the plan's network?

What will I pay if I have major health problems?

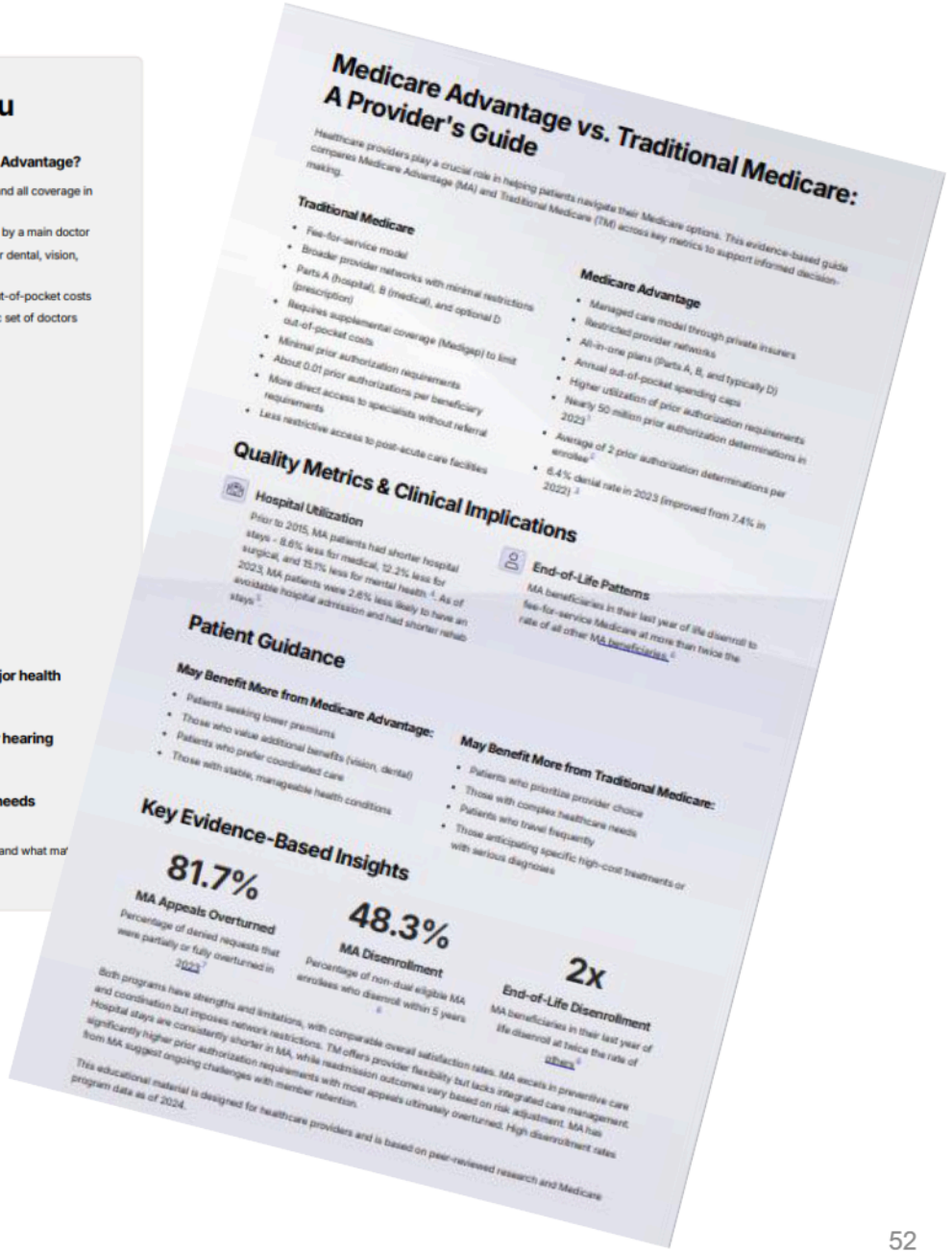
Do I want my care coordinated by a primary doctor?

Do I need dental, vision, or hearing coverage?

How often do I travel away from home?

Do I have complex health needs requiring specialists?

Remember: There is no one right choice for everyone. The best plan depends on your health, budget, and what ma
most to you.



Medicare Advantage vs. Traditional Medicare: A Provider's Guide

Healthcare providers play a crucial role in helping patients navigate their Medicare options. This evidence-based guide compares Medicare Advantage (MA) and Traditional Medicare (TM) across key metrics to support informed decision-making.

Traditional Medicare

- Fee-for-service model
- Broader provider networks with minimal restrictions
- Parts A (hospital), B (medical), and optional D (prescription)
- Requires supplemental coverage (Medigap) to limit out-of-pocket costs
- Minimal prior authorization requirements
- About 0.01 prior authorizations per beneficiary
- More direct access to specialists without referral requirements
- Less restrictive access to post-acute care facilities

Medicare Advantage

- Managed care model through private insurers
- Restricted provider networks
- All-in-one plans (Parts A, B, and typically D)
- Annual out-of-pocket spending caps
- Higher utilization of prior authorization requirements
- Nearly 50 million prior authorization determinations in 2023
- Average of 2 prior authorization determinations per enrollee
- 6.4% denial rate in 2023 (improved from 7.4% in 2022)

Quality Metrics & Clinical Implications

Hospital Utilization

Prior to 2015, MA patients had shorter hospital stays - 8.6% less for medical, 12.2% less for surgical, and 15.1% less for mental health. As of 2023, MA patients were 2.8% less likely to have an avoidable hospital admission and had shorter rehab stays.

End-of-Life Patterns

MA beneficiaries in their last year of life disenroll to fee-for-service Medicare at more than twice the rate of all other MA beneficiaries.

Patient Guidance

May Benefit More from Medicare Advantage:

- Patients seeking lower premiums
- Those who value additional benefits (vision, dental)
- Patients who prefer coordinated care
- Those with stable, manageable health conditions

May Benefit More from Traditional Medicare:

- Patients who prioritize provider choice
- Those with complex healthcare needs
- Patients who travel frequently
- Those anticipating specific high-cost treatments or with serious diagnoses

Key Evidence-Based Insights

81.7%
MA Appeals Overturned
Percentage of denied requests that were partially or fully overturned in 2023

48.3%
MA Disenrollment
Percentage of non-dual eligible MA enrollees who disenroll within 5 years

2x
End-of-Life Disenrollment
MA beneficiaries in their last year of life disenroll at twice the rate of others

Both programs have strengths and limitations, with comparable overall satisfaction rates. MA excels in preventive care and coordination but imposes network restrictions. TM offers provider flexibility but lacks integrated care management. Hospital stays are consistently shorter in MA, while readmission outcomes vary based on risk adjustment. MA has significantly higher prior authorization requirements with most appeals ultimately overturned. High disenrollment rates from MA suggest ongoing challenges with member retention.

This educational material is designed for healthcare providers and is based on peer-reviewed research and Medicare program data as of 2024.

Thank You! Any Questions?

Scan to complete post-test

Mount Sinai

Appendix

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Disclosure:

Artificial Intelligence was utilized administratively in the coordination and organization of the literature review, development of educational pamphlets and power point presentation.

Perplexity AI was utilized to pull and organize literature following an initial review of available scholarly data. Data collected by AI generation was reviewed and verified prior to inclusion. Prompts used include:

"Provide scholarly references for outlining the advantages and disadvantages of Managed Medicare (Medicare Advantage) vs. Traditional Medicare."

"Review scholarly articles that outline influencing factors for disenrollment from Managed Medicare vs Traditional Medicare."

"What is the disenrollment rate from Managed Medicare to Traditional Medicare at end of life."

"Provide a review of scholarly articles comparing satisfaction with Managed Medicare (Medicare Advantage) hospice coverage versus Traditional Medicare hospice coverage."

"Provide a review of scholarly articles reviewing the differences in hospital lengths of stay with Managed Medicare versus Traditional Medicare."

"Literature review of the barriers to care with Medicare Advantage."

"Scholarly review of disenrollment rates from Managed Medicare, why and when."

"Scholarly review of the largest barriers to care for providers with Managed Medicare versus Traditional Medicare."

"Statistical review of advantages versus disadvantages of Managed Medicare versus Traditional Medicare."

Claude AI was utilized to create a pre/post tests and educational pamphlets. Pamphlets were created from the organized research summary Perplexity compiled which was manually reviewed to verify. Gamma AI was utilized to provide imagery and artistic direction of the content for educational pamphlets.

Gamma AI was utilized to create this power point presentation derived from the reviewed literature review and research summary.

Thank you!

Scan to complete
post-test