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FAQs Elaborate on MA Rule; CMS Audits Will Cover 88% of Enrollees

By Nina Youngstrom

In new FAQs, CMS clarified the ties that bind Medicare Advantage (MA) plans in terms of coverage and payment denials courtesy of a 2024 rule—and said that enforcement of the rule is getting under way.[1] Already complaints about MA plan noncompliance may be shaking things up.

"When we submit examples of MA plan noncompliance with longstanding policy or clarifications made in the 2024 final rule, I am not asking for CMS to help get claims paid," said Richelle Marting, director of managed care at North Kansas City Hospital in Kansas City, Missouri. "I am reporting examples of MA plan noncompliance by using claims as examples to illustrate the noncompliant activities." Already, the FAQs have been helpful in reinforcing her perception that some MA plans are not complying with aspects of the MA rule.

The 2024 rule on policy and technical changes to Medicare Advantage codifies that MA plans must live by the same coverage and payment criteria as traditional Medicare, such as the two-midnight rule, and may only use internal coverage criteria in medical necessity determinations when Medicare coverage criteria isn't "fully established."[2] CMS has made it abundantly clear that MA plan coverage is not allowed to be more restrictive than traditional Medicare policies found in national coverage determinations (NCDs), local coverage determinations and Medicare laws.

The Feb. 6 FAQs are seen as a way to get MA plans to accept the inevitable, said Ronald Hirsch, M.D., vice president of R1 RCM. "From what we have been hearing, several of the MA plans had not quite gotten the message that this [rule] applies to them," he said. "CMS is facing a lot of pressure from the American Hospital Association and everybody else to make sure MA plans are following the rules."

Explaining What Publicly Accessible Means

For example, the rule said internal coverage criteria must be publicly accessible and CMS elaborated on the meaning of that in the FAQs: "The internal coverage criteria used by plans must be accessible via a website and cannot be behind a paywall or require a subscription for access. The information must be available to all in the public (not just enrollees and/or contracted providers of the MA plan) and may be hosted on the MA plan's website or a delegated vendor's website that is accessible from the MA plan's website." Requiring some information is OK, but CMS essentially warned against forcing people to jump through more than a hoop or two.

Marting was thrilled to see this in the FAQs after finding that some MA plans have refused to show their internal coverage criteria because they assert the criteria is proprietary. She has taken arms against this sea of trouble. "We have built into our regular revenue cycle an extremely tedious and time-consuming process to take those examples of when a payer is referencing criteria but not publishing it and send them to the CMS regional office," Marting said.

The FAQs also drill down on whether MA plans are allowed to do post-claim audits and deny payment without running afoul of prior authorization limits in the rule. The answer is yes and no. The FAQs state that MA plans

can't deny coverage of services for lack of medical necessity if they already gave the green light in a prior authorization or pre-service determination, but reopening a claim for good cause (e.g., fraud) is another story (mirroring traditional Medicare). CMS also warned MA plans not to play semantic games to evade restrictions on after-the-fact denials of preauthorized services.

"We have heard frequently that MA organizations utilize post-claim review audits and examinations that routinely result in the denial of payment for the inpatient care that was provided to the enrollee. Further, we have heard that MA organizations characterize these reviews as 'payment' reviews and that these reviews are 'not organization determinations' or 'level of care or medical necessity reviews.' We disagree with those characterizations of decisions that are denials of coverage or otherwise a refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the MA organization," CMS said. It noted that refusing to pay for services, including inpatient admissions, is an "organization determination," and it must be reviewed by a physician or other health care professional with expertise in a relevant medical field and knowledge of Medicare coverage criteria.

Marting is watching how this plays out. When she sees an inpatient status denial that had been prior authorized, she requests a confirmation that the member was notified and the name and credentials of the physician who denied the inpatient admission. If the MA plan isn't responsive, "I share the information, or lack thereof, with the CMS regional office." She said many of the area's MA plans have told her that patient-status reviews are conducted by people supervised by a medical director. "There's no physician reviewing these organization determinations and making those decisions individually"—information she's also sharing with CMS.

In fact, since she has been forwarding her concerns, MA plans have overturned denials of more than half the claims she has complained about, "even though I am not asking for CMS's help getting paid." Her take is that the MA plans don't want CMS breathing down their necks.