

Evolving Expectations: Medicare Advantage Compliance for Plans and Providers



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AHLA ANNUAL MEETING 2025

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About Us: Annie

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Practicing health care law for over 15 years



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Director of Compliance, Senior Compliance Counsel at Central Health Plan of CA



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Citation Editor – Journal of Health & Life Sciences Law

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Agenda

- Whose job is MA compliance anyway? Differing expectations for plans and providers.
- The MA landscape.
- What's new for plans?
- Operational impacts for providers including applicability of FFS guidelines, promoting social determinants of health, and living with prior authorizations.
- The impact of new government guidance: the OIG Compliance Guidance for Managed Care (expected); the 60-day Refund Rule (as revised effective Jan. 1, 2025)
- The changing environment for enforcement actions against plans and providers.
- Practical tips for aligning compliance programs with the new expectations

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Whose job is MA Compliance anyway?

Plans

- Monthly screening
 - Medicare payment may not be made for items or services furnished or prescribed by an excluded provider or entity.
 - Shall not use federal funds to pay for services, equipment or drugs prescribed or provided by a provider, supplier, employee or FDR excluded by the DHHS OIG or GSA.
- Identifying and recommending providers for exclusion, including those who have defrauded or abused the system to the NBI MEDIC and/or law enforcement.
- Should maintain files for a period of 10 years on both in-network & out-of-network providers who have been the subject of complaints, investigations, violations, and prosecutions.
- Comply with requests by law enforcement, CMS and CMS' designee regarding monitoring of providers within the sponsor's network that CMS has identified as potentially abusive or fraudulent.

Providers

- Providers should not claim payments for items or services that are prescribed or provided/performed by an excluded individual or entity (enforced by CMPs and potential exclusion).
- CMS' Preclusion list should assure that those individuals or entities that are excluded, or whose Medicare billing privileges have been revoked, cannot be paid by Medicare Advantage or Part D.
- All health care providers doing business with Medicare that want to disclose violations of law are eligible to disclose fraudulent conduct under the OIG's Provider Self-Disclosure Protocol.
- State Medicaid programs have additional compliance requirements, e.g., enrollment to provide services for Medicaid managed care plans.
- Other duties as required by contract/network agreement, e.g., fraud, waste and abuse training.

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The Medicare Advantage Landscape



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April 8, 2025

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Ben Curtis/AP

Republicans are proud of creating Medicare Advantage. Now some are urging reform amid runaway costs

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Landscape for Medicare Advantage (MA)

- MA allows Medicare beneficiaries to receive Medicare benefits from private plans rather than from Traditional Medicare Fee-for-Service (FFS)
- 2024 – 54% of Medicare beneficiaries are enrolled in Medicare Advantage; average Medicare beneficiary has access to 43 plans in 2024
- Total number of plans = 3959 per kff.org.
- United Healthcare AND Humana accounted for approximately 47% of lives in 2023 per kff.org.
- Dr. Oz (Trump's CMS Administrator) is on record as supporting expansion of Medicare Advantage.
- Medicare payments to plans = \$453B in 2023. For an explanation as to how plans are paid, see https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_MA_FINAL_SE C.pdf.

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Landscape: MAO Must Provide Basic Benefits

- [42 C.F.R. § 422.2] **Basic benefits** means Part A and Part B benefits except—(1) Hospice services; and (2) Beginning in 2021, organ acquisitions for kidney transplants, including costs covered under section 1881(d) of the Act.
- [42 C.F.R. § 422.100(a)] **Basic rule.** Subject to the conditions and limitations set forth in this subpart, an MA organization offering an MA plan must provide enrollees in that plan with coverage of the basic benefits described in paragraph (c)(1) of this section (except that additional telehealth benefits may be, but are not required to be, offered by the MA plan) and, to the extent applicable, supplemental benefits as described in paragraph (c)(2) of this section, by furnishing the benefits directly or through arrangements, or by paying for the benefits. CMS reviews these benefits subject to the requirements of this section and the requirements in subpart G of this part.
- [42 C.F.R. § 422.100(c)] **Types of benefits.** An MA plan includes at a minimum basic benefits, and also may include mandatory and optional supplemental benefits.(1) Basic benefits are all items and services (other than hospice care or, beginning in 2021, coverage for organ acquisitions for kidney transplants) for which benefits are available under Parts A and B of Medicare, including additional telehealth benefits offered consistent with the requirements at § 422.135.

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“Basic Benefits” Must Comply with Traditional Medicare Rules, Including Who May Provide a Service and in What Setting [per 2024 Final Rule]

- In the Preamble, CMS observed that as originally stated in the June 2020 Final Rule, MAOs must cover all Part A and B benefits (excluding hospice services and the cost of kidney acquisitions) *on the same conditions that items and services are furnished in Traditional Medicare*.
- In the Final Rule, CMS concludes that this basic tenet means that limits or conditions on payment and coverage in the Traditional Medicare program – such as who may deliver a service and in what setting a service may be provided, the criteria adopted in relevant National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs), and other substantive conditions – apply to set the scope of basic benefits as defined in 42 C.F.R § 422.100(c).
- Flexibility for the MA plans to furnish and cover services that do not meet all the conditions of coverage in Traditional Medicare is limited to and in the form of the provision of supplemental benefits.

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Landscape: MAO May Provide Supplemental Benefits

(See “Medicare Advantage Supplemental Benefits: Origins, Evolution, and Issues for Policy Making”, Health Affairs Forefront (Sept. 19, 2024))

- \$64B annual expenditures (1% of payments to MAO plans)
- Originally limited to health-related benefits, e.g., dental, vision and hearing services
- 2019 – CMS expanded definition of “health-related” benefits – added in-home support services by home health aides, caregiver supports, adult daycare services and therapeutic massage
- Bipartisan Budget Act of 2018 – added a third category called Special Supplemental Benefits for Chronically Ill (SSBCI) – benefits first offered in 2020, do not have to be health-related but must “have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee”.
 - Includes food and produce benefits, transportation for non-medical appointments and financial support for living expenses such as rent or utilities; Plans must target SSBCI to enrollees with specific health conditions.
 - Data as to use of supplemental benefits by enrollees is not thought to be complete.

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Landscape: Provider/Plan Relations (not MA Specific)

Key Takeaways:

- Nearly 15 percent of all claims submitted to private payers for reimbursement are initially denied, including many that were pre-approved to move forward through the prior authorization process.
- Denied claims tended to be more prevalent for higher-cost treatments, with the average denial pegged to charges of \$14,000 and up.
- Over half (54.3%) of denials by private payers were ultimately overturned and the claims paid, but only after multiple, costly rounds of provider appeals.
- The average cost incurred by providers fighting denials is \$43.84 per claim – meaning that providers spend \$19.7 billion a year just to adjudicate with payers.

(Per <https://premierinc.com/newsroom/blog/trend-alert-private-payers-retain-profits-by-refusing-or-delaying-legitimate-medical-claims>)

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Top Complaints about Medicare Advantage (as identified by AI overview)

AI responses may include mistakes. This is provided for amusement purposes only as the speakers cannot assess its reliability.

"Top 10 biggest complaints about medicare advantage"

https://www.google.com/search?scaesv=a89d269aec3ce157&rlz=1C1GC EA_enUS1118US1119&sxsrf=AE3TifMjJilHpUL1r9gHti3290ZUHVkBXA:1749011946206&q=Top+10+biggest+complaints+about+medicare+advantage&sa=X&ved=2ahUKEwiZ1oue-daNAxVr_skDHSZgH0IQ1QJ6BAhYEAE&biw=962&bih=624&dpr=1.5

1. Limited Provider Networks: Medicare Advantage plans often have smaller provider networks compared to Original Medicare, meaning you may have fewer doctors and hospitals to choose from. This can be a particular issue if you have a preferred doctor or hospital that's not in the network.

2. High Out-of-Pocket Costs: While Medicare Advantage plans have maximum out-of-pocket limits, these limits can still be quite high. Additionally, you may have to pay more for services outside the network or if you choose a higher-cost plan.

3. Prior Authorization Requirements: Many Medicare Advantage plans require prior authorization for certain medical services, meaning you need to get approval from the insurer before receiving care. This can sometimes lead to delays and bureaucratic hurdles.

4. Denials of Service: Some individuals have reported difficulties getting services covered due to denials by the insurance company. This can be frustrating and can lead to financial burdens.

5. Limited Coverage: Medicare Advantage plans may have coverage limitations compared to Original Medicare, meaning they may not cover certain services or medications. Additionally, some plans may not include prescription drug coverage.

6. Complexity of Plans: The many different types of Medicare Advantage plans, with their varying benefits and costs, can be confusing to navigate. This complexity can make it difficult to choose the right plan for your needs.

7. Limited Coverage for Out-of-Network Care: While some Medicare Advantage plans offer coverage for out-of-network care, it's often limited or comes with higher costs. This can be a problem if you need to see a specialist or have a medical emergency outside of your plan's network.

8. Difficulty Switching Plans Later: It can be difficult to switch from a Medicare Advantage plan back to Original Medicare or to a different plan later on. This can be a concern if you're not happy with your current plan.

9. Changing Benefits: Medicare Advantage plans can change their benefits each year, which can be disruptive to individuals who rely on certain benefits.

10. State-Specific Coverage: Some Medicare Advantage plans have state-specific coverage, which means that coverage may vary depending on your location.

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Medicare Advantage Compliance for Plans

Compliance for Medicare Advantage Plans

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What's new for plans? A new administration and CMS Administrator!

Currently effective regulations & policies under review by the Trump Administration:

- Health Equity Index Reward for the Parts C & D Star Ratings
- Annual health equity analysis of utilization management policies & procedures
- Requirements for MA plans to provide culturally & linguistically appropriate services
- Quality improvement & health risk assessments (HRAs) focused on equity and social determinants of health (SDOH)

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What's new for plans for CY 2026?

Proposed Rule – Not Finalized

- Anti-obesity medication (AOM) coverage
 - Would have applied to Medicare & Medicaid to allow coverage for AOMs when used for treatment of obesity.
 - Current policy remains in place – only covered when used to treat another medically accepted condition (e.g., type 2 diabetes or cardiovascular risk).
- Enhanced guardrails for artificial intelligence (AI)
 - Did not finalize proposals requiring plans to utilize AI in a manner that preserves equitable access, to adhere to existing Medicare regs prohibiting discrimination, and requiring disclosure of use of AI tools.
- Health equity related initiatives in MA & Part D
 - Proposal not finalized to require MAOs to conduct annual health equity analyses of UM policies.
- Behavioral health parity
 - Did not finalize proposals to establish stricter parity protections or expand network adequacy standards.
- Agent & broker oversight
 - Would have broadened definition of “marketing” to enhance agency oversight of materials submitted to CMS and promoting informed choice by requiring agents & brokers to provide more comprehensive information to potential enrollees, such as low-income assistance options & implications of switching to traditional Medicare.
- Promoting transparency for pharmacies
 - Did not finalize or address proposal to require Part D sponsors (or FDRs) to allow pharmacies the right to terminate network contracts without cause following the same notice period that Part D sponsors have for terminating contracts without cause.
- Formulary placement of generics
 - Did not finalize proposal to include additional step in formulary review process to check that Part D sponsors provide broad access to generics, biosimilars, and other lower cost drugs.
- Administration of Supplemental Benefits through Debit Cards
 - Did not finalize proposal to impose new requirements on use debit cards to administer plan-covered benefits, including new guardrails to ensure beneficiaries are fully aware of covered supplemental benefits & how to access benefits.
- Community-Based Services and In-Home Service Contractors
 - Did not finalize or directly address proposals related to improving transparency & beneficiary protections through expanded provider directory requirements.
- Part D Medication Therapy Management (MTM) Program
 - Deferred for subsequent rulemaking a proposal to expand the regulatory list of core chronic diseases used to identify Part D enrollees who have multiple chronic diseases for purposes of determining eligibility for MTM enrollment to include other causes of dementia in addition to Alzheimer's.

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What's new for plans?

Finalized MA & Part D Proposals	Description
Covered Insulin Products & Vaccines	<ul style="list-style-type: none"> • Includes Part D coverage for drug products that are a combination of more than one type of insulin or both insulin and non-insulin drugs. • Eliminate cost sharing for both covered insulin products and for adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) covered under Part D.
Medicare Payment Prescription Plan	<ul style="list-style-type: none"> • Operational processes, election procedures, & outreach requirements. • Automatic renewal: Beginning in 2026, enrollees who participate in the program will be automatically re-enrolled the following year unless they opt out. A separate renewal notice must be sent after the end of the annual election period & include the plan's upcoming terms & conditions. • Voluntary termination: requires plan sponsors to process opt-out requests within 3 calendar days, rather than the initially proposed 24-hour timeframe, to reduce administrative burden.

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What's new for plans?

Finalized MA & Part D Proposals	Description
Medicare Payment Prescription Plan	<ul style="list-style-type: none"> • Standardized communications: new requirements finalized for model & standardized materials, including “likely to benefit” notice, voluntary & involuntary termination notices, & renewal notices. Part D sponsor websites must also display information about the program. • Waiver for LI NET: will not apply to the Limited Income Newly Eligible Transition (LI NET) program. • Election processing & real-time requirements: 24-hour processing requirement for election requests received during the plan year, did not finalize proposed real-time processing requirement for phone or web-based requests.
Timely Submission Requirements for Prescription Drug Event (PDE) Records	<ul style="list-style-type: none"> • General PDEs: within 30 days of claim receipt • Adjustments/deletions: within 90 days of issue discovery • Rejected PDEs: resubmitted within 90 days of rejection notice • Selected drugs (Negotiation Program): initial PDEs due within 7 days to support timely Manufacturer Fair Price refunds.

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What's new for plans?

Finalized MA & Part D Proposals	Description
Medicare Transaction Facilitator Requirements for Network Pharmacy Agreements	<ul style="list-style-type: none"> • Require network pharmacies to be enrolled in the Medicare Drug Price Negotiation Program's Medicare Transaction Facilitator Data Module (MTF DM) & certify accuracy & completeness of enrollment information. • The MTF DM will provide enrolled pharmacies with remittances or ERAs to reconcile Maximum Fair Price (MFP) refund payments when a Primary Manufacturer of a drug selected by CMS for price negotiation chooses to pass payment to the pharmacy through the MTF PM rather than prospectively ensuring that the price paid by the pharmacy entity when acquiring the drug is no greater than the MFP. • Streamlined access for enrolled pharmacies to submit complaints & disputes to help identify issues with timely MFP refund payment. • Central repository for information about enrolled pharmacies that self-report that they anticipate material cashflow concerns due to reliance on retrospective MFP refunds within the 14-day prompt MFP payment window.

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What's new for plans?

Finalized MA & Part D Proposals	Description
Medicare Transaction Facilitator Requirements for Network Pharmacy Agreements	<ul style="list-style-type: none"> View status of MFP refunds from Primary Manufacturers through the MTF DM. Collect & share financial information belonging to enrolled pharmacies with Primary Manufacturers that pay MFP refunds to pharmacies outside the MTF PM. Enrollment expected to begin in June 2025.
Clarifying MA Organization Determinations to Enhance Enrollee Protections in Inpatient Settings	<ul style="list-style-type: none"> Explicitly includes decisions made when a beneficiary is receiving care, particularly inpatient services. Whether a decision is made before, during, or after a service is provided, it must be treated as a formal organization determination. This prevents MA plans from not affording appeal rights by reclassifying care decisions as claims reviews. May not retroactively deny or downgrade previously authorized inpatient admissions, even based on clinical data collected after admission. Only exceptions are fraud or qualifying good cause. Beneficiary's financial liability doesn't attach until an MA plan has made a formal claim determination.

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What's new for plans?

Finalized MA & Part D Proposals	Description
Non-Allowable Special Supplemental Benefits for the Chronically Ill (SSBCI)	<ul style="list-style-type: none"> Non-exhaustive list of non-allowable SSBCI benefits, or non-primarily health related items or services that do not meet the standard of having a reasonable expectation of improving or maintaining the health or overall function of the enrollee: <ul style="list-style-type: none"> Procedures that are solely cosmetic in nature & do not extend upon Traditional Medicare coverage (cosmetic surgery, such as facelifts, or cosmetic treatment for facial lines, atrophy of collagen & fat, & bone loss due to aging) Hospital indemnity insurance Funeral planning & expenses Life insurance Alcohol Tobacco Cannabis products Broad membership programs inclusive of multiple unrelated services & discounts Non-healthy food Did not finalize proposals to expressly incorporate as non-allowable SSBCI "cash & monetary rebates" (which are prohibited by SSA or "gambling items" (online casino games, lottery tickets), firearms & ammunition.

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What's new for plans?

Finalized MA & Part D Proposals	Description
Improving Experiences for Dually Eligible Enrollees	<ul style="list-style-type: none"> Integrated member ID cards for both Medicare & Medicaid plans (limited to Applicable Integrated Plans (AIPs)) AIPs conduct a single, integrated Health Risk Assessment (HRA) for both Medicare & Medicaid, replacing separate HRAs currently utilized for each. Delayed implementation to 1/1/2027. Conduct initial HRA within 90 days of effective date of enrollment. Make at least 3 non-automated phone call attempts, unless enrollee agrees or declines to participate in the HRA before 3 attempts are made, on different days at different times. If enrollee hasn't responded, SNP must send a follow-up letter. SNP must document attempts to contact enrollee, and if applicable, enrollee's choice not to participate. Update ICPs as warranted when there are changes in enrollee's health status or they have a healthcare transition.

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What's new for plans?

Finalized MA & Part D Proposals	Description
Risk Adjustment Data	<ul style="list-style-type: none"> Technical changes to definitions related to risk adjustment data, including Hierarchical Condition Categories (HCC), to remove reference to a specific version of the ICD to keep the HCC definition current as newer versions of the ICD become available & are adopted by CMS. Substitutes terms "disease codes" with "diagnosis codes" and "disease groupings" with "diagnosis groupings". Mandatory submission of risk adjustment data by PACE organizations and Section 1876 Cost plans, consistent with risk adjustment data requirements applicable to MA plans.

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What's new for plans?

Finalized MA & Part D Proposals	Description
Medical Loss Ratio (MLR) Reporting	<ul style="list-style-type: none">• Excludes Medicare Prescription Payment Plan unsettled balances from the MLR numerator.• Not finalized:<ul style="list-style-type: none">• Requiring provider incentive & bonus arrangements tied to clinical or quality improvement standards to be included in the MA MLR numerator;• Requiring administrative costs to be excluded from quality-improving activities in the MA & Part D MLR numerators; and• Codifying current practice by which MA & Part D MLR reports include a description of how expenses are allocated across lines of business.

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Medicare Advantage: Compliance for Providers

Operational impacts for providers: CY 2024 Final Rule, New Enforcement Actions

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What's New for Providers?

- New Administration/ New Priorities
- OIG Compliance Guidance for Managed Care Entities - Delayed
- CY 2024 Final Rule Clarifies Expectations for Coverage in Significant Areas
- CMS Updates the 60-Day Refund Regulation for Parts C and D – Addressing only the Plans
- Litigation Holds Providers Responsible for Compliance with MA Rules

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Medicare Advantage Regulations and Privity

- Regulations for the Medicare Advantage Program (MA) are located in 42 CFR Part 422.
- Subpart E includes criteria that must be passed through from the MA organization to health care providers via contract:
“sets forth the requirements and standards for the MA organization's relationships with providers including physicians, other health care professionals, institutional providers and suppliers, under contracts or arrangements or deemed contracts under MA private fee-for-service plans.” 42 C.F.R. § 422.200.
- While health care providers performing services for Medicare beneficiaries and/or MA enrollees may be enrolled in Medicare, they do not have direct “privity” with CMS with respect to the requirements in 42 C.F.R. Part 422.

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2025 Update: CMS Revises 60-Day Overpayment Refund Rule for Parts C & D

- Final Rule published December 9, 2024; effective January 1, 2025
- Revises provisions for both A/B and C/D overpayments
 - Note applicability to MAOs, not to providers of services to MAOs (lack of privity)
- Changes the standard for refunds required when an overpayment is “identified” from “reasonable diligence” to the False Claims Act standard of “knowingly receives or retains an overpayment”
- The 6-month period for investigation (in addition to the 60-days) is limited to Parts A/B as there are other alternatives to correct mistakes available to Parts C/D plans.

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The 2024 (CY 2024) Final Rule, 88 Fed. Reg. 22120 (Apr. 12, 2023)

On April 12, 2023, CMS issued a rule (the “2024 Final Rule”) amending regulations for MA, or Part C effective on June 5, 2023 and generally applicable to coverage beginning January 1, 2024:

- Designed to address operational approaches by MA organizations that were inappropriately delaying and limiting access to medically necessary and reasonable care;
- Had a significant impact on MAOs, health care providers and suppliers of services to MAO; and
- May result in increased costs and reduced flexibility for MA plans as to how they meet the requirements to provide the basic benefits available under Traditional Medicare.

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The CY 2024 Final Rule

The 2024 Final Rule focused on the following areas:

- Parts C/D Quality Rating Systems;
- Health Equity in Part C;
- **Utilization Management Requirements**;
- Parts C/D Marketing;
- Behavioral Health in Part C;
- Enrollee notification requirements for Part C Contract Terminations;
- Limited income newly eligible transition (LI NET); and
- Expanding Eligibility for low-income Subsidies under Part D.

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2024 Final Rule Clarifies Applicability of Some Traditional Medicare Rules

Some Traditional Medicare coverage criteria may – or may not – apply to MA plans.

- **Two Midnight Rule Benchmark.** CMS confirmed that 42 C.F.R. § 412.3 applies. CMS distinguishes between the two midnight benchmark (42 C.F.R. § 412.3(d)), which specifies when inpatient admissions will be considered covered by CMS, and the two midnight presumption. The benchmark applies to MA plans, but the two midnight presumption (which is in essence an audit approach where Medicare contractors do not look behind the orders of the treating physician that inpatient care is medically necessary and reasonable if the two midnight benchmark applies), does not apply to MA plans.

See also, CMS, Frequently Asked Questions related to Coverage Criteria and Utilization Management Requirements in CMS Final Rule (CMS-4201-F) (Feb. 6, 2024) (hereinafter “CMS FAQs”); see also 88 Fed. Reg. 22120 (Apr. 12, 2023).

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2024 Final Rule Clarifies Applicability of Some Traditional Medicare Rules (cont.)

- Inpatient Only (IPO) List Applies to MA. Section 422.101(b)(2) was revised to state the applicability of the IPO list. CMS notes that when there are conditions associated with a basic benefit, including the prescribed setting for the service, the MA plan must meet those conditions in order for it to be considered a basic benefit. The same service in an alternate setting would be considered to be a supplemental benefit.
- Three-Day Stays for Qualification for SNF Benefit Not Necessarily Required. As noted in the Final Rule, in accordance with 42 C.F.R. § 422.101(c), MA plans may elect to furnish, coverage of SNF care in the absence of a prior qualifying hospital stay.

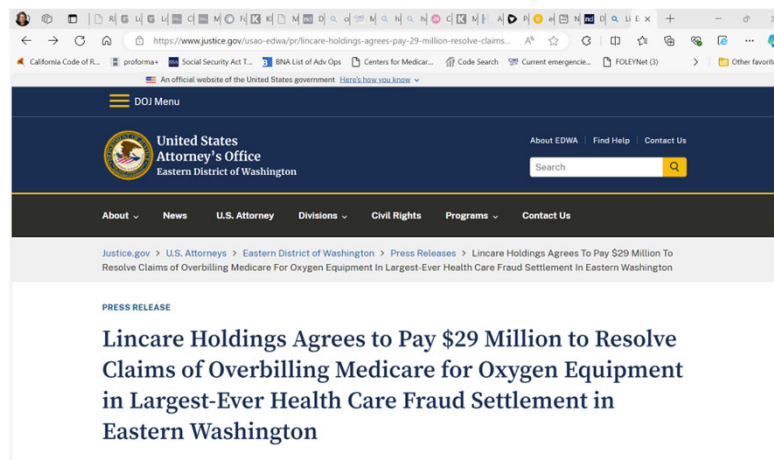
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DOJ Enforcement Actions Against MA Providers - Lincare



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Lincare CIA

Claims Review. The IRO shall review claims submitted by Lincare and reimbursed by the Medicare program and Medicare Advantage Organizations (MAOs) to determine whether the items and services furnished were medically necessary and appropriately documented and whether the claims were correctly coded, submitted, and reimbursed (Claims Review) and shall prepare a Claims Review Report, as outlined in Appendix B to this CIA, which is incorporated by reference.

Lincare CIA (cont.)

First Reporting Period Reviews. [. . .]Lincare shall identify the five MAOs from which it received the highest amount of revenues during the prior 12-month period and that have a 36-month limit on payments for Oxygen Equipment Rental. The IRO (or the OIG, at its discretion) shall randomly select two MAOs from the five MAOs identified by Lincare for purposes of the sampling described in this paragraph (referred to as the "Selected MAOs").

a. Oxygen Equipment Rental Review. For the first Reporting Period, the IRO shall select a random sample of 30 Medicare program beneficiaries from the Oxygen Equipment Rental Review Population and 15 beneficiaries from each of the two Selected MAOs (each of the three (3) subset samples shall be an "Oxygen Equipment Rental Review Sample"). The IRO shall review all Paid Claims in the Oxygen Equipment Rental Review Sample only for oxygen equipment rental items or services for the selected beneficiaries based on Lincare's documentation and the applicable Medicare program requirements and MAO requirements specific to that MAO.... The applicable Error Rate, as defined in Section A.1.g., for each of the three (3) subset samples shall be calculated against the applicable Oxygen Equipment Rental Review Sample.

DOJ Enforcement Actions: Provider Falsification of MA Diagnoses



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Plan Compliance Obligations – Administrative Enforcement

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The changing environment for enforcement actions against plans and providers.

Date Action Taken	Organization Name	Action Taken	Basis for Action
2025-1-17	Humana Inc.	Civil Money Penalty (\$99,064)	2021 Financial Audit – failed to reprocess prescription drug claims in accordance with enrollee's LIS levels within 45 days of receiving complete information regarding enrollees LIS status.
	Centene Corporation	Civil Money Penalty (\$2,000,000)	2021 Financial Audit – charged enrollees more than the annual Part C MOOP limit.
	Baylor Scott & White Holdings	Civil Money Penalty (\$37,816)	2021 Financial Audit – overcharged enrollees for Part C medical services & charged enrollees more than the annual Part C MOOP limit.

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The changing environment for enforcement actions against plans and providers.

Date Action Taken	Organization Name	Action Taken	Basis for Action
2025-1-17	Medco Containment Life and Medco Containment NY	Civil Money Penalty (\$32,364)	2021 Financial Audit – failed to reprocess prescription drug claims in accordance with enrollee's LIS levels within 45 days of receiving complete information regarding enrollees LIS status.
	The Carle Foundation	Civil Money Penalty (\$101,500)	2021 Financial Audit – charged enrollees more than the annual Part C MOOP limit.
	Elevance Health, Inc.	Civil Money Penalty (\$149,060)	2021 Financial Audit – overcharged enrollees for Part C medical services & charged enrollees more than the annual Part C MOOP limit.

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The changing environment for enforcement actions against plans and providers.

Date Action Taken	Organization Name	Action Taken	Basis for Action
2025-1-17	Molina Healthcare, Inc.	Civil Money Penalty (\$67,976)	2021 Financial Audit – failed to reprocess prescription drug claims in accordance with enrollee's LIS levels within 45 days of receiving complete information regarding enrollees LIS status.
2025-4-1	Aware Integrated Inc.	Civil Money Penalty (\$31,088)	2024 Program Audit – inappropriate rejection of formulary medications due to errors with enrollees' eligibility files.

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The changing environment for enforcement actions against plans and providers.

Date Action Taken	Organization Name	Action Taken	Basis for Action
2025-4-1	Point32 Health, Inc	Civil Money Penalty (\$55,796)	2024 Program Audit – inappropriate rejection of formulary medications due to errors with enrollees' eligibility files & did not consistently identify & initiate coverage requests when enrollees called; misrouted coverage requests to incorrect department.
	BlueCross BlueShield of Tennessee, Inc.	Civil Money Penalty (\$21,692)	2024 Program Audit – inappropriate rejection of formulary medications due to errors with enrollees' eligibility files

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The changing environment for enforcement actions against plans and providers.

Date Action Taken	Organization Name	Action Taken	Basis for Action
2025-4-1	Geisinger Health Plan	Civil Money Penalty (\$5,800)	2024 Program Audit – incorrect “Individual Start Date” loaded in PBM’s adjudication system resulting in inappropriate rejection of transition supply.
	Presbyterian Health Plan	Civil Money Penalty (\$14,152)	2024 Program Audit – when switched to a new PBM, active authorizations were not properly carried over and claims were rejected even though enrollee had approved prior authorization.

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The changing environment for enforcement actions against plans and providers.

Date Action Taken	Organization Name	Action Taken	Basis for Action
2025-4-1	Centene Corporation	Civil Money Penalty (\$20,648)	2024 Program Audit – when enrollees submitted coverage or appeal requests as part of a complaint, did not initiate the request until a fax request form was returned from the prescriber.
	Molina Healthcare, Inc.	Civil Money Penalty (\$285,476)	2024 Program Audit – programming errors generated an inaccurate eligibility file sent to PBM which inappropriately voided enrollees’ active coverage & rejected enrollee claims for “coverage terminated” even though enrollee had active coverage.

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The changing environment for enforcement actions against plans and providers.

Date Action Taken	Organization Name	Action Taken	Basis for Action
2025-4-3	EternalHealth, Inc.	Suspension of Enrollment	Failed to meet state financial solvency requirements.
2025-4-11	BoldAge PACE	Civil Money Penalty (\$47,596)	2024 Program Audit – Did not provide all approved services and did not track, document, and monitor provision of services across all care settings.
	LIFE Northwestern Pennsylvania, LLC	Civil Money Penalty (\$47,596)	2024 Program Audit – Did not provide all approved services and did not track, document, and monitor provision of services across all care settings.

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The changing environment for enforcement actions against plans and providers.

Date Action Taken	Organization Name	Action Taken	Basis for Action
2025-4-11	Suncoast PACE, Inc.	Civil Money Penalty (\$47,596)	2024 Program Audit – Did not provide all approved services and did not track, document, and monitor provision of services across all care settings. Insufficient providers & staff to provide all necessary services & failed to understand PACE program requirements.

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Conclusions!

- Medicare Advantage is an area of focus for plans, providers, the Trump Administration, and the general public.
- The expectations for compliance for MA plans are ever increasing.
- The expectations for compliance for MA providers are emerging, with high risk for non-compliance.

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Questions?

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