Medicare Advantage: Audits

THE BETTER WAY

REAFFIRMING THE PROMISE OF MEDICARE ADVANTAGE FOR NURSING HOME CARE: PAYMENT AUDITS

Healthcare providers nationwide are increasingly burdened by the payment audit and utilization management practices of certain Medicare Advantage (MA) plans. While audits play a legitimate role in safeguarding program integrity, there is a growing and deeply concerning trend of excessive, arbitrary, and inconsistent audit activity that disproportionately targets long term care and post-acute care (LTPAC) providers and disrupts the delivery of timely, medically necessary care.

Providers consistently report a high volume of prepayment and retroactive (post-payment) audits for pre-approved services that lack clinical nuance or good cause and appear to be driven primarily by cost containment objectives rather than evidence-based care review. The administrative burden imposed by these audits is substantial with some plans auditing over 90% of all claims. Providers must invest significant resources to respond to the high volume of documentation requests, diverting time away from patient care. Retroactive denials may induce payment claw backs, threatening financial sustainability even though the service met medically necessary criteria and was previously approved and paid for. Even when services are ultimately deemed to meet coverage requirements, the delay in payment and the effort required to respond to audits create financial strain and operational inefficiencies.

The current audit practices of some MA plans reflect a misalignment between the goals of program integrity and the realities of clinical care delivery. Without greater transparency, standardization, and oversight, these practices risk eroding provider participation and compromising patient access to timely, high-quality care.

THE BETTER WAY

Thoughtful reform of Medicare Advantage audit practices should prioritize greater transparency, standardization, and oversight. Audits must be initiated and conducted for good cause and not be arbitrary or without merit, since overly burdensome or inconsistent auditing risks eroding provider participation and compromising patient access to timely, high-quality care. Medicare Advantage plans should be prohibited from retroactively denying or clawing back payments for care authorized and delivered in good faith, except in cases of fraud, waste, or abuse. Current audit practices too often misalign program integrity goals with clinical realities, underscoring the need for balanced solutions that protect integrity while supporting efficient care delivery and reducing unnecessary administrative strain.