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Jessica L. Bailey-Wheaton, Esq., Editor
Todd A. Zigrang, MBA, MHA, FACHE, CVA, ASA, ABV, Publisher

Valuation of MA Plans: Regulatory Environment

Healthcare provider organizations, including Medicare Advantage organizations (MAOs), face a range of federal and state legal and regulatory constraints, which affect their formation, operation, procedural coding and billing, and transactions. This final installment of the three-part series on the valuation of Medicare Advantage (MA) plans will review the regulatory environment in which these plans operate.

The MA Program is regulated under Title 42, Part 422 of the Code of Federal Regulations (CFR), but because MA organizations (MAOs) that wish to operate MA plans must have an insurance license in every state in which they operate, their conduct is also governed by state law. Federal law requires MA plans to offer the same benefits as Original Medicare, but they are also permitted to cover additional benefits, subject to the approval of the Centers for Medicare & Medicaid Services (CMS). Further, a plan is required to have an adequate network of providers who can offer all necessary services to the plan's beneficiaries, known as network adequacy. In order to demonstrate network adequacy, MAOs are required to file annual Health Service Delivery (HSD) tables to show the plan has enough facilities, primary care and specialty physicians, and other provider types within a certain time and distance requirement set by CMS.[1] To have proper network adequacy, an MAO must have contracts with these providers. CMS has several requirements that must be included in each provider contract between a MAO and a provider. It is then left to the two parties to negotiate a payment rate.

As MA utilization (by both MAOs and Medicare beneficiaries) has grown, so has regulatory enforcement of MA plans and organizations. In a September 2021 report, the U.S. Department of Health & Human Services (HHS) Office of Inspector General (OIG) found that MAOs were leveraging chart reviews and health risk assessments to maximize risk-adjustment payments – in other words, MA plans were fraudulently depicting their patients as sicker than they actually were in order to obtain higher payments from Medicare.[2] Subsequently, in April 2022, the OIG issued a report finding that 15 of the largest MAOs "have at times denied or delayed beneficiary access to care and provider payment requests for services that met Medicare coverage and MAO billing rules."[3] As a result, the OIG recommended that CMS:

(1) "Issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews";
(2) "Update its audit protocols to address the issues identified in this report, such as MAO use of clinical criteria, and/or examine particular service types"; and,
(3) "Direct MAOs to take additional steps to identify and address vulnerabilities that can lead to manual review errors and system errors."[4]

CMS concurred with all three of these OIG recommendations,[5] indicating that additional MA regulation may be forthcoming.

In addition to additional regulations aimed at MAOs, the U.S. Department of Justice (DOJ) has been active over the past decade in regulatory enforcement, largely by pursuing fraud actions against MAOs. A recent New York Times review of "dozens of fraud lawsuits, inspector general audits and investigations by watchdogs" found that 9 of the top 10 MAOs have been accused of fraud, largely in the form of overbilling, which has resulted in overpayments from Medicare totaling billions of dollars.[6] As recently as 2022, the DOJ has made clear in press releases that one of its priorities is "investigating and litigating a growing number of matters related to the Medicare Advantage program."[7]

MAOs are expected to face increased enforcement and scrutiny going forward, as MA grows in terms of enrollment and federal spending.[8] Enforcement actions against MAOs have largely focused on violations of the False Claims Act (FCA), and has primarily involved risk adjustment activities.[9] Allegations, which vary among MAOs, include:

(1) Adding unsupported diagnosis codes;
(2) Conducting "one-sided" reviews of patient charts to identify codes (but not deleting them);

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(4) Developing data mining software to identify missed diagnosis codes, and using addenda to retroactively add them;
(5) Using vendors to identify diagnosis codes through in-home assessments of patients; and
(6) Failing to delete diagnosis codes that are not supported.[10]

In a 2022 report, the HHS OIG criticized MAOs for using prior authorization to deny their members access to services that were medically necessary, and to deny payments to providers for these services.[11] The OIG is also expected to increase enforcement actions against MAOs for denial of services that are deemed medically necessary.[12]

On April 5, 2023, CMS released a final rule that would increase the oversight of MA plans, and align them more with Original Medicare plans.[13] This ruling would:

- Access gaps in behavioral health services;
- Further streamline the prior authorization process;
- Establish additional health plan utilization management oversight processes to include required annual reviews of MA plan policies;
- Establish reviews of coverage denial reviews by healthcare professionals with relevant expertise;
- Tighten MA marketing rules to protect beneficiaries from misleading advertisements and pressure tactics;
- Expand requirements for MA plans to provide culturally and linguistically appropriate services; and
- Make changes to MA star ratings to address social determinants of health.[14]

The various government actions described above, with the most recent final rule from CMS, indicate that the federal government may continue its relatively intense regulatory scrutiny of MA plans in the future. CMS, which regulates MAOs, has been urged by MedPAC, the OIG, and the U.S. House of Representatives, among others, to increase oversight and enforcement of MA plans.[15] Whether it will heed these urgings, and further intensify MA scrutiny, remains to be seen.

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9 *Ibid*.

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Todd A. Zigrang, MBA, MHA, FACHE, CVA, ASA, ABV, is the President of **HEALTH CAPITAL CONSULTANTS** (HCC), where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 25 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 2,000 transactions and joint ventures. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

Mr. Zigrang is the co-author of "*The Adviser's Guide to Healthcare - 2nd Edition*" [AICPA - 2015], numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: *The Guide to Valuing Physician Compensation and Healthcare Service Arrangements* (BVR/AHLA); *The Accountant's Business Manual* (AICPA); V*aluing Professional Practices and Licenses* (Aspen Publishers); *Valuation Strategies; Business Appraisal Practice*; and, *NACVA QuickRead*. Additionally, Mr. Zigrang has served as faculty before professional and trade associations such as the American Society of Appraisers (ASA); the National Association of Certified Valuators and Analysts (NACVA); the American Health Lawyers Association (AHLA); the American Bar Association (ABA); the Association of International Certified Professional Accountants (AICPA); the Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute.

Mr. Zigrang holds a Master of Science in Health Administration (MHA) and a Master of Business Administration (MBA) from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives (FACHE) and holds the Certified Valuation Analyst (CVA) designation from NACVA. Mr. Zigrang also holds the Accredited Senior Appraiser (ASA) designation from the American Society of Appraisers, where he has served as President of the St. Louis Chapter. He is also a member of the America Association of Provider Compensation Professionals (AAPCP), AHLA, AICPA, NACVA, NSCHBC, and, the Society of OMS Administrators (SOMSA).

Jessica L. Bailey-Wheaton, Esq., is Senior Vice President and General Counsel of HCC. Her work focuses on the areas of Certificate of Need (CON) preparation and consulting, as well as project management and consulting services related to the impact of both federal and state regulations on healthcare transactions. In that role, Ms. Bailey-Wheaton provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services.

Additionally, Ms. Bailey-Wheaton heads HCC's CON and regulatory consulting service line. In this role, she prepares CON applications, including providing services such as: health planning; researching, developing, documenting, and reporting the market utilization demand and "need" for the proposed services in the subject market service area(s); researching and assisting legal counsel in meeting regulatory requirements relating to licensing and CON application development; and, providing any requested support services required in litigation challenging rules or decisions promulgated by a state agency. Ms. Bailey-Wheaton has also been engaged by both state government agencies and CON applicants to conduct an independent review of one or more CON applications and provide opinions on a variety of areas related to healthcare planning. She has been certified as an expert in healthcare planning in the State of Alabama.

Ms. Bailey-Wheaton is the co-author of numerous peer-reviewed and industry articles in publications such as: The Health Lawyer; Physician Leadership Journal; The Journal of Vascular Surgery; St. Louis Metropolitan Medicine; Chicago Medicine; The Value Examiner; and QuickRead. She has previously presented before the ABA, the NACVA, and the NSCHBC. She serves on the editorial boards of NACVA's QuickRead and AHLA's Journal of Health & Life Sciences Law.

Janvi R. Shah, MBA, MSF, serves as Senior Financial Analyst of HCC. Mrs. Shah holds a M.S. in Finance from Washington University Saint Louis. She develops fair market value and commercial reasonableness opinions related to healthcare enterprises, assets, and services. In addition she prepares, reviews and analyzes forecasted and pro forma financial statements to determine the most probable future net economic benefit related to healthcare enterprises, assets, and services and applies utilization demand and reimbursement trends to project professional medical revenue streams and ancillary services and technical component (ASTC) revenue streams.

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