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Private Equity in the Crosshairs: Administration Continues to Raise Questions Over Role of Private Equity in Long Term Care

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Over the past year, the Biden administration has expressed serious doubts about the developing role of private equity investment in the long term care industry. In a Fact Sheet released in late February 2022, the White House cited a number of concerns, which President Biden echoed in his State of the Union on March 1, 2022. While industry advocates and leaders have repeatedly disputed the validity of many of these concerns, the government continues to announce False Claims Act settlements involving health care providers and private equity owners.

In a move designed to help federal, state, and local governments identify entities backed by private equity and increase accountability, President Biden announced several changes to certain disclosure requirements in his February 7, 2023, State of the Union address. That announcement was closely followed by the release of proposed regulations that would change Medicare and Medicaid enrollment disclosure requirements for long term care facilities.

Specifically, the proposal seeks to implement Section 6101 of the Affordable Care Act (and Section 1124(c) of the Social Security Act), to require additional disclosure of ownership and managerial information in the enrollment and revalidation processes for Medicaid and Medicare providers.

The proposed regulations would significantly increase the types of relationships that must be reported as part of Medicare and Medicaid enrollment by creating a new category – "additional disclosable party" – broadly defined to include any individual or entity that:

- Exercises operational, financial, or managerial control over the facility;
- Provides policies or procedures for any operations of the facility;
- Provides cash management services to the facility;
- Leases or subleases real property to the facility;
- Owns a whole or part interest equal to or exceeding five percent of the total value of the property;
- Provides management or administrative services, management; or
- Provides clinical consulting, accounting, or financial services to the facility.

Not only would these individuals and entities have to be disclosed, so too would their organizational structures. Currently, Medicare and Medicaid only require facilities to report five percent or greater indirect ownership in the facility. But under the proposed regulations, an "additional disclosable party" would be required to disclose its own ownership interests, regardless of whether that ownership overlaps with the ownership in the facility itself.

The proposed rule would also require facilities to specifically identify whether a disclosed party is a "private equity company" or a real estate investment trust (REIT). CMS proposes to use simplistic definitions of these terms, but acknowledges that these may not necessarily align with existing industry definitions. Under the proposed definitions, a private equity company would mean "a publicly traded or non-publicly traded company that collects capital investments from individuals or entities and purchases an ownership share of a provider."

A REIT would mean "a publicly traded or non-publicly traded company that owns part or all of the buildings or real estate in or on which the provider operates."

CMS also proposes to expand the types of managing employees who must be disclosed by facilities, including "an individual, including a general manager, business manager, administrator, director, or consultant who directly or indirectly manages, advises, or supervises any element of the practice, finances, or operations of the facility."

The proposed rule would require facilities to provide the expanded disclosures at initial enrollment and revalidation, and to report any changes or updates to ownership and control information within 30 days of the change. Importantly, CMS stated its intent to make information reported under these new provisions publicly available.

These proposed changes are significant and likely to create additional administrative burdens for long term care facilities and organizations that are already heavily regulated. Among other things, the broadened and/or additional definitions and heightened reporting requirements will necessitate frequent updates to a facility's Medicare and Medicaid enrollment record. Further, while CMS states that Medicare will not duplicate the collection of information already obtained via the 855A enrollment application, Medicaid programs have fewer uniform mechanisms for enrollment and reporting that can vary by state.

Moving forward, long term care facilities may expect that ownership information, including disclosures related to any changes in ownership, will be a focus of regulatory enforcement.

CMS has broad discretion to revoke Medicare billing privileges for failure to report enrollment changes and maintain an accurate enrollment record. Whether such disclosures will be said to be "material" to the government's decision to reimburse claims – potentially creating a new line of False Claims Act liability – remains to be seen.

If you have questions about this topic, reach out to Thomas H. Barnard, Alison Schurick, Kathleen R. Salsbury, Sabrina Marquez, or any member of Baker Donelson's Long Term Care Team.