

MedPAC Examines Private Equity Involvement in Medicare

In 2020, at the request of the U.S. House Committee on Ways and Means (the Committee), the Medicare Payment Advisory Commission (MedPAC) began investigating the role that private equity (PE) plays in healthcare provided to Medicare beneficiaries. In its June 2021 “Report to the Congress on Medicare and the Health Care Delivery System,” MedPAC included for the first time a chapter on PE’s effect on Medicare, wherein it discussed the findings and observations from its investigation and answered a number of questions posed by the Committee. This Health Capital Topics article will analyze MedPAC’s answers to those questions, review its investigation of PE’s role in healthcare, and summarize reactions from stakeholders.

Over the past decade, the number of deals involving PE has increased, from 107 physician medical group deals in 2011 (totaling \$464 million) to 188 in 2020 (totaling \$3.5 billion).¹ In total, PE firms were involved in 1,329 physician medical group deals over the past 10 years, signaling a growing interest in this healthcare sector.²

Due to PE’s growing interest and involvement in healthcare, the U.S. House Committee on Ways and Means (the Committee) requested in March 2020 that MedPAC investigate PE’s effect on Medicare, focusing on the following four questions:

- “1. *What are the current gaps in Medicare data that create issues tracking private equity investments in Medicare? Are there levers that facilitate or allow for the collection of PE-related information in the current Change of Ownership (CHOW) process administered by the Centers for Medicare & Medicaid Services (CMS)?*
2. *What are private equity funds’ business models when investing in health care? How do these strategies vary by health care setting?*
3. *How has private equity investment in health care affected Medicare costs and the beneficiary and provider experience?*
4. *To what extent are private equity firms investing in companies that participate in Medicare Advantage, and is it possible to evaluate the effects of such investments on Medicare costs?”³*

In answer to the Committee’s first question regarding current gaps in Medicare data that create tracking issues with PE investments, MedPAC did find gaps in tracking PE’s effect on Medicare. If an entity wants to participate in a PE-related CHOW, it must adhere to CMS’s approval process, wherein the CHOW is reported to the Provider Enrollment, Chain, and Ownership System (PECOS).⁴ However, this system is based on self-reporting providers, and CMS has no centralized data source for verifying PE ownership or financial details of PE transactions.⁵ CMS only collects data on provider ownership to support the Medicare enrollment process, payment, fraud, and law enforcement.⁶ When a CHOW occurs, PECOS does not require provider organizations to submit a hierarchy of parent organizations.⁷ Since PECOS does not closely track ownership data, providers may structure themselves within multi-level corporations that makes ownership difficult to trace, limiting their legal liability.⁸ However, improving transparency of ownership could help beneficiaries when choosing a provider as well as researchers investigating the effects of PE in healthcare.

In MedPAC’s answer to the Committee’s first question, the Commission reported that increased transparency has become a growing concern, especially in nursing homes, which rely heavily on Medicare funding. Over the past few decades, nursing homes have been restructuring from one entity to several single-purpose entities (SPEs).⁹ MedPAC found that unpacking the hierarchy of control in these relationships is often difficult for those involved in the approval process, and applicants may not provide complete information unless specifically asked.¹⁰ For example, stakeholders are concerned that some high-profile nursing home bankruptcies have occurred over the past few years, but there may not be an entity to blame because the hierarchy is ambiguous.¹¹ Consequently, stakeholders are pushing for policies that improve and expand the required information reported to PECOS. MedPAC concluded their answer to the Committee’s first question by indicating that evolving legal structures will continue to prevent CMS from making most data public; however, access to more complete ownership data could improve CMS’s ability to address quality, access, and spending benchmarks, and whether to extend billing privileges.¹²

The Committee's second question requested that MedPAC investigate the types of business models PE funds use when investing in different healthcare settings. MedPAC remarked again that due to limited data sources for PE ownership, the actual numbers of providers with PE investment may be higher than estimated.¹³ MedPAC examined the business models of hospitals, nursing homes, and physician practices and found that PE firms currently have at least some ownership in 4% of hospitals, 11% of nursing homes, and 2% of provider practices.¹⁴ Once a PE firm acquires a hospital, practice, or nursing home, its main goal is to make the entity more profitable, either by reducing costs (such as lowering labor costs), increasing revenues (such as through providing the most profitable mix of services), or some combination of the two.¹⁵ The pressure for PE investors to quickly make a return within a five to seven year timeframe has raised concerns regarding quality, safety, and referral issues.¹⁶ Other PE business models, and related strategies, are specific to the particular healthcare sub-sector. For instance, hospitals and nursing homes may sell their real estate to PE firms and become tenants of that PE firm.¹⁷ For PE firms, buying real estate from hospitals or nursing homes provides them with opportunities to reduce their corporate taxes if they meet requirements for real estate investment trusts (REITs).¹⁸ Additionally, REITs are beneficial to PE firms because the nursing homes pay a portion of their income to the REITs, thus shifting nursing home profits to the REITs and further reducing corporate taxes.¹⁹ In hospitals, PE firms may advise the hospital to sell some of their real estate holdings and allocate any profits among the hospital and its PE investors.²⁰ Another strategy PE firms use to make a profit is through the acquisition and subsequent consolidation of physician practices and hospitals within a region.²¹ Because many of these acquisitions and consolidations are relatively smaller in value (\$60-70 million), they tend to fly under the radar of antitrust enforcement agencies and "quietly increase market power and reduce competition."²² Ultimately, PE acquisitions are predicted to stay small for hospitals, remain constant in nursing homes, and grow among physician practices.²³

The Committee's third question to MedPAC asked how PE investment affected Medicare costs and beneficiary and provider experiences. While interviewing physicians for the report, MedPAC established that quality of care metrics and practice patterns did not change as a result of PE investment. Further, the metrics and patterns have improved because the physicians do not have to focus as much attention on running a business and can focus more on the clinical side of a practice.²⁴ A February 2021 study from the National Bureau of Economic Research (NBER) found similar results when investigating PE-owned nursing homes. The NBER study reported that PE-owned facilities had positive impacts not only on the quality of clinical services, but also benefited the healthcare organization overall.²⁵ Further, NBER found that PE investment in nursing homes may lead to better quality through "better management, stronger incentives,

and greater access to credit."²⁶ As regards hospitals, MedPAC found that PE-owned hospitals were more inclined to report lower costs and patient satisfaction than other hospitals (such as non-profit or federal, state, or local hospitals), but this did not directly impact Medicare costs.²⁷ Lastly, there is minimal evidence of PE's impact on Medicare costs in physician practices. However, PE firms may increase Medicare costs by putting pressure on physicians to perform more services and procedures to increase revenue.²⁸

The Committee's fourth and final question regarded the extent to which PE firms are investing in companies and startups that participate in Medicare Advantage (MA), as well as the effects of the investments on Medicare costs. Again, MedPAC's results on Medicare costs may be inconclusive due to a lack of data.²⁹ However, the commission did find that PE funds own six companies of the 309 payors that offer MA plans who mainly target beneficiaries in nursing homes.³⁰ Through their research, MedPAC found that MA plans would not have an effect on Medicare spending unless they influenced plan bids, quality bonuses, or risk scores.

While the regulatory, demographic, and payment conditions that have made health care an attractive investment other regulations such as those related to the corporate practice of medicine (CPOM) may drive PE firms away from healthcare investments.³¹ CPOM laws vary by state, but were enacted primarily out of concern that PE ownership obligations to shareholders may not align with a physician's duty to patients or medical judgments.³² After a PE firm buys or invests in a provider practice, they must not influence or appear to influence a physician's behavior.³³ If a PE firm is suspected of influencing a physician's decision making, this could trigger enforcement of CPOM laws or raise concerns about inducement of services under the Anti-Kickback Statute or the False Claims Act.³⁴ However, some physicians still seek PE ownership so they can focus on their clinical practice and be less involved (and burdened) with day-to-day management and operations.

As of the date of this article's publication, a number of stakeholders have spoken out about MedPAC's investigation. First, the American Investment Council touted PE's important role in improving patient care, providing capital, and creating innovation that will reduce Medicare costs, even though no recommendations were outlined in the report.³⁵ Further, the American Investment Council said that providing capital to healthcare organizations has been vital to lowering healthcare costs, delivering necessary treatments, and driving research.³⁶ Second, the American College of Emergency Physicians (ACEP) highlighted the need to close gaps in Medicare data for PE-owned provider practices, nursing homes, and hospitals, and that data was often incomplete.³⁷ ACEP found that PE firms' common strategy is to first acquire a "platform practice," then subsequently acquire multiple smaller physician practices in a region and then "roll up" the practices into the platform practice to maximize the combined entity's

market power and create a continuum of care.³⁸ This strategy, however, does not always lead to cost savings.³⁹

While MedPAC's June 2021 report found that PE investors have had increased interest and involvement in healthcare, mainly through hospitals, nursing homes, physician practices, and MA companies, their percent of ownership remains relatively small among the entire healthcare industry.⁴⁰ The major concerns surrounding

the recent increases of PE in healthcare are the consolidation of providers and increased market power to raise payment rates, which may have insignificant effects on Medicare because those prices are set by CMS (i.e., not negotiated).⁴¹ MedPAC's final comment in its report concluded that the commission will continue to monitor investment activity to see if certain sectors will highlight the need for regulation in payment or quality measures in future years.⁴²

1 "The Health Care M&A Report, 4th Quarter, 2011" Norwalk, CT: Irving Levin Associates, Inc., 2012, p. xxxvii; "The Health Care M&A Report, 4th Quarter, 2020" Norwalk, CT: Irving Levin Associates, Inc., 2021, p. 35.

2 As derived and calculated from reported Physician Medical Group transactional data from The Healthcare M&A Report by Irving Levin Associates, Inc. Quarterly Reports from 2011 to 2020.

3 "Report to the Congress: Medicare and the Health Care Delivery System" Medicare Payment Advisory Commission, June 2021, http://www.medpac.gov/docs/default-source/reports/jun21_medpac_report_to_congress_sec.pdf?sfvrsn=0 (Accessed 6/28/21), p. 75.

4 *Ibid.*, p. 81.

5 *Ibid.*

6 *Ibid.*

7 *Ibid.*, p. 72.

8 *Ibid.*, p. 72, 81-82.

9 *Ibid.*, p. 81.

10 *Ibid.*

11 *Ibid.*, p. 84.

12 *Ibid.*, p. 85.

13 *Ibid.*, p. 72.

14 2% of provider practices only include acquisitions from 2013-2016. Does not include previous transactions, or take into account how PE acquisitions of provider practices have grown since 2016; *Ibid.*, p. 72.

15 *Ibid.*, p. 72-73, 89.

16 *Ibid.*, p. 98, 100.

17 *Ibid.*, p. 91.

18 *Ibid.*, p. 108.

19 *Ibid.*

20 *Ibid.*, p. 79.

21 *Ibid.*, p. 93.

22 *Ibid.*, p. 94.

23 *Ibid.*, p. 94-96.

24 *Ibid.*, p. 96.

25 "Does Private Equity Investment in healthcare Benefit Patients? Evidence from Nursing Homes" By Atul Gupta et al., Nation Bureau of Economic Research, February 2021, https://www.nber.org/system/files/working_papers/w28474/w28474.pdf (Accessed 6/28/21), p. 1.

26 *Ibid.*, p. 10.

27 Medicare Payment Advisory Commission, June 2021, p. 100.

28 *Ibid.*, P. 101.

29 *Ibid.*, p. 73.

30 *Ibid.*

31 *Ibid.*, p. 91.

32 *Ibid.*

33 *Ibid.*

34 *Ibid.*

35 "Private Equity Investments Support American Health Care & COVID-19 Response" American Investment Council, February 18, 2021, <https://www.investmentcouncil.org/icymi-new-medpac-report-highlights-value-of-private-equity-investments-in-health-care/> (Accessed 6/29/21).

36 "ICYMI: New MedPAC Report Highlights Value of Private Equity Investments in Health Care" American Investment Council, June 15, 2021, <https://www.investmentcouncil.org/private-equity-investments-support-american-health-care-covid-19-response/> (Accessed 6/29/21).

37 "MedPAC Issues Another Annual Report to Congress: Includes Insights on Private Equity, Alternative Payment Models, and Rural Health" American College of Emergency Physicians, June 24, 2021, <https://www.acep.org/federal-advocacy/federal-advocacy-overview/regs--eggs/regs--eggs-articles/regs--eggs---june-24-2021/> (Accessed 6/29/21).

38 *Ibid.*

39 *Ibid.*

40 Medicare Payment Advisory Commission, June 2021, p. 106.

41 *Ibid.*

42 *Ibid.*



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