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Americans for
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Education Fund



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Policy Solutions for Private Equity in Healthcare

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Executive Summary

Private equity bodes ill for U.S. health care

Private equity (PE) companies have established a strong presence in health care over the past two decades. From 2000 to 2018, PE activity in the health care sector grew from five percent of all leveraged buy-out (LBO) activity to 14 percent. In 2021 there were over 1,400 private equity deals in health care, with an aggregate value of over \$208 billion. PE is an extreme manifestation of the profit-driven health care that is common in the United States; respected commentators and journalists have characterized PE as “termites in the house of health care”¹ and accuse them of “hijacking”² and “ruining”³ the health care system.

The goals and methods of PE investment are incompatible with sustained support for a well-functioning, improving health care system, and this clash has harmed patients, increased costs, and deprived communities of essential resources. PE firms are in the business of buying and selling companies to turn a profit. A typical approach is the “buy and build” strategy of acquiring a platform company and then merging it with smaller companies, then exiting the investment in three to seven years. This short-term commitment, with focus on generating a large return on investment, can degrade the

quality and safety of medical care. Key to the business model is that transactions are highly leveraged, with the acquired company bearing most of the risk of the debt. PE owners may also sell off a facility’s real estate, extracting value for investors but burdening the facility’s finances with rent payments. For health care providers, these obligations can result in staff reductions and increased prices; revenues that might otherwise go to improving care instead are used to pay rent or pay down debt. In the extreme, financial pressure can push a health facility into bankruptcy.

The malign impacts of PE ownership on the health care system and the people who use it are serious and well-documented. Studies of nursing homes found increased probabilities of mortality, greater use of anti-psychotic medications, and increases in emergency department visits and hospitalizations in PE-owned facilities, coupled with increased costs and Medicare claims. Studies of PE-owned physician practices have found increased costs, greater use of lesser trained staff providing care without supervision, and pressure on doctors to meet production targets, “up-sell” services, and refer patients to affiliated businesses. PE

companies can hinder access to health care by closing facilities and practices in areas where they are needed and by increasing the burden of medical debt through acquisitions of companies that undertake aggressive bill collection activities on behalf of hospitals. Stories relating similar impacts are plentiful, in academic literature and journalistic accounts.

Prescriptions for relief: federal policy levers to rein in private equity

PE's goals and methods, when applied to the health care sector, can be dangerous and costly. Federal policy strategies can seek to shrink or eliminate these harmful effects in several ways.

1. Reduce incentives to game Medicare payment rules

About half of the 60 million Medicare beneficiaries are enrolled in Medicare Advantage (MA) plans — commercial managed care plans that receive a monthly “capitation” payment for each member, regardless of the amount of services the member uses. The other half of Medicare beneficiaries are in Traditional Medicare (TM), where most care is paid for on a “fee-for-service” basis. PE firms find ways to take advantage of the incentives created by both systems. Certain policy approaches can make some of these plays less attractive.

Medicare Advantage

MA's capitation payment methodology rewards MA plans that aggressively add diagnosis codes to patients' records. MA plan have become “money machines,”⁴ generating payments in 2020 that were \$12 billion higher than they would have been for the same beneficiaries in TM. Capitation can also create incentives to stint on care, restrict access, or use less expensive providers to deliver

services. PE companies take advantage of these opportunities with their acquisition strategies, and staffing practices in PE-owned practices and facilities demand close attention.

The Centers for Medicare and Medicaid Services (CMS), the federal agency that manages the Medicare program, has policy tools at its disposal that can weaken some of these negative incentives and, with them, profit opportunities that attract PE investment:

- Dismantle the “Medicare money machine” by **increasing the coding intensity adjustment** CMS uses to reconcile MA and TM pricing levels, and making greater use of its **overpayment audit and recoupment** authority
- Weaken the incentives to stint on care by **tying payments more closely to rigorous quality standards** and **setting minimum staffing standards**, for example in nursing facilities



Traditional Medicare

In contrast to MA, health care providers that receive fee-for-service payments in TM have an incentive to do more, even if the utility of “more,” in terms of improved health, is

marginal. PE acquisitions of physician practices center on specialties that largely operate in a fee-for-service world. Practices can increase revenue by increasing their volume — adding acquisitions to a platform practice, acquiring companies that provide related, expensive services to which its practices can refer — or by reducing costs, for example by using lesser-trained staff with minimal supervision. There also are flaws and inconsistencies in Medicare’s fee-for-service payments, which reimburse physicians more for using more expensive drugs and pays different amount for the same care in different settings, for example. These payment loopholes offer further opportunities for PE owners to extract profits from Medicare.



Limiting these incentives and the attractiveness to PE of investments in TM-centric providers would likely require congressional action. New laws could:

- **Require specialist providers to accept payment from Medicare that rewards value** (such as capitation or “bundled payments”) rather than volume — while guarding against the type of price gaming common in MA

- **Close Medicare payment loopholes** by changing the method for reimbursing physicians for prescription drugs; reducing the bias toward procedures, tests, and specialist care in the Medicare physician fee schedule; and aligning payments so that hospital outpatient departments are not paid more for services that can be delivered as effectively in a physician’s office.

2. Step up enforcement of laws against nefarious business practices

Another way that PE-owned companies gain advantage is through practices that walk right up to — and sometimes cross — the line of existing laws against fraud and self-dealing that boost revenue without helping, and sometimes harming, patients. In addition, federal antitrust approaches leave room for PE’s roll-up acquisition strategy to consolidate markets and drive up prices while evading scrutiny for anti-competitive practices. Existing laws and authority could be used more effectively to reduce PE’s negative impact.

Fraud and abuse laws

Key federal laws that protect the Medicare program and its beneficiaries from exploitive and fraudulent practices: the physician self-referral law (commonly known as the Stark Law)⁵, the anti-kickback statute⁶, and the False Claims Act.⁷ A physician practice making referrals to an ancillary service provider that has overlapping ownership might be a Stark or anti-kickback violation. Claiming payment for services provided by non-physicians without supervision or for unnecessary services, or “upcoding” services without clinical justification to receive higher payments, might violate the False Claims Act. Violations of these laws can result in significant financial penalties, exclusion from Medicare and Medicaid, and even prison sentences.

Some of PE's core strategies should regularly attract investigation and enforcement. The tools that federal enforcement agencies have available can and should be used more forcefully to penalize and deter bad behavior, thereby altering the incentives that draw PE to health care.

- **Seek maximum penalties for violations of anti-fraud laws;** the False Claims Act allows for a \$27,000 per claim penalty (in 2023) and triple damages, though the Department of Justice (DOJ) typically seeks penalties less than the maximum, which PE owners may perceive simply as a cost of doing business.
- **Build coalitions to identify whistleblowers,** including specialist physicians who have had negative experiences with PE firms buying their practices, and who can bring actions under the False Claims Act.
- **Increase investigations of likely Stark Law violations;** it may be difficult for many PE-owned companies to meet the requirements of a Stark exception, which means that a violation of Stark is likely in many transactions between practices with common owners.
- **Better monitor and publicize the Medicare and Medicaid exclusions list,** which bars individuals and entities convicted of fraud from participating in these potentially lucrative programs.

Laws prohibiting anti-competitive behavior

Many PE-driven mergers evade federal anti-trust scrutiny because the value of a single transaction is below the threshold that triggers review by the Federal Trade Commission (FTC), even if a platform company acquires multiple companies (per the PE business model) that may far exceed the threshold in

aggregate. This makes possible PE-backed "stealth consolidation" of a local health care market, which can do real harm: a recent study concluded that the absence of FTC review of acquisitions in the dialysis industry cost thousands of lives because of poorer quality of care following mergers.⁸

Many PE-driven mergers evade federal anti-trust scrutiny because the value of a single transaction is below the threshold that triggers review by the Federal Trade Commission (FTC).

Small, accretive acquisitions in health care fly under the radar of antitrust law and deserve greater policy attention, given their impact on health and health spending. Potential approaches include:

- **Lower the financial thresholds for reporting health care mergers to antitrust agencies,** which would require legislative action by Congress
- **Update FTC and DOJ merger guidelines** to consider the competitive threat of smaller, serial acquisitions
- **Monitor roll-up acquisition activity using consent agreements resulting from merger reviews,** for example by requiring prior approval of further acquisitions in a defined area
- **Expand approval requirements for health care acquisitions,** which is the purview of the Department of Health and Human Services, in its capacity overseeing health care quality and safety for millions of Medicare beneficiaries and stewarding hundreds of billions of dollars spent annually by Medicare and Medicaid

3. Shine a light on ownership

PE-owned health care providers often structure themselves to limit their legal liability, and providers with common owners can obscure this overlap with complex corporate structures. Understanding who or what entity owns a health care provider and what related businesses they also own is important for accountability, for monitoring financial stability and health care quality, for better understanding motives and strategies of owners and investors, and for enforcing anti-fraud laws. Lack of transparency, vital to a well-functioning market, is another weakness in the health care system that PE exploits for financial gain.

CMS issued a draft rule in February 2023 that represents a significant stride toward greater transparency. The rule would require the disclosure of ownership of nursing facilities and, importantly, would require the owners to disclose whether they are a PE company or a real estate investment trust. Further actions that CMS and other federal health care agencies might take include:

- **Expand the new ownership disclosure requirement** to other providers beyond nursing facilities, particularly where PE ownership is prominent: hospitals, home health agencies, hospice, physician practices, and others; this would require legislation.
- **Expand existing requirements for annual cost reporting by health care providers** to include consolidated financial statements that include data from operating entities and other entities with common ownership.

- **Update CMS's Care Compare website**, which many people use to select hospitals, nursing homes, and other providers, to enhance users' decision-making information with the ability to identify chains and common ownership interests across facilities.
- **Specify minimum criteria for purchase, change of ownership, or management of a facility**, to prevent ownership by entities with a history of low staffing and poor quality, or with past fraud settlements.
- **Create a national online PE ownership data base**, which CMS and academic researchers could use to monitor the effects of PE ownership on price, quality, patient experience, and utilization.

Conclusion

Private equity's ventures into health care are fueled by money-making opportunities that arise from payment incentives, gaps in anti-fraud and antitrust rules, and the ability to obscure ownership interests in health care entities. Congress could make changes, but we do not have to wait for them to do so. There are many policy tools that Federal agencies have at their disposal and could use without Congressional action. Action by Federal executive agencies would close off some of the most attractive opportunities for abuse and harm, and in so doing also dampen the ardor of private equity for health care businesses.

Prescriptions For Relief:

Federal Policy Levers to Reduce Private Equity's Harm to Health Care

Private equity (PE) companies have established a strong presence in health care over the past two decades, and the goals and methods of private equity firms, when applied to the health care sector, can be dangerous and costly. Private equity (PE) firms find profits by deploying their business models where there are market imperfections or opportunities for financial engineering or regulatory arbitrage. In that sense, PE is an extreme manifestation of the profit-driven health care that is common in the United States, to the point that respected commentators and journalists have characterized PE as “termites in the house of health care”⁹ and accuse them of “hijacking”¹⁰ and “ruining”¹¹ the health care system.

Private equity's purpose clashes with health care's mission

PE firms are in the business of buying and selling companies to turn a profit. A PE company that

uses the “buy and build” strategy, in which it acquires a platform company and then merges it with smaller companies, hopes to exit the investment with a large return in three to seven years. This short-term commitment can degrade the quality and safety of medical care. Transactions are highly leveraged, with the acquired company bearing most of the risk of the debt. PE owners may also sell off a facility's real estate, extracting value for investors but burdening the facility's finances with rent payments. For health care providers, these obligations can result in staff reductions and increased prices, and revenues that might otherwise go to improving care instead are used to pay rent or pay down debt. In the extreme, financial pressure can push a health facility into bankruptcy.

The malign impacts of this business model and of PE ownership on the health care system and the people who use it are serious and well-documented. Studies of nursing homes found

increased probabilities of mortality, greater use of anti-psychotic medications, and increases in emergency department visits and hospitalizations in PE-owned facilities, coupled with increased costs and Medicare claims.^{12,13} Studies of PE-owned physician practices have found increased costs, greater use of lesser trained staff providing care without supervision, and pressure on doctors to meet production targets, “up-sell” services, and refer patients to affiliated businesses.^{14,15,16} Evading antitrust scrutiny by merging multiple companies through relatively small transactions can actually cost lives.¹⁷ PE companies can hinder access to health care by closing facilities and practices in areas where they are needed and by increasing the burden of medical debt through acquisitions of companies that undertake aggressive bill collection activities on behalf of hospitals.¹⁸ Stories relating similar impacts are plentiful, in academic literature and journalistic accounts.

profit for themselves — frequently at the expense of patients, care providers, and the public purse. Federal policy strategies can seek to shrink or eliminate PE’s harmful impacts by:

- **Reducing the incentives** in complex Medicare payment systems to deliver care in certain ways and manipulate payment levels, which PE and other profit-seeking owners can game, to great financial benefit;
- **Taking a firm stand against predatory business practices** by aggressively enforcing federal fraud statutes and monitoring “stealth consolidation” that evades federal antitrust scrutiny;
- **Shining light on patterns of ownership associated with poor care and high costs** by requiring comprehensive, accurate ownership and financial information and making it public.

Advancing new policies in these areas — and forcefully applying existing ones — would shrink opportunities for all who prioritize profit over health and safety and therefore discourage PE investment. They could also bring the broader benefit of enhanced equity and accountability throughout the health care system. The following discussion elaborates on these approaches.

1. Medicare payment incentives

More than 60 million people in the United States are covered by the federal Medicare program. Most are enrolled in Traditional Medicare (TM), which allows broad freedom in choosing providers, and which pays those providers largely on a “fee for service” basis — that is, there is a payment made for each service or procedure delivered. A growing portion of Medicare beneficiaries are enrolling in Medicare Advantage (MA) plans, an alternative to TM. MA plans are commercial managed care plans that offer coverage for all Medicare services, often including prescription



Policy approaches to reining in PE

PE owners take advantage of incentives created by the methods by which providers are paid, the structure and competitiveness of an industry, gaps in information about ownership of facilities and practices, and shortcomings in laws and regulations and their enforcement to extract

drugs and additional benefits such as vision and hearing services. Medicare pays MA plans a fixed per member per month fee, called a “capitation payment,” regardless of the amount of services the member uses in that month.

Both payment systems create incentives for care to be delivered in certain ways and opportunities to manipulate payment levels to increase revenues. PE firms, in their search for profit opportunities, find ways to take advantage of both. Certain policy approaches can make some of these plays less attractive.

Medicare Advantage and value-based payments

Value-based payments (VBP) are not tied to a specific service but instead may be based on an episode of care, a diagnosis code, or simply the number of people in a practice’s panel or a health plan’s membership. VBPs are intended to motivate efficiency and innovation in ways that will reduce costs and improve outcomes but, as with any type of health care payment, specific methodologies create opportunities to extract profit without necessarily increasing value. This has been the case in the Medicare Advantage program, which gives Medicare beneficiaries the option to receive their care from a commercial health plan contracting with Medicare. Medicare Advantage is an attractive financial opportunity and one that can be made more lucrative through aggressive coding of diagnoses, care delivery practices, and market acquisitions.

The MA capitation payment methodology rewards aggressive coding of diagnoses to “risk adjust” the MA plan’s monthly payment amount. Plans have a financial incentive to add diagnoses to raise a member’s risk score. This risk score gaming turns MA plans into “money machines”¹⁹: rather than MA reducing Medicare costs, payments to MA plans are higher than

intended, by \$9 billion over what they would have been in 2019 for the same beneficiaries in fee-for-service, and by \$12 billion in 2020.^{20,21} MA plans also pass the coding incentive along to physicians, who have access to medical records to support additional diagnoses.²² Private equity has seized this opportunity in a variety of ways: by investing in physician practices that serve patients in MA plans; by forming joint ventures with provider groups or insurers; and by vertically integrating a PE-owned primary care practice and an MA plan.²³ One study found that the coding intensity that drives MA rates increases with vertical integration.²⁴

Capitation and other value-based payment models can also create incentives to provide less care than is needed, to make access to care difficult, or to use less expensive providers to deliver services. This is a long-standing concern about managed care and value-based payments in general, and modern value-based models include rigorous quality measurement and benchmarks to counter the incentive. Examples of private equity-owned practices and facilities in other settings stinting on care demand close attention and safeguards against using them under value-based payment in MA.

Remedies

- Increase coding intensity adjustments to counter risk code gaming (*Regulatory*)
- Increase overpayment audits and recoupment (*Regulatory*)
- Tie payments more closely to rigorous quality standards and measurement (*Regulatory*)
- Set minimum staffing standards to prevent stinting on care (*Regulatory*)

CMS issues rules every year updating policies and methodological details of Medicare Advantage payment and invites public comment on its proposals. The public comment process is a vehicle that MA plans and corporate interests use to voice their positions. Individuals and organizations concerned about the malign impacts of business strategies to extract excessive profits from Medicare can do the same, on these and other topics:

Dismantle the “Medicare Money Machine”

Overpaying MA plans has long been a flaw in the Medicare program. A law requires CMS to conduct an annual analysis of coding pattern differences between MA and TM and, to correct differences that do not have a clinical basis, apply a coding intensity adjustment to MA of at least 5.9 percent. The same law gives CMS authority to impose a higher adjustment through administrative action, but it has not done so. Given that MedPAC estimates of the difference in coding intensity between MA and TM was 9.5 percent in 2020, and as high as 15 to 20 percent for several health plans, more aggressive action to rein in MA payments is warranted. This could include both publishing the results of the annual coding analysis and increasing the coding intensity adjustment above the 5.9 percent floor.²⁵

CMS also can increase audits and enforcement of the Overpayment Rule using its regulatory authority. The rule legally obligates MA plans to return known overpayments that are based on unsupported risk coding and to exercise reasonable diligence to identify overpayments. Bringing additional CMS resources to auditing and enforcement could yield positive results for Medicare, while also inhibiting profit-seeking investors.²⁶ Further, aggressive coding that is clinically unsupported could violate the False Claims Act, which is discussed below.

Weaken incentives to stint on care

The primary safeguard against managed care plans depriving patients of needed care in the pursuit of profit is a robust quality measurement protocol that reflects desired outcomes and is tied to payment. MedPAC, the Commission that advises the federal government on Medicare payment policy, has determined that the current state of quality reporting in the MA program is inadequate to provide an accurate description of the quality of care, and it has recommended that MA policy adopt a new value incentive program that better accounts for patient need and provides an incentive to improve quality.²⁷

Staffing requirements can thwart a strategy of using lower-level professionals to deliver care, which reduces costs and increases profits in a value-based payment environment, but also skimps on care. CMS can promulgate rules about staffing for providers where Medicare and Medicaid are predominant payers, such as nursing facilities and perhaps hospitals. A proposed regulation on minimum nursing home staffing levels is expected this year, providing another opportunity to influence federal policymaking through the public comment process. To the extent that these rules exist, strong enforcement is also required.

Traditional Medicare and fee-for-service payment

While MA providers receiving capitation payments may be tempted to skimp on care, traditional Medicare faces the opposite challenge. Health care providers that receive fee-for-service payments have an incentive to do more, even if the utility of “more,” in terms of improved health, is marginal. PE acquisitions of physician practices center on specialties that largely operate in a fee-for-service world — dermatology, ophthalmology, orthopedics, and

gastroenterology, for example. Practices can increase revenue by increasing their volume — numbers of patients seen, services provided, procedures per-formed. And demand for these specialties is expected to grow as the pop-ulation ages. Practices increase volume by:²⁸

- Adding acquisitions to a platform practice, which often has the additional effect of raising prices by reducing competition.
- Acquiring companies that provide services such as imaging and lab testing, or adding lucrative subspecialties, like Mohs surgery in a dermatology practice, so that referrals may be kept in-house.
- Using lesser-trained staff, such as physician assistants and nurse practitioners, to per-form procedures, with minimal or no super-vision from a physician. This tactic reduces costs to the practice and, in dermatology, has led to an increase in unnecessary skin biopsies and procedures performed on patients near the end of life. In 2015, one-fifth of Mohs procedures paid for by Medi-care were performed on a patient aged 85 or older.²⁹

In addition to the incentive to do more, there are flaws and inconsistencies in Medicare fee-

for-service payment that offer further opportunities for PE owners:

- Medicare reimburses physicians much more for certain drugs they administer in their offices than the price the physician pays for them. There also is an incentive to use more expensive drugs because the fee for dis-pensing the drug is a percentage of the price. One drug in particular, to treat wet macular degeneration, is 40 times the cost of an equally effective drug. This differential is considered a major driver of the rapid acquisitions by PE firms of ophthalmology practices.³⁰
- Similarly, Medicare pays more for a service delivered in a hospital outpatient depart-ment than it does for the very same service in a free-standing physician’s office, often without a clinical reason. This encourages hospitals to acquire physician practices and convert them to outpatient departments of the hospital, which can reduce competition and increase unnecessary spending.
- There also are distortions within Medicare’s fee schedule for physician payments, which values procedures over primary and pre-ventive care.³¹

An analysis of 2015 Medicare bills for three physician assistants and one nurse practitioner employed by Bedside Dermatology in Michigan found that 75 percent of the patients they treated for skin problems had been diagnosed with Alzheimer’s disease. Most of the lesions they were treated for were very unlikely to be dangerous. Bedside Dermatology is owned by Advanced Dermatology and Cosmetic Surgery. PE firm Harvest Partners took a majority stake in Advanced Dermatology with a \$600 million investment in 2016.

Hafner and Palmer, “Skin Cancers Rise, Along With Questionable Treatments.”

Remedies

- Require specialist providers to accept value-based payment rather than fee-for-service from Medicare (*Legislative*)
- Close Medicare payment loopholes that attract profit seekers (*Legislative*)

Move away from fee-for-service

The incentives of fee-for-service payment that attract private equity firms are the same that motivate overtreatment, self-referral, and other costly, low-value behavior across the health care system. The remedy would also be similar: move payment away from a system that rewards volume to one based on value that rewards positive outcomes. Such payments usually come with rigorous quality metrics to guard against skimping on care. Payment models that, for example, pay a set price for an episode of care or a bundle of services, or that award quality bonuses on top of fee-for-service payments, are becoming more common in Medicare, Medicaid, and commercial health insurance. Further development of the models for certain specialties could dampen profit opportunities for private equity. At the same time, however, policy makers and program administrators should design payment models that discourage the strategies health plans and providers use for gaming these systems to increase payments, as described in the discussion of Medicare Advantage above

Close Medicare payment loopholes

CMS can dampen the incentives for profit-driven physician behavior by correcting payment inconsistencies in the Medicare program. Medicare can remove the profit opportunities for physician practices that

come from purchasing and administering very expensive drugs by shifting to market-based pricing and de-linking the administration fee from the price.³² It can rebalance the physician fee schedule to place more value on evaluation, management, and patient communication and less on procedures, tests, and imaging performed by specialists.³³ And Medicare can align payments so that hospital outpatient departments are not paid more for services that can be delivered as effectively in a physician's office.³⁴ These changes have all been recommended by the Medicare Payment Advisory Commission (MedPAC), and would have the added benefit of strengthening primary care for Medicare beneficiaries.³⁵ All would require congressional action.

2. “Nefarious” business practices

Another way that PE-owned companies gain advantage is through business practices that walk right up to — and sometimes cross — the line of existing laws and regulations, making the most of exceptions in the laws. In health care, several key laws guard against fraud, self-dealing, and other “nefarious” practices³⁶ that boost revenue without helping, and sometimes harming, patients. Federal antitrust approaches leave room for PE's roll-up acquisition strategy to consolidate markets and drive up prices while evading scrutiny for anti-competitive practices. Rules and authority that are already in place in these areas could be used more effectively as vehicles for reducing PE's negative impact on health care.

Fraud and abuse

Long-standing federal laws protect government programs such as Medicare and its beneficiaries from exploitive and fraudulent practices by health care providers and their owners. These tools include the physician self-referral law (commonly known as the Stark Law),³⁷ the anti-kickback statute,³⁸ and the

False Claims Act.³⁹ The Office of the Inspector General (OIG) in the U.S. Department of Health and Human Services has the authority to investigate violations of these laws, and often does so in partnership with the Department of Justice (DOJ). Aggressive application of these laws can weaken the incentives that attract private equity to health care.

The Stark Law prohibits physicians from making referrals to entities with which the referring physician has a financial relationship, unless that referral is to an in-house service (such as imaging or lab tests) that are part of a group practice, as defined in the law. The anti-kickback statute proscribes any payments for referring a patient or recommending the purchase of any item or services paid for by a federal health care program. And the False Claims Act imposes liability for presenting false or fraudulent claims for payment by the federal government.

Some of the strategies that PE-owned companies use to increase profits potentially run afoul of these statutes. A physician practice making referrals to an ancillary service provider that has overlapping ownership might be a Stark or anti-kickback violation, if the entities involved do not meet the specific rules of being part of a group practice. Claiming payment for services provided by non-physicians without supervision or for unnecessary services, or “upcoding” services without clinical justification to receive higher payments, might violate the False Claims Act.

Violations of these laws can result in significant financial penalties, including, under the False Claims Act, triple the value of each individual claim, which can add up to multi-million-dollar penalties. (In fact, however, actual settlements have been for significantly less than the maximum possible, limiting the Act’s deterrent effect.⁴⁰) Penalties can also



entail exclusion from Medicare and Medicaid, which often are vital sources of revenue for PE-owned health care providers. (There are gaps in the enforcement of these exclusions as well.⁴¹) The False Claims Act and anti-kickback statute also include jail time as a possible penalty for violators.

At least 25 PE-owned companies paid over \$570 million in penalties from 2013 to 2021 to settle False Claims Act lawsuits. The PE firms that owned those companies own nearly 200 other health care companies.⁴² Recent examples of actions that federal agencies have taken against PE-owned health care companies include:

- In 2020, Cordant Health Solutions paid \$12 million dollars to settle allegations that it paid kickbacks for urine test referrals, in violation of the anti-kickback statute and False Claims Act.⁴³ Cordant is owned by PE firm Waud Capital.⁴⁴ The CEO of the lab that received the kickbacks was later sentenced to 24 months in prison and fined \$7.6 million.⁴⁵
- In 2019, Diabetic Care Rx (DCRX) and its owner, PE firm Riordan, Lewis and Haden (RLH), settled a False Claims Act lawsuit with a payment of \$21.3 million. DCRX allegedly paid kickbacks to marketers to

target military veterans and their families for medically unnecessary creams and vitamins. The Department of Justice argued that RLH played an active role in the fraud because two RLH partners were involved in the governance of DCRX and because of RLH's "high return expectations" for DCRX.⁴⁶

Remedies

- Seek maximum penalties for violations of anti-fraud laws (*Enforcement*)
- Build coalitions to identify whistleblowers and increase enforcement actions (*Enforcement*)
- Step up investigations of likely self-referral (Stark) violations (*Enforcement*)
- Better monitor and publicize the Medicare and Medicaid exclusions list (*Enforcement*)

These anti-fraud laws are potent tools for slowing PE's extraction of profits from health care. Some of PE's core strategies — internalizing ancillary services, generating unnecessary volume, relying on non-physician practitioners without proper supervision — should regularly attract investigation and enforcement.⁴⁷ Law firms have raised the warning to PE clients of increased federal scrutiny⁴⁸ for the past several years. The tools are available; they can and should be used more forcefully to penalize and deter bad behavior, thereby altering the incentives that draw PE to health care.

False Claims Act

The Department of Justice recovered \$2.2 billion from 351 False Claims Act settlements in 2022, with 77 percent of that amount coming from health care-related

businesses.⁴⁹ The volume of cases pursued by federal enforcement agencies reflects the appropriate focus on health care organizations, but the penalties assessed could be higher. The False Claims Act allows for a \$27,000 per claim penalty (in 2023) and triple damages, but the DOJ typically seeks penalties less than the maximum — closer to double damages.⁵⁰

PE owners may perceive the relatively modest penalties imposed on False Claims Act violations as a cost of doing business.⁵¹ The PE business model gives prosecutors the opportunity to show that PE firms exercise control over the business and are thereby liable for fraud. Prosecutors should pursue maximum penalties in these cases, to more effectively deter egregious practices.

There are many specialist physicians who have had negative experiences with PE firms buying out their practices. They are potential whistleblowers: the False Claims Act allows whistleblowers to file a complaint on behalf of the United States, which the government is then statutorily required to investigate.⁵² Patient and consumer advocates, financial reform organizations, and others can work with like-minded physician groups, *qui tam* (whistleblower) attorneys, and local US attorneys to identify more opportunities for enforcement actions.

Stark Law

The Stark Law's self-dealing prohibition permits an exception for in-office ancillary referrals if the practice making and receiving the referral meets the law's definition of a "group practice." This may be difficult for a portfolio of PE-owned companies to demonstrate; for one example, a group practice must be a single legal entity, not "separate group practices under common ownership or control through a physician practice management company... or other

entity or organization.”⁵³ This means that non-compliance with Stark rules is likely in many transactions between practices with common owners; deeper investigations into the structure of these relationships by enforcement authorities within the Department of Health and Human Services and Department of Justice could reveal more violations.⁵⁴

Medicare and Medicaid exclusions list

The Office of the Inspector General (OIG) in the Department of Health and Human Services is required to exclude from participation from Medicare and Medicaid individuals and entities convicted of fraud.⁵⁵ The OIG makes available a downloadable database of the exclusions on its website.⁵⁶ Unfortunately, CMS does not have the resources to actively monitor the list; rather, the OIG encourages potential employers to consult the list and it relies on people to self-report that they are banned when applying to participate in federal programs. It often is left to whistleblowers and journalists to report possible violations of a ban, and working around a ban by using aliases or omitting names from key documents is not uncommon. A recent investigation examined a sample of 300 people on the exclusion list and found that 10 percent were serving in roles in health care, had transferred control of a business to family members, had prior fraud or felony convictions, or were repeat violators who committed fraud after a previous exclusion before being excluded again.⁵⁷ The value of the exclusions list could be strengthened by adopting the types of recommendations, addressing enhancing controls and assessing fraud risk, made to the Veterans Administration in a 2021 review.⁵⁸ Though flawed, the exclusions list can be a tool to deter people and businesses that have committed fraud from doing further damage.

Anti-competitive behavior

The PE strategy of acquiring a central platform company and then adding small acquisitions weakens competition in local health care markets, which raises prices and may also harm quality. Many of these PE-driven mergers evade federal antitrust scrutiny because of their size. Under the Hart-Scott-Rodino (HSR) Act, a merger transaction that exceeds \$111.4 million in value in 2023 requires pre-merger notification to the Federal Trade Commission. Smaller transactions do not receive similar FTC review, even if a platform company acquires multiple companies (per the PE business model) that may far exceed the threshold. This allows PE-backed companies the opportunity for “stealth consolidation”⁵⁹ of a local health care market.

A recent study provided evidence that transactions that were exempt from the pre-merger reporting requirement in the dialysis industry resulted in both higher hospital-ization rates and lower survival rates.

A recent study provided evidence that transactions that were exempt from the pre-merger reporting requirement in the dialysis industry resulted in both higher hospital-ization rates and lower survival rates. In short, the study concluded that *eliminating pre-merger notification exemptions would save thousands of lives*, and the benefits of increased reporting would far exceed the costs.⁶⁰ While this analysis looked only at dialysis services, it refers to other work showing harm from rapid consolidation in physician groups and hospitals.

Remedies

Antitrust agencies

- Lower the financial thresholds for reporting health care mergers to antitrust agencies (*Legislative*)
- Update merger guidelines to include considering impact of accretive acquisitions (*Administrative/ Enforcement*)
- Monitor roll-up acquisition activity using consent agreements (*Enforcement*)

Dept. of Health and Human Services

- Expand approval requirements for health care acquisitions (*Regulatory*)

Small, accretive acquisitions in health care fly under the radar of antitrust law and deserve greater policy attention, given their impact on health and health spending. Congress can revise the Hart-Scott-Rodino reporting requirements by lowering the threshold for review of health care acquisitions. This would help to close the gap that allows “stealth consolidation” by PE-owned companies.

There are other possible policy approaches that would not require legislative action. The FTC and DOJ are modernizing their merger guidelines.⁶¹ Current guidelines focus on individual acquisitions and do not consider the competitive threat of smaller, serial acquisitions. Updates to the merger guidelines can remedy this.⁶² The FTC may also scrutinize pre-merger filings by PE firms to gain insight on future acquisitions that may be unreportable, and to actively identify enforcement targets that may be engaged in monopolization.⁶³

Antitrust agencies can also intervene in a PE company’s acquisition strategy using consent

agreements that result from merger reviews. In 2022, the FTC used its authority to protect competition to require a PE owner of a chain of veterinary clinics to obtain prior approval before acquiring additional clinics within 25 miles of one it already owns in California or Texas, and to notify the FTC prior to acquiring a clinic anywhere else in the country that otherwise would not be required to be reported under the Hart-Scott-Rodino rules.⁶⁴ This agreement gives the FTC a clearer view into a PE firm’s roll-up activity in the pet medical field, and it is an approach that would work as well for human health care.

The Department of Health and Human Services (HHS) is responsible for overseeing health care quality and safety for millions of Medicare beneficiaries and is responsible for hundreds of billions of dollars spent annually by Medicare and Medicaid. Separate from antitrust concerns, HHS might use this authority to expand reporting and approval requirements for health care mergers and acquisitions.⁶⁵

3. Ownership transparency

Ownership of health care facilities is often opaque. Health care providers structure themselves to limit their legal liability, and providers with common owners can obscure this overlap with complex corporate structures. One strategy is the “taxi cab model,” in which each entity in a chain of providers (a hospital or nursing facility, say) is a separate limited liability corporation (LLC), to insulate the full system from legal action against a single member of the chain.⁶⁶ Owners of Medicare providers also own companies, such as management and staffing companies, that provide services under contract to the facilities.⁶⁷ These related party transactions are common in the nursing home industry. They are a source of profit for owners and investors and can leave facilities short of the

resources they need to provide adequate patient care.⁶⁸ When nursing home residents suffer because of these practices — as studies show they have⁶⁹ — it is difficult to assign accountability for the deficiencies and for correcting them if it is unclear what individuals and corporate entities are ultimately responsible for a facility's operations and finances.

The database that CMS uses to keep track of ownership of Medicare's providers and suppliers does not capture much of the complexity of these corporate structures. In particular, the system does not include passive investors, such as those investing in a PE fund, and it does not capture relationships among interrelated LLCs.⁷⁰ Information is self-reported, and CMS is not able to audit the accuracy of submissions.⁷¹

Understanding who or what entity owns a health care provider and what related businesses they also own is important for accountability, for monitoring financial stability and health care quality, for better understanding motives and strategies of owners and investors, and for enforcing anti-fraud laws. Transparency of ownership can help people choose their health care providers.

Government can use comprehensive ownership information to analyze patterns in program performance and make their analyses available to the public. Lack of transparency, vital to a well-functioning market, is another weakness in the health care system that PE exploits for financial gain.

A step in the right direction

CMS issued a draft rule in February 2023 which, when finalized, would represent a significant stride toward greater transparency. The draft rule would require the disclosure of ownership of nursing facilities that provide care to Medicare and Medicaid enrollees and would make this information public. In addition to requiring information about the ownership and governance of the individual facility, it also asks for people or entities who exercise financial or managerial control, lease or sublease property, and provide management, clinical consulting, or financial services, and for the organizational structures of these entities. And importantly, the rule would require owning and managing entities of nursing facilities to disclose whether they are a private equity company or real estate investment trust (REIT).⁷²



Remedies

Finalizing a strong nursing home transparency rule would offer a starting point for further advances in ownership transparency. Further actions that CMS and other federal health care agencies might take include:



- Expanding the ownership disclosure requirement to other providers beyond nursing facilities, particularly where PE ownership is prominent: hospitals, home health agencies, hospice, physician practices, and others. (*Legislative*)
- Expanding existing requirements for annual cost reporting to include consolidated financial statements that include data from operating entities and “all entities related by common ownership or control,” and showing the relationships among the related party entities.⁷³ (*Regulatory*)
- Updating CMS’s Care Compare website, to enhance users’ decision-making information, with the ability to identify chains and common ownership interests across facilities.⁷⁴ (*Administrative*)
- Specifying minimum criteria for purchase, change of ownership, or management of a facility, to prevent ownership by entities with a history of low staffing and poor quality, or with past fraud settlements.⁷⁵ (*Regulatory*)
- Creating a national online PE ownership data base. CMS and academic researchers could use the ownership information to monitor the effects of PE ownership on price, quality, patient experience, and utilization, and to analyze patterns to inform future policy making.⁷⁶ (*Administrative*)

Conclusion

In the US healthcare system as currently structured, limiting private equity's negative impact means changing the incentives that enable and attract them to extractive practices in these markets, and reducing and changing their assessment of the profit potential.

Private equity's ventures into health care are fueled by money-making opportunities that arise from payment incentives, gaps in anti-fraud and antitrust rules, and the ability to obscure ownership interests in health care entities. Often, these

categories overlap: strategies to take advantage of payment models that result in market consolidation are engineered to evade antitrust scrutiny, for example. Congress could make changes, but we do not have to wait for them to do so. There are many policy tools that Federal agencies have at their disposal and could use without Congressional action. Action by Federal executive agencies would close off some of the most attractive opportunities for abuse and harm, and in so doing also dampen the ardor of private equity for health care businesses.



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