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Key Medicare Concepts in Health Care Investing

Ryan P. Hooper, Esq.

Over the last decade, few industries have experienced the strong and consistent growth of the health care industry. Despite struggles with new pressures, such as skyrocketing insurance premiums and increasing unfunded mandates, the health needs of this nation have propelled many sectors of the health care industry to a status of relative stability. Investors are taking notice.

"…Medicare challenges create opportunities for knowledgeable investors."

The track record of health care service providers has not been entirely rosy. Many thought-to-be stalwarts have been the subject of bankruptcies and corporate scandals. Health South, the owner of a large hospital chain, collapsed in early 2003 as the result of Medicare fraud liabilities and corporate accounting irregularities. Beverly Enterprises, one of the nation's largest nursing home providers, pled guilty to defrauding Medicare in the amount of $460 million in 2000. Another large nursing home provider, Integrated Health Services (IHS), filed for bankruptcy the same year after the accumulation of several Medicare liabilities. These unfortunate examples have scared away many of the lenders stung by Medicare risks. For every defeat, however, there are more victories—examples of more efficient and better governed players in the field who have rewarded their investors with healthy returns.

Winning Investments

The key to winning the Medicare investment game plays into the strengths of private equity firms. Unlike some commercial banks that lend to waves of providers across industry sectors, many private equity firms are armed with a more selective investment model. Private equity firms with the dedicated resources and patience for due diligence are positioned to find the gems. To find the right business, an investor must be knowledgeable in the areas that directly affect a company's profitability. Two keys to the profitability of a health care business are reimbursement systems and corporate governance.

Reimbursement systems are the main source of cash flow for health care organizations. Chief among these for many health care sectors are the Medicare and Medicaid Programs established by Titles XVIII and XIX of the Social Security Act. Generally speaking, Medicare is a benefit plan offered to the elderly and disabled and Medicaid is a benefit plan offered to low-income individuals.

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Medicare is chiefly run by the Centers for Medicare and Medicaid Services (CMS), a division of the U.S. Department of Health and Human Services, and more specifically, private contractors charged with the day-to-day administration of the program in various regions of the country. Medicaid is generally a state-run benefit plan, albeit subject to federal oversight due to significant federal funds. This article focuses on three key implications of Medicare funding on the identification and structuring of an investment: Medicare due diligence, assumption of the Medicare provider number, and assignment of Medicare receivables.

Medicare Due Diligence

All business investments require financial due diligence. Heavily regulated businesses require a deeper probe for legal compliance. Medicare providers are highly regulated businesses. Each claim submitted by a Medicare provider is subject to volumes of regulations and various Medicare manuals. A common requirement is that the claim be for a medically necessary service that was actually provided. Claims that do not comport with applicable regulations could result in liability under the federal False Claims Act, 31 U.S.C. § 3729, et seq. (FCA). The FCA provides for civil and criminal liabilities for improper claims and has been interpreted broadly by U.S. Attorneys and CMS to a wide range of activities. In one pending case, a U.S. Attorney has brought an action against an accounting firm for giving incorrect advice to a Medicare provider on whether a claim was proper.

In addition to the FCA, Medicare providers are subject to the federal Anti-Kickback Statute, 42 U.S.C. 1320a-7b(b) (AKS) and the Stark Law, 42 U.S.C. 1395nn (Stark). The AKS and Stark are intended to curb improper referrals of health care business. The AKS makes it illegal to pay, offer, accept, or solicit remuneration in exchange for referrals of health care business. Stark makes it illegal for a physician to refer business to an entity with which she has a financial relationship. Although these prohibitions seem straightforward in the abstract, many apparently harmless scenarios that are accepted and commonplace in other industries are the source of indictments and recoupments under the AKS or Stark. For instance, a supplier may send baseball tickets to a manufacturing company after a large order, but a pharmacy may not send tickets to the administrator of a nursing home after a large order.

A good example would be the facts that gave rise to the infamous Abbott Laboratories settlement reached in 2003. In that case, large nursing home chains were receiving free equipment from a subsidiary of Abbott Laboratories, a nutritional supplement (*Ensure*) supplier. It is unlikely that an individual with only general corporate diligence experience would identify this practice as problematic. In reality, the

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arrangement (which was more complex than described here) was a kickback for the purchase of nutritional products that resulted in a historic $615 million settlement with the U.S. Department of Justice and the Illinois Attorney General. The lesson: investors must bring health care expertise to the diligence room.

Assumption of the Medicare Provider Number

A key decision for an acquirer of a Medicare business is whether to assume the Medicare provider agreement and number of the previous owner. Every Medicare-participating entity is issued a unique provider number under which all of the entity's Medicare claims are billed. The advantage of assuming the Medicare number is that the new provider can continue to provide services and receive payment on an uninterrupted basis. The disadvantage to assuming the Medicare number is that the new owner will assume the lingering Medicare liabilities of the previous owner.

Assuming the provider number means that CMS and the Department of Justice may seek recoupments or cost report adjustments from the buyer's business for pre-closing violations. Recoupments can be enormous. For instance, if a buyer had come along for the Abbott Laboratories business prior to the charges brought by the U.S. Department of Justice described above, the buyer would have unwittingly subjected itself to the liability that resulted in the $615 million settlement.

This dilemma of payment interruption versus successor liability is what makes the Medicare provider number an important aspect of an acquisition. Because assuming the number is the most commonly taken avenue, investors must focus on legal due diligence and the security received under the acquisition agreement. The security (guaranty, escrowed holdback, or note) should be based on an analysis of recent cost report adjustments, whereby CMS determines whether the provider has been over- or under-paid for the prior year, and any discovered arrangements that could be the subject of an investigation under the FCA, the AKS or Stark.

Assignment of Medicare Receivables

Another quirk of the Medicare system with which investors should be familiar is the anti-assignment rule. Basically, Medicare prohibits a provider from assigning its right to be paid to another entity. While there are exceptions to this rule, the prohibition has implications for a lender intending to take a security interest in Medicare receivables and for a purchaser intending to buy the receivables as part of a business acquisition.

For a lender, the prohibition causes uncertainty over whether the lender may take a security interest in Medicare receivables and what effect a foreclosure

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action would have. Many believe that a lender may indeed take a security interest, but that the lender may never actually wrest possession from the borrower. This puts a kink into some lending structures. For instance, a lending bank cannot require that Medicare payments be made directly into the bank's account. To avoid this problem, many Medicare providers agree to set up lockbox accounts to receive the Medicare funds. In a typical situation, the lockbox would be swept into the bank's account daily.

In an acquisition setting, the assignment prohibition means that the buyer will not be able to acquire the Medicare receivables directly. Instead, the buyer could acquire the "right to receive an amount equal to the Medicare receivables" to be satisfied by sweeping the receivables from the seller's account as they are received. Although this method solves the problem of acquiring the receivables, it introduces a degree of risk because the seller will retain technical control over its receivables account post-closing. Also, this may mean that the seller must "stick around" post closing to ensure that collection and banking operations continue as normal.

The important message regarding the anti-assignment rule is that investors and/or lenders who intend to acquire or take a security interest in a Medicare provider's assets must be aware that they may never be able to directly acquire the Medicare receivables. Although the mechanisms described above attempt to cure the ills of the anti-assignment rule, they introduce other challenges.

The Payoff

Investing in Medicare business is not recommended for unprepared firms. Daunted by Medicare risks and complexities, many firms do not participate in the capital market for health care businesses, but Medicare challenges create opportunities for diligent and knowledgeable investors. An equity firm that knows how to navigate key Medicare concepts and business implications will reap the rewards of its diligence as the health care industry continues to grow to meet the nation's needs.

Ryan P. Hooper may be reached at 216-363-4195 or via e-mail at rhooper@bfca.com.