Real Estate Financing in the Healthcare Space: Keep Your Eye on the Ball

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The authors of this article discuss two important developments that could affect a lender's decision whether to finance real estate transactions involving entities and individuals in the healthcare field.

Recently, there have been two important developments that could affect a lender's decision whether to finance real estate transactions involving entities and individuals in the healthcare field. Lenders should be cognizant of these developments and update their due diligence checklists to include these issues.

Advisory Opinion No. 19-05 (Purchasing Real Estate from an Excluded Party)

The Department of Health and Human Services Office of Inspector General ("HHS OIG" or "OIG") recently issued an advisory opinion regarding the proposed purchase of real estate from a company owned and managed, in part, by an excluded individual. The Proposed Arrangement involved a community health center that receives federal grant funding and owns and operates community health centers enrolled in the Medicare program ("Health Center"). The Health Center sought to purchase the real estate on which one of its community health centers is located. The Company from which the Health Center sought to purchase the property is owned and managed, in part, by an individual who was excluded from participation in all federal healthcare programs by HHS OIG ("Excluded Person").

HHS OIG concluded that the Proposed Arrangement would not constitute grounds for the imposition of sanctions against the Health Center. The OIG based its decision on the Health Center's certifications that it would not submit any claims to, or otherwise request payment from, any federal healthcare program for the purchase of the property. Specifically, the Health Center certified that the purchase of the property would *not* be:

- Listed in an itemized claim for federal healthcare program payment or a request for payment;
- Included in any federal or state healthcare program reimbursement method, such as a prospective payment system or managed care system;

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- Included in any claim based on costs; or
- Included in a cost report, books of account, or other documents supporting a claim based on costs (whether or not actually entered).

The Health Center also certified that it would not use any federal grant funds to purchase the property or receive any financing from the Company or the Excluded Person for the purchase of the property. Finally, the Health Center certified that it would be the sole titleholder of the property and that neither the Company nor the Excluded Person would have any ongoing relationship—financial, ownership, control, management, or otherwise—with the Health Center after purchase of the property.

Based on the Health Center's certifications, the OIG concluded that the Proposed Arrangement would not involve the provision of items or services for which payment may be made under any federal healthcare program, and the OIG would not subject Requestor to administrative sanctions under Section 1128A(a)(6) of the Social Security Act in connection with the Proposed Arrangement.

Assessing Affiliation with an Excluded Party

The Centers for Medicare and Medicaid Services ("CMS") has issued the Program Integrity Enhancements to the Provider Enrollment Process Final Rule. Among other changes, the Final Rule adds 42 C.F.R. § 424.519, titled "Disclosure of affiliations." The Final Rule expands CMS's authority to deny or revoke healthcare providers from participating in federal healthcare programs. The Final Rule requires federal healthcare providers (Medicare, Medicaid, and the Children's Health Insurance Program) to disclose the individuals and entities with whom they have directly or indirectly affiliated that have "disclosable events."

Disclosable events include:

- Suspended or excluded from participation in a federal healthcare program;
- Enrollment denied, revoked, or terminated by a federal healthcare program;
- Billing privileges suspended, revoked, or denied by a federal healthcare program; or
- Uncollected debt (*e.g.*, overpayments, civil monetary penalties, or other assessment) to a federal healthcare program.

A healthcare provider is now required to disclose individuals and entities with which the provider has or had a direct or indirect affiliation. Under the Final Rule, "affiliation" includes:

- Direct or indirect ownership of five percent or greater;
- General or limited partnership interest, regardless of the percentage;
- Managing employees;
- Officers or directors; or
- Any reassignment relationship under 42 C.F.R. § 424.80.

The Final Rule's focus is to weed out bad actors, including individuals who potentially fall through the cracks and end up reenrolling in a federal healthcare program. However, the

Final Rule could have unintended (or maybe intended) consequences in the context of corporate transactions, including real estate financing.

Takeaways

Beginning November 4, 2019, lenders needed to delve deeper into the background, management, and structure of entities involved in financing transactions to reach a comfort level commensurate with the applicable transaction. Simply searching federal healthcare program exclusion lists is no longer sufficient. Lenders should update their due diligence checklists to include these issues.