

| March 5, 2024

#### Tamar Katz:

Good morning and welcome to Private Capital Public Impact, an FTC workshop on private equity in healthcare. My name is Tamar Katz and I'm an attorney advisor in the FTC's Office of Policy Planning. On behalf of the entire FTC Workshop team, we're delighted that you're joining us today via our live webcast. Before we begin our program, I have a few housekeeping details to cover. First, we encourage viewers to participate in this event in real time by joining us on Twitter. Our Twitter handle is @FTC and we'll be tweeting using the hashtag PEHealthcareFTC.

Second, we have another opportunity for public participation and input in these important issues. This morning, the FTC, the Department of Justice and the Department of Health and Human Services launched a joint public inquiry into corporate profiteering and healthcare. We encourage the public and all interested market participants to contribute by submitting their stories and views. You can submit a comment at regulations gov and we'll also post a link to that opportunity to comment from the webpage for this event.

Third, shortly after the event, a video recording and transcript of this workshop will be available on our workshop webpage. Our intent is to create a lasting resource for everyone who's interested in this important topic. Finally, as with any virtual event, please bear with us if we experience any technical issues with our livestream. And now I have the great pleasure of introducing our first speaker, Chair Khan, to kick off our workshop. Chair Khan?

### Chair Khan:

Great. Thanks so much, Tamar. Good afternoon, everybody. It's so great to be here with you all and I'm so excited to learn from the knowledge and expertise on this critical topic. Really just want to start by thanking all of the speakers that you'll hear from today spanning leaders from the Department of Justice and Department of Health and Human Services, respected academics and healthcare workers who have seen firsthand the impact of private equity investments in healthcare. I also want to thank our Office of Public Policy and Bureau of Economics for spearheading today's workshop and bringing together such a terrific group. And lastly, just want to also give a thanks to congressional leaders, particularly Senators Grassley and Whitehouse, who are spearheading a congressional investigation into private equity buyouts of hospital and also providing some much needed light in this opaque area.

So much has changed in the provision of healthcare over the past decades. One area that has been top of mind for the FTC is private equity acquisitions of healthcare service providers such as outpatient dinics, nursing homes, and physician practices. In recent years, these private investments have soared. Private investments can sometimes be an important source of capital, especially for small to mid-size companies that can benefit from the access that this financing provides. Some private equity firms take

a more long-term view and focus on creating real operational improvements to generate value in ways

order to faithfully enforce the Clayton Act, we cannot turn a blind eye to serial acquisitions and just look at each deal in isolation. As the guidelines note, we will consider individual acquisitions in light of the cumulative effect of related patterns or business strategies.

The commission's case against Welsh Carson and USAnesthesia Partners illustrates what this roll-up

Jonathan Kanter:

So far, because of the division's efforts, 15 interlocking directors have resigned from 11 different corporate boards. This is the antitrust delivering results for the people, and there's much more that we can and need to do. We're continually looking for interlocking directorates imposed by private equity, venture capital and corporate venture capital firms and others. Our newly released merger guidelines provide direction for enforcers on how to consider serial acquisitions, sometimes called roll-ups, including those by private equity firms in the healthcare industry or elsewhere.

Our newly released RFI on healthcare and private equity will give us the information to tackle private equity and corporate greed head on, and we'll continue to explore whether and how private equity firms might violate state corporate practice of medicine and other statutes that implicate the antitrust laws and competition. More than anything, we will stay laser focused on the intermediaries that sit between you and your doctor.

What I hope this short discussion shows is how seriously the Antitrust Division takes the problems presented by private equity and healthcare. The stakes are about way more than money. They're about people's health, people's lives. Let me give you an example of that. As I've mentioned to some before, I sat just a few weeks ago by a loved one who received a life-saving surgery. It happened to be at a community hospital. The level of care and attention from the nurses, the doctors, the aides, the technicians were unheard of by today's standards at this community hospital. I can't help but think that type of care occurred because the community nature of that hospital. That type of care must be protected even when it doesn't comply with a spreadsheet. The American people value and demand that kind of care because it's what our loved ones deserve.ly 11.9(ev3(at 2(t. As I')4ec)8(8(e))9(will g)4(ive)62(y)(11.96Te

make it difficult to know who is in charge, where the money is going and the effect on patients and

Thank you so much, Ohristi, and it's been a great pleasure working with you and your team during the past couple of years during my time here at CMS. And I wanted just start off with just saying, just a couple of remarks from CMSs standpoint that it was certainly true, say 10, 15 years ago that CMStook a more quiet view towards consolidation within the healthcare industry, that CMSpayment systems that ran through the Medicare program, for example, generally paid the same amount regardless to the consolidation. But what we're seeing now with newer ways that we're paying for care, that consolidation can grow CMScosts, can grow Medicare costs. So we have to in order to ensure that we're being strong stewards to the Medicare Medicaid programs, to really work more closely with our federal partners to ensure that we're doing everything that we can beyond just the cost to our programs, that we see quality of care issues that are heartbreaking.

We see nursing homes, some nursing homes produce harm to their residents. We see through our various programs run through private managed care plans that we see confusion and CMS gets per month more than 5,000 complaints coming into us just through that confusion. So we have to do more to ensure that those that are carrying out the Medicare programs, those that are carrying out the Medicaid programs really have good intentions. So we have to pay more attention, not just for cost reasons, but also for quality reasons.

For CMS, we really have four or five key strategies right now. We heard from the other speakers that we are working better together to share data. We really want to understand the impacts to what consolidation means for us and more complexity that we see in our programs, but to really understand

Those that want to be in these relationships need to hire more staff. They need to have better data capabilities, which then creates more opportunities to either sell or to partner with private equity firms. What we want to do going forward is to ensure that those that wish to be strong partners to CMS can afford to do so. They have their resources, we want to lower those costs, but those are our strategies. Couldn't be happier to be here today and again, look forward to the conversations. And with that, we'll turn it back to Tamar, and thank you again for the opportunity to be here today.

#### Tamar Katz:

Thank you all for such thoughtful remarks. Next, I have the pleasure of introducing Dr. Eleen Applebaum, co-director of the Center for Economic and Policy Research, who will be giving the keynote remarks this morning. In addition to her work at CEPR, Dr. Applebaum is a fellow at the Rutgers University Center for Women in Work and the co-author of the award-winning book, Private Equity at Work: When Wall Street Manages Main Street. Welcome, Dr. Applebaum.

# Eleen Applebaum:

[inaudible 00:34:42] Tamar, for that very kind introduction and thank you to the FTC for inviting me to speak at this very important workshop. I'm very pleased to be able to be here and to share some of

# Eleen Applebaum:

The insights that I gained from studying private equity, I've been studying private equity in healthcare since 2013, so I've seen a lot of the way in which they manage healthcare companies that they buy. As Chair Khan pointed out, healthcare is being transformed from a social good into a commodity that can be bought, sold, and sold again for private gain. Money that's intended to provide high quality care for patients is instead being diverted to the pockets of some of the most wealthy people in the country. What we see is that providers and clinicians whose mission is to care for patients are being gobbled up by private equity firms whose mission is to make outsized profits for themselves and their investors. Chair Khan has already spoken quite a lot about the private equity business model. I'll just describe it briefly and one of the reasons I wanted to do that is to help people understand why the FTC is focused on private equity.

After all, there are many for-profit companies operating in healthcare. What is private equity and what makes it different so that it warrants this kind of focus? So private equity firms are financial firms. They recruit investors into their private equity funds. They get about a third of their money from pension funds, public pension funds, and they are also funded by insurance companies, endowments, sovereign wealth funds, and high net worth individuals. And these investors are promised outsized returns that are going to beat the stock market and that are going to really pay off for them. And the way that it operates is that the private equity firm will buy a healthcare company or actually any company using a lot, a lot of debt. These are called leveraged buyouts. The private equity fund puts up a little bit of money. It's like the down payment on a mortgage, and then the rest of the purchase price is covered by debt. And the interesting thing about this, which many people do not realize, the private equity firm owns the hospital or the nursing home, loads the debt onto the hospital or the nursing home, and has no responsibility for repaying the debt. That debt falls on the hospital chain, the nursing home to repay. And that debt is what drives a lot of the poor quality care in private equity owned facilities. You have to pay back that debt ... or we'll see other ways that they do this when I give some examples, but initially they have to pay back that debt and this reduces their ability to staff properly, have proper safety provisions, provide the necessary time with patients, all of the things that the other speakers have already pointed out. The private equity firm then engages in a consolidation as we've already heard. It

much use of healthcare services. That doctors are ordering unnecessary tests, unnecessary lab work, unnecessary procedures, driving up the cost of caring for seniors. The idea behind it is that by controlling access to services, QMS is going to be able to save money. And what it wants to do is control unnecessary services. But the way that this payment system works, value-based care means that providers receive capitated payments.

They receive a flat payment for every person they have enrolled in their care network, in their care system. So in the case of hospice, which is easy to understand, we see that the hospice is paid more than \$200 a day for every person enrolled in that hospice agency. The idea behind it is by giving the providers money upfront to take care of the patients, they will invest in caring for these patients at a very high level in order to keep them healthy so that they require less expensive care, less intensive care, and are healthier and that the private equity firms or the hospice providers are going to make money by improving the care of patients and cutting down on the use of services. Well, that may work if you ... and we have seen it work and of course our research, we have interviewed hospice providers in many parts of the country and we have seen really good nonprofit hospice providers that act exactly as CMShad intended.

But when private equity enters the hospice business, which they have, and were a for profit center, we see that taking care of patients and making them healthier is not the only way that you can hold down costs. You can hold down costs by denying patients the care that they really deserve. So in the case of hospice, all that is required once the hospice is certified is that a nurse visit the patient once every 14 days. So the hospice agency is collecting more than \$200 a day for care of that patient. And the requirement is so minimal that you can get away with sending a nurse once every 14 days. Now, the nonprofits that we talked to said that a minimum is sending a nurse once a week, and that in their case,

there is one doctor and two nurses per 12-hour shift. Prior to being taken over by private equity, the emergency rooms regularly employed a mid-

which graduates 20 to 30 RNs yearly. However, the hospital cannot maintain local staff because of low pay and poor working conditions.

During COVID no nurse at this hospital received hazard pay or a raise. We never received any sort of bonus during the COVID surges. Our Christmas bonus last year was a \$50 gift card. When our timekeeping system went down, we resorted to paper time sheets. Even though I worked overtime during the holidays, I never received my overtime, holiday pay or charge nurse pay from that period, despite multiple attempts at contacting the director as well as HR. A coworker of mine told me a few weeks ago that he has documented \$2,300 worth of bonuses for picking up overtime that the hospital

equity, describe how this usually works, and exactly the same playbook has happened here in Chester. The real estate was sold off in a sale leaseback.

Hundreds of millions of dollars were taken out of Prospect Medical. The current real estate, well, the former real estate owner, was Medical Properties Trust. So the hospital was then paying lease money to Medical Properties Trust on land that it had owned for 100 years. It couldn't afford to do that. So what happens? Well, care disintegrates. About six weeks ago, I was sitting in the office of Chester's new mayor, Stefan Roots, and his phone rang. Somebody said, "Have you heard that the surgical residency program at Chester Crozier has just been de-accredited?" Stefan, knowing that I wrote a book about a hospital, hung up, and he said to me, "Tell me what that means." I said, That means something is seriously wrong because an accreditation agency does not de-accredit a program with 48 hours notice, and in fact, something was seriously wrong. I have interviewed employees and former employees of Chester Crozier who tell me staff morale has sunk to all-time lows.

They're holding equipment together with duct tape and bailing wire, and the quality of care has disintegrated. Now, Leonard Green already took hundreds of millions of dollars out of Prospect Medical, and you'll hear more about that, I imagine, from Rhode Island's attorney general, Peter Neronha, who had a conversation with me about this subject just a couple of weeks ago. So I won't spend a lot of time on that, but I want to tell you how this affects people. Chester Crozier is a big employer in Chester. As I mentioned, Chester is a poor city. A lot of people are in poverty there.

The kinds of jobs that people get in the hospital are maintenance, housekeeping, kitchen staff, health aides, and so on. They depend on these jobs. If Chester Crozier goes bankrupt and it is in danger of going bankrupt, those people lose those jobs. Secondly, Prospect, which owns four hospitals in this Keystone Crozier system, is stiffing local communities of the taxes that these communities are owed, to the point that one community, Ridley Park in Delaware County, has just had to raise taxes on its citizens to make up for the taxes they're being stiffed by Prospect Medical.

Just about almost nine months ago, Medical Properties Trust sold Prospect Medical back the land that they had purchased. They sold Chester Crozier back for \$149 million. Well, Chester Crozier didn't have \$149 million. So what is this? This is a mortgage, and the reason that Medical Properties Trust did this

intermittent diversions and inconveniencing patients and their families who had to be sent to the next nearest cath lab over two hours away. The most heartbreaking change occurred on our surgical unit, a hub for orthopedic total joint care and various surgeries.

Our former ŒO, Tim Trottier's, decision to shut down the entire medical oncology unit, combining it with the post-surgical unit, eradicated beds and left us ill-equipped to handle the flu season demand. This confluence of patients from those admitted from the 🗈 to post-surgery patients and ICU downgrades leads to patients being transferred due to insufficient beds, an unfortunate reality that we now face. In October of 2019, negotiations commenced between the hospital and Regence BlueShield of Idaho, a healthcare insurance company catering to over 15,000 individuals in our community. Faced with the challenge of inadequate premiums, the hospital declared its attention to sever ties with Regence's network on January 16th, 2020. This decision meant that non-emergent services, including lab tests, office visits, elective surgeries, to name a few, would be subject to out-of-pocket network payment rates, which were much higher. Only critical services, such as those related to heart attacks, strokes, and emergencies, would retain in-network billing.

The repercussions were profound, compelling individuals to navigate abrupt changes during their midtreatment, seeking new facilities, doctors, and even places for elective procedures and childbirth. While the hospital and Regence eventually reached an agreement, the period of uncertainty exacted a heavy toll on our community, particularly those grappling with chronic illnesses and expectant families. As I reflect on these changes, it's disheartening to acknowledge that no department has grown or had cutbacks since our acquisition except for those far removed from direct patient care. Those departments, being administration and human resources, our community, and dedicated healthcare professionals deserve better, and I implore you to consider a human cost of these decisions. Together, let us advocate for return to the principles that put patient wellbeing and community care at the forefront of our mission. Thank you very much.

### Tamar Katz:

Thanks so much, Joe. And we're now going to hear from Dr. Jonathan Jones, an emergency room physician with broad experience in urban and rural medicine as well as with multiple different practice models. Dr. Jones.

## Dr. Jonathan Jones:

Hi. Thank you, Tamar. Hi, I'm Dr. Jonathan Jones, and I'm an emergency physician in Jackson, Mississippi. I've been in practice for over a decade. I'm also the president of the American Academy of Emergency

what is considered safe by any of the emergency medicine specialty societies. Additionally, this change was not made in consultation with the physicians or the medical director, which is typically the case. Instead, these changes were simply dictated to us despite having no discussions that they would be made. When we said this was unsafe, they said too bad. Very soon after the coverage was decreased, the PE-

not

And sadly, I have to think that so many of the warnings and allegations that we're hearing today from experts like Professor Appelbaum, or Nurse Joe Thon, or Dr. Jones stem from situations where private equity is taking control away from doctors and medical professionals. I have a hard time thinking that doctors would close an urgent care center to shunt their patients into an emergency room and emergency level prices. I have a hard time thinking that doctors would accept a stroke patient when they know for a fact, as Dr. Jones explained, that no doctor is on staff who could adequately care for that patient. I have a hard time thinking that doctors would sell out the land from under their hospital. I have a hard time thinking that doctors would force unresponsive hospice patients into occupational therapy. And so for all these reasons, I'm particularly interested in the responses to our request for information that get at the way providers practice medicine under the private equity model, their incentives, their prescribing decisions, as well as the changes to management that providers have experienced under these models.

As a reminder, comments on that request for information are due in about 60 days. You can comment at regulations.gov, and I encourage everyone listening to comment. In dosing, I'll just say that I'm proud that, under Chair Khan's leadership, the FTC has shown its willingness and resolve to address anticompetitive business strategies used by private equity in all industries, but particularly healthcare. You see this commitment in the recently issued merger guidelines and you see it in the cases that the FTC is bringing, and I'm also proud to be doing this work alongside Assistant Attorney General Kanter

What about the specific stories? What about the human stories? The story that I often return to, and it's the one that I think illustrates what makes private equity unique in healthcare and elsewhere, is about Carlyle's acquisition of the nursing home chain HCR Manor Care. HCR Manor Care was at one point the second largest nursing home chain in the United States, and Carlyle bought it in about 2007. It then executed a number of what are fairly familiar tactics in the industry. So they had required HCR to sell its underlying real estate and then lease it back, something that we heard about in the last session, staffing got cut, and health code complaints rose.

Eventually, at least one resident died at one of these allegedly understaffed facilities. She needed to go to the bathroom by herself, but hit her head on a bathroom fixture, ultimately died of subdural hematoma. When her family sued Carlyle, the private equity owner for wrongful death, Carlyle was able to get the case against it dismissed saying that it was not the technical owner of the nursing home chain, rather it merely advised a series of funds who, through several shell companies, ultimately owned the nursing home chain. And that was enough to get the case against Carlyle, the private equity firm, dismissed.

And I think it's illustrative of what makes private equity unique, which is that private equity firms typically have effective operational control over the businesses they buy. But when things go wrong, when somebody gets sick, when somebody dies, it is going to be very hard to hold the private equity firm responsible. So when you consider what would happen if the exact same thing happened, but it wasn't a private equity firm, but it was a healthcare conglomerate or a hospital or somebody else that bought up that nursing home chain, they probably would be held responsible. The private equity firm

hospitalizations that involved surgery, but it was nevertheless concerning to us. Private equity hospitals also increased their transfer rate of patients to other acute care hospitals by about 12% and notably, by 36% for patients with sepsis, whom we typically considered to be on average sicker patients in the hospital. All of this was relative to the non-private equity control group. Medicare beneficiaries admitted to private equity hospitals after acquisition were younger and less likely to be dual eligible for Medicaid than beneficiaries at control hospitals. This signaled a shift towards lower risk patients as younger patients are healthier on average and dual eligible beneficiaries are more socioeconomically disadvantaged and sicker on average. Although coded diagnoses at private equity hospitals increased after acquisition, we could not disentangle that from coding intensity, sometimes phrased upcoding, which is independently financially rewarding relative to actually sicker patients coming into the hospital. And again, because patients were younger and less dual eligible, we believe that on average these patients were lower risk and likely healthier. Lower risk patients and increased transfers to other hospitals were both consistent with our finding that in-hospital mortality actually declined by about 3% after acquisition among what is plausibly a healthier population. At 30 days after discharge, however, there was no longer a differential change in mortality at private equity hospitals relative to control.

So in brief, on evidence in other domains of healthcare, in recent years, private equity firms have acquired, as you've heard, healthcare providers across a variety of clinical settings. In addition to physician practices and nursing homes, acquisitions have also been described in other important clinical domains. For example, private equity has acquired hundreds of OBGYN practices across the country, over 500 as of 2020, in another one of our studies. Private equity has also invested in the large majority of fertility chains in the U.S., which has been found to be associated with an increase in the volume of IVF procedures resulting in increased IVF successes, births. Towards the end of life as opposed to the

market segments because they have found a revenue opportunity to exploit. We follow the money to identify the revenue playbooks that are drawing the investors. If we can find the loopholes, then we can potentially fashion a policy response to close them.

So payment loopholes tend to be very specific to the particular sector or specialty being targeted. However, some strategies are common across specialty types. As I mentioned before, consolidation via the roll-up model is a common strategy across all specialty types to increase the market power of the physician practice then and portfolio that is being acquired and merged.

Another common tactic across the board is for the investors to control the captive physicians. The management services organization takes control over the practice, again, not necessarily by outright owning it, but through management service agreements, including control over hiring, firing, scheduling, contracting, billing, coding, all of which can threaten professional autonomy, cause burnout and moral injury while using non-competes and gag clauses to prevent physicians and clinical staff from leaving or speaking out if they have concerns about these practices or about the quality of patient care.

## Thank you, Erin.

And our last, but certainly not least, speaker today is Dr. Joseph Bruch, who's an assistant professor of public health Sciences at the University of Chicago. Dr. Bruch's research focuses on the compatibility of different financial actors with medical expenditure, healthcare quality, and population health.

### Dr. Bruch?

### Dr. Jonathan Jones:

Thank you. I want to first begin by expressing my gratitude to FTC Chair Kahn as well as Commissioners Bedoya and Saughter for hosting this workshop, as well as to Mark Katz and Carter Page for organizing this event. I'm honored to speak here on this panel with my esteemed colleagues.

My name is Joseph Dov Bruch and I'm an assistant professor at the University of Chicago. As mentioned, I study the role of the financial sector and how financial actors in healthcare influence population health and healthcare delivery.

As my colleagues have noted, private equity activity in U.Shealthcare has surged in recent years. More and more we are seeing a small number of private equity firms acquire larger and larger swaths of our health system. Dialysis clinics, fertility centers, hospitals, nursing homes, physician practices, and behavioral health centers to name a few. As private equity has become a growing force within the healthcare industry, several researchers have tried to study its implications.

Generally, researchers examine before and after a private equity acquisition and compare changes in the quality operations and finances of a private equity acquired entity to an entity that was not acquired by private equity. Becaucto and healthcare delivery.

However, the authors found that private equity acquired nursing homes had less personal protective equipment than other nursing homes.

In another study, Gandhi and colleagues found that nursing homes owned by private equity were more sensitive to competition than non-private equity owners. Specifically, they found that in highly competitive markets, private equity owned nursing homes increased staffing by more than \$72,000 worth of care. However, in less competitive markets, they reduced staffing by an average of \$18,604 in care.

So I've discussed physician practice in nursing homes, but the research on private equity activity extends way beyond these two areas, as discussed by the previous researchers.

In a recent systematic review by Borsa and colleagues, we reviewed the evidence across 55 studies that focused on the prevalence and impact of private equity across all of the other areas as well as including physician practices and nursing homes. What we found is that private equity ownership has rapidly increased, but in terms of impact, we found that private equity ownership was most consistently associated with increasing cost to patients and payers. Additionally, private equity ownership was associated with mixed to harmful impacts on quality. Health outcomes showed both beneficial and harmful results as did cost to operators, but the volume of studies for these outcomes was too low For conclusive interpretation. Private equity ownership was also associated with reduced nursing staffing levels or a shift towards lower nursing skill mix. What is important is we found no consistent beneficial impacts to private equity ownership across the literature.

While understudied, we are also seeing private equity firms working with real estate investment trusts, RBTs. Here, healthcare entities sell their real estate to RBTs and then pay yearly rental fees to the RBT in what is referred to as a sale leaseback. Generally, these transactions consist of a 10 year triple net lease whereby the healthcare tenant is responsible for facility rent, maintenance, insurance, and taxes. Sale leasebacks can provide desired capital for healthcare entities, allowing healthcare operators to use the proceeds from the sale to invest in patient care expansions or capital investments. However, oftentimes private equity firms are selling the real estate of the acquired healthcare operator and the income from the sale leaseback is flowing as dividends back to the private equity firm, leaving the

We now have about 20 minutes to spend on Q&A, which is not nearly enough, but let's go ahead and dive in and see what we can cover.

I'd like to start with you, Zirui and Joe. Both your presentations discussed the evidence about how and whether private equity acquisitions have been associated with different effects than other types of acquisitions, particularly increased costs and mixed or negative impacts on patient care and quality.

Could you explain why private equities' acquisition of hospitals or physician practices might lead to these different outcomes that have been observed in literature?

We'll start first with you, Zirui, and then, Joe, if you want to add on.

# Zirui Song:

Sure, Laura. Thank you for the question.

We have a primary hypothesis that staffing reductions and cuts and expenses likely explain these changes in patient adverse events and patient outcomes within hospitals. We are starting to work on this second phase of this overall broader project and understanding hospital acquisitions and beginning to see evidence consistent with that hypothesis. We don't yet have estimates that we can report, but it seems to be clear that staffing reductions, which you've seen in nursing homes and that's been well documented and in physician practices, which a study led by be has also documented last year in Health Affairs, likely translates to a similar or analogous type of mechanism within hospitals. The staffing reductions are part of what you might call more broadly cost cutting. Both salary and non-salary expenses might be involved, and there might be variation across hospitals in exactly where the costs are cut or what types of labor or non-labor types of costs

# Zirui Song:

[inaudible 02:20:01], but that remains our primary mechanism and we look forward to presenting evidence on that in the near future.

#### Dr. Jonathan Jones:

Yeah, I agree with Dr. Song. I'll add though staffing I think is definitely contributing to the more acute quality implications, but I also think the financial implications here may create long-term quality and patient related harms. So while we may not see in the short term the effects of the high amounts of debt private equity firms generally load onto the healthcare entities as well as the stripping of real estate and other financially engineered tactics that private equity firms may pursue, over the long term we may expect to see that these financial changes may have really lasting impacts all the way leading to dosures ultimately, as well as patients having limited access and staff no longer having jobs in the places that they've held jobs for decades.

#### Laura Alexander:

Thank you. Building on that, I wanted to turn next to you, Brendan, and ask you to weigh in on to what extent this is the types of staff cutting, et cetera, building on Joe's remarks about this greater issue with commercialization and monetization of healthcare, and to what extent can the kind of accountability changes that you talked about in your presentation go to address those issues?

### Brendan Ballou:

Yeah, it's really interesting and maybe I can talk more about some of the tactics that Joe was talking about and then transition to staffing specifically. So one of the basic challenges of the private equity

business model is that the incentives of the private equity firm are not often, are not always aligned with the incentives or what constitutes success for the portfolio company or even for the investors that invest with the private equity firms, so the pension funds and sovereign wealth funds that fund the private equity firm's acquisitions.

So just to give you an example, Joe was talking about sale leasebacks. Just to reiterate the idea here is the hospital or the healthcare facility owns its real estate, will sell that real estate and then lease it back to itself. Now that generates a quick hit of cash, but suddenly you're responsible or the company's responsible for indefinitely paying for something that it used to own. Sometimes that might make sense, often it doesn't.

But why would a private equity firm do it? Well, oftentimes a private equity firm's compensation structure is such that it will get a "transaction fee", which is a fee that they get specifically when a sale leaseback or other sort of deal is executed. So the private equity firm will actually get more money from the sale lease back then just the ordinary profits and that money from the transaction fee will go to the

And so if we can't study the effects of this and we honestly can't regulate it and can't oversee it if, we don't have ownership transparency. So to me, that's a starting point as a bedrock principle for all of the other policy solutions.

The second is antitrust enforcement and competition policy. And we're here with the Federal Trade Commission and the Department of Justice, but this is core because the roll-up strategy employs a consolidation approach, the use of competition policy, the use of the existing antitrust laws to apply it to the strategy used by private equity is very important. It's also important as we've seen the Federal Trade Commission doing, to modify, and the merger guidelines from both agencies, to modify some of the guidance that might've been developed in earlier days to embrace the type of consolidation we're seeing with the serial cumulative effect roll-ups that we know individually may not appear to have an anticompetitive impact, but when you add them all together as we see across an entire market, that is certainly the case. So using antitrust and enforcement policy is extremely important to potentially constrain the cost effects, but also the access and quality effects that we're seeing, the non-price effects as well.

The third policy lever I would say is fraud and abuse enforcement. We heard a lot of strategies about this incentive to increase revenues, captive referrals, upcoding and other revenue generating tactics may violate in many instances federal and state fraud and abuse laws. And so to the extent that there is investigation, again that linking those strategies not just to the portfolio company or the end of the line dinician or the billing and coding person who's just being told what to do, but to actually link it back to the revenue strategy of the management company and the private equity fund that's in the driver's seat. I think it would be really important. It's challenging under current laws, but I think that that's another potential avenue to create at least some guardrails around some of the most nefarious billing and coding activities.

And then a fourth would be policies to protect the clinical autonomy of the workforce, including the physicians, the nurses, and other clinical workforce. So we heard today in the first panel about ways in which private equity investment in particular, like a lot of other corporate behemoths coming into the healthcare space, is stripping away clinical autonomy, professional autonomy, and putting the clinical workforce in a bind through reduced staffing levels, through the revenue incentives that they are being forced to carry out.

And so one way to protect the clinical workforce would be to strengthen state Corporate Practice of Medicine Doctrine. There are a couple of states that are trying it right as we speak, Oregon being one of them. It's trying to strengthen the Corporate Practice of Medicine Doctrine in order to get at the contractual workarounds that private equity and other investors have been using for years to control physician practices, even if they don't own them outright, as well as physician non-competes and other types of anticompetitive employment agreements, gag clauses and the like. Again, the Federal Trade Commission has a proposed rule on non-competes, and I think a lot of states are also looking at shoring up those requirements.

And the final policy option is to close those payment loopholes that are being exploited by private equity to increase revenues as we see primarily without increasing value for patients or the taxpayer. But those are, again, a bit specific and in the weeds, but I would just characterize that as find the revenue loophinlice

I'm curious the types of conduct that we've been talking about here, and Erin mentioned roll-ups, serial acquisitions, these are issues that go beyond private equity and certainly are competition problems that are not specific to private equity. I'm curious about your perspective on whether this is a particular issue with private equity in this area or whether this is simply a broader competition issue related to roll-ups and other factors, and what makes private equity roll-ups different?

#### Brendan Ballou:

Yeah. Well, at the risk of being a little repetitive, I'd say that what makes private equity roll-ups a little different is that when a private equity firm rolls up an industry, it's going to be very hard to hold the private equity firm responsible for those portfolio company's responsibilities. If the exact same roll up occurred by a traditional company, a hospital or an insurer or something like that, generally you would be able to hold the hospital or the insurer responsible. So I think that makes private equity acquisitions qualitatively different in some ways than other kinds of roll-ups.

Now, I need to be a little circumspect here because as I said at the outset, I'm speaking in a purely personal capacity, but let me just emphasize some of the things that you already heard from Assistant Attorney General Kanter, and a lot of the participants over the course of the day, private equity firms are engaged in all sorts of roll-ups. You can essentially throw a dart at any part of the healthcare industry and you'll see private equity getting active there. One of the challenges that I think all parts of government face is often these acquisitions are occurring below what's called the HSR reporting threshold. So that's the threshold at which the companies need to report to the government that an acquisition is happening. Individually each one of these acquisitions might not be anticompetitive, but collectively they have the power to raise prices, reduce the quality of care, reduce employment and so forth. And you hear that again and again in the research that we've been talking about over the course of this panel.

I will say I think that there's been a lot of interesting work done to address that. For instance, as Chair Khan mentioned at the outset, new merger guidelines are helping to add some precision to what we mean by a serial acquisition and when such an acquisition might be anticompetitive. You see actions happening at the state level. California right now is considering a bill that the State Attorney General have the authority to review hospital acquisitions before they're approved, separate and over and above from the traditional antitrust analysis that goes on at the federal level. So I think that there are things that make private equity acquisitions unique, but again, speaking personally, I'm encouraged by some of the things that we're seeing both at the federal and state level to help address the problems posed specifically by private equity.

### Laura Alexander:

Thank you. I want to open it up to the rest of the panelists to the extent anyone wants to jump in on that question or respond to any of the other points that have been made.

#### Dr. Jonathan Jones:

I would like to speak to the first comment Erin made, which is about transparency. And all of us have, we're like a broken record on this panel. If you come to any of our talks, that will be one thing that you will be sure to hear. But think about it for a second, we actually don't know, and the government doesn't

able to capture all the private equity deals in real estate investment trust ownership structures within our nursing home industry.

So that means regulators can't regulate. That means researchers like us cannot assess the impact of private equity and other financial actors, and it ultimately means patients are not able to know who owns the healthcare operator that they're going to. It means they don't know whether it's a financial firm that has a history of doing X, Y, Zor it's some other type of healthcare entity. And so at the very, very minimum, and I imagine all of us are going to keep having to say this, transparency really does seem like a baseline for this conversation.

Laura Alexander:

Thank you.

# Zirui Song:

I would just add another fact that I think is helpful for just keeping on the table, which is the heterogeneity across all of the private equity acquisitions we see in the delivery system. When we speak about private equity, especially across many of our research papers, we tend to present them as the average effect of an average private equity acquisition. But there are sort of two facts to consider there. One is that around every average there's a distribution. There are some acquisitions that produce results that don't give you the average finding that we report in a paper or that most studies report.

And the second fact is that increasingly in today's world, private equity acquisitions are on the margin at least deviating from the classic private equity approach, meaning the high level of debt or leverage or the high debt financed price of the acquisition, be it 70 or 80% debt, 20 to 30% existing equity, that classic approach, which may have applied more to hospitals and nursing homes may not apply as frequently, though it still is relevant to physician practice acquisitions and the acquisitions of other healthcare providers. So understanding the variation and the heterogeneity across these acquisitions is important as well as understanding the variation and the heterogeneity beneath, one level below the average results that we see in these studies.

# Attorney General. Peter F. Neronha:

What really concerned me was how the financial security, the financial wherewithal of Prospect Medical Holdings had changed over just a couple of years. They had gone from a firm that was well financed, was financially stable to one that was financially unstable. Now remember, this is a national hospital company. They owned 17 to 20 hospitals all around the country, including our two here in Rhode Island. And so what had happened was that Prospect Medical Holdings had gone from a company in say, 2018, where their assets exceeded their liabilities by \$67 million to really being now upside down to where

being able to raise funds, they didn't want to be anywhere near this hospital company when it started to become insolvent. So that was the motivation for them getting out. There's no doubt in my mind. They didn't want to still be on board the ship when the ship hit the rocks.

And so what we did was we forced them and the other two owners, the individual owners, to put \$80 million in an escrow that this office controls as a backstop for their promises. Their promises were to keep the hospitals open, their promises were to pay their vendors. Their promises were to keep lines of services open and not reduce workforce, and a number of other promises. But I didn't feel like we could take those promises at face value, we needed security for them. And so we took what was then, and I think still is, the unprecedented step of forcing Leonard Green and Mr. Lee and Mr. Topper to put \$80 million in escrow that they only got back in pieces as they kept the hospital operations going. And again, what's happened since has only confirmed what I worried about, Prospect is in tough shape today, frankly. We're in court, we're suing them to pay their vendors, but I think this is all something we could

No, it is astonishing actually. And look, these private equity firms are smart, they know how to hide the ball through layers of ownership and more. So part of what the Hospital Conversion Act envisions here in Rhode Island is getting public comment and being very deliberate about that. So we had a number of public meetings where the community was invited to come forward and share with them, share with us their perspectives. And I will tell you there was community support for this change in ownership, and a lot of that was because the public didn't have the information that we had. There was something called the Health Advisory Council here in Rhode Island that advises the Department of Health. They voted in favor of the transaction, I think in large part because they couldn't see what we could see. The Lieutenant Governor came out and supported the transaction along with other political leaders because they couldn't see what we saw.

And so it was really important for us when we issued our decision some months later, back in June of 2021, to be really clear and explicit as to why we took the steps we did. And look, they were not happy with us, Prospect Medical Holdings, Leonard Green, Mr. Lee and Mr. Topper were not happy with this office. There was an attempt to blame us for any bad outcomes going forward. But we knew, I knew at that point that we had to fight right then and there, we couldn't wait because we had to act while we still had leverage over Leonard Green. They so badly wanted out, they were willing to put up a big part of that 80 million in escrow because they were so desperate to get out.

Reputationally, they just can't be there when a hospital closes with patients waiting outside the doors, as it literally happened in Pennsylvania. They just can't be the owner at that point for purposes of their

Islanders in their healthcare. And so I think that could be darified. I mean, one of the major things that we added to it, if you were to look at it four years ago, what it didn't the major things that

Attorney General. Peter F. Neronha:

Yes.

## Rebecca Kelly Saughter:

And I think that it is a really important guiding principle for enforcers. How have you worked with other state AGs or federal regulators in some of this work? When you talk about the Leonard Green transaction, you mentioned that it was ongoing in multiple states simultaneously.

Attorney General. Peter F. Neronha:

Mm-hmm.

Rebecca Kelly Saughter:

Do you compare notes? How does that work for you?

### Attorney General. Peter F. Neronha:

Yeah, one of the challenges here, when I was a United States attorney, we all read off the same sheet of music, meaning we all were applying the same statutes across the country, criminal and civil. So you could pick up the phone and call the US attorney in another state and instantly be know exactly what each other were facing. This was harder because I don't know, for example, what William Tong, he's a great attorney general in Connecticut, but what's his ability to deal with the three Prospect-owned hospitals over there? It's very different than the ability for me to take action here.

Same thing in Pennsylvania with my colleague there and Governor Shapiro when he was AG. Certainly, somebody wasn't afraid to take on a powerful interest, but if you don't have the tools in the toolbox, it could be much harder climb to make. So certainly, we compare notes. I talked to my colleague, Attorney General Tong, about this issue of the Prospect-owned hospitals that we're facing today because things did turn... take a turn for the worse as we had forecasted two years ago, but without... because we're often so differently structured, our ability to cooperate as much is... can be much more of a challenge.

# Rebecca Kelly Saughter:

You're also all, I think it's fair to say, grossly under-resourced. I mean, we think that we are grossly under-

out of public service what I like to think I've always gotten out of it, which is you go home every night, or at least most nights, and you feel pretty good about what you did that day in a way that I didn't have that experience in private practice. At Big Law back when I started out of law school. I learned a lot there, taught me a lot of great lessons, but I've stayed in public service because the gift is the work, and I think lawyers appreciate that more than ever today. Young lawyers in particular.

# Rebecca Kelly Saughter:

Yeah, I think that's absolutely true, and we have experienced that very much in our recruitment efforts, which have included recruiting from the incredibly talented staff at the state AGs offices because we all don't have non-compete clauses that prohibit our staff from moving from office to office and we want the best people doing the best work in the environment that is the most satisfying to them. I'll just mention that I recall well that large transaction that you referenced from a few years ago and how critical our partnership was, and it was another one in which there was very extensive political lobbying-

Attorney General. Peter F. Neronha: [inaudible 03:03:05] absolutely.

### Rebecca Kelly Saughter:

... and keeping our eyes on the facts and the information in the case in front of us was really critical to make sure we got to the right outcome for the people of Rhode Island and the areas that those systems served.

Attorney General. Peter F. Neronha: You know, Rebecca-

## Rebecca Kelly Saughter:

[inaudible 03:03:20]... Sorry, go ahead.

# Attorney General. Peter F. Neronha:

... [inaudible 03:03:21] if I could. I just... You've asked me a couple of times, "How do you do?" And I think part of it is just understanding what your job is. But I'll never forget meeting a former nurse who had lost her pension because regulators had not been careful enough when I was running for this office back in 2017. And her words to me have stayed with me ever since, and I knew coming in that we just had to pick up our healthcare game. But there are many ways in which running for political office have forced me to do things outside of my comfort zone.

I don't think I was born to do politics, but I will tell... I will say this. Getting out there and talking to voters or residents of your state will really reinforce while the... why the work is important. [inaudible 03:04:15] sometimes, as an assistant US attorney and as US attorney, I felt sometimes we were so divorced from everyday Rhode Islanders that I couldn't really put our mission in context. One thing about being an AG and an assistant attorney general is you are much closer to the people you serve, and it helps remind you of why it's really important to do what's best for them.

### Rebecca Kelly Saughter:

Yeah, I think that's such a great and key point. And I'd like to particularly express admiration and appreciation for the work of Chair Khan and AAG Kanter in, as they say, democratizing the work of the

Well, I think a really important point in that too is effectuating deterrence. I think something that is critical about the work you did with respect to this key transaction was sending the message to the marketplace that you were willing to do it and that taking that model of value extraction and then get out of the business is not something that's going to fly in Rhode Island and sending that message loudly and clearly, hopefully, will send... will prevent other players from trying to repeat that playbook because they will see that it doesn't work.

We focus very, very much on making sure that not just which cases we bring but the way we bring them and the way we resolve them will help deter other bad actors in the market because, ideally, we don't want to have to go in after the fact and fix a problem. We want it to not happen in the first place. And I'm wondering if that's how you think about some of these things.

# Attorney General. Peter F. Neronha:

Yeah, I do, and you just have to look across the border to Massachusetts, where they're facing crisis with 13 safety net hospitals and Steward Health Care, which has done something very similar to what Leonard Green and Mr. Lee and Mr. Topper did as owners of Prospect. Again, we've got 13 community hospitals in danger of closing because the equity has been sucked out of them, and the properties have been leased back. It's the same playbook, and we see it over and over again.

And Massachusetts now is really scrambling to figure out what to do with these 13 hospitals, how to save them and keep them open when the money's gone, and they really don't have much leverage over them. We've really got to just accept the fact that private equity is going to keep doing this and give ourselves the tools to try to prevent it because if we don't, we're going to see the same thing playing out. And look, it's not like the remaining hospitals can absorb the dosures. That's what Massachusetts worries about. If you dose those 13 hospitals, it's going to weaken the other hosgoin8(an)4(d)3(o)3(va8710(Qq8(That'0(

Attorney General. Peter F. Neronha: Correct.

Rebecca Kelly Saughter:

... or transfers.

Attorney General. Peter F. Neronha: Yeah, that's right. That's right.

# Rebecca Kelly Saughter:

I'm wondering if, in thinking about deterrence or how to use the tools that you have most effectively, you draw any lessons from your time as US attorney. Obviously criminal enforcement is a little bit different but is similarly plagued by too many problems, not enough resources, and real serious stakes for real people.

## Attorney General. Peter F. Neronha:

Yeah. Look, I think there my... one thing from that experience was a case we brought against Google for helping foreign pharmacies import opioids into the United States without a prescription, and if we could have seen... if had known then what we know today, that that alone, the fact that there was so much money to be made by Google simply by doing that, simply by helping foreign pharmacies get their ads higher up in the ad search, it showed how addictive opioids were or are, and that what a problem it was becoming for people all across this country. And the actions we took there seemed like they had an impact at the time, but looking back on it was a 500 million dollar forfeiture, one of the five largest in the history of the United States, but I don't... Certainly, it changed Google's behavior on that particular issue, but how much of a deterrent effect it had, I'm not entirely certain. There is so much money to be made out there from dever schemes that try to stay two steps ahead of the regulators.

We really have to be on our games. And when we take our eye off the prize for a minute, that nurse loses her pension and loses her house. I mean, I met her in a public housing complex, and she was there because she lost her house, because she lost her pension because private equity didn't take over the pension when they bought Prospect, and the regulators let it spin off into a pension system that was destined to fail.

Those are the people who get impacted, and it's why it's so important to do this work with a careful and enthusiastic guy. I mean, I call it objective skepticism. We should always be fair, which means we should be objective, but we should always be skeptic... always be skeptical of what the proposed outcome's going to be from the perspective of the people that are trying to sell the transaction to us. We just can't get rolled, and we have to stand up for the people of our states.

# Rebecca Kelly Saughter:

Yeah, I think about that as the consider the source lesson in terms of evaluating an argument. I mean, it doesn't mean the argument is wrong, but you understand what are the interests of the person who is making that argument, and that is important context. I think the lesson that I hear in what you say about that Google case, though, is important and does reflect some of the work that you've been talking about as Attorney General, which is follow the money.

You pay attention to where the money is going, and that can help you understand incentives and outcomes. I'm wondering when you talk a little bit about... you talked about stepping up the healthcare

When you're scanning the horizon, are there other areas where you're concerned about the sort of private equity style model of acquisitions affecting important services?

Attorney General. Peter F. Neronha:

Well, look, one thing I worry about in terms of any competitive behavior is broadband. In some places, like Rhode Island, for example, there are some parts of the state where there's only one broadband

What I've seen with my brother is he worked so hard to go to medical school to get through medical school and his residency and his training, and he didn't do it for personal profit. He did it because he wants to serve. And that's what I heard from the folks we heard from today. And I'm so grateful to Chair Khan, to Tamar, to AAG Kanter, to our colleagues at HHSfor convening this k400m(h).irt(o)-5t(w)-vks HHSfor convening