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“CODE BLUE”

TESTIMONY BY

DIGNITY ALLIANCE MASSACHUSETTS RELATIVE TO THE INFLUENCE OF PRIVATE EQUITY OWNERSHIP OF HEALTH CARE

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"CODE BLUE"

Concerns Relative to Private Equity and Real Estate Investment Trust in Nursing Homes and Other Health Care Facilities.

"Code Blue,"[1]as defined in Merriam-Webster's Medial Dictionary is a "declaration of or a state of medical emergency and call for medical personnel and equipment to attempt to resuscitate a patient especially when in cardiac arrest or respiratory distress or failure."

The state of health care, in nearly all of its forms, from cradle to grave, is in "Code Blue" status primarily because of profit-focused ownership models that have become dominant in health care at every level.

"For-profit" hospitals are not new. Indeed, in the early 1900s more than half of the hospitals in the United States were proprietary. However, the proprietary share shrank thereafter (Steinwald and Neuhauser, 1970), and since 1970 the for-profit proportion has remained relatively stable at around 13 percent.

The makeup of that 13 percent share, however, has been anything but stable, as independent proprietaries have become less common and companies owning and managing chains of hospitals and other health care institutions have grown rapidly. Most of today's largest companies were founded as recently as the last 20 years."[2]

In Massachusetts, however, it's not simply a serious issue that may result in closing up to nine hospitals under the Steward banner – hospitals that provide health care for some our most vulnerable residents. It is a concern for the future of smaller health care facilities such as nursing homes and hospice care.

As the Boston Globe highlighted in a January 17, 2024 editorial (Scrutinize private equity's involvement in health care), even companies that repair wheelchairs for older adults and people with disabilities, are owned by private equity firms.[3] These firms bought out competitors and created less competition and a need to costs low to please investors, by using lower-quality parts or hiring fewer repair technicians. The result when a wheelchair needs repairs, the user waits months and loses their all-important mobility.

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[1] "Code blue." *Merriam-Webster.com Medical Dictionary*, Merriam-Webster, https://www.merriam-webster.com/medical/code%20blue. Accessed 2 Mar. 2024.

[2] Changes in the Ownership, Control, and Configuration of Health Care Services - For-Profit Enterprise in Health Care - NCBI Bookshelf (nih.gov)

[3] https://www.bostonglobe.com/2024/01/17/opinion/health-care-private-equity-medical-equipment-wheelchairs/

Nursing Homes

For-profit ownership has long been predominant among nursing homes.[5] Before the 1930s, people in need of long-term care outside their homes were admitted to private charitable homes. Demographic changes, the availability, of funding through the Social Security Act of 1935, subsequent amendments to the act, and the enactment of Medicaid and Medicare stimulated the growth in nursing homes. The number of facilities increased from 1,200 in 1939 to nearly 15,000 in 1969, while the United States population increased approximately 50 percent. Much of the growth in nursing homes was in the proprietary sector, which by 1969 had 64.5 percent of nursing home beds (U.S. National Center for Health Statistics, 1984). During the 1970s the growth in the total number of nursing homes slowed, but the proprietary sector share continued to increase. By 1980, 81 percent of the 17,700 nursing homes and 69 percent of the 1.5 million beds were proprietary.

Information about the market share of investor-owned nursing homes is made up of approximations. One estimate suggests that between 1979 and 1982 the major investor-owned chains increased their control (owned, leased, and managed) of nursing home beds by 50 percent to more than 200,000 beds, representing roughly 17 percent of all nursing home beds.

In the investor-owned sector, ownership is concentrated in relatively few corporations. In 1984 the largest system, Beverly Enterprises, operated 950 homes. The three largest systems (Beverly Enterprises, Hill-haven—a subsidiary of National Medical Enterprises, and ARA Living Centers) together operated approximately 1,500 homes comprising about 70 percent of the investor-owned nursing homes identified by *Modern Healthcare* (Punch, 1985).

Multi-institutional system growth among not-for-profit nursing homes has lagged substantially behind the investor-owned sector. Investor-owned nursing home systems operated six times as many nursing home beds as were operated by not-for-profit systems in 1984.

Multihospital systems are rapidly increasing their nursing home operations; in 1984 they operated 365 freestanding nursing homes (an increase of 17 percent over a year earlier), of which 127 were operated by investor-owned systems (Punch, 1985).

Home Care

Home care services comprise a broad and increasing range of services provided by several different types of personnel affiliated with thousands of home health agencies. Types of care include skilled nursing, occupational speech and physical therapy, meals, homemaker services, respiratory therapy, and intravenous therapy. Employees include nurses, home health aides, homemakers, and specialists in specific therapies. The organizations that employ these personnel and supply these services are varied. For some, home care is the only line of business. Others combine temporary staffing (nurse and clerical) with home care. Some are affiliated with pharmaceutical manufacturers, some with nursing homes, some with hospitals, and some with large national hospital corporations.

Because of the fragmented and diverse nature of the home care market, no reliable source of aggregate data is available. Medicare assembles data covering agencies licensed as Medicare providers, but these data undoubtedly understate the number of home care providers.

The dynamic growth in the number of these Medicare-certified agencies (almost doubling between 1978 and 1984) and the growth of the for-profit sector are particularly striking trends (Table 2.8). Much of this growth predated the likely increased demand for home care that Medicare's prospective payment methods for hospitalized patients will encourage. The striking increase in for-profit agencies (from 186 to 628) between 1980 and 1982 was caused by a change in Medicare reimbursement legislation. Before the Omnibus Reconciliation Act of 1980, for-profits could not get certification in states not having a home health agency licensure law. The removal of this restriction opened up more than 20 states to for-profit home health agencies (Frost and Sullivan, Inc., 1982).

TABLE 2.8 Medicare-Certified Participating Home Health Agencies, 1978 to 1984

	1978	1980	1982	1984
Visiting Nurse Association	502	515	517	525
Government	1,272	1,269	1,211	1,226
Hospital-based	316	359	507	894
Proprietary	145	186	628	1,569
Private nonprofit NA		484	619	756
Other	488	119	157	277
Total	2,723	2,925	3,639	5,247

SOURCE: Health Care Financing Administration, Health Standards and Quality Bureau, Certification, Baltimore, Md.

TABLE 2.8

Medicare-Certified Participating Home Health Agencies, 1978 to 1984.

Medicare expenditures on home health care reached $2 billion in 1984. Using a broader definition that would include durable equipment and consumables, a private market research firm estimated the home health market to be $4.9 billion, growing to $9.4 billion by 1990 (*Modern Healthcare*, 1985a).

There are many new providers in the home health care field, apart from the growing number of independent for-profit operations. For instance, major medical supply companies such as Abbott Laboratories and Baxter Travenol Laboratories are offering home care services in conjunction with their new, high-technology, home care products. The nursing home subsidiary of National Medical Enterprises provided home care in 21 locations in 1984, and Beverly Enterprises, a large nursing home chain, had 134 home care units in 1984. Hospital Corporation of America and American Medical International both entered the home care field in 1984 (Kuntz, 1984; Fackelman, 1985b).

The degree of ownership concentration is difficult to estimate. Knowledgeable observers list such investor-owned companies as Upjohn Health Care Services, Personnel Pool of America, Beverly Enterprises, and Quality Care, Inc., as the largest home care providers. The only multihospital system listed among leading providers of home health care in 1984 was National Medical Enterprises' National Medical Home Care Inc. (Fackelman, 1985b).

“A pervasive trend is the increasing for-profit presence in almost all forms of health care. In some, such as nursing homes and freestanding surgery centers, for-profits are the dominant form. In others, such as dialysis and home care, for-profit is a very substantial presence. An adjunct to the proliferation of for-profit activity is the creation of not-for-

profit/for-profit hybrids, which bring to the not-for-profit form the advantages of the for-profit form (particularly access to equity capital) and which may be regarded as the not-for-profit way of circumventing some of the disadvantages of the not-for-profit status."[4]

Adult Day Health

The adult day health (ADH) industry consists of approximately 4,300 operators generating aggregate revenues of nearly $6.9 billion in 2015. Between 2010 and 2015, the industry grew at a CAGR of 4.0 percent, with the top four companies accounting for less than 5 percent of industry revenue.

As the US population continues to age, government-funded programs such as Medicaid and Medicare are faced with rising costs. In response, these programs are shifting to more cost-effective alternatives such as ADH, rather than more expensive acute care options such as nursing homes and assisted living. As a result, the ADH industry was expected to grow at an annualized rate of 5.4 percent to $9.0 billion in 2020.[5]

Private Equity is acquiring interests in adult day health programs. Audax Group in 2015 announced that it has partnered with management to acquire Active Day / Senior Care, a leading national adult care day provider, from Clearview Capital. Terms of the transaction were not disclosed.

Headquartered in Trevose, Pennsylvania, Active Day / Senior Care (the "Company") is a leading national provider of adult day health services and in-home personal care. With more than 80 locations across the country, the Company provides therapeutic activities, opportunities for socialization, and expert health and nursing care to improve its members' daily functioning and delay the onset of chronic illness. The Company's in-home senior care provides assistance with daily living activities such as meal preparation, bathing, and exercising in addition to entertainment, emotional support, and companionship.[6]

Hospice Care

In a March, 2022 report from the Private Equity Stakeholder Project, investigator noted that, 'While non-profits have previously constituted the majority of home healthcare and hospice companies, both sectors are now dominated by for-profit companies. Although the industries remain fragmented, private equity firms have acquired large home healthcare and hospice companies and consolidated smaller ones to establish large footholds in both industries.

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[4] Changes in the Ownership, Control, and Configuration of Health Care Services - For-Profit Enterprise in Health Care - NCBI Bookshelf (nih.gov)

[5] Case Study: Mass ADH (cpboston.com)

[6] Audax Private Equity | Audax Private Equity Acquires Active Day / Senior Care

'For-profit home healthcare and hospice companies have experienced their share of controversy, including:

'Underpaid and overworked employees (who are mostly women of color);

'Medicare fraud; and

'Lower quality of care compared to their non-profit counterparts.

'Such problems have the potential to be exacerbated by the common private equity strategy of pursuing outsized returns over relatively short periods of time (e.g., 25% return over a period of 3-7 years)."[7]

The PESP report went on to explain, 'As private equity continues to consolidate the home healthcare and hospice industries through acquisitions and add-on investments, it is increasingly important to ensure that private equity's outsized profits do not come at the expense of patient care. Policymakers should implement laws that promote greater transparency and oversight over private equity transactions in the home healthcare and hospice industries to guard against excesses that could harm patients and employees alike.'

Physician Practices

The Washington Post reported that "Private equity firms are rapidly acquiring physician practices, gaining significant market share in many cities and boosting medical prices in an array of specialties, according to an academic study released Monday.

"The study focused on private equity "roll ups" of physician practices, in which investors buy up several doctor groups in a city, consolidating a significant share of the market which they can use to raise prices.

"The report found that "PE acquisitions are associated with price increases in 8 of 10 specialties, and that these price increases are particularly high in [metropolitan areas] where a single PE firm controls more than 30% of the market."[8]

[7] Private Equity at Home: Wall Street's Incursion into the Home Healthcare and Hospice Industries - Private Equity Stakeholder Project PESP (pestakeholder.org)

[8] Private equity firms are buying up physician practices and raising prices - The Washington Post, 7/10/23

Medical Device Suppliers

"Private equity's encroachment into healthcare services has increasingly attracted scrutiny by regulators, lawmakers, healthcare advocates, workers, and consumers. The business model, which targets high profits over relatively short periods of time and relies heavily on debt, has had demonstrably harmful impacts in nursing homes, hospitals, home health and hospice providers, and a range of other healthcare providers. However, private equity's impact extends beyond care delivery; firms have been buying up the companies that manufacture and supply the medical software, devices, and equipment that healthcare providers and consumers rely on."[9]

This profit seeking has clear impacts. Cuts to staffing means that it can take weeks or even months for wheelchair users to get critical repairs. Companies are pushing consumers to bring their equipment into their central shops for repairs, also to cut down on staffing costs, which is often infeasible for individuals who are dependent on their wheelchairs for basic mobility and may have no means for transporting their broken equipment. Private equity firms meanwhile lobby against legislation that would require timely repair of wheelchairs they have provided or, being unable to get timely repairs from the companies themselves, would at least allow wheelchair users the right to repair and maintain their own wheelchairs. PE-owned respiratory and sleep equipment suppliers have paid settlements for defrauding the federal government, in one instance by allegedly pressuring sales representatives to upsell costly equipment to people who did not need it while the private equity firm was at the same time piling debt onto the company to fund payouts to itself.

Massachusetts wheel chair users have been fighting the impacts of private equity for the past few years as they've advocated for more fairness in wheel chair repairs. Only two firms – both owned by private equity – have made life difficult for those who require wheel chairs in their daily lives. Private equity's demand for profits has led to the use of lower quality replacement parts and the reduction in qualified technicians that have forced consumers to wait on the sidelines of life for months.

It's Not Just Private Equity's Impact on Cost and Quality of Health Care

The Commonwealth Fund reported in November, 2023, "Concerns over how private equity is affecting health care access, quality, and costs in the United States have exploded in the past few years, reflecting the growing activity of private investors in health care markets."

[9] PESP_Report_DME_2023.pdf (pestakeholder.org)

"Private equity investors spent more than $200 billion on health care acquisitions in 2021 alone, and $1 trillion in the past decade. Private equity firms have long been active in hospital, nursing home, and home care settings. But recently, acquisitions of physician practices have skyrocketed, especially in high-margin specialties like dermatology, urology, gastroenterology, and cardiology. A recent study showed that in 13 percent of metropolitan areas, a single private equity firm owns more than half of the physician market for certain specialties."

"Given their potential impact on the cost, quality, and access to health care in the U.S., these developments have generated considerable interest among federal and state policymakers."[10]

As the Commonwealth Fund report explains, "As a form of ownership, private equity is not new to health care. A variety of private investors have invested in and owned health care facilities in the past. These have included individual physicians who invest in and own their for-profit private practices and pay taxes on their earnings. Physicians and other private investors have long owned health care facilities, such as specialty hospitals, dialysis units, ambulatory surgical centers, and imaging units."

"There have been two key shifts in recent years. The first is in ***who's doing the investing***. Instead of physicians or small groups of investors using their own funds, investors now also include firms that manage funds for large groups of wealthy individuals or institutions. Fund managers and their investors may have little knowledge of health care, viewing it as just another market opportunity."

"The second change relates to ***how they're investing***. Aggressively pursuing quick profits**, some private equity firms are taking out loans**, using their newly acquired health care facilities as collateral. The loans are used to pay back investors quickly and handsomely, while the health care organizations carry the debt. Another strategy is to sell the health care organization's land, facilities, and other capital assets to other investors. The proceeds from the sales generate returns for fund managers and their investors. Health care organizations then rent those assets back from the new owners."

- Should private equity firms be eligible for zero interest loans as proposed in H.4193?

"A third approach to getting a quick return is to flip the asset — selling the newly purchased health care organization to another buyer, such as a publicly traded company like CVS or Amazon, for a large multiple of the original price. To attract such a buyer, however, the private equity firm must boost the organization's profits, which usually requires rapidly cutting costs, raising prices, or increasing the number of services provided."

"All these strategies are legal, but until recently they hadn't been deployed as widely or intensively in health care."

[10] Private Equity's Role in Health Care | Commonwealth Fund

"More research is needed on how private equity ownership affects health care costs, quality, access, and equity. So far, the results on cost are clearest. Given its short-term financial focus, private equity tends to increase health care prices and utilization — and thus costs — to both patients and the larger society."

"Regarding quality, there is no evidence that private equity ownership leads to systematic improvements in care. In fact, a widely cited study of nursing homes acquired by private equity owners showed a 10 percent increase in mortality among Medicare patients. However, there haven't been additional studies demonstrating such dramatic, harmful effects."

"In terms of access to care and equity, the financial pressures on acquired facilities to pay rent or repay loans are raising alarms about possible bankruptcies and closures of hospitals, nursing homes, and other health care facilities. This is especially concerning for those serving poor and rural communities, since these entities tend to be less lucrative financially."

Another interesting study by the American Antitrust Institute, was published in May, 2021, entitled: "Soaring Private Equity Investment In The Healthcare Sector: Consolidation Accelerated, Consolidation Undermined, and Patients at Risk."[11] The major conclusions of that report are identified below:

- **"Private equity investment in healthcare has grown dramatically over the last decade.**

  Estimated annual deal values have gone from $41.5 billion in 2010 to $119.9 billion in 2019, for a total of approximately $750 billion over the last decade. Still, we expect that this rate will only increase in coming years. This explosive growth is being driven by a perfect storm of projected increases in healthcare spending, tremendous stores of uninvested capital already dedicated to private equity funds, and market disruption caused by the COVID-19 pandemic. This investment is disproportionately directed at the outpatient care and home health markets."

- **"The private equity business model is fundamentally incompatible with sound healthcare that serves patients.**

  Private equity funds, by design, are focused on short-term revenue generation and consolidation and not on the care and long-term wellbeing of patients. This in turn leads to pressure to prioritize revenue over quality of care, to overburden health care companies with debt, strip their assets, and put them at risk of long-term failure, and to engage in anticompetitive and unethical billing practices. Adding to the mounting evidence of the negative impact of private equity on healthcare, two recent National Bureau of Economic Research studies of the nursing home and

[11] Private Equity I Healthcare Report (amazonaws.com), 5/18/21.

dialysis markets found that private equity ownership is correlated with worse health outcomes and higher prices."

- **"Private equity's focus on short-term revenue generation and consolidation undermines competition and destabilizes health care markets.**

  Private equity companies seek to consolidate health care providers and companies not, primarily, to deliver higher quality healthcare more efficiently, but to engage in financial arbitrage and to gather leverage that can be used to bargain against suppliers, payors, and patients. The result impacts stability and leads to more concentrated and less competitive healthcare markets."

- **"Private equity acts as an anti-maverick force in healthcare markets, amplifying and accelerating concentration and anticompetitive practices.**

  Healthcare markets already face serious concentration and competition problems. Recent empirical work demonstrates why this makes private equity investment in healthcare particularly dangerous to competition. Whereas mavericks counter concentration and anticompetitive tendencies in markets with their disruptive competition, private equity has the opposite effect in markets lacking competition; private equity supercharges existing market concentration and anticompetitive tendencies, as a sort of anti-maverick."

- **"Private equity firms operate under the public and regulatory radar. Private equity is, in a word, private**.

  Most private equity acquisitions in healthcare are not reportable to antitrust or financial regulatory authorities under current law. And, even where transactions are reportable, the complex structure of private equity funds obscures the competitive impact of those deals. As a result, private equity companies operate in healthcare without any effective oversight."

- **"Urgent action is needed to oversee, investigate and understand the impact of private equity in healthcare on patients and markets**.

  Updates by the Federal Trade Commission to antitrust reporting requirements to capture potentially significant healthcare deals by private equity firms and others that currently go un- or under-reported are urgently needed. We also call on the Department of Justice to withdraw guidance suggesting private equity companies are preferred divestiture buyers. Instead, both the Federal Trade Commission and the Department of Justice should incorporate financial risk analysis into healthcare mergers. Finally, we urge the Department of Health and Human Services to consider imposing reporting and approval requirements on healthcare mergers."

The Problems in Health Care May Not Solely Relate to Private Equity[12]

John, Canham-Clyne, an independent investigative reporter, in a January, 2024 report published by FAIR, the national media watch group, has been offering well-documented criticism of media bias and censorship since 1986. The article stated, "If you get healthcare news from major media outlets, the industry press or even medical journals, you might conclude that private equity investors are "taking over" US healthcare. But when it comes to hospitals and doctors, you'd be wrong." He suggests that the significant attention being paid to the role of private equity in health care has distorted the issue.

He focuses his concern on the role of private ownership as opposed to non-profit ownership of health care facilities, not that private equity is still a relatively small part of the health care picture. However, he does conclude that, "Profit-focused healthcare is a bad idea, and private equity–controlled companies have outsized influence on nursing homes and specialty hospitals, where patients are held for a long time. There is evidence that private equity–owned nursing homes kill even more patients than the rest of that chronically underfunded and understaffed industry."

"But when it comes to general acute care hospitals and physician services, the degree of private equity control has been exaggerated, often with sloppy academic research. Private equity firms employ far fewer doctors than hospitals and insurance companies do, own less than 5% of general acute care hospitals, and are showing signs of exiting these segments of healthcare."

Richard Mollot, Executive Director of the New York Long-Term Care Community Coalition, has stated that he thinks that private equity ownership of nursing homes seems to be declining, but the real estate investment trust, REIT's, are very much a part of the long-term care ownership. However, he noted that this was his impression, and not based on any statistical evidence.

[12] Private Equity 'Takeover' Is Not Driving Healthcare Crisis - FAIR, 1/16/24.

Conclusion

In August, 2023, the Journal of the American Medical Association (JAMA) [13] reported that "Private equity firms have increasingly used investors' funds to buy health care facilities and then sell them 3 to 7 years later for significant profit. Experts who are skeptical of private equity's growing role in health care have worried that the industry's focus on maximizing profit comes at a cost to patients and clinicians, but large-scale studies have been limited."

"Now, a recent systematic review that included 55 studies from 8 countries concluded that not only has private equity ownership increased over time across many health care sectors, but it has also been linked with higher costs to patients or payers. Although results for the 27 studies that looked at health care quality were mixed, the researchers found evidence that private equity ownership was tied to worse quality in 21 of them compared with evidence of beneficial impact on quality in 12 studies."

Similarly, the BMJ Journal[14] also explained, "Over the past decade, private equity (PE) firms have increasingly invested in, acquired, and consolidated healthcare facilities, with global healthcare buyouts exceeding $200bn (£157bn; €184bn) since 2021 alone. PE firms use capital from institutional investors and individuals of high net worth in combination with large amounts of debt to acquire other companies, and they generally seek to sell their holdings on a quick 3-5 year turnaround for substantial returns. PE firms often enter fragmented markets through an "anchor investment," in which an initial "platform practice" is acquired and then used to acquire more practices in a region and to consolidate them. One of the distinguishing features of PE investment is that the firms provide direct managerial oversight to acquired organizations, often making changes to increase valuation and future profit potential.

The recent influx of PE ownership in the healthcare sector has prompted considerable speculation and debate among the medical community, pertaining to the possible impacts on healthcare delivery and the ethical dimensions of this form of investment structure. Critics argue that PE ownership could jeopardize patient safety by prioritizing profits, overburdening healthcare companies with debt, impeding care delivery through ongoing management changes and sellouts, and over-emphasizing profitable service lines in place of less profitable ones. Meanwhile, proponents advocate that in addition to an infusion of capital, PE ownership may bring valuable managerial expertise, reduce operational inefficiencies, leverage economies of scale, and increase healthcare access by synergistically aligning profit incentives with high quality care provision.

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[13] Private Equity Ownership in Health Care Linked to Higher Costs, Worse Quality | Health Care Economics, Insurance, Payment | JAMA | JAMA Network

[14] https://www.bmj.com/content/382/bmj-2023-075244, 6/11/23.

Recommendations

Early Action

- **Include in the FY'25 State Budget an Outside Section prohibiting the state employee and teachers' retirement funds from investing in Private Equity and Real Estate Investment Trusts**. The Commonwealth has previously banned such funds from investing in tobacco products because they are harmful to health. There is solid evidence that health care facilities owned by Private Equity firms and Real Estate Investment Trusts (REIT) increase health care costs and decrease quality and safety of care. (see Appendix B for draft)
- **Amend H.4193 to prohibit any facility owner in whole, or in part, by a private equity firm or REIT from applying for or receiving zero-interest loans or grants from the proposed Long-Term Care Workforce and Capital Fund in Section 1 of the bill.** It makes no sense to provide benefits to for profit nursing homes with zero interest loans of grants that will, ultimately serve to increase profits for owners and investors.
- **Strengthen DPH and AGO c.93A regulations for initial licensing and transfer of license for nursing homes, and possibly other health care facilities**, to require that any applicant owned, in whole or in part, by a private equity firm or REIT which is seeking a new license or seeking to receive transfer of a license submit detailed ownership information and require the approval of the Public Health Council.

Other Actions

- **Draft and file legislation modelled on the proposed California Bill to provide transparency and accountability for private equity firms and REITs owning or investing in health care facilities, including nursing homes.** (see Appendix A for copy of California bill A 3129).

APPENDIX A

LEGISLATIVE COUNSEL'S DIGEST

AB 3129, https://legiscan.com/CA/text/AB3129/id/2932439, as introduced, Wood. Health care system consolidation.

Existing law requires a nonprofit corporation that operates or controls a health facility or other facility that provides similar health care to provide written notice to, and to obtain the written consent of, the Attorney General prior to entering into any agreement or transaction to sell, transfer, lease, exchange, option, convey, or otherwise dispose of the asset, or to transfer control, responsibility, or governance of the asset or operation, to a for-profit corporation or entity, to a mutual benefit corporation or entity, or to a nonprofit corporation, as specified.

This bill would require a private equity group or a hedge fund, as defined, to provide written notice to, and obtain the written consent of, the Attorney General prior to a change of control or an acquisition between the private equity group or hedge fund and a health care facility or provider group, as those terms are defined, except as specified. The bill would require the notice to be submitted at the same time that any other state or federal agency is notified pursuant to state or federal law, and otherwise at least 90 days before the change in control or acquisition. The bill would authorize the Attorney General to extend that 90-day period under certain circumstances. The bill would additionally require a private equity group or hedge fund to provide advance written notice to the Attorney General prior to a change of control or acquisition between a private equity group or hedge fund and a nonphysician provider, or a provider with specified annual revenue.

The bill would authorize the Attorney General to give the private equity group or hedge fund a written waiver or the notice and consent requirements if specified conditions apply, including, but not limited to, that the party makes a written waiver request, the party's operating costs have exceeded its operating revenue in the relevant market for 3 or more years and the party cannot meet its debts, and the acquisition or change of control will ensure continued health care access in the relevant markets. The bill would require the Attorney General to grant or deny the waiver within 60 days, as prescribed.

The bill would authorize the Attorney General to grant, deny, or impose conditions to a change of control or an acquisition between a private equity group or hedge fund and a health care facility, provider group, or both, if the change of control or acquisition may have a substantial likelihood of anticompetitive effects or may create a significant effect on the access or availability of health care services to the affected community, applying a public interest standard, as defined. The bill would authorize any party to the acquisition or change of control to apply to the Attorney General to reconsider the decision and to modify, amend, or revoke the prior decision, and to seek subsequent judicial review of the Attorney General's final determination on that reconsideration application if the Attorney General denies consent or gives conditional consent.

The bill would prohibit a private equity group or hedge fund involved in any manner with a physician or psychiatric practice doing business in this state, from controlling or directing that practice, as specified. The bill would also prohibit a physician or psychiatric practice from entering into an agreement or arrangement with an entity controlled in part or in whole directly or indirectly by a private equity group or hedge fund in which that private equity group or hedge fund manages any of the affairs of the physician or psychiatric practice in exchange for a fee. The bill would authorize the Attorney General to adopt regulations to implement its requirements, as specified.

BILL TEXT
THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1.

Division 1.7 (commencing with Section 1190) is added to the Health and Safety Code, to read:

DIVISION 1.7. HEALTH CARE SYSTEM CONSOLIDATION

1190.

(a) For purposes of this division, the following definitions shall apply:

(1) "Acquisition" means the direct or indirect purchase in any manner, including, but not limited to, lease, transfer, exchange, option, receipt of a conveyance, creation of a joint venture, or any other manner of purchase, by a private equity group or hedge fund of a material amount of the assets or operations, as used in Sections 5914 and 5920 of the Corporations Code, of a health care facility or provider doing business in this state. A transfer includes, but is not limited to, any arrangement, written or oral, that alters voting control of, responsibility for, or control of the governing body of the health care facility or provider.

(2) "Change of control" means an arrangement in which a private equity group or hedge fund establishes a change in governance or sharing of control over health care services provided by a health care facility or provider doing business in this state, or in which a private equity group or hedge fund otherwise acquires direct or indirect control over the operations of a health care facility or provider in whole or in substantial part doing business in this state, as consistent with subdivision (a) of Section 5914 of, and subdivision (a) of Section 5920 of, the Corporations Code. For purposes of this division, an "arrangement" shall include any agreement, association, partnership, joint venture, or other arrangement that results in a change of governance or control. A change of control does not exist where a health facility only extends an offer of employment to, or hires, a provider.

(3) "Health care facility" means a facility, nonprofit or for-profit corporation, institution, clinic, place, or building where health-related physician, surgery, or laboratory services are provided, including, but not limited to, a hospital, clinic, long-term health care facility, ambulatory surgery center, treatment center, or laboratory or physician office located outside of a hospital.

(4) "Health plan" means a health care service plan or a specialized health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2).

(5) "Hedge fund" means a pool of funds by investors, including a pool of funds managed or controlled by private limited partnerships, if those investors or the management of that pool or private limited partnership employ investment strategies of any kind to earn a return on that pool of funds.

(6) "Hospital" means a general acute care hospital, acute psychiatric hospital, or special hospital, as those terms are defined in subdivision (a), (b), or (f) of Section 1250, respectively.

(7) "Insurance products" means any product provided by the following:

(A) A health insurer licensed to provide health insurance, as defined in Section 106 of the Insurance Code.

(B) A publicly funded health care program, including, but not limited to, Medi-Cal and Medicare.

(C) A third-party administrator.

(D) Any other public or private entity, other than an individual, that pays for or reimburses for any part of the cost for the provision of health care.

(8) "Nonphysician provider" means a group of two or more individuals that are licensed as defined under Division 2 (commencing with Section 500) of the Business and Professions Code that does not provide health-related physician, surgery, or laboratory services to consumers.

(9) "Private equity group" means an investor or group of investors who engage in the raising or returning of capital and who invests, develops, or disposes of specified assets.

(10) "Provider" means any group of two to nine individuals, except for a provider group, that provides health-related physician, psychiatric, surgery, or laboratory services to consumers.

(11) "Provider group" means a group of providers of 10 or more providers that provide health-related physician, psychiatric, surgery, or laboratory services to consumers or a group of providers of two to nine individuals that provide health-related physician, psychiatric, surgery, or laboratory services to consumers that generate annual revenue of ten million dollars ($10,000,000) or more. This definition includes licensed health care providers such as dentists, optometrists, and pharmacists who provide health-related surgery or laboratory services within the scope of their practice as licensees under the Business and Professions Code.

(b) These definitions do not apply to acquisitions or changes of control entered into prior to January 1, 2025, including subsequent renewals, as long as those acquisitions or changes of control do not involve a material change in the corporate relationship between the private equity group or hedge fund and a health care facility or provider group, on or after January 1, 2025.

1190.10.

(a) Except as provided in subdivision (f), a private equity group or hedge fund shall provide written notice to, and obtain the written consent of, the Attorney General prior to a change of control or an acquisition between the private equity group or hedge fund and a health care facility or provider group. The notice shall be submitted at the same time that any other state or federal agency is notified pursuant to state or federal law, and otherwise shall be provided at least 90 days before the change in control or acquisition, and shall contain information sufficient to evaluate the nature of the acquisition or change of control and information sufficient for the Attorney General to determine that the criteria set forth in subdivisions (a) and (b) of Section 1190.20 have been met or that a waiver may be granted pursuant to subdivision (f).

(b) The Attorney General may extend this 90-day period for one additional 45-day period, in addition to any time for which the period is stayed, if any of the following conditions apply:

(1) The extension is necessary to obtain additional information.

(2) The proposed acquisition or change of control is substantially modified after the original notice was provided to the Attorney General.

(3) The proposed acquisition or change of control involves a multifacility or multi-provider health system serving multiple communities, rather than a single facility or entity.

(c) The Attorney General may extend any time period set forth in subdivision (a) or (b) by 14 days if the Attorney General decides to hold a public meeting under subdivision (b) of Section 1190.30.

(d) A private equity group, or hedge fund, shall provide advance written notice to the Attorney General prior to a change of control or acquisition between a private equity group or hedge fund and

a nonphysician provider or between a private equity group or hedge fund and a provider, where the nonphysician provider has annual revenue of more than four million dollars ($4,000,000) or the provider has annual revenue between four million dollars ($4,000,000) and ten million dollars ($10,000,000). Transactions between a private equity group or hedge fund and a nonphysician provider, or transactions between a private equity group or hedge fund and a provider, that are required to be notified under this subdivision shall not be subject to consent by the Attorney General.

(e) The Attorney General may stay any time period in this section, upon notice to the parties to the acquisition or change of control, pending any review by a state or federal agency that has also been notified as required by federal or state law.

(f) (1) Written notice to, and the consent of, the Attorney General shall not be required under subdivision (a), if the Attorney General has given the private equity group or hedge fund a written waiver of this section as to the proposed acquisition or change of control. The Attorney General may grant a waiver if all of the following conditions apply:

(A) The party makes a waiver request by submitting, in writing, a description of the proposed acquisition or change of control, a copy of all documents that effectuate any part of the proposed acquisition or change of control, an explanation of why the waiver should be granted, and any other information the Attorney General determines is required to evaluate the waiver request.

(B) The party's operating costs have exceeded its operating revenue in the relevant market for three or more years and the party cannot meet its debts as they come due.

(C) The party is at grave risk of immediate business failure and can demonstrate a substantial likelihood that it will have to file for bankruptcy under Chapter 11 of the Bankruptcy Act (11 U.S.C. Sec. 1101 et seq.) absent the waiver.

(D) The party would likely be substantially unable to reorganize successfully under Chapter 11 of the Bankruptcy Act (11 U.S.C. Sec. 1101 et seq.).

(E) The acquisition or change of control will ensure continued health care access in the relevant markets.

(F) The party has made commercially reasonable best efforts in good faith to elicit reasonable alternative offers that would keep its assets in the relevant markets and that would pose a less severe danger to competition and access to care than the proposed acquisition or change of control.

(2) Any consideration of a party's finances under this subdivision may include consideration of the finances of any affiliates that are under common control or are under the control of the party.

(3) The Attorney General shall grant or deny the waiver request within 60 days after all information needed to evaluate the waiver request has been submitted to the Attorney General. In determining whether to grant a waiver, the Attorney General shall consider whether any of the decisional factors set forth in Section 1190.20 are applicable to the proposed acquisition or change of control. A waiver may be denied if any of these decisional factors require full Attorney General review of the proposed agreement or transaction. The Attorney General may condition the grant of a waiver in a manner that eliminates the need for full Attorney General review.

1190.20.

(a) The Attorney General may grant, deny, or impose conditions to a change of control or an acquisition between a private equity group or hedge fund and a health care facility, provider group, or both, if the change of control of an acquisition may have a substantial likelihood of anticompetitive

effects or may create a significant effect on the access or availability of health care services to the affected community.

(b) The Attorney General, in making a determination to grant, deny, or impose conditions pursuant to this section, shall apply the public interest standard. The term "public interest" is defined as being in the interests of the public in protecting competitive and accessible health care markets for prices, quality, choice, accessibility, and availability of all health care services for local communities, regions, or the state as a whole. Acquisitions or changes of control shall not be presumed to be efficient for the purpose of assessing compliance with the public interest standard.

1190.30.

(a) The Attorney General shall make the determination required by Section 1190.20 in writing that provides the basis for the determination.

(b) Prior to issuing a written determination pursuant to subdivision (a), the Attorney General may hold a public meeting, which may be held in any of the counties in which the acquisition or change of control will take place, or, in case of a declaration of an emergency in any of those counties or in the state, online, to hear comments from interested parties. Prior to holding a public meeting, the Attorney General shall provide notice of the time and place of any meetings by electronic publication, or publication in newspapers of general circulation, to consumers that may be affected by the acquisition or change of control. If a substantive change or modification to the acquisition or change of control is submitted to the Attorney General after a public meeting, the Attorney General may conduct an additional public meeting to hear from interested parties with respect to the change or modification. To the extent that a public meeting has already occurred under Sections 5916 and 5922 of the Corporations Code, the Attorney General may waive a subsequent meeting requirement under this section.

(c) Within 10 days of the Attorney General's notice of the decision to consent to, give conditional consent to, or not consent to the acquisition or change of control, any party to the acquisition or change of control may make an application to the Attorney General to reconsider the decision and to modify, amend, or revoke the prior decision in whole or in part based upon new or different facts, circumstances, or law. The party making the application shall state by affidavit what order or decisions were made, and what new or different facts, circumstances, or law are claimed to be shown. Pursuant to Section 1008 of the Code of Civil Procedure, the Attorney General shall order or deny reconsideration within 30 days following receipt of the application and affidavit. A decision by the Attorney General on an application filed under this subdivision shall have the same force and effect as the original decision.

(d) (1) If the Attorney General does not consent or gives conditional consent to an acquisition or change of control, any of the parties to the acquisition or change of control may, within 30 calendar days of a decision pursuant to subdivision (a) or subdivision (c), seek judicial review of the Attorney General's final determination by a writ of mandate to the superior court pursuant to Section 1085 of the Code of Civil Procedure.

(2) Barring extraordinary circumstances or the consent of the parties, the superior court shall issue its response to the petition within 180 days of receipt of the petition. After a review of the records, including any administrative record and any material submitted in support of the petition, the court may grant the petition upon finding that the decision was a gross abuse of discretion.

(e) The Attorney General's determination in subdivision (a) or subdivision (c) shall be based on an administrative record that shall be provided to the court and to the parties to the acquisition or change of control in the event that the parties notify the Attorney General of their intent to appeal

the Attorney General's final determination pursuant to subdivision (d). The administrative record shall consist of any evidence submitted by the parties to the acquisition or change of control, any comments offered by interested parties at a public meeting held pursuant to subdivision (b), any official reports by any experts hired by the Attorney General to review the transaction, any evidence obtained by the Attorney General from the parties to the acquisition or change of control or third parties, and any other evidence or information relied on by the Attorney General in making the determination required by subdivision (a) or subdivision (c), including information required to be submitted as part of the notice required by subdivision (a) of Section 1190.10. To the extent that any evidence or other information is confidential, the Attorney General may take reasonable measures to ensure the confidentiality of that evidence or other information in the administrative record.

1190.40.

(a) A private equity group or hedge fund involved in any manner with a physician or psychiatric practice doing business in this state, including as an investor in that physician or psychiatric practice or as an investor or owner of the assets of that practice, shall not control or direct that practice, including, but not limited to, influencing or entering into contracts on behalf of that practice or physicians or psychiatrists in that practice with any third party, influencing or setting rates for that practice or physicians or psychiatrists in that practice with any third party, or influencing or setting patient admission, referral, or physician or psychiatrist availability policies. The corporate form of that physician or psychiatric practice as a sole proprietorship, a partnership, foundation, or a corporate entity of any kind shall not affect the applicability of this section.

(b) Any physician or psychiatric practice, whether a sole proprietorship, a partnership, a foundation, or corporate entity of any kind, doing business in this state shall not enter into any agreement, or arrangement, with any entity controlled in part or in whole directly or indirectly by a private equity group or hedge fund in which that private equity group or hedge fund manages any of the affairs of the physician or psychiatric practice in exchange for a fee to be charged to that practice or passed through by that practice directly or indirectly to any health plan, insurer product, or patient. This provision does not bar revenue-sharing between any such practice and any private equity group or hedge fund.

(c) Any contract involving the management of a physician or psychiatric practice doing business in this state by, or the sale of real estate or other assets owned by a physician or psychiatric practice doing business in this state to, a private equity group or hedge fund shall not explicitly or implicitly include any clause barring any provider in that practice from competing with that practice in the event of a termination or resignation of that provider from that practice, or from disparaging, opining, or commenting on that practice in any manner as to any issues involving quality of care, utilization of care, ethical or professional challenges in the practice of medicine, or revenue-increasing strategies employed by the private equity group or hedge fund. Any such explicit or implicit contractual clauses are void, unenforceable, and against public policy.

(d) The Attorney General shall be entitled to injunctive relief, and other equitable remedies, a court deems appropriate for enforcement of this section and shall be entitled to recover attorney's fees and costs incurred in remedying any violation of this section.

1190.50.

The Attorney General may adopt regulations to implement this division, including, but not limited to, regulations to extend time periods or to provide a process for requesting a waiver, pursuant to Section 1190.10.

1190.60.

(a) This division is intended to address health care practices by private equity groups, and hedge funds that can lead to higher prices for services, lower quality at a given price for services, less cost-efficient services, restricted access to, or the closure of services, and less choice for services, which ultimately leads to higher prices and more inconvenience for consumers, and higher total cost of care for services.

(b) This division shall be construed, as a matter of state law, to be enforceable up to, but no further than, the maximum possible extent consistent with federal law and constitutional requirements, even if that construction is not readily apparent, as these constructions are authorized only to the extent necessary to save the statute from judicial invalidation.

(c) The provisions of this division are severable. If any provision of this division or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

APPENDIX B

Prohibition of Investment of Public Pension Funds in Private Equity Firms and Real Estate Investment Trusts (REIT) that Own or Invest in Long-Term Care Providers

SECTION XX. Paragraph (h) of subdivision (1) of section 23 of chapter 32 of the General Laws, as appearing in 2020 Official Edition, is hereby further amended by inserting after the phrase, "sale of tobacco products;" the following: -

"and no public pension funds under this subdivision shall remain invested in the stocks, securities, or other obligations of a private equity firm or REIT which derives revenues from any ownership or return on investment from long-term care facilities licensed pursuant to chapter 111 of the general laws or a third party business related thereto;"

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