PRIVATE EQUITY STAKEHOLDER PROJECT

Senate Democratic Policy Committee
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March 10, 2024

Testimony for the Senate Democratic Policy Committee Hearing: Healthcare Accessibility and Hospital Closure Impacts

Dear Chair Miller and Senators Cappelletti, Kane, Kearney, and Williams,

My name is Mary Bugbee, and I am the Healthcare Research and Campaign Director for the Private Equity Stakeholder Project (PESP). PESP is a non-profit organization that seeks to bring transparency and accountability to the private equity industry for the benefit of impacted communities and limited partners.

We appreciate this opportunity to testify at the Senate Democratic Policy Committee Hearing: Healthcare Accessibility and Hospital Closure Impacts. My testimony will focus on private equity's impacts on hospitals and on Pennsylvania's healthcare infrastructure.

Private equity has invested over $1 trillion in the US healthcare sector over the last decade, and touches virtually every corner of the industry, including hospitals, physician specialties such as gastroenterology and anesthesiology, emergency medicine, dentistry, travel nursing, durable medical equipment, behavioral health, disability services, and healthcare services for people in prisons and jails.

Pennsylvania has faced direct impacts from private equity investments in its health system, including the closure of three hospitals (Hahnemann University Hospital in 2019,[1] Delaware County Memorial Hospital in 2022,[2] and Sharon Regional Medical Center in 2025[3]) and the financial ruin of others.

PESP's private equity hospital tracker shows at least 13 hospitals in Pennsylvania that are currently owned by private equity firms, and there are more that were previously owned by private equity and are still experiencing the impacts years later, such as the Crozer Health system.

Private equity ownership of hospitals has drawn scrutiny in recent years as some private equity hospital acquisitions have produced troubling impacts for patients and workers across the country. We have seen private equity firms aggressively loot safety net

hospitals, strip out valuable real estate, cut critical but less profitable services, and exploit government funding programs designed to support and stabilize healthcare access.

The consequences have been borne by patients, healthcare workers, and their communities. Private equity's hospital profiteering has resulted in dangerous conditions, closures and reduced access to services, declining quality, fraud, and bankruptcies.

Hospitals are not the only area in which private equity is investing in the Pennsylvania health system. A recent report from PESP found that there were over 900 private equity-owned healthcare providers in Philadelphia and the surrounding region, including physical therapy, outpatient specialty care, and dental care. This number is likely an undercount.

The private equity business model

Private equity firms often seek to double or triple their investment over 4-7 years. The pursuit of outsized returns over relatively short time horizons can lead to cost-cutting that hurts care. In addition, use of high levels of debt can divert cash from operations to interest payments and dividends paid out to private equity owners.

Below are some financial tactics characteristic of private equity investment:

- High leverage: Private equity firms often utilize significant amounts of debt when buying companies. Firms typically buy companies through leveraged buyouts, whereby a private equity firm finances a substantial portion of an acquisition by taking out a loan secured by the company it is buying. High leverage can divert cash away from operations to paying interest on debt and leave companies more at risk for restructuring or bankruptcy.

- Sale-leaseback of real estate: Private equity firms that own hospitals sometimes conduct sale-leaseback transactions, where the firm will sell the hospital's real estate to a third party and lease it back. While these transactions provide a quick way to monetize real estate and generate cash, they can leave hospitals with fewer assets and higher monthly lease payments.[4]

- Debt-Funded Dividends: Some private equity firms siphon money out of companies they own through dividend recapitalizations, where a private equity firm directs its portfolio company to take on new debt and use the proceeds to pay the private equity owner a cash payout. These transactions can unnecessarily load healthcare providers with debt. While the private equity firm in these situations makes money, the healthcare provider often does not receive proceeds from the loan and still

must pay it back, leaving it more vulnerable to market conditions and with fewer resources to support operations as it pays its monthly debt service obligations.[5]

- Roll-ups: Private equity companies often conduct "roll-ups" by buying up multiple companies in the same industry segment and merging them under the same corporate umbrella. These transactions can allow firms to take advantage of economies of scale. However, a wide body of research has shown that provider consolidation leads to higher healthcare prices for private insurance and public healthcare programs like Medicare.[6]

- Fees: Private equity firms often charge management or advisory fees to the companies they own, which can cost companies millions of dollars each year. Fees are typically stipulated in a management services agreement between the private equity firm and a company that it controls. In some cases, companies must pay fees to the private equity firm even for services never rendered ("accelerated monitoring fees"). These fees can further drain a company's cash away from hospital operations into the pockets of investors.[7]

Putting profits before patients is not unique to private equity–owned healthcare companies. But because there's less transparency around private equity deals and the companies they own, and because private equity firms tend to use more debt than other types of investors to fund their business strategies, the private equity business model can amplify the profit-seeking behaviors that put patients and healthcare workers at risk.

Private equity buyouts of healthcare companies too frequently end in bankruptcy, threatening the stability of the healthcare system. In 2024, one-fifth (21%) of healthcare bankruptcies involved private equity-owned companies. Seven out of eight (88%) of the largest (liabilities over $500 million) bankruptcies in the healthcare industry in 2024 were at companies with a history of private equity ownership.[8]

2024 saw the historic bankruptcy of Steward Health Care, a multistate hospital system previously owned by Cerberus Capital Management. Steward's bankruptcy was one of the largest hospital bankruptcies in decades.[9] Less than a year later, Prospect Medical Holdings, the parent company of Crozer Health, filed for bankruptcy.[10]

Already in 2025, there have been announced or completed closures of at least six private equity or former private equity-backed hospitals including Sharon Regional Hospital in Pennsylvania and Rockledge Hospital in Florida (both formerly owned by Steward Health Care/Cerberus Capital Management), Johnstown Heights Behavioral Health hospital in Colorado (Patient Square Capital) and three ScionHealth hospitals (Apollo Global

Management) across Illinois and Florida (Kindred Sycamore, Kindred Hospital Lakeshore, and Kindred Hospital Tampa).[11]

The case studies below of Prospect Medical Holdings, Steward Health Care, and Lifepoint/ScionHealth provide examples of how private equity firms employed the extractive financial tactics described above, and will demonstrate how investors' unbridled profit-seeking can harm patient care. All three of these multistate hospital systems have hospitals located in Pennsylvania.

Prospect Medical Holdings/Leonard Green & Partners

Between 2010 and 2021, private equity firm Leonard Green & Partners owned Prospect Medical Holdings.[12] After Leonard Green acquired Prospect in 2010, it used the hospital chain as a platform to raise debt so it could siphon off hundreds of millions of dollars in dividends and fees. According to Prospect's own financial statements, the owners collected at least $658 million from the hospitals—despite dramatic operating challenges, substantially underfunded pensions, and increasing regulatory scrutiny.[13]

The largest dividend that Prospect's owners collected in 2018 directly contradicted a commitment Prospect had made to Rhode Island state regulators. When it bought several hospitals in Rhode Island in 2014, it told regulators it would not pay out any more dividends. Just four years later, it paid the ownership an almost $460 million dividend. That same year, Prospect generated a $244 million net loss.[14]

As a result of that dividend, Prospect ran out of cash by early 2019, forcing the owners to provide an emergency cash infusion.

Prospect was eventually able to pay off the existing $1.1 billion in debt it had accrued in part to fund dividends, but only by selling off the bulk of Prospect's real estate to Medical Properties Trust (MPT), a real estate investment trust (REIT). The transaction replaced debt with lease liabilities and left Prospect with fewer assets.[15] These lease liabilities would come to play a central role in Prospect' 2025 bankruptcy. As reported by *Bloomberg*, Prospect's second largest creditor in the bankruptcy is MPT, to which Prospect reportedly owed $1.7 billion in unpaid rent and loans as of January 2025.[16]

Leonard Green's Representations to Members of Congress, Regulators

Leonard Green and Prospect misrepresented the financial condition of some of the hospitals when lawmakers and other stakeholders raised concerns.

Members of Congress with Prospect hospitals in their districts have written to Leonard Green twice, raising concern about the firm's treatment of the safety net hospital company and asking it to return the fees and dividends it collected.[17] Leonard Green dismissed the

lawmakers' concerns, writing: "We can assure you with firm, empirical confidence that Prospect remains well-capitalized with adequate liquidity and resources for its staff to address the current COVID-19 epidemic."[18]

In response to a letter my organization wrote to Rhode Island regulators, Prospect wrote: "Contrary to PESP's assertions, Prospect today remains extraordinarily well capitalized, faces no material financial challenges, and is at no risk of financial failure."

Hospitals Suffered While the Owners Lined Their Pockets
Here is what was happening at the hospitals while Leonard Green was siphoning money from the company:

- Prospect's hospitals had some of the lowest quality ratings from the Centers for Medicare and Medicaid Services—all but one had received one or two stars, the lowest quality ratings from CMS.[19]

- In Connecticut, state regulators placed Prospect's three hospitals under review in 2019 for deteriorating conditions that placed patients in "immediate jeopardy."[20]

- Prospect completely shut down all of its facilities in San Antonio in 2019—laying off nearly 1,000 workers[21]—and sold its hospital building to a hotel developer.[22]

- The California Attorney General formally charged Prospect executives with "gross negligence" related to persistent mold contamination of a hospital pharmacy, including in equipment used to mix patient medications. In March 2021, the California Attorney General and State Pharmacy Board entered into a settlement with Prospect's Southern California subsidiary, placing its hospital pharmacy permit and sterile compounding on probation for two years.[23]

- In Rhode Island, poor infection control led to COVID-19 infection of 19 of the 21 geriatric psychiatric ward residents: six of them died. Six housekeeping staff also contracted COVID due to limited access to PPE. The head of the department died.[24]

- Workers have complained of inadequate staffing. When Leonard Green first tried to sell Prospect in 2015, the company's prospectus touted its "cost-effective care" model, daily "flex" management of hospital staffing, and use of low-cost sources for

medical supplies. In Pennsylvania, workers reported in September 2020 that staffing shortages forced scheduling delays for medical procedures.[25]

Despite what happened to Prospect and its hospitals, Leonard Green is off the hook – in June 2021 Leonard Green sold its majority stake in Prospect to the minority shareholders after a contentious year-long investigation by Rhode Island state regulators into the company's finances.[26]

In the following years, Prospect's hospitals in Connecticut and Pennsylvania faced increasing financial distress, bringing risks to communities of losing access to local healthcare services.[27]

Prospect's four hospitals in eastern Pennsylvania, under the name of Crozer Health, have struggled significantly since Leonard Green exited its investment in 2021. In 2022, Prospect/Crozer laid off hundreds of workers,[28] shuttered the maternity ward at Delaware County Memorial Hospital,[29] shuttered the hospice unit at Taylor Hospital,[30] and threatened municipalities with severing paramedic services in just 90 days if they didn't pay up.[31]

In September 2022, Prospect announced it would permanently shut down Delaware County Memorial Health (DCMH), one of the hospitals in the Crozer Health system, and transition it to a behavioral health facility. The announcement sparked outrage in the Delaware County community, including by the nonprofit Foundation for Delaware County, which sued Prospect to keep the hospital open on the basis that when it converted Crozer Health from nonprofit to for profit status Prospect committed to keep the hospitals open for at least 10 years.[32]

Due to Prospect's failure to adequately staff the emergency department, the state health department suspended emergency room services and patient admissions at Delaware County Memorial in November of 2022,[33] effectively closing the hospital. The Attorney General asked the court to hold Prospect in contempt for failing to address the staffing issues at the hospital. The Pennsylvania Supreme Court would ultimately rule in January 2025 for the hospital to stay open, but the decision came years too late.[34]

Since the closure, area emergency rooms and EMS services have been strained.[35] For a while, the hospital had an onsite nurse and ambulance to transfer patients in need of emergency care to other facilities, but this service was ended in August 2023.

Prospect laid off over two hundred more Crozer employees in early 2023.[36]

The challenges faced by Prospect are directly related to the legacy of Leonard Green's past ownership of the health system in which it extracted hundreds of millions to leave patients, workers, and communities holding the bag.

In January 2025, Prospect filed for bankruptcy.[37] The bankruptcy comes on the heels of a damning report released by the Senate Budget Committee on January 7, in which the results of a year-long bipartisan senate investigation into Prospect were made public. The report highlights how Leonard Green's and Prospect's "primary focus was on financial goals rather than quality of care at their hospitals, leading to multiple health and safety violations as well as understaffing and the closure of several hospitals."[38] The report also notes how Leonard Green's and Prospect's financial and operational mismanagement of the health system left it in "severe financial distress."[39]

> For more on Prospect Medical Holdings, see our report: "How Private Equity Raided Safety Net Hospitals and Left Communities Holding the Bag" (November 2022) and here for a November 2023 update.

Steward Healthcare – Cerberus Capital Management

In 2010, private equity firm Cerberus Capital purchased Caritas Christi Health in Massachusetts in a $420 million leveraged buyout through its affiliate Steward Healthcare, converting the nonprofit health system to for-profit. Steward also assumed $475 million of debt and pension liabilities in the transaction, putting the value of the overall deal at $895 million.[40]

Because of the conversion to for-profit status, the deal required approval from the state Attorney General's office, which imposed conditions on the transaction and a five-year monitoring period.[41] These conditions included a requirement for the new owners to invest $400 million into the system's infrastructure.[42] Despite Cerberus Capitals's deep pockets, these "investments" would come from debt loaded onto Steward as well as sale-leasebacks of some of its medical office buildings.[43] Another condition of the deal was that the system could not take additional debt to pay investor dividends for the first three years following the transaction.[44]

After its five-year monitoring period with the Attorney General expired, Steward Health Care executed a $1.2 billion sale-leaseback transaction in 2016 with real estate investment trust (REIT) Medical Properties Trust (MPT). MPT made an additional $50 million equity investment in Steward.[45] Many Steward hospitals were then on the hook for rent payments and no longer owned their most valuable asset. Meanwhile, Cerberus Capital Management collected $484 million in dividends from the sale.[46]

Under most state laws, real estate transactions are not regulated in healthcare – only transactions involving operations. Major financial decisions involving the sale of Steward's real estate that would come to impact hospital operations and the long-term viability of the health system were able to get past regulators because they involved the hospitals' real estate rather than operations.

MPT helped finance Steward's national expansion when it acquired new hospitals around the country by buying the property and then leasing it to Steward.[47] In 2022, MPT brought in another investor, Macquarie Asset Management,[48] as well as a consortium of lenders headed by Apollo Global Management which now have a financial interest in the Massachusetts properties through the $920 million loan they provided.[49]

When Steward ran out of real estate to sell, it worked with MPT to scrape together other byzantine deals that have left some observers scratching their heads.[50]

During its ownership under Cerberus Capital, Steward also:

- Took on millions more in debt;[51]
- Saw poor financial performance;
- Broke commitments to regulators by failing to share financial information with regulators in a timely manner[52] and attempting to close hospitals or cut services at hospitals it had acquired;[53]
- Collected $675 million in federal loans and grants during the pandemic;[54]
- Was sued under the False Claims Act (ultimately the system would reach a $4.7 million settlement with the Department of Justice in 2022).[55]
- Saw higher than average patient hospital-acquired infections, falls, and readmissions at its Massachusetts hospitals.[56]

In March 2020, Steward sent a letter to Pennsylvania's governor requesting a $40 million bailout to prevent the closure of its Easton Hospital. With the pandemic underway, the state was preparing for a surge in patients, and Steward told the governor's office that Easton Hospital would be forced to close and would "no longer be able to serve the community's healthcare needs" without the money. Easton mayor Sal Panto told *WSJ*, "That's how they kept the state hostage." The state ultimately agreed to provide the hospital with $8 million.[57]

Steward went on to sell Easton Hospital to St. Luke's University Health Network in a $15 million transaction in July 2020, according to a local newspaper.[58] The county's property records show a $62 million price tag paid to MPT for the property.[59]

Around the same time, Cerberus was moving to exit its investment in Steward. Between Steward's financial troubles, which preceded the pandemic, and the pandemic itself, finding a buyer would have been challenging.[60] Ultimately, Cerberus was able to enlist MPT to help with its exit: MPT provided a $335 million loan to a new set of physician owners, including CEO Ralph de la Torre,[61] and made a $400 million cash infusion into the struggling hospital chain allowing Cerberus to exit.[62]

All in all, Cerberus reportedly made at least $800 million in the decade it owned Steward.[63] Around the time of Cerberus' exit, Steward paid out a $111 million dividend to its owners, including Ralph de la Torre.[64] Not long after, de la Torre bought himself a $40 million yacht. The company also bought two private jets and a private suite at Dallas' AA arena.[65]

On May 6, 2024, Steward filed for Chapter 11 bankruptcy in the Southern District of Texas bankruptcy court, Houston Division,[66] reporting more than $9 billion in liabilities. Long term lease liabilities accounted for the largest portion of debt ($6.6 billion). It owed nearly $1 billion to vendors and medical suppliers, had $1.2 billion in loan debts, and owed nearly $290 million in unpaid compensation to employees and staffing firms.[67] Steward's bankruptcy is one of the largest hospital bankruptcies in decades.[68]

The pillaging of Steward was made possible by its partnership with MPT that helped finance investor payouts to Cerberus Capital Management as well as finance Steward's national expansion by acquiring Steward's hospital real estate. Those left holding the bag are the communities and patients in crisis around the country as their hospitals cut services, go bankrupt, and even close.

The consequences are tragic. In September 2024, the *Boston Globe* published the results of a comprehensive investigation that show a disturbing pattern of understaffing and equipment issues at Steward hospitals from 2019 to 2024 that resulted in the deaths of at least 15 patients and the injuries of 16 others.[69] In one tragic case, a patient died waiting in a registration line on a day that just eight nurses were working when there were supposed to be 19.[70]

In another tragedy, a woman who gave birth at a Steward hospital died after the embolism coil needed to stop a bleed following childbirth was unavailable. The hospital's supply of embolism coils had been repossessed by the company that owned them because Steward had not paid its bill.[71] In addition to patient deaths and injuries, at least 2,000 patients were found by federal regulators to have been put in immediate peril at Steward hospitals during the time period examined by the *Boston Globe*.[72]

The looting of Steward Health Care has not only contributed to reduced quality care that has crossed the line into patient tragedies but has also resulted in reduced access to care

through hospital closures around the country. In the years leading up to its bankruptcy, Steward closed six hospitals, resulting in the layoffs of at least 2,650 workers and reduced access to care for the communities they served in Massachusetts, Texas, Arizona, and Ohio.[73]

Since filing for bankruptcy, Steward has closed two more hospitals in Massachusetts, resulting in the layoffs of 1,243 workers[74] and impacting timely access to emergency care for thousands of patients.[75]

Already in 2025, a Steward hospital in Pennsylvania, Sharon Regional, has closed.[76] A former Steward hospital, Rockledge Hospital in Florida, which was purchased by Orlando Health out of bankruptcy last fall, is also going to close. As reported by *Florida Today*, the company informed Rockledge Hospital employees in February that the hospital was in such poor condition that it would not be cost-effective to renovate, so the hospital would close, then be torn down.[77]

Lifepoint Health, ScionHealth – Apollo Global Management

Lifepoint Health and ScionHealth are two of the largest hospital systems in the US.[78] They are both owned by private equity firm Apollo Global Management.[79]

The two companies are the result of a series of hospital acquisitions by Apollo, which in 2018 bought Lifepoint and merged it with another hospital chain, RegionalCare Hospital Partners.[80] Then, in December 2021, Lifepoint acquired the large long term acute care hospital chain Kindred Healthcare. As part of the transaction, Lifepoint shifted some of the acquired facilities and some of its existing hospitals into a new company called ScionHealth,[81] which is also controlled by Apollo.[82]

Through Lifepoint and Scion together, Apollo has an extensive hospital footprint, owning approximately 220 hospitals across 36 states.[83] As of December 2021, Lifepoint employed 50,000 workers,[84] and Scion reportedly employed approximately 25,000 workers as of 2023.[85]

As healthcare consolidation continues to accelerate and drive up healthcare costs,[86] Apollo's merger of Lifepoint and Kindred and creation of ScionHealth merits scrutiny for potentially anti-competitive impacts. Though Lifepoint and Scion now position themselves as entirely separate businesses, they are both owned and controlled by Apollo.[87]

Press reports and regulatory investigations describe operating challenges that pose a threat to quality care and access to medical services at Apollo's Lifepoint and ScionHealth hospitals around the country.

- Lifepoint's Wilson Medical Center in North Carolina faced regulatory scrutiny in 2022 and 2023, including threats by CMS to revoke its Medicare payments and an investigation by the state's attorney general. On three separate occasions in under a year, compliance surveys by state regulators found that quality deficiencies warranted an "immediate jeopardy" designation for the hospital. Wilson is the only hospital in Wilson County, located about an hour east of Raleigh.[88]

- In 2020 the *Wall Street Journal* reported on how in Wyoming Lifepoint chipped away at staffing and services at its hospital in working-class Riverton until most services were transferred to another Lifepoint hospital in Lander, 30 miles away. Riverton residents reported that the consolidation severely reduced access to medical services and the transfer led to increased utilization of air ambulances, from 155 in 2014 to 937 in 2019.[89]

- According to The Lown Institute Hospital Index, which ranks hospitals and health systems based on health equity, value, and outcomes, multiple Lifepoint facilities rank among the worst hospitals in their states, including in Virginia, New Mexico, and North Carolina.[90]

- Lifepoint hospitals have notably high readmission rates; in 2022 Lifepoint's North Alabama Medical Center, National Park Medical Center in Arkansas, and Fauquier Hospital in Virginia each had the highest readmission rate in their respective states.[91] Fauquier Hospital and Lifepoint's Nason Hospital in Pennsylvania each faced the maximum Medicare payment cut for FY 2022 as a penalty for their high readmission rates.[92]

Lifepoint was also the subject of the report released by the Senate Budget Committee on January 7, in which the results of a year-long bipartisan senate investigation into both Prospect and Lifepoint were made public. The Committee's investigation of Apollo-owned Lifepoint focused on Ottumwa Regional Health Center (ORHC) in Iowa. Key findings from the report include:

- Lifepoint and OHRC's operating companies failed to fulfill at least seven promises, including legally binding ones, made to the hospital. These include failures related to capital commitments, patient satisfaction, and provision of charity care.
- Underinvestment by Apollo, Lifepoint, and ORHC's previous private equity owners "has resulted in declining conditions and quality of care that allowed egregious events to occur."[93]

- As ORHC's financial status and quality of care declined, Apollo "received benefits to the tune of millions of dollars annually from its fund's investment in Lifepoint Health and its predecessors."[94] This includes annual management fees and transaction fees that Apollo extracts from Lifepoint. The report states that "Apollo refused to provide Committee staff with exactly how much money it has made in relation to its funds' investment into Lifepoint Health."[95]

Apollo owns eight hospitals in Pennsylvania through its two brands. Lifepoint owns: Conemaugh Memorial Medical Center, Conemaugh Meyersdale Medical Center, Conemaugh Miners Medical Center, Conemaugh Nason Medical Center, Crichton Rehabilitation Center, Lancaster Rehabilitation Hospital, and St. Mary Rehabilitation Hospital. Additionally, ScionHealth owns Kindred Hospital – Philadelphia.

> For more on Apollo's ownership of Lifepoint Health and ScionHealth, see our report: "Apollo's Stranglehold on Hospitals Harms Patients and Healthcare Workers" (January 2024).

A note on joint ventures

As scrutiny of private equity hospital acquisitions has increased, private equity firms have increasingly used joint ventures with non-profit health systems as a growth strategy, giving the firms access to trusted brands and geographic markets they may otherwise not readily access. Joint venture partnerships may help both parties to evade antitrust scrutiny compared to traditional merger and acquisition growth strategies.[96]

PESP has identified multiple private equity owned-healthcare companies that have entered into joint ventures with large, nonprofit systems.

Lifepoint Health's Joint Ventures

Lifepoint Health, owned by Apollo Global Management, uses joint ventures (JVs) and other forms of partnerships to grow its business.[97] As of November 2024, at least 78 of Lifepoint hospitals[98] involving at least 26 health systems were covered by joint venture arrangements. Its largest JV is with Duke Health ("Duke Lifepoint") and consists of 14 hospitals across North Carolina, Virginia, and Pennsylvania.[99] Many of Lifepoint's most recent JVs involve the construction of new rehabilitation and behavioral health hospitals in partnership with local healthcare providers.[100]

Examples of Lifepoint's recent joint ventures with nonprofits to construct and/or operate rehabilitation and behavioral hospitals include:

- Lifepoint/PeaceHealth – In October 2024, nonprofit health system PeaceHealth announced a partnership with Lifepoint to build and operate a behavioral health hospital in Lane County, Oregon.[101]

- Lifepoint/Providence Swedish—In August 2024, Lifepoint announced the opening of a new rehabilitation hospital in Lynwood, Washington in partnership with nonprofit system Providence Swedish.[102]

- Lifepoint/The Hospitals of Providence—In October 2024, Lifepoint announced a partnership to operate a rehabilitation hospital owned by the nonprofit The Hospitals of Providence in El Paso, Texas.[103]

Compassus Health's Joint Ventures

In September 2024, nonprofit OhioHealth entered a partnership with Compassus Health in which Compassus now owns three hospice and four home health locations, which will be operated under a new brand, OhioHealth at Home.[104] Compassus is jointly owned by Towerbrook Capital Partners and Ascension Health, which purchased it in a $1 billion deal from Formation Capital and Audax Private Equity in 2019.[105] According to Moody's Investors Service, Compassus and Ascension have an agreement in which Compassus is Ascension's exclusive preferred provider of hospice services.[106] As a tax-exempt health system, Ascension's partnerships with for-profit private equity-backed companies, some of which it has also partially owned, merits further scrutiny.

In October, nonprofit Providence Health also entered into a partnership with Compassus to provide home-based services. Per the press release, "Under the agreement, Compassus will manage operations for the joint venture, which will include 24 home health locations in Alaska, California, Oregon and Washington, and 17 hospice and palliative care locations in Alaska, California, Oregon, Texas and Washington. The joint venture will also include private duty services in Southern California."[107]

Policy solutions

In recent months, multiple states have moved to address private equity's negative impacts in healthcare, demonstrating how widespread of an issue it has become.[108]

The Private Equity Stakeholder Project supports state efforts to safeguard against the risks of private equity in healthcare and urges Pennsylvania policymakers to join the growing chorus of lawmakers that are choosing to prioritize the long-term health of their citizens over short-term profits.

The financialization of healthcare in the US is a multi-faceted issue that cannot be pinned on private equity alone. However, private equity business strategies are an amplification of the typical profit-seeking strategies seen in healthcare, and are having outsized impacts on the healthcare system.

Much of PESP's proposed policy solutions to address private equity in healthcare would go above and beyond regulating private equity investments in healthcare to address broader financialization of healthcare issues that show up in nonprofit and for-profit business models alike. However, it is important to point out that private equity does depart from other types of for-profit healthcare ownership in three key ways, and these have implications for how regulations need to be designed to ensure that private equity investment strategies are captured alongside other profit-seeking strategies that can harm patients and workers.

1. **Lack of transparency**: Private equity-owned companies are less regulated than publicly traded companies. They do not need to make the same disclosures to the Securities and Exchange Commission (SEC) or to their investors. As such, critical financial information about private equity investments often remains in the shadows.

2. **Use of debt**: Private equity investment strategies involve using much more debt than is typical in other types of investments. Firms use debt to buy companies in leveraged buyouts, and the company – not the PE firm and its investors – will be on the hook for the debt. Portfolio companies can also be directed by their PE owners to take on more debt during the ownership period in order to finance add-on acquisitions or pay dividends to investors.

3. **The moral hazard of limited liability**: A private equity firm can generate returns on an investment even if the company ends up in financial distress or bankruptcy. This is because private equity firms are not liable for the debt secured by their portfolio companies, and so they cannot lose more money than the amount they invested, which is often not much. In other words, private equity firms take on little risk but get to make outsized returns.[109]

For the reasons above, updated healthcare regulations must take these factors into account. Regulations that require increased transparency and financial disclosures, regulations on use of debt, and requirements for private equity firms and other investors to have more liability for their healthcare investments are all ways to put guardrails in place to protect patients and workers. These regulations should be bare minimums, and policymakers and regulators can and should go much farther to protect patients from the increasing financialization of healthcare that is seen in both "nonprofit" and for-profit healthcare.

The Private Equity Stakeholder Project advocates for state policymakers to pass laws that would do the following:

Merger Review

- Create a robust set of change-of-ownership regulations for healthcare facilities that give Pennsylvania the authority to approve or deny transactions based on multiple factors, including cost and market share, long term access to quality healthcare for the community, and preservation of jobs and collective bargaining rights. Such regulations should include healthcare mergers and acquisitions, as well as joint venture arrangements.

- In July 2024, the National Academy for State Health Policy (NASHP), a nonpartisan organization committed to developing and advancing state health policy innovations and solutions, published an updated version of its Comprehensive Consolidation Model Addressing Transaction Oversight, Corporate Practice of Medicine and Transparency.[110] NASHP's model legislation is a valuable resource for state policymakers seeking to curb anti-competitive investment practices in healthcare. Additionally, Rhode Island's 1997 Hospital Conversions Act presents an effective model of enacted legislation in this area.

- Require review of all private equity-backed healthcare provider transactions, regardless of dollar value.

Transparency

- Require full financial transparency of licensed hospital operators and other health facilities and their investors, including private equity firms, real estate investment trusts (REITs), and other shareholders. States should have statutory requirements for all hospitals and health facilities to produce annual, audited financial disclosures to the state, including for their parent companies and any subsidiaries.

- Such laws must be enforceable and have real consequences for noncompliance. Businesses should lose their licenses to operate healthcare facilities and be barred from acquiring or opening new facilities if they demonstrate a pattern of noncompliance.

Anti-Looting

- Require that acute care hospital operators offer a minimum package of services, including emergency care and labor and delivery services, to maintain or be granted a license to operate.

- Give states the authority to put hospitals in receivership in the event of mismanagement by their owners, in order to protect access to healthcare for the communities the hospital serves. States can implement a tax on for-profit providers to fund state receivership.

- Bar hospital investors from paying themselves debt-funded dividends from health systems (also called dividend recapitalizations) or dividends from real estate sales. If dividends are allowed, they should only be paid as a percentage of overall profit and may not be funded by taking on additional debt or lease liabilities. Investors should be able to prove that the dividends can be funded without impacting the short -and long-term financial viability of the hospital/health system.

- Ban or place limits on sale-leasebacks and similar types of real estate transactions involving hospital real estate, for all hospital types.

    - If sale-leasebacks are permitted, states should have the authority to approve or deny the transaction, and there should be limits or bans on their proceeds being used for investor payments; requirements for the health system and investors to prove that the transaction will not negatively impact the short- and long-term sustainability of the system appraisal of the property; and a requirement for a certain percentage of the proceeds to go toward capital improvements in the hospital(s).

    - Triple net leases for hospital real estate, which require the tenant to pay property taxes, property insurance and maintenance, should be prohibited.

- Place limits on the ratio of debt-to-equity used to finance healthcare buyouts.

Joint and Several Liability

- Require joint and several liability for corporate owners and investors of hospital systems (both operations and real estate) and other healthcare companies. This would mean that if the hospital or company was sued for violations of the False Claims Act, a right of action would automatically exist against the private equity owner(s), landlord, and other investors.

Limit management fees

- Place limits on management fees. Investor owners may not charge arbitrary fees to hospital companies, such as management fees for services not provided. Management fees for services unrendered (or to be rendered in the future - i.e. charging a company management fees for the next five years) should be prohibited.

Investors should have to report management fees collected from hospital portfolio companies (and for what services rendered and when) to state regulators.

Minimum Staffing Ratios

- Have state minimum staffing ratios for healthcare facilities that vary, depending on the type of care being provided and the type of facility. Employers that demonstrate a pattern of noncompliance should face severe financial penalties and lose their licenses to operate.

Corporate Practice of Medicine

- States should update corporate practice of medicine (CPOM) statutes to ensure that private equity-owned physician practice management companies cannot use loopholes to direct clinical care.

In addition to updating regulations, it is imperative that lawmakers ensure that agencies tasked with review and enforcement have ample resources to do so.

PESP applauds the Senate Democratic Policy Committee's efforts to investigate and understand the impacts of hospital closures on healthcare accessibility in Pennsylvania. Private equity investors have been behind significant hospital closures in the state, and any legislation and regulatory changes to address healthcare accessibility must address private equity's risky business model that has put patients, workers, and communities at risk.

Sincerely,

Mary Bugbee
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