MASSACHUSETTS
HEALTH POLICY COMMISSION

JULY 2024

HPC POLICY BRIEF

Private Equity Investments in Massachusetts Health Care and State Policy Opportunities

Unlike other types of health care investment, the **unique business model** and **incentive structure** of private equity firms often result in the use of financial strategies that pose **substantial risks** to the health care market.

SUMMARY

Private equity investments in health care have grown significantly in the U.S. Nationally, concerns have been raised about the potentially anticompetitive and destabilizing impact of private equity investment in health care, and a growing body of research on private equity acquisitions of health care providers has documented that such acquisitions can impact health care spending, quality, and access for patients. In this policy brief, the Massachusetts Health Policy Commission (HPC) describes the unique financial strategies used by private equity firms, reviews literature of private equity's impact on health care outcomes, and presents a novel analysis of health care provider mergers and acquisitions in Massachusetts from 2013 to 2023. Of 199 transactions analyzed during this time period, 101 (51 percent) involved private equity firms. Both the number of private equity investments in Massachusetts and their share of all transactions accelerated over the last decade: from 2013 to 2016, 32 percent of transactions (19 of 60) involved private equity, compared to 52 percent from 2017 to 2020 (33 of 63) and 64 percent from 2021 to 2023 (49 of 76). The HPC found that private equity investments in Massachusetts are especially active in behavioral health, home health and hospice, dentistry, and physical therapy. These sectors share a common characteristic of being relatively fragmented and may present attractive targets for consolidation. The brief also summarizes potential policy approaches to enhance transparency and oversight to minimize the potential harms of private equity involvement in health care.

INTRODUCTION

Private equity investments have grown in size and influence throughout many sectors of the U.S. economy, including health care.[1,2] These investments can enable access to capital for providers and allow physicians to outsource burdensome administrative duties to focus on clinical care. However, unlike other types of health care investment, the unique business model and incentive structure of private equity firms often result in the use of financial strategies that pose substantial risks to the health care market. With the financial strain many health care providers have experienced during and following the COVID-19 pandemic, providers may be increasingly looking to private equity as a source of capital.[3,4] This context underscores the importance for policymakers to understand the dynamics of the private equity industry and the impact of these investments on health care spending, access, and quality.

As an independent state agency established by Chapter 224 of the Acts of 2012, the mission of the HPC is to advance a more transparent, accountable, and equitable health care system through its independent policy leadership and innovative investment programs. The HPC's goal is better health and better care – at a lower cost – for all residents across the Commonwealth.

In this policy brief, the HPC describes the business model of private equity, provides a literature review of private equity's impact on health care, and presents a novel analysis of health care provider mergers and acquisitions in Massachusetts from 2013 to 2023. In addition, the brief summarizes potential policy approaches to enhance transparency and oversight to minimize the potential harms of private equity involvement in health care.

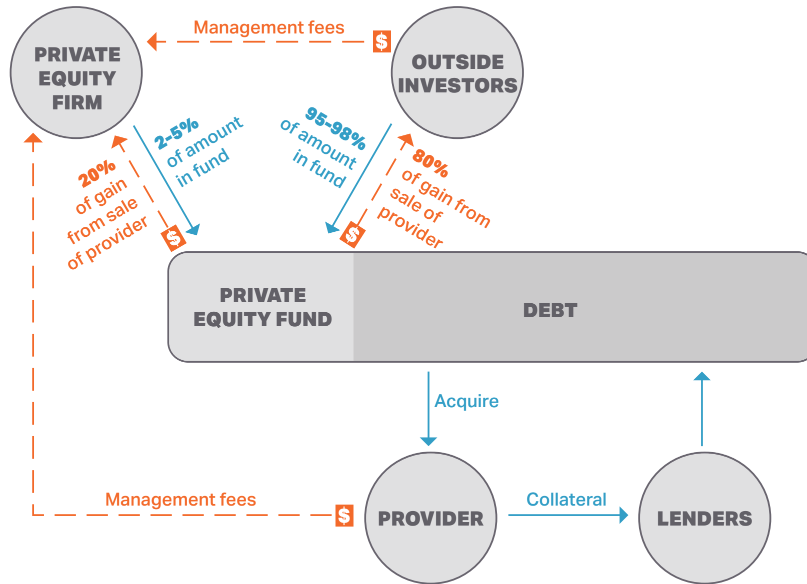
BACKGROUND

The business model of private equity

The private equity industry first originated in the U.S. in the 1940s. By the 1980s, three major models of investments have emerged: venture capital (investing in start-ups and early ventures), growth equity (focusing on maturing but still relatively new businesses), and leveraged buyouts (acquiring established businesses using mostly debt). Since then, strategies used by leveraged buyout firms have evolved and diversified, and these firms are generally referred to today as private equity firms. Private equity firms that rely on buyouts typically acquire a majority stake (i.e. more than 50 percent ownership) in mature businesses, in contrast to venture capital investors, which tend to acquire a minority stake in start-ups and early-stage ventures.[5,6,7]

In a leveraged buyout, the private equity firm uses a small portion of equity from its fund and a large portion of debt to finance the acquisition, using the company it is buying as collateral.

Exhibit 1: Illustration of private equity acquisition of a health care provider



Private equity firms form funds to make acquisitions, with the goal of improving the acquired company's financial performance and value and then selling the company for a profit within a short timeframe, typically three to seven years.[5] Private equity firms often contribute a small portion of the overall capital to the funds (2-5 percent), raising the vast majority of capital by pooling outside investments from large institutional investors (e.g., pension funds, endowments, sovereign wealth funds) and high net-worth individuals.[5,8] In a leveraged buyout, the private equity firm uses a small portion of equity from its fund and a large portion of debt to finance the acquisition, using the company it is buying as collateral. The firm charges the outside investors an annual management fee and takes a percentage (typically 20 percent[i]) of the profit when the company is sold, returning the rest of the profit to other investors in the fund (**Exhibit 1**).[5,8]

Private equity differs from other forms of health care investments in several ways. First, private equity investors are "lay investors" who are not bound by institutional norms and ethical obligations expected in the health care profession.[9] Second, private equity investors aim to produce high returns on investments on a short timeline, which are difficult to achieve through efficiency gains alone. As such, private equity firms have few incentives to consider the long-term impact of their actions and often employ financial strategies that can be destabilizing to the health care market. In addition to leveraged buyouts, private equity firms may engage in a type of transaction known as the sale-leaseback of real estate, in which a private equity firm that owns a health care entity with physical plant (such as hospitals or nursing homes) sells the provider's real estate to a third-party company and then leases the property back. Private equity firms often use the proceeds from the property sales to pay dividends to the firm and the investors while the health care entity incurs the obligation to pay rent for property it previously owned, often adding significant financial burdens.[10] Third, private equity firms enjoy a number of tax advantages that make the industry more lucrative and susceptible to risky behaviors. For example, the carried interest loophole allows private equity investors to claim large parts of their compensation for services as investment gains, which are taxed significantly lower than ordinary income. Another example is the ability to deduct interest payments from taxable income, which encourages private equity's heavy reliance on debt.[11] Lastly, the lack of transparency in the private equity industry makes it challenging for regulators, researchers, and the public to track their activities and evaluate the impact of their investments. Unlike securities such as stocks and mutual funds, private equity funds are not registered with the U.S. Securities and Exchange Commission (SEC) and thus not subject to regular public disclosure requirements.[12] Private equity firms that manage smaller funds are exempt from registering with the SEC as investment advisors. Furthermore, private equity firms and the companies they acquire frequently use complex corporate structures with multiple levels and subsidiaries, which may render existing transparency efforts ineffective (see sidebar: **The role of management services organizations in health care**).[5] These complex structures can also shield private equity firms from the legal and financial consequences of their actions.

Private equity investors aim to produce high returns on investments on a short timeline, which are difficult to achieve through efficiency gains alone. As such, private equity firms have few incentives to consider the long-term impact of their actions and often employ financial strategies that can be destabilizing to the health care market.

i Private equity firms are generally expected to achieve a minimal rate of return, called the hurdle rate, before they can receive profits from a sale. A typical hurdle rate is 8%.[5]

While certain practices and characteristics may be unique to private equity, private equity investors also employ strategies that are commonly used by other for-profit and non-profit health care providers to maximize financial performance. Some strategies (such as reductions in staffing levels and benefits, as well as reliance on non-physician practitioners) aim to reduce costs; others focus on increasing revenue (such as offering more services, shifting towards more profitable services, or raising prices through consolidation).

Growth in private equity investment nationally

Private equity investments have expanded in many sectors of the U.S. economy. Early private equity investments in health care focused on nursing homes and hospitals in the 1990s and 2000s, and private equity has now expanded into nearly every corner of the health care provider market ranging from physician practices and home health agencies to ambulance operators. By one estimate, the number of private equity health care transactions nationwide grew more than 250 percent from 352 in 2010 to 937 in 2020, representing a total of $750 billion in transaction values.[2]

By one estimate, the number of private equity health care transactions nationwide grew more than 250 percent from **352 in 2010** to **937 in 2020**, representing a total of **$750 billion** in transaction values.

Given the lack of transparency surrounding private investments and the complexity of corporate structures, identifying private equity-backed heath care entities is difficult. The relatively rapid turnover of companies resulting from the limited timespan of a private equity fund introduces additional challenges in assessing the prevalence of such investments in health care. Researchers estimate that 5 to 11 percent of nursing homes nationwide are owned by private equity.[13,14] The variation in estimates may be partly due to differences in definitions (e.g., including only skilled nursing facilities or various types of long-term care facilities) as well as the year in which the estimates were made. Estimates also vary for hospitals.[5,15,16,17] According to the Private Equity Stakeholder Project, which tracks private equity-owned hospitals sourced from the Centers for Medicare & Medicaid Services (CMS), approximately 460 hospitals are owned by private equity firms as of January 2024, representing 22 percent of all U.S. for-profit hospitals or 8 percent of all private (i.e., non-government owned) hospitals.[15] Research on behavioral health practices suggests that 6.2 percent of mental health facilities and 7.1 percent of addiction treatment facilities nationwide were acquired by private equity between 2012 and 2023.[18] For physician practices, research shows that private equity acquisitions have accelerated rapidly nationwide but with significant geographic variation.[19,20] One analysis that examined private equity acquisition of six office-based physician specialties in 2019 – dermatology, ophthalmology, gastroenterology, urology, obstetrics/gynecology, and orthopedics – estimated that while an average of 5.6 percent of physicians in these specialties worked in private equity-acquired practices, the level of private equity penetration was much higher in some states, such as Washington DC (18.2 percent), Arizona (17.5 percent) and New Jersey (13.6 percent).[21]

THE ROLE OF MANAGEMENT SERVICES ORGANIZATIONS IN HEALTH CARE

Management services organizations (MSOs) provide practice management and administrative support services to and on behalf of many health care providers, both non-profit and for-profit. MSOs can provide a wide array of nonclinical services, ranging from billing, provision of IT services, and space rental to employment of nonclinical staff and payer negotiations. Outsourcing these tasks can improve operational efficiency and alleviate administrative burden for clinicians, which can be particularly beneficial for smaller provider groups.

In recent years, MSOs have been increasingly used by for-profit entities, including private equity firms, enabling them to become involved in health care practices without violating states' rules regarding the "corporate practice of medicine" (CPOM). CPOM rules exist in at least 30 states in the U.S., including Massachusetts, and are designed to ensure that clinicians retain full and autonomous decision making over patient care, regardless of for-profit or non-profit status or financial incentives of the practice.[22] Generally, under CPOM rules, all owners of a physician practice entity must be licensed to practice medicine, and corporations are typically prohibited from controlling the practice of medicine or employing physicians to provide medical services, although there are exceptions (e.g., hospitals are allowed in many states to employ physicians). The MSO model allows corporations, including private equity, to indirectly invest in health care by purchasing providers' nonclinical assets and providing nonclinical services. Even with a focus on nonclinical areas, MSOs can nonetheless have significant impact on health care market functioning and patient care. For example, MSOs may create extensive provider networks that negotiate jointly with insurers, increasing the bargaining leverage of those providers relative to insurers and leading to increased prices.[23] MSOs may influence patient care in a number of ways, such as where the MSO directly selects a physician owner of the medical practice who is receptive to MSO directives (i.e., the "friendly physician" model).[22]

The extent to which MSOs are involved with the business of providers varies greatly: while some MSOs contract with providers to provide exclusively certain nonclinical services, other MSOs may take over the employment of nonclinical staff and acquire physical assets of the providers (e.g., space, equipment) in addition to providing administrative services. In the HPC's analysis, the HPC included MSO transactions that include some element of acquisition and did not include MSO transactions that are exclusively administrative in nature.

Kannan et al. found that private equity acquisition of hospitals was associated with a **25.4 percent increase in hospital-acquired conditions,** such as falls and central line associated bloodstream infections, despite having a lower risk patient population compared to control hospitals. Gupta et al. concluded that going to a private equity-owned nursing home **increased an individual's short-term mortality by 11 percent.**

PRIVATE EQUITY IN HEALTH CARE AND ITS IMPACT ON SPENDING AND PATIENT CARE

A growing body of research suggests that private equity ownership can affect health care spending, quality, and access. The evidence on the utilization and cost impact of private equity is most consistent. Researchers have examined the impact of private equity investments on spending in nursing homes,[24,25] ambulatory surgical centers,[26] hospitals,[18,27,28] and physician practices,[14,29,30,31] with most finding that private equity investments are associated with increased utilization and higher prices. For example, an analysis that examined anesthesia prices before and after the anesthesiologists contracted with an MSO found that prices increased 26.0 percent for anesthesiologists contracted with private equity backed MSOs, compared to 12.9 percent for anesthesiologists contracted with MSOs without private equity investment.[23]

Findings from these studies suggest a variety of mechanisms through which private equity acquisition can raise spending, including directly, through increasing the number of patients, the number of visits, and the length of visits, and indirectly, through market consolidation. For example, a national study on physician practices found private equity acquisition was associated with statistically significant price increases for nearly all specialties studied, but the increases were particularly high in markets where a single private equity firm had 30 percent or more market share in a given physician specialty.[19]

Regarding the impact on quality, the evidence is more mixed but indicates concerns with quality. A 2023 systematic review of the impact of private equity ownership identified 27 studies that assessed health care quality, including 12 that found harmful impacts, three that found beneficial impacts, nine that found mixed impacts, and three that found neutral impacts.[32] While these results are inconsistent, there appears to be more evidence of harm than improvements to the quality of care, and new evidence continues to emerge. For example, a 2023 study by Kannan et al. (published after the aforementioned systematic review) found that private equity acquisition of hospitals was associated with a 25.4 percent increase in hospital-acquired conditions, such as falls and central line associated bloodstream infections, despite having a lower risk patient population compared to control hospitals.[33] Gupta et al. concluded that going to a private equity-owned nursing home increased an individual's short-term mortality by 11 percent.[25] Results from multiple studies suggest that changes in staffing may be one mechanism through which private equity ownership affects the quality of care.[25,34,35] The Gupta et al. study reported a 3 percent decline in hours for frontline caregivers at private equity-owned nursing homes compared to the industry average. Given that nursing assistants and other frontline caregivers provide the vast majority of caregiving hours on crucial tasks such as bed turning and infection prevention, the authors hypothesized that reduced staffing helps to explain their finding of higher rates of mortality in private equity-owned nursing homes.

Private equity's impact on health care is not limited to spending and quality. For instance, private equity-owned providers may shift patient mix to favor commercial patients with higher reimbursement rates, which can create access barriers for other patients, particularly those with lower incomes. A 2022 study on urology practices found that Medicaid acceptance was considerably lower at private equity-affiliated practices (52.1 percent) compared to non-private equity affiliated practices (66.8 percent).[36]

One of the most significant access risks in connection with private equity investment is closures of facilities or services. An analysis tracking bankruptcies of health care companies found that 17 of 80 (21 percent) health care companies that filed for bankruptcies in 2023 were private equity-owned.[37] While the HPC did not identify literature that examined systematic differences in the rate of health care closures between private equity-owned facilities and other facilities (likely because closures are relatively rare events), one analysis across industries found that large companies acquired by private equity firms through leveraged buyouts had a rate of bankruptcy within 10 years that was 10 times higher than controls.[38] The bankruptcy of HCR ManorCare in 2018, then the nation's second largest nursing home operator, and the closure of Hahnemann University Hospital, a safety net hospital, in Philadelphia in 2019 are two high-profile examples of private equity failures widely reported in the media.[39,40] More recently, previously private equity-owned Steward Health Care, encompassing physician networks and 31 hospitals in Massachusetts and seven other states, filed a petition for bankruptcy.[41,42] Such disruptions and closures not only reduce access to care for patients, but also have far reaching economic consequences for local communities, including unemployment in the local workforce.

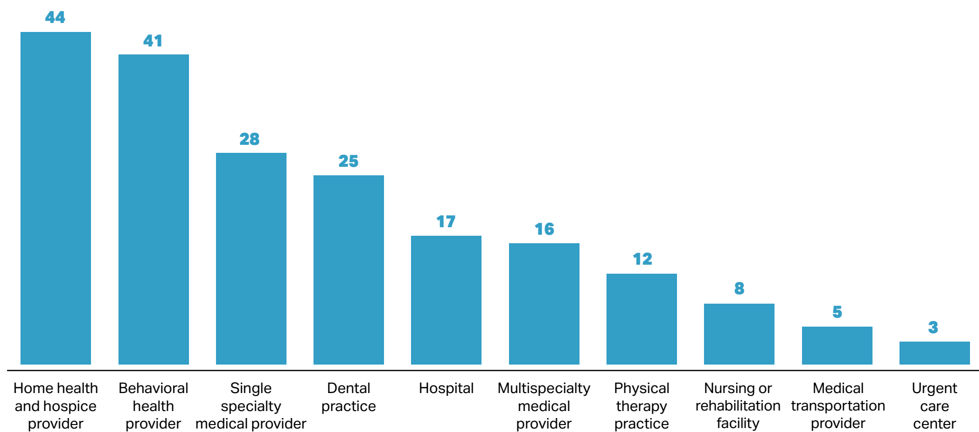
PRIVATE EQUITY IN MASSACHUSETTS HEALTH CARE

Methods

While literature has characterized private equity investments in health care at the national level, recent trends in private equity investments in health care in Massachusetts have not been documented previously. To identify private equity activities in Massachusetts, the HPC combined three datasets to identify mergers and acquisitions among Massachusetts health care providers from 2013 to 2023, including those that involve private equity and those that do not. The HPC used two proprietary datasets that

A total of 199 health care provider **mergers and acquisitions** were identified from 2013 to 2023 in Massachusetts.

Exhibit 2: Number of health care provider transactions in Massachusetts, 2013-2023



SOURCES: HPC analysis of FactSet financial data and analytics; HPC Material Change Notice filings; LevinPro HC, Levin Associates, May 2024, levinassociates.com; and other publicly available information.

track health care transactions (FactSet and LevinPro HC) and Material Change Notices (MCN) submitted to the HPC.[43] Massachusetts law requires that certain providers and provider organizations must submit notice to the HPC for any proposed "material changes", which includes mergers and acquisitions between providers and between providers and payers.[ii] Extensive validation of transactions through online search was performed using publicly available information, such as press releases and news articles.

The HPC included transactions in which the acquired provider was based in Massachusetts or had locations in Massachusetts at the time of the transaction, regardless of the location of the acquirer. Private equity firms were defined as those that collect capital from individuals or entities and purchase ownership stakes in a provider. The HPC examined private equity acquisitions as well as exits.

Three types of acquisitions were included:

- Platform acquisitions: private equity firm directly acquires a platform company (a platform company refers to the initial acquisition made by a private equity firm, which can serve as a springboard for future acquisitions).
- Add-on acquisitions: private equity firm uses a platform company it owns to acquire a company, also known as roll-up transactions (for example, a private equity firm acquires company A as a platform company, and then company A acquires company B).
- Growth investments: private equity firm makes a non-controlling investment in a company.

Acquisitions of multiple entities announced together, or which occurred on the same day, were counted as one transaction. The following transactions were excluded: cancelled or pending transactions, transactions of entities that are not patient-facing (e.g., device manufacturers, labs), transactions of entities that operate largely outside of insurance (e.g., e-health), changes in clinical or contracting affiliations, and transactions solely between payers.

Results

A total of 199 health care provider mergers and acquisitions were identified from 2013 to 2023 in Massachusetts (**Exhibit 2**). The largest number of transactions occurred in the home health and hospice sector[iii] (44 transactions) and the behavioral health sector[iv] (41), followed by single specialty medical providers (28), dental practices (25), hospitals (17), and multispecialty medical providers (16). There were a smaller number of transactions involving physical therapy providers (12), nursing homes or rehabilitation facilities[v] (8), medical transportation providers (5), and urgent care centers (3).

Of the 199 transactions, **101 involved private equity firms:** 85 were private equity acquisitions, 4 were private equity exits, and 12 were acquisitions and exits.

Of the 199 transactions, 101 (51 percent) involved private equity firms: 85 were private equity acquisitions, 4 were private equity exits, and 12 were acquisitions and exits (i.e.,

ii MCNs are publicly available. Only transactions that meet certain financial thresholds and which involve two providers or a provider and a payer are generally required to be noticed to the HPC, meaning that MCNs do not currently capture all private equity health care transactions in Massachusetts.

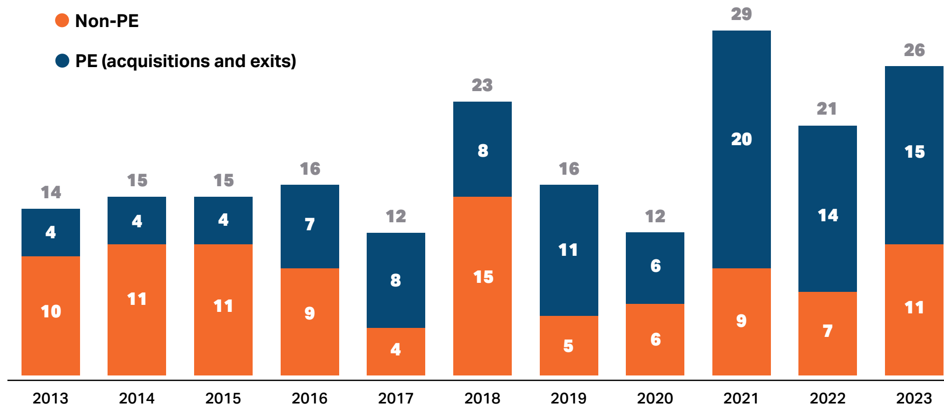
iii Of the 44 transactions in the home health and hospice sector, the vast majority involved providers of home health services. Only five transactions include hospice services. Of these five transactions, private equity was involved in two transactions.

iv Behavioral health providers include both office-based providers and facility-based providers (e.g., psychiatric hospitals). Providers for autism and other pediatric development disorders were also included in this category.

v Assisted living facilities which do not provide medical or nursing services were not included.

Both the number of private equity investments in Massachusetts and their share of all transactions **accelerated over the last decade:** from 2013 to 2016, **32 percent** of transactions (19 of 60) involved private equity, compared to **52 percent** from 2017 to 2020 (33 of 63) and **64 percent** from 2021 to 2023 (49 of 76).

Exhibit 3: Number of provider transactions by year in Massachusetts, 2013-2023



SOURCES: HPC analysis of FactSet financial data and analytics; HPC Material Change Notice filings; LevinPro HC, Levin Associates, May 2024, levinassociates.com; and other publicly available information.

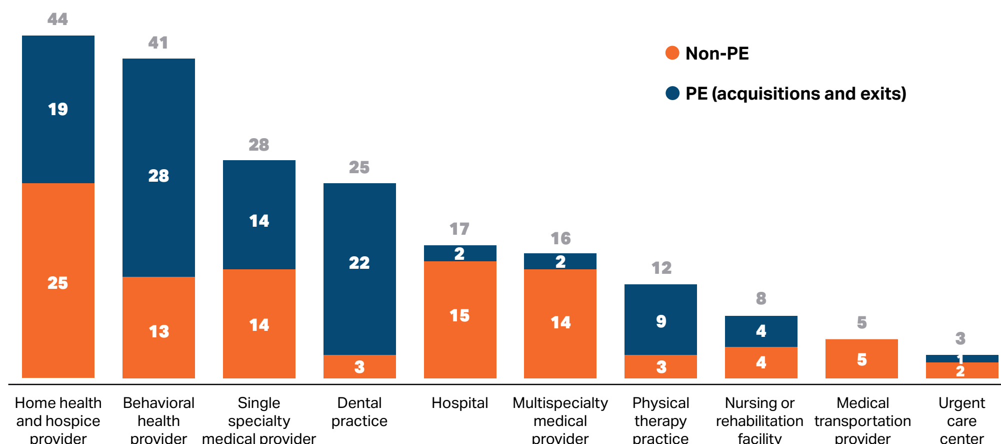
one private equity firm selling to another private equity firm). Both the number of private equity investments in Massachusetts and their share of all transactions accelerated over the last decade (**Exhibit 3**): from 2013 to 2016, 32 percent of transactions (19 of 60) involved private equity, compared to 52 percent from 2017 to 2020 (33 of 63) and 64 percent from 2021 to 2023 (49 of 76).

By sector (**Exhibit 4**), private equity investments have been most active among behavioral health providers, home health and hospice providers, and certain specialty providers (e.g., dentistry, physical therapy). Twenty-eight private equity transactions occurred in behavioral health, the largest number among all sectors. Of note, 11 private equity transactions within this sector were acquisitions of pediatric behavioral and developmental disorder (e.g., autism) providers. This focus is consistent with national trends: an analysis of the autism provider market found that private equity firms completed 85 percent of all buyouts of autism service providers from 2017 to 2022.[44]

The largest share of transactions that involved private equity was in the dental sector, where 88 percent of all transactions (22 out of 25) were private equity acquisitions. In addition, all dental transactions were acquisitions by dental management services organizations, or DSOs, which function similarly to management services organizations (see sidebar: **The role of management services organizations in health care**). These trends in the dental sector in Massachusetts reflect national trends, in which an increasing share of dental providers are joining DSOs, and the growth of DSOs is closely linked to private equity investments: a 2021 analysis found that 27 of the top 30 DSOs in the U.S. are private equity-owned.[45,46]

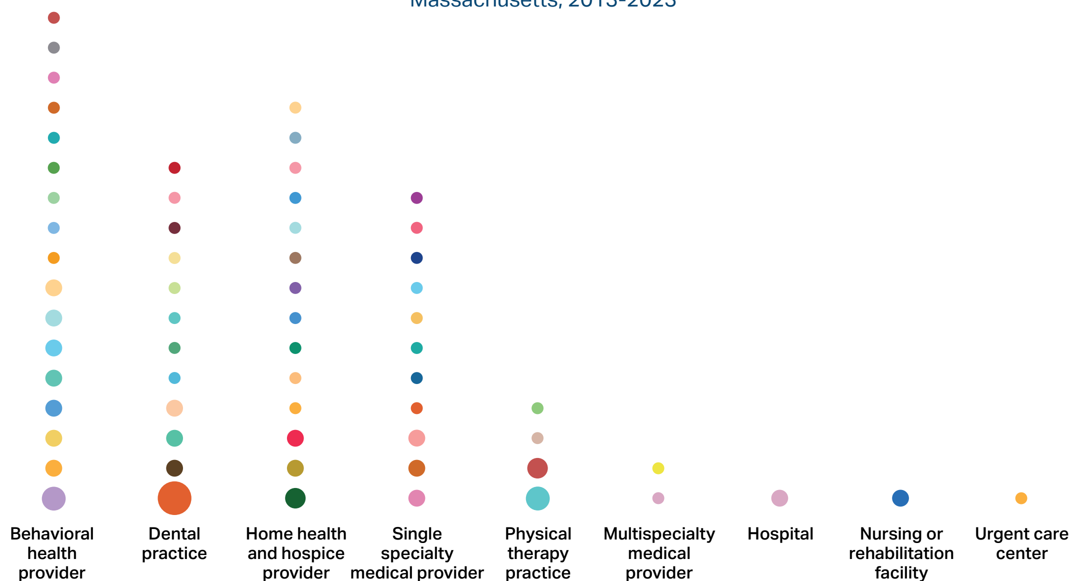
By sector, private equity investments have been most active among **behavioral health** providers, **home health** and **hospice** providers, and certain specialty providers

Exhibit 4: Number of provider transactions by health care sector in Massachusetts, 2013-2023



NOTES: Of transactions that involved private equity, 85 were private equity acquisitions, 4 were private equity exits, and 12 were acquisitions and exits. One exit occurred in the behavioral health sector and in the home health sector; 2 exits were rehabilitation facilities.
SOURCES: HPC analysis of FactSet financial data and analytics; HPC Material Change Notice filings; LevinPro HC, Levin Associates, May 2024, levinassociates.com; and other publicly available information.

Exhibit 5: Private equity acquisitions by health care sector and acquiring private equity firm in Massachusetts, 2013-2023



NOTES: Each bubble represents a private equity firm that made acquisitions in a given sector. Bubble size is proportional to the number of acquisitions per private equity firm. Bubble color represents a distinct firm or distinct group of firms.

SOURCES: HPC analysis of FactSet financial data and analytics; HPC Material Change Notice filings; LevinPro HC, Levin Associates, May 2024, levinassociates.com; and other publicly available information.

The HPC found that private equity investments have **accelerated in Massachusetts** in recent years, and are especially active in behavioral health, home health and hospice, dentistry, and physical therapy. These sectors share a common characteristic of being **relatively fragmented** and may present attractive targets for consolidation. The Massachusetts hospital and physician markets are already highly concentrated, which may explain the relatively small number of private equity transactions in these sectors.

Lastly, the HPC identified the private equity firms involved in each transaction and examined the patterns of their investments. Many private equity acquisitions in Massachusetts had been one-offs, although there were also instances of individual private equity firms acquiring multiple practices in the same sector (**Exhibit 5**). For example, in dentistry, one private equity firm completed eight transactions, while 11 other private equity firms acquired only one or two practices each.

In summary, the HPC found that private equity investments have accelerated in Massachusetts in recent years, and are especially active in behavioral health, home health and hospice, dentistry, and physical therapy. These sectors share a common characteristic of being relatively fragmented and may present attractive targets for consolidation. The Massachusetts hospital and physician markets are already highly concentrated, which may explain the relatively small number of private equity transactions in these sectors. These results suggest that private equity firms appear to be highly attuned to local market conditions and trends in the health care market, and their investment activities will likely continue to evolve. For instance, researchers have noted that private equity's investment in autism service providers occurred after states began mandating insurance coverage of autism therapies in the mid-2010s (with no age or dollar limits on billing in some states, such as Massachusetts), creating significant and continuous sources of revenue.[44] Another example is the recent surge in private equity investments in home health. As long-term care and post-acute care continue to shift away from institutional settings, private equity investors may see the home health sector as an attractive investment target with significant growth potential.[47]

STATE POLICY OPPORTUNITIES

Recognizing the growing role of private equity investment in health care in Massachusetts and the risks associated with such investment, policymakers should consider approaches to increase transparency and oversight of private equity in healthcare and to reduce the likelihood of negative consequences from such investment in the future.

At the federal level, legislation has been proposed to increase the transparency of or limit private equity investment in health care, and a number of agency actions have signaled increased interest in private equity oversight and enforcement.[48,49,50] For example, the Federal Trade Commission (FTC) and The Department of Justice (DOJ) recently finalized revised merger guidelines that address some of the private equity behaviors identified.[49] Additionally, CMS finalized a rule that would require more transparency of nursing home ownership.[51]

Massachusetts has additional opportunities to address the growing risk from private equity investment in health care through state level policy, including by broadening existing transparency and oversight tools in Massachusetts to ensure that private equity investments in health care

Massachusetts has additional opportunities to address the growing risk from private equity investment in health care through state level policy, including by **broadening existing transparency and oversight tools** in Massachusetts to ensure that private equity investments in health care are included, by **fostering opportunities for providers to access capital** without private equity investment, and by **addressing known pricing dysfunctions and areas of misalignment** in the health care system that make providers attractive targets for private equity investors.

are included, by fostering opportunities for providers to access capital without private equity investment, and by addressing known pricing dysfunctions and areas of misalignment in the health care system that make providers attractive targets for private equity investors. Policy interventions should be broadly applicable and flexible, given the evolving nature of private equity and other forms of investment, coupled with the fact that many of the specific actions engaged in by private equity investors in health care that are potentially destabilizing could be pursued by other for-profit or non-profit providers.

Broaden existing state-level health care transparency and oversight processes to include private equity

While Massachusetts has greater transparency into health care market functioning than many other states, current transparency and oversight processes, such as the HPC's Registration of Provider Organizations (RPO) program and associated financial reporting and Material Change Notice (MCN) filings, do not fully capture private equity activities in the Massachusetts health care provider market.

Massachusetts RPO Program: The Massachusetts RPO program is a first-in-the-nation effort to collect key information about the organizational structure, affiliations, and financial status of the largest health care providers in Massachusetts.[52] Under current law, the RPO program may only collect information from providers with significant revenue from commercial insurers, which largely excludes behavioral health providers, nursing homes, and other provider types that are frequently targeted by private equity investors. The statue should be updated to allow the RPO program to collect information from a broader range of provider types, including those with revenue primarily from self-pay and from Medicare and Medicaid. Given the importance of financial oversight, adjustments to penalties and other enforcement mechanisms to address non-compliance may also be warranted.

Material Change Notices (MCNs): One of the key mechanisms through which Massachusetts understands and assesses health care provider transactions (mergers, acquisitions and other types of affiliations) is the Material Change Notice (MCN) and Cost and Market Impact Review (CMIR) processes. Under current law, an MCN generally must be filed with the HPC when a provider proposes a transaction that involves merging or affiliating with other providers or payers, and the HPC can initiate a full investigation or CMIR of those transactions it determines are likely to result in a significant impact to health care costs or market functioning in Massachusetts, culminating in a public report on the likely impacts.[53]

The law authorizing the HPC to review health care provider transactions should be broadened to ensure that all significant health care transactions involving private equity require notice to the HPC. For example, significant new, for-profit investment in a provider or acquisition of a provider by any entity including private equity investors should require the filing of an MCN. Additionally, the acquisition of a provider's assets (such as real estate) by any entity including private equity investors, such as in a sale-leaseback, should also require notice and review. Expanding the filing requirements in these ways would allow for public notice and thorough HPC review of a greater number of transactions and would provide additional insight into the potential cost, quality, access, and equity impacts of transactions before new private equity investments in or sales of health care providers occur.

Additionally, the Commonwealth could consider a process for imposing conditions upon parties to transactions, in ways similar to approaches used in other states.[54] Conditions that could be applied to risky transactions could include, among other things, requirements that essential services and/or staff be maintained for a specific period of time, the fulfillment of specific requirements for charity care or community benefits, limitations on debt as well as dividend distributions, maintenance of adequate financial reserves, and other conditions related to quality standards, ongoing compliance monitoring, and exit and sale.[55] For example, in 2021, Rhode Island Attorney General Peter Neronha approved a private equity firm's sale of a hospital system under the condition that the firm contribute $80 million to an escrow account to keep the hospitals in the system open.[56]

Address known pricing dysfunctions that incentivize private equity investment in health care

The state can also pursue policies to address the underlying reasons why organizations are identified for (and interested in) acquisition or investment by private equity.

First, policymakers should address the inefficiencies and market failures that make health care an attractive opportunity for investors to make a quick profit in ways not aligned with public interest. For example, private equity investments in several hospital-based specialties, such as emergency medicine, were incentivized by the ability to "surprise bill," a practice in which patients receive unexpected bills from out-of-network providers that they had seen unknowingly. Notably, after the passage of the federal No Surprises Act in 2020 that curtailed the practice, private equity backed Envision Healthcare and American Physician Partners, which staffed emergency rooms in hundreds of hospitals nationwide, both filed for bankruptcy and cited the legislation as one of the contributing factors.[57,58]

Other known pricing dysfunctions in the health care market that can be exploited by private equity investors

and others can be addressed by requiring site-neutral payments, adopting a default out-of-network payment rate for surprise billing scenarios as well as potentially further expanding out-of-network protections, reducing unwarranted price variation, and limiting excessive provider prices,[59] all of which were recommended in the HPC's 2023 Annual Cost Trends Report.[60] These and other policies that reduce profit incentives that are at odds with the public interest, and instead align payment with quality and value, may not only address market failures that make health care attractive to private equity investors, but also serve to advance an affordable, equitable and high-quality health care system overall.

Additional policy opportunities

Health planning

Massachusetts could develop and engage in a comprehensive process for assessing health needs across the state and ensuring the supply of health services aligns with that need, as recommended in the HPC's 2023 Annual Cost Trends Report.[60] This approach could support efforts to ensure that providers are focused on providing services needed by Massachusetts residents, and not only those services that are the most profitable.

Administrative complexity

Administrative and operational burdens on physician practices often accelerate retirements, contribute to the sale of a practice, or make arrangements with management services organizations attractive.[21] The state could continue pursuing opportunities to reduce administrative complexity for providers and consider other ways to support provider independence, as recommended in the HPC's 2023 Annual Cost Trends Report.[60]

Other areas for consideration

Finally, there are other policies that the Commonwealth could consider to mitigate potential harms from private equity investment in the health care market. These include enhancing consumer protections, including by prohibiting certain predatory financing and debt collection practices; enhancing protections for workers, including potential whistleblowers; prohibiting or limiting potentially harmful financial strategies like sale-leasebacks and dividend recapitalizations; and strengthening corporate practice of medicine prohibitions to keep decision-making with medical professionals.

POLICY BRIEF PREPARED BY:
Yue Huang
Senior Manager, Research and Cost Trends

Sara Sadownik
Deputy Director, Research and Cost Trends

Dr. David Auerbach
Director, Research and Cost Trends

ACKNOWLEDGEMENTS:
Kate Scarborough Mills
Kathy Mikk
Sasha Hayes-Rusnov
Dhruv Mandalia
Lois Johnson

EXECUTIVE DIRECTOR:
David Seltz

DEPUTY EXECUTIVE DIRECTOR
Coleen Elstermeyer

HPC BOARD
Ms. Deborah Devaux
Chair
Mr. Martin Cohen
Vice Chair
Ms. Barbara Blakeney
Dr. Matilde Castiel
Dr. David Cutler
Mr. Timothy Foley
Ms. Patricia Houpt
Mr. Ron Mastrogiovanni
Dr. Alecia McGregor
Sec. Matthew Gorzkowicz
Administration and Finance
Sec. Kate Walsh
Health and Human Services

The Massachusetts Health Policy Commission (HPC) is an independent state agency charged with monitoring health care spending growth in Massachusetts and providing data-driven policy recommendations regarding health care delivery and payment system reform. The HPC's mission is to advance a more transparent, accountable, and equitable health care system through its independent policy leadership and innovative investment programs. For more information about the HPC, please visit our website: masshpc.gov

REFERENCES

1. Blumenthal, D. Private Equity's role in health care. The Commonwealth Fund. Nov 17, 2023. Available at: https://www.commonwealthfund.org/publications/explainer/2023/nov/private-equity-role-health-care
2. Scheffler RM, Alexander LM, Godwin JR. Soaring private equity investment in the healthcare sector: Consolidation accelerated, competition undermined, and patients at risk. American Antitrust Institute and the Nicholas C. Petris Center at UC Berkeley. May 18, 2021. Available at: https://publichealth.berkeley.edu/wp-content/uploads/2021/05/Private-Equity-I-Healthcare-Report-FINAL.pdf
3. Bruch J, Gondi S, Song Z. COVID-19 and private equity investment in health care delivery. JAMA Health Forum 2021 Mar 1 (Vol. 2, No. 3, pp. e210182-e210182).
4. Song Z, et al. Economic and clinical impact of COVID-19 on provider practices in Massachusetts. NEJM Catalyst Innovations in Care Delivery. 2020 Sep 11;1(5).
5. The Medicare Payment Advisory Commission. June 2021 report to the Congress: Medicare and the Health Care Delivery System, Chapter 3, Congressional request: Private equity and Medicare. Jun 15, 2021. Available at: https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/default-document-library/jun21_ch3_medpac_report_to_congress_sec.pdf
6. Ikram U, Aung KK, Song Z. Private equity and primary care: Lessons from the field. NEJM Catalyst Innovations in Care Delivery. 2021 Nov 19;2(6).
7. Private equity, history and further development. Harvard University. Dec 27, 2008. Available at: https://archive.blogs.harvard.edu/nhonma/2008/12/27/private-equity-history-and-further-development/
8. Morran C, Petty D. What private equity firms are and how they operate. ProPublica. Aug 3, 2022. Available at: https://www.propublica.org/article/what-is-private-equity
9. Fuse Brown EC, Hall MA. Private equity and the corporatization of health care. Stanford Law Review. 2024;76.
10. Batt R, Appelbaum E, Katz T. The role of public REITs in financialization and industry restructuring. Institute for New Economic Thinking Working Paper Series. 2022 Jul 9(189). Available at: https://www.ineteconomics.org/uploads/papers/WP_189-Batt-Appelbaum-Public-REITS-2.pdf
11. Gupta A, Howell S. The role of private equity in the U.S. economy, and whether and how favorable tax policies for the sector need to be reformed. Washington Center for Equitable Growth. Sep 14, 2023. Available at: https://equitablegrowth.org/the-role-of-private-equity-in-the-u-s-economy-and-whether-and-how-favorable-tax-policies-for-the-sector-need-to-be-reformed/
12. U.S. Securities and Exchange Commission. Private equity funds. Available at: https://www.investor.gov/introduction-investing/investing-basics/investment-products/private-investment-funds/private-equity
13. Braun RT, et al. Comparative performance of private equity-owned US nursing homes during the COVID-19 pandemic. JAMA network open. 2020 Oct 1;3(10):e2026702-.
14. U.S. Government Accountability Office. Nursing homes: limitations of using CMS data to identify private equity and other ownership. Sep 22, 2023. Available at: https://www.gao.gov/products/gao-23-106163
15. The Private Equity Stakeholder Project. PESP private equity hospital tracker. Available at: https://pestakeholder.org/private-equity-hospital-tracker/
16. Offodile II AC, et al. Private equity investments in health care: An overview of hospital and health system leveraged buyouts, 2003–17. Health Affairs. 2021 May 1;40(5):719-26.
17. Bruch J, Zeltzer D, Song Z. Characteristics of private equity–owned hospitals in 2018. Annals of Internal Medicine. 2021 Feb;174(2):277-9.
18. Zhu JM, et al. Geographic penetration of private equity ownership in outpatient and residential behavioral health. JAMA Psychiatry. 2024;81(7):732–735.
19. Scheffler RM, et al. Monetizing medicine: Private equity and competition in physician practice markets. American Antitrust Institute. Jul 10, 2023. Available at: https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf
20. Abdelhadi O, et al. Private equity-acquired physician practices and market penetration increased substantially, 2012–21. Health Affairs. 2024 Mar 1;43(3):354-62.
21. Singh Y, et al. Geographic variation in private equity penetration across select office-based physician specialties in the US. JAMA Health Forum 2022 Apr 1 (Vol. 3, No. 4, pp. e220825-e220825).
22. Zhu JM, Rooke-Ley H, Fuse Brown E. A doctrine in name only–strengthening prohibitions against the corporate practice of medicine. New England Journal of Medicine. 2023 Sep 14;389(11):965-8.
23. La Forgia A, Bond AM, Braun RT, Yao LZ, Kjaer K, Zhang M, Casalino LP. Association of physician management companies and private equity investment with commercial health care prices paid to anesthesia practitioners. JAMA Internal Medicine. 2022 Apr 1;182(4):396-404.
24. Braun RT, et al. Association of private equity investment in US nursing homes with the quality and cost of care for long-stay residents. JAMA Health Forum 2021 Nov 2 (Vol. 2, No. 11, pp. e213817-e213817).
25. Gupta A, et al. Owner incentives and performance in healthcare: Private equity investment in nursing homes. National Bureau of Economic Research working paper 28474. Feb 2021. Available at: https://www.nber.org/papers/w28474

26 Bruch JD, et al. Private equity acquisitions of ambulatory surgical centers were not associated with quality, cost, or volume changes. Health Affairs. 2022 Sep 1;41(9):1291-8.

27 Bruch JD, Gondi S, Song Z. Changes in hospital income, use, and quality associated with private equity acquisition. JAMA Internal Medicine. 2020 Nov 1;180(11):1428-35.

28 Liu T. Bargaining with private equity: Implications for hospital prices and patient welfare. Available at SSRN 3896410. 2022 Nov 1.

29 Braun RT, et al. Private equity in dermatology: Effect on price, utilization, and spending. Health Affairs. 2021 May 1;40(5):727-35.

30 Singh Y, et al. Association of private equity acquisition of physician practices with changes in health care spending and utilization. JAMA Health Forum 2022 Sep 2 (Vol. 3, No. 9, pp. e222886-e222886).

31 Nie J, et al. Association between private equity acquisition of urology practices and physician Medicare payments. Urology. 2022 Sep 1;167:121-7.

32 Borsa A, et al. Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: systematic review. BMJ. 2023 Jul 19;382.

33 Kannan S, Bruch JD, Song Z. Changes in hospital adverse events and patient outcomes associated with private equity acquisition. JAMA. 2023 Dec 26;330(24):2365-75.

34 Bruch JD, et al. Workforce composition in private equity-acquired versus non-private equity-acquired physician practices. Health Affairs. 2023 Jan 1;42(1):121-9.

35 Cerullo M, et al. Financial impacts and operational implications of private equity acquisition of us hospitals. Health Affairs. 2022 Apr 1;41(4):523-30.

36 Nie J, et al. Access to urological care for Medicaid-insured patients at urology practices acquired by private equity firms. Urology. 2022 Jun 1;164:112-7.

37 Private Equity Stakeholder Project. Private equity healthcare bankruptcies are on the rise. Available at: https://pestakeholder.org/private-equity-healthcare-bankruptcies-are-on-the-rise/

38 Ayash B, Rastad M. Leveraged buyouts and financial distress. Finance Research Letters. 2021 Jan 1;38:101452.

39 Whoriskey P, Keating D. Overdoses, bedsores, and broken bones: what happened when a private equity firm sought profits in caring for society's most vulnerable. Washington Post. Nov 25, 2018. Available at: https://www.washingtonpost.com/business/economy/opioid-overdoses-bedsores-and-broken-bones-what-happened-when-a-private-equity-firm-sought-profits-in-caring-for-societys-most-vulnerable/2018/11/25/09089a4a-ed14-11e8-baac-2a674e91502b_story.html

40 Pomorski C. The death of Hahnemann Hospital. The New Yorker. May 31, 2021. Available at: https://www.newyorker.com/magazine/2021/06/07/the-death-of-hahnemann-hospital

41 Weisman R. Cerberus says its investment in Steward hospitals yielded an $800 million profit. Boston Globe. Apr 2, 2024. Available at: https://www.bostonglobe.com/2024/04/02/business/cerberus-capital-management-steward-health-care/

42 Schooley M, Hager C, Kaplan M. Steward Health Care files for Chapter 11 bankruptcy. CBS News. May 7, 2024. Available at: https://www.cbsnews.com/boston/news/steward-health-care-bankruptcy/

43 Massachusetts Health Policy Commission. Information about Material Change Notices/Cost and Market Impact Reviews. Available at: https://www.mass.gov/info-details/information-about-material-change-noticescost-and-market-impact-reviews

44 Batt R, Applebaum E, Nguyen QT. Pocketing money meant for kids: Private equity in autism services. Center for Economic and Policy Research. Jun 21, 2023. Available at: https://www.cepr.net/press-release/pocketing-money-meant-for-kids-private-equity-in-autism-services/

45 Ganski K. More dentists affiliating with DSOs. ADA News. Jun 1, 2023. Available at: https://adanews.ada.org/ada-news/2023/june/more-dentists-affiliating-with-dsos/

46 Private Equity Stakeholder Project. Deceptive marketing, Medicaid fraud, and unnecessary root canals on babies. Jul, 2021. Available at: https://pestakeholder.org/wp-content/uploads/2021/08/PESP_DSO_July2021.pdf

47 Moss DL, Valdes Viera O. The growth of private equity ownership in the home healthcare market. American Antitrust Institute, Americans for Financial Reform Education Fund. Jun 6, 2023. Available at: https://ourfinancialsecurity.org/wp-content/uploads/2023/06/AFFR_AAI_PE-Home-Health_Complete_6.6.23-1.pdf

48 See, e.g., HR 5648 and S 3022, Stop Wall Street Looting Act (introduced October 2021); HR 1754, Healthcare Ownership Transparency Act (introduced March 2023); Discussion Draft, Health Over Wealth Act (April 2024) available at https://www.markey.senate.gov/imo/media/doc/health_over_wealth_act.pdf

49 U.S. Department of Justice and the Federal Trade Commission. Merger guidelines. Available at: https://www.ftc.gov/system/files/ftc_gov/pdf/2023_merger_guidelines_final_12.18.2023.pdf

50 U.S. Federal Trade Commission. FTC challenges private equity firm's scheme to suppress competition in anesthesiology practices across Texas. Available at: https://litigationtracker.law.georgetown.edu/litigation/federal-trade-commission-v-u-s-anesthesia-partners-inc-et-al/

51 88 FR 80141, Medicare and Medicaid Programs; Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities and Nursing Facilities; Medicare Providers' and Suppliers' Disclosure of Private Equity Companies and Real Estate Investment Trusts. Available at: https://www.federalregister.gov/documents/2023/11/17/2023-25408/medicare-and-medicaid-programs-disclosures-of-ownership-and-additional-disclosable-parties

52 MGL CH 6D §11 and §12.

53 MGL Ch.6D § 13.

54 See, e.g., Nebraska (Neb. Rev. Stat. § 71-20,107), Oregon (HB 2362), and Rhode Island (23 RI Gen Laws §§ 23-17.14-7, 23-17.14-10). Additional states with approval, disapproval, and/or the power to apply conditions to transactions described at The Source on Healthcare Price & Competition at https://sourceonhealthcare.org/state-action/

55 Montague AD, et al. Considerations for state-imposed conditions on healthcare provider transactions. Frontiers in Public Health. 2023 Aug 16;11:1220624.

56 Office of Attorney General Peter F. Neronha. Attorney General imposes unprecedented conditions on hospital ownership change to ensure future operations. Jun 21, 2021. Available at: https://riag.ri.gov/press-releases/attorney-general-imposes-unprecedented-conditions-hospital-ownership-change-ensure

57 Declaration of Paul Keglevic, Chief Restructuring Officer of Envision Healthcare Corporation, In Support of the Debtor's' Chapter 11 Petitions. United States Bankruptcy Court for the Southern District of Texas Houston Division, May 15, 2023. Available at: https://www.courtlistener.com/docket/67385012/2/envision-healthcare-corporation/

58 Knauth D. Medical staffing co. says "surprise billing" ban hastened bankruptcy. Reuters. Sep 21, 2023. Available at: https://www.reuters.com/legal/litigation/medical-staffing-co-says-surprise-billing-ban-hastened-bankruptcy-2023-09-21/

59 See, e.g., Seifert, R. Americans for Financial Reform and Education Fund Report: Doctored by Wall Street: Policy Solutions for Private Equity in Healthcare (June 2023); Antitrust Institute, citing to Cooper, Z., Scott Morton, F., & Shekita, N. (2020). Surprise! Out-of-Network Billing for Emergency Care in the United States. Journal of Political Economy, 128(9), 3626–3677. https://doi.org/10.1086/708819.

60 Massachusetts Health Policy Commission. 2023 Annual Cost Trends Report. Sep 2023. Available at: https://www.mass.gov/info-details/annual-cost-trends-report