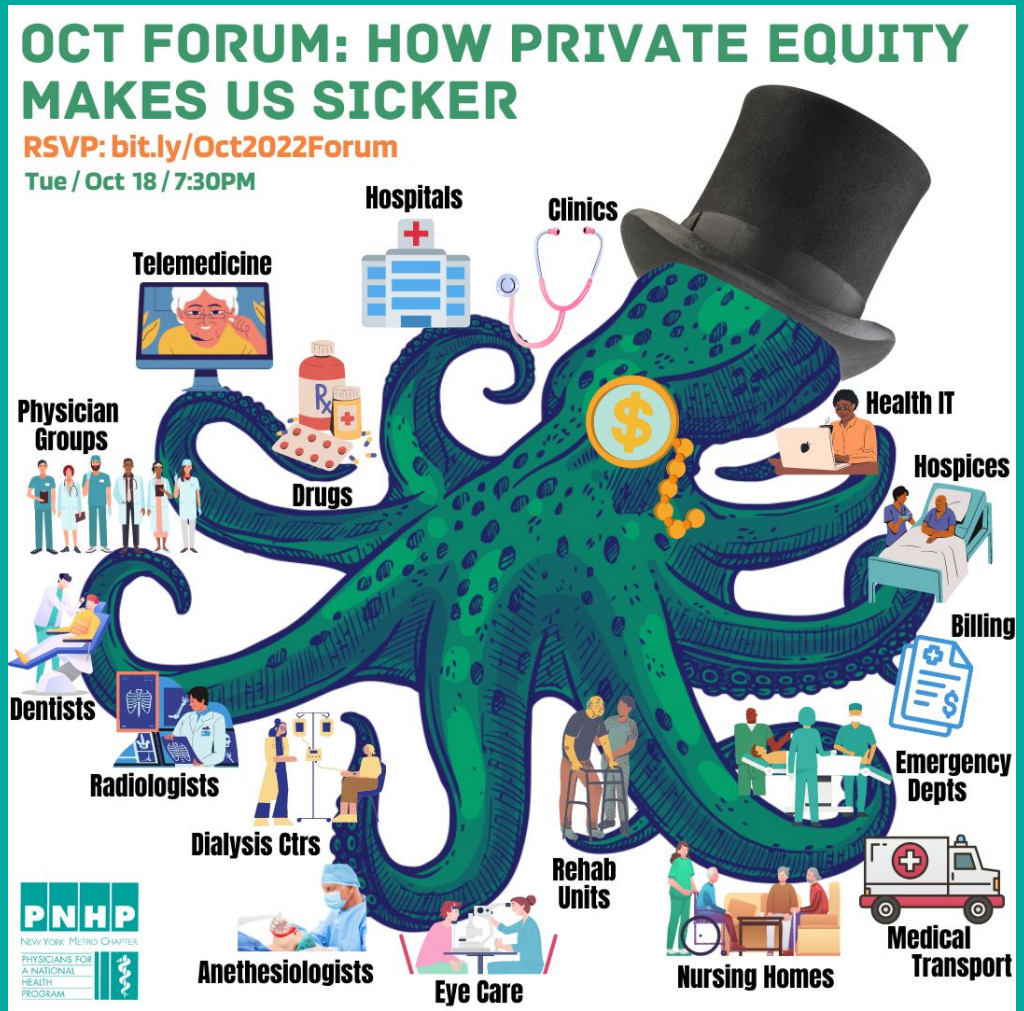


We are giving folks a few minutes to join.

To ask questions:

- Q+A Function
- PNHPQuestions@gmail.com
- Facebook @PNHPNYMetro
- Twitter @PNHPNYMetro

PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM — NEW YORK METRO CHAPTER

LONG TERM CARE COMMUNITY COALITION

TAKE MEDICINE BACK

CEPR CENTER FOR ECONOMIC AND POLICY RESEARCH

PRIVATE EQUITY STAKEHOLDER PROJECT

AFR EF Americans for Financial Reform Education Fund

AMERICAN ECONOMIC LIBERTIES PROJECT

ILR Worker Institute

ZOOM MEETING FEATURES

- We are recording!
- Please use Chat for intros and monitor for resources
- Closed Captions available in toolbar
- Ask questions for the presenters in the chat or email PNHPQuestions@gmail.com for our Q&A!
- Amplify on social media - tag us @PNHPNYMetro

LAND ACKNOWLEDGEMENT native-la.ca

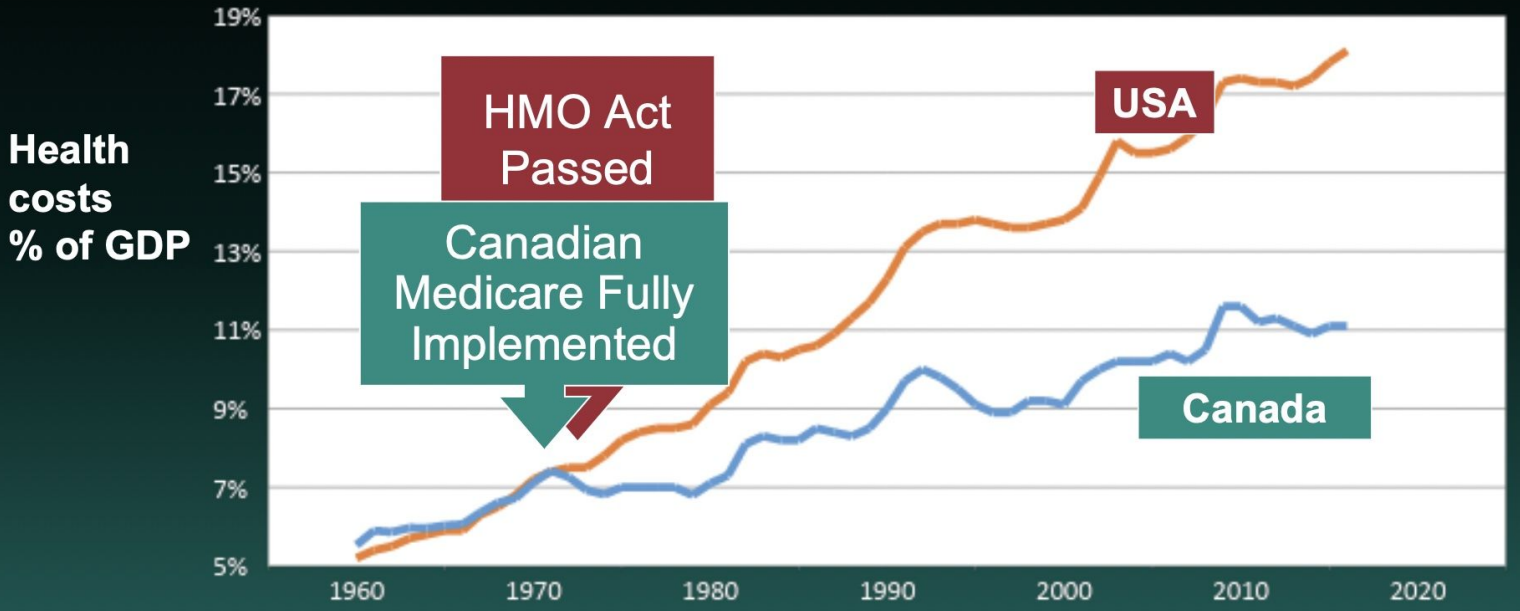
The land on which we are based is the occupied and unceded territory of the Wappinger, Munsee Lenape, Canarsie, and Rockaway peoples.

PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM NEW YORK METRO CHAPTER

How Private Equity Makes US Sicker

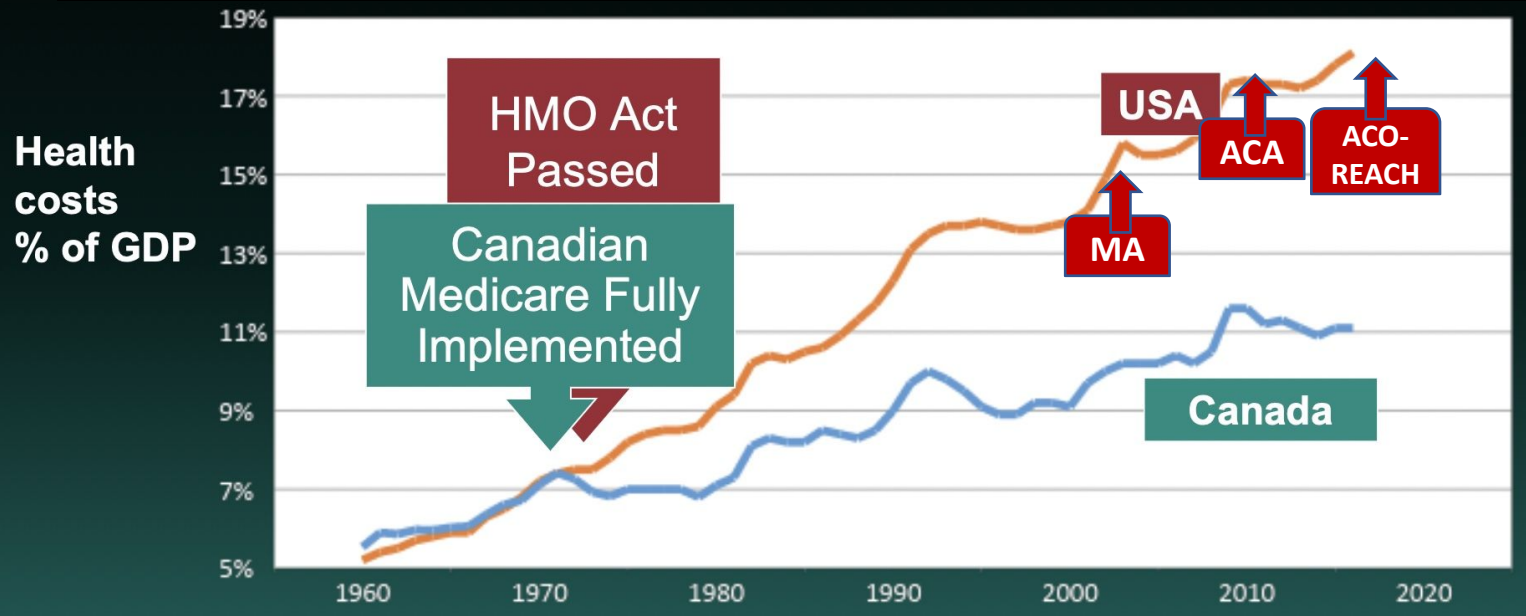
- Rosemary Batt, Ph.D.— Private Equity in Healthcare
- Robert McNamara, M.D., MAAEM — PE: A Danger to Patients & Caregivers
- Richard Mollot, J.D. — Impact on Nursing Home Residents & Families
- Calls To Action
- Q&A

The Grand Experiment:
Canada implements Single Payer, U.S. Passes the (for-profit) HMO Act
Outcome 1: Canada cuts spending growth compared to U.S.



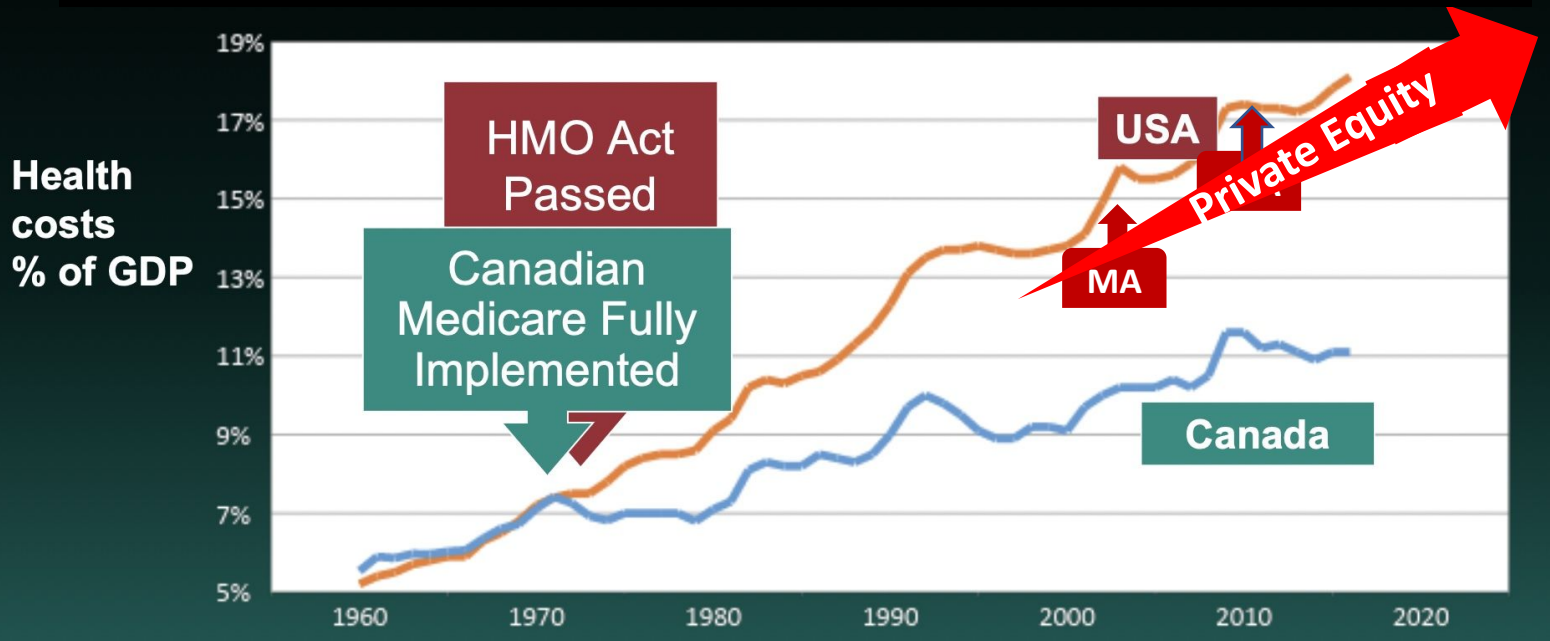
Sources: Statistics Canada, Canadian Inst. for Health Inf., and NCHS/Commerce Dept.

Privatization Continues:
Medicare Advantage & Affordable Care Act



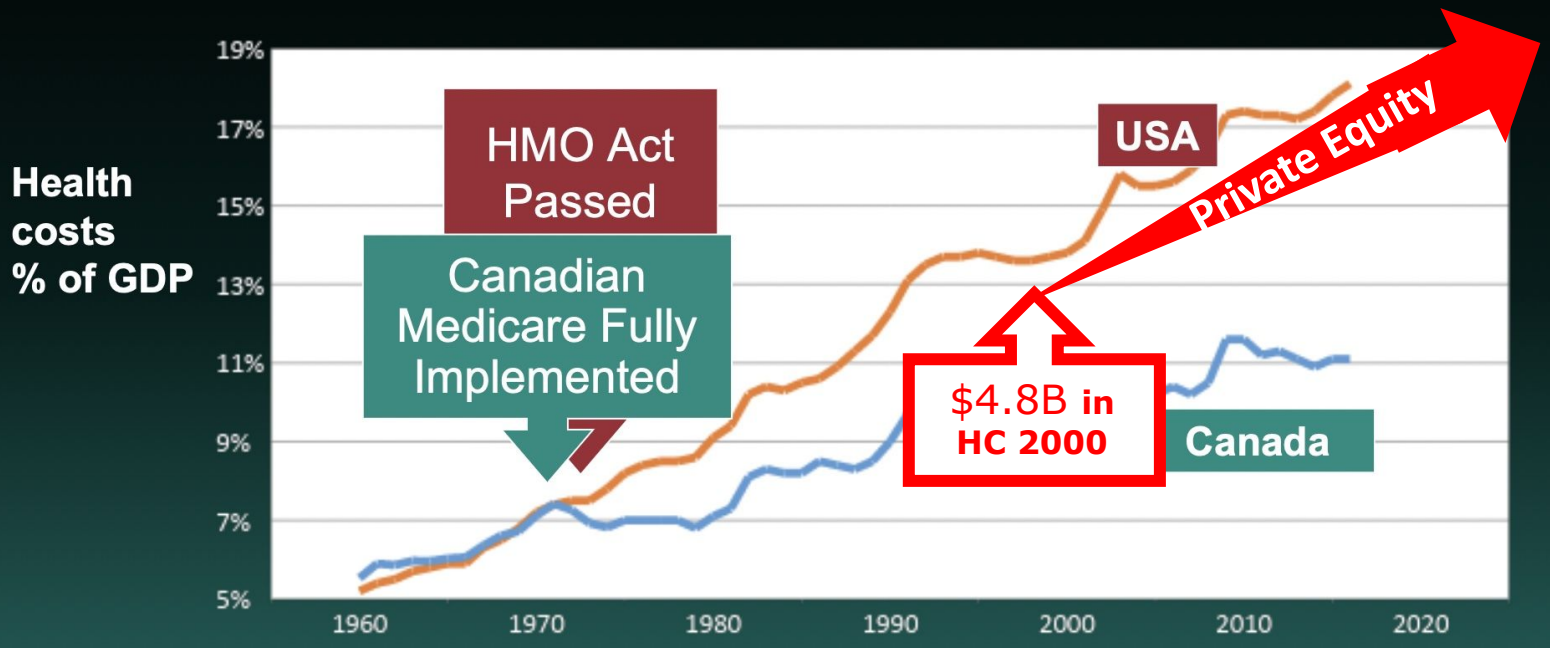
Sources: Statistics Canada, Canadian Inst. for Health Inf., and NCHS/Commerce Dept.

Privatization Continues:
Private Equity Targets Healthcare



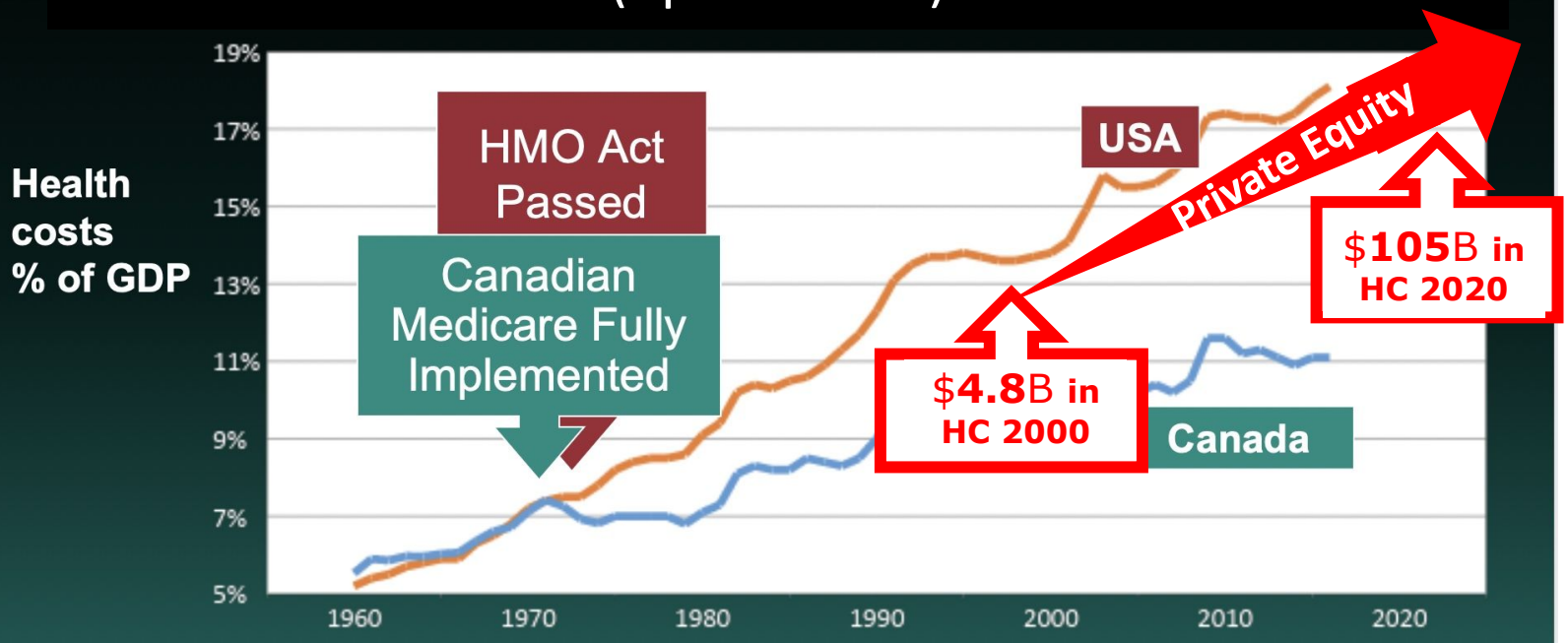
Sources: Statistics Canada, Canadian Inst. for Health Inf., and NCHS/Commerce Dept.

2000: Private Equity invested $4,800,000,000



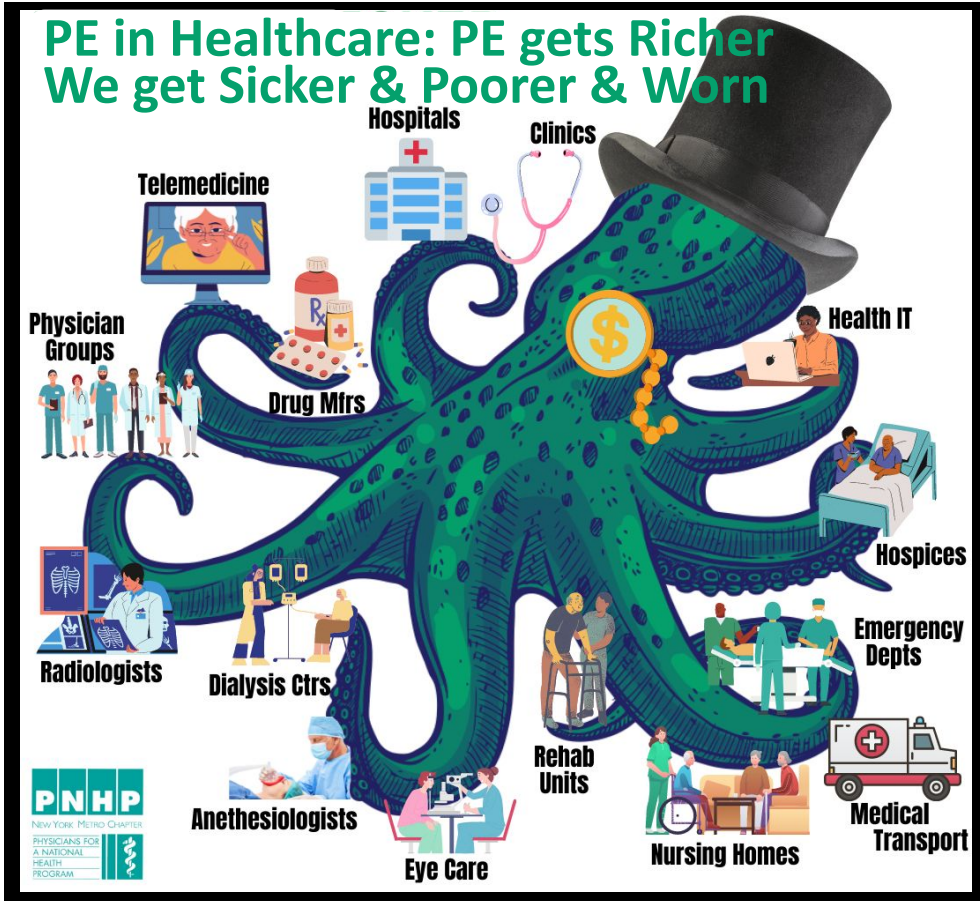
Sources: Statistics Canada, Canadian Inst. for Health Inf., and NCHS/Commerce Dept.

2020: Private Equity invested $105,000,000,000 (up 25 times)



Sources: Statistics Canada, Canadian Inst. for Health Inf., and NCHS/Commerce Dept.

PE in the US Economy — Storied Brands we loved: Gone



2000-2020

$833B & 7300

Deals:

Extracting money

No regulatory oversight

A veil of secrecy

Anesthesiologists	Clinics
Behavioral Health	Dentists
Emergency Depts	Dialysis
Medical Transport	Drug Mfrs
Nursing Homes	Hospices
Radiologists	Eye Care
PACE Programs	Health IT
Physician Groups	Hospitals
Troubled Teens	Maternity
Telemedicine	Rehab Units

How Private Equity Makes US Sicker

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Private Equity in Health Care: Profits vs. People

Rosemary Batt (ILR School, Cornell University)
Eileen Appelbaum (Center for Economic & Policy Research)

Presentation to the Physicians for a National Health Program

October 18, 2022

Private equity in healthcare: Why it matters

It is the most extreme form of shareholder capitalism

- PE creates a **private** investment fund and promises its investors ‘outsized returns’ -- that *substantially* ‘beat the stock market’
- To provide ‘outsized returns,’ it buys up healthcare providers to extract wealth -- not to provide healthcare services
- How does it extract outsized returns? Cuts staffing, supplies, services; reduces service access; sells assets; uses monopoly power to charge higher rates
- It has penetrated virtually every healthcare segment - -- hospitals, physician’s practices, nursing homes, outpatient care
- It is almost completely unregulated

How does private equity change healthcare?

It turns healthcare from a social good into a financial asset

Lego chips to be bought and sold

Before

After

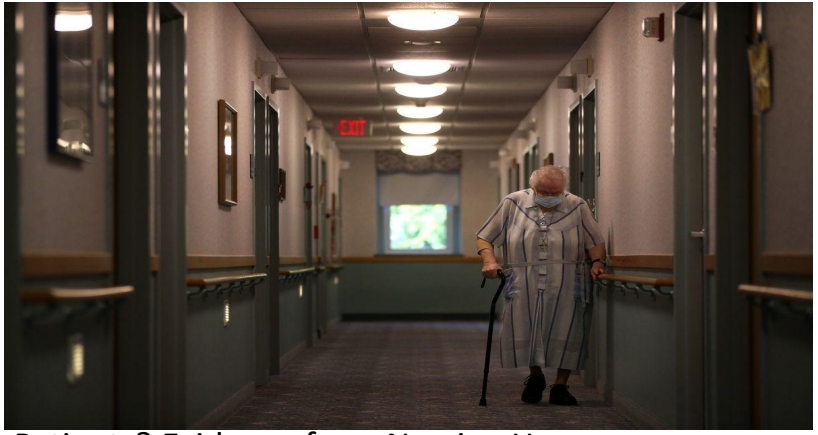
- It extracts wealth through financial strategies –
- Not by providing healthcare services

Who pays the costs of private equity actions?

Healthcare providers, patients, workers, communities

Nursing home case example

- Mortality rates in PE-owned nursing homes were 10 % higher than the overall average
- But Medicare billing was 11% higher
- Frontline nurses spent fewer hours with patients
- The homes made 50% greater use of antipsychotic drugs (drugs associated with higher mortality rates)

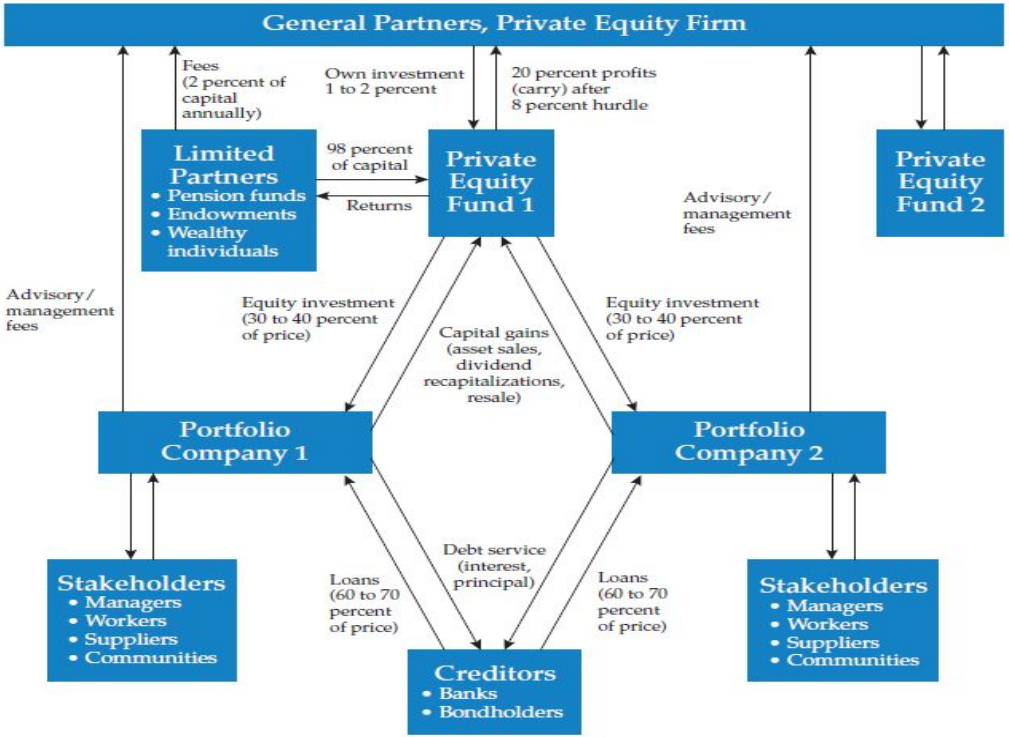


Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes
A. Gupta et al. (U. of Chicago, Becker Friedman Institute for Economics Wkg Paper No. 2021-20

Why the negative outcomes?
The private equity business model

PE firm level business model: Conglomerate

Figure 1.1 The Structure of Private Equity: Firms, Funds, and Portfolio Companies

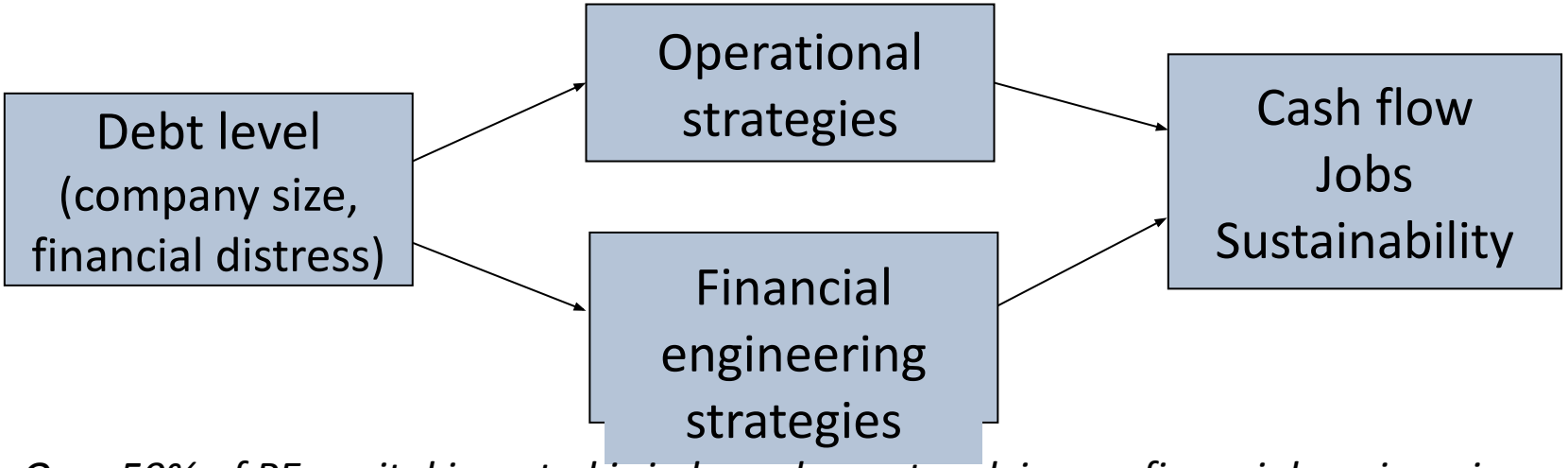


Source: Adapted from Watt 2008.

Source:
Appelbaum & Batt 2014.
Private Equity at Work

How finance drives strategy & outcomes

Capital structure Strategy Enterprise outcomes



Over 50% of PE capital invested is in large buyouts relying on financial engineering

Source: Appelbaum & Batt 2014. *Private Equity at Work*

Financial engineering: Portfolio company level

- Excessive use of debt to buy out provider
  - Loads debt on provider reduces taxes, increases bankruptcy risk
  - Forces cost cutting to service debt, short staffing & supplies

- Excessive portfolio company fees (transaction, advisory services)

- Dividend recapitalizations
  - Takes out more loans, load on providers to pay dividends to PE
  - Junk bond status, Higher interest for portfolio company

Financial engineering: Portfolio company level

- ‘Sale-leaseback’ deals
  - Sells off property proceeds to pay dividends to PE
  - Providers saddled with long-term inflated rents with annual escalators on property once owned

- Monopoly power
  - Targets markets with potential for monopoly power
  - Buys more providers to create large chain (anti-trust issues)
  - Buyouts in healthcare below anti-trust oversight threshold of $200M in 2022 (Hart-Scott-Rodino threshold)
  - Responsible for 45% of M&A activity in healthcare

How are PE & For-profit corporations different?

	Private Equity	For-Profit Corporations
Capital structure	70% debt/ 30% equity	30% debt/ 70% equity
Regulatory oversight	Very low to none	High
Transparency	Very low to none	Higher
Accountability	Very low to none	Higher
Risk taking	High	Low

How are PE & For-profit corporations different?

	Private Equity	For-Profit Corporations
Asset sales used for investor dividends	Frequent	Rare
Debt used for dividends	Frequent	Rare
Fees paid by HC enterprise	Large	None
Taxes	Low capital gains rate	Corporate income rate
Reputational risks	Little to none	High

How does PE make money in healthcare?

Case examples & outcomes

Sequel Youth and Family Services

- Provides residential treatment centers; autism and mental health programs for children and youth
- Operates 40 facilities in 15 states
- 2010: Bought out by private equity firm Levin Leichtman
- 2013: Sold to second PE firm Alaris Royalty
- 2016: Alaris does 'dividend recapitalization' worth $175 million
- 2017: Sold to 3rd PE firm, Altamont Capital

- How does it make money?
  - 100% funded by Medicaid and Medicare: Charges $250-$800 per day per child
  - "We get paid, on time, and it's government money and there's plenty of it and that's what makes this the ideal business to invest in," according to the owner
  - Uses sophisticated marketing to states to recruit children
  - When state finds violations, closes facility and moves elsewhere

Sequel Youth and Family Services: Outcomes

Impact on healthcare staff

- Hires unqualified, low-cost labor, no background checks; Low staff/patient ratios ("You can make money in this business if you control staffing," owner reports)
- Willfully fails to report patient abuses to the authorities (Psychcrime.org, 2022)

Impact on children: "A profitable death trap" *(NBC News 2020)*

- Patient Rts Groups & State Investigations found widespread abuse in 18 states.
- Foster children moved to out-of-state facilities around the country
- Verbal, mental, & sexual abuse; Improper restraints
- Rampant violence, little or no supervision
- In one death: ".. Connor was horrifically brutalized sexually, physically, and emotionally by other residents"

Several states have cancelled Sequel contracts, but it still operates in 17 states

Hospitals: Steward Healthcare – Selling Real Estate to Pay Dividends

- 2011
  - Cerberus Capital buys 6 Massachusetts Catholic hospitals (Caritas)
- 2011-15
  - Complies with Mass. AG agreement
- 2016: Sale-leaseback
  - Cerberus sells hospital property for $1.25 billion
  - Cerberus takes > $500 million for private equity dividends
  - Hospitals saddled with long-term leases on property they used to own
  - Their leases have 3% annual escalator clauses

Source: Lafrance, Batt & Appelbaum 2021

Hospitals: Steward Healthcare – Selling Real Estate to Pay Dividends

- 2016-19
  - Steward launches national buying spree financed by REIT
  - 33 hospitals, most via horse trading with other PE owned chains
- 2019
  - Steward found to be worst performing system in MA; Highest debt
  - Higher than average patient falls, infections, & patient readmissions
  - Investigation finds vendor non-payment, understaffing, doctors constrained
- 2020
  - Cerberus exits Steward; sells debt ridden chain to doctors
- 2021 Cerberus pure profit = $700 million

Source: Lafrance, Batt, & Appelbaum 2021

Hospitals: Prospect Medical -- Raiding Safety-Net Chains

- 2011-19: PE firm Leonard Greene buys 20 *safety net hospitals*
- Used extensive debt, cut costs, cut labor, stripped real estate
- Collected $658 million in dividends/ fees despite telling regulators it wouldn't
- Received over $300 million in CARES Act Relief in 2020-2021
- RI AG sets conditions for Prospect Medical Conversion 9/21
  https://www.cga.ct.gov/INS/related/20210924_2021%20Consolidation,%20Private%20Equity%20and%20Drug%20Prices%20in%20Health%20Care%20Cost/Rhode%20Island%20Attorney%20General%20Presentation%20on%20HCA.pdf
- Senate oversight hearing 10/21

Source:
https://pestakeholder.org/after-paying-658-million-in-dividends-and-fees-to-investors-prospect-medical-holdings-received-283-million-in-federal-covid-19-aid/

Hospital Emergency Services – Surprise Billing

Emergency Room Staffing Companies

- Envision (KKR) and TeamHealth (Blackstone)
- Employ 90,000 HC employees
- Control 40% of national ER market
- Leaders in surprise medical billing
- 2020: PE spends millions lobbying against Ban on Surprise Billing
- 2021: CA doctors fill suit against Envision for violation of Corporate Practice of Medicine
  https://www.nbcnews.com/health/health-news/doctors-sue-envision-healthcare-say-private-equity-backed-firm-shouldn-rcna9276
- 2022: Ban on surprise bills takes effect Envision can't pay debt
- 2022: Leaders in litigation challenging surprise billing arbitration rulings

Source: Appelbaum & Batt 2020.

Hospital Emergency Services – Surprise Billing

Emergency Air Ambulances

- 2 PE-owned carriers control 65% of US market
- Had average charges/ride of $48,250
- Not covered by ban on surprise medical bills
- Particularly affects rural towns where hospitals have closed

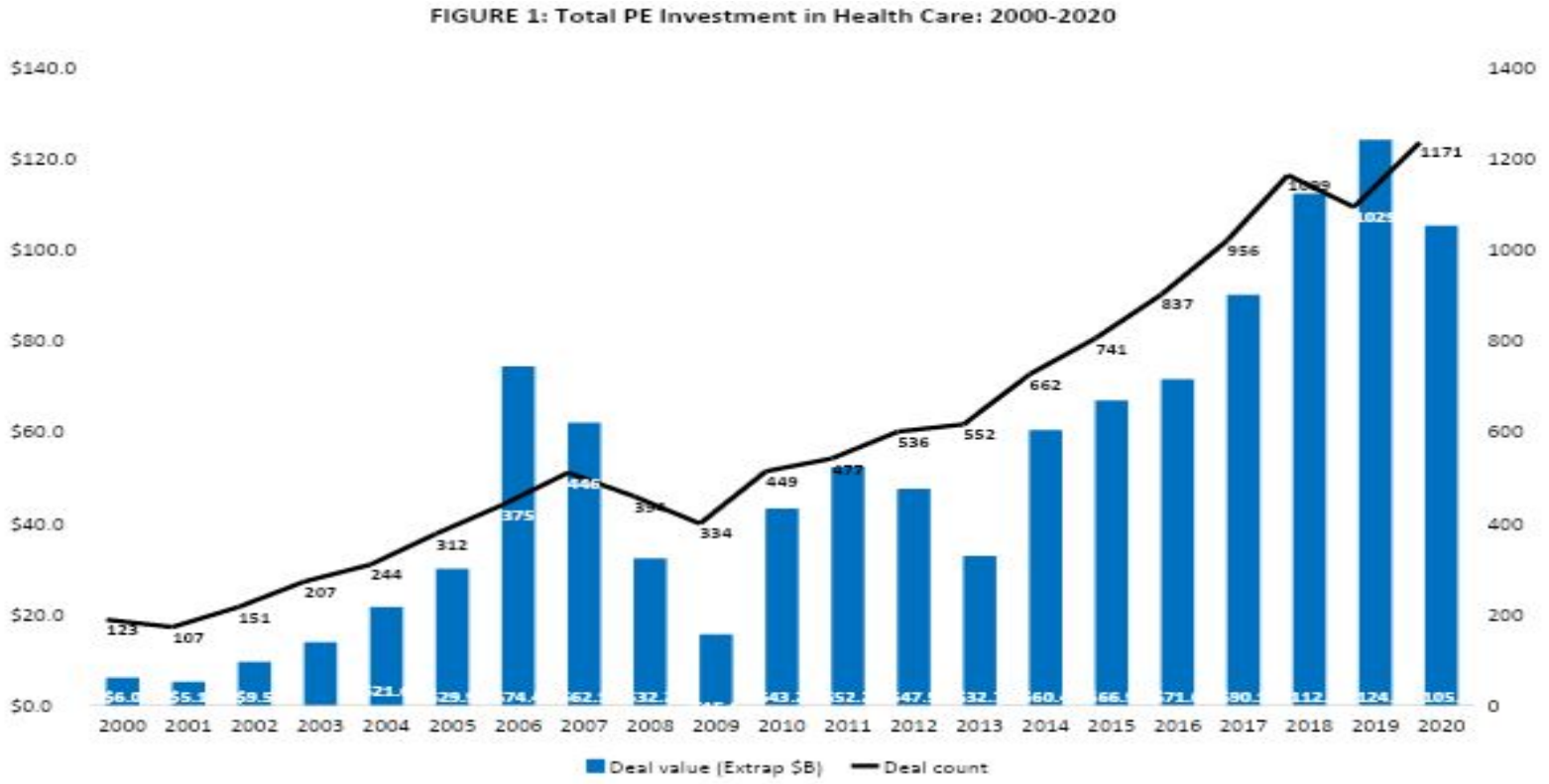
Global Medical Response

AirMethods

Source: Appelbaum & Batt 2020.

Growth of private equity in health care

Private Equity in HC: 2000-2020: 25-fold increase in 20 years



Source:
https://cepr.net/report/working-paper-financialization-in-health-care-the-transformation-of-us-hospital-systems/

Why does private equity invest in healthcare?

- Market opportunities
  - Market is fragmented -- > Opportunities for consolidation, market power
  - Market demand rising, aging baby boomers
  - ACA increased insurance, patient volume
  - Demand for niche services growing (outpatient care, behavioral health, homecare, hospice)
  - Third payer guaranteed payment system (government = about 50%)

- Supply side push
  - Financial pressures healthcare management cutting costs
  - Hospitals outsourcing services (ER, IT, rehabilitation, elective surgery)
  - Doctors “don’t want to do paper work”

Conclusions: Why PE ownership matters in healthcare

- PE shifts the primary goal from serving patients to extracting wealth for ‘outsized’ returns in short time frame
- Leveraged debt, property sell-off, dividend recapitalizations undermine providers’ financial stability, employment stability, patient care
- Targets are hospitals, nursing homes, outpatient, physician specialties
- ‘Hot markets’ are mental health, hospice, homecare
- Macro effects
  - Wealth extraction at taxpayers’ expense
  - Fragmentation of local healthcare systems
  - Strategies (debt, tax evasion, etc.) spread to mainstream organizations

Regulating private equity

Smart regulation

General regulation

- Increase transparency
- Limit leverage to limit risk to workers, creditors, others
- Discourage financial engineering
- Close tax loopholes: Tax carried interest as ordinary income
- Hold PE firms and funds accountable as employers
- Update employment, bankruptcy, & pension laws (WARN Act, 363 bankruptcies, ERISA)

Healthcare specific regulation

- State oversight over non-profit to for-profit conversions
- Anti-trust enforcement
- False Claims Act
- Corporate Practice of Medicine Law enforcement

How Private Equity Makes US Sicker

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  Alice Hanson Professor of Women and Work, ILR School, Cornell University

- **Robert McNamara, M.D., MAAEM**
  — PE: A Danger to Patients & Caregivers —
  Chairman of Emergency Medicine at Temple University Hospital, a leader of TakeMedicineBack, Past President of the American Academy of Emergency Medicine (AAEM)

- **Richard Mollot, J.D. — Impact on Nursing Home Residents & Families**

- **Calls To Action**
- **Q&A**

Private equity in Medicine
A danger to patients and caregivers

Robert McNamara, MD, MAAEM

Past President, CMO of the AAEM Physician Group

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AMERICAN ACADEMY OF EMERGENCY MEDICINE

Why an EM physician is on the panel

- Our specialty opened the door to PE
- EM Physician “leaders” abetted this
- We are also leading the fight against it
  - AAEM
  - TakeMedicineBack
  - Active litigation

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AMERICAN ACADEMY OF EMERGENCY MEDICINE

Envision (EmCare)

- EmCare sold to Laidlaw in 1996, lay owners
  - Leonard Riggs MD, 1980 ACEP President
- Laidlaw sells to PE: Onex 2004
- Merge with AmSurg 2017
- Acquired by KKR 2018 $9.9 Billion

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AMERICAN ACADEMY OF EMERGENCY MEDICINE

Current state of EM

- Controlled by Private Equity
  - Team Health, Envision, Schumacher
- Private equity has major stake and likely control
  - USACS, Apollo, APP
- Estimates >40% controlled by CMGs

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AMERICAN ACADEMY OF EMERGENCY MEDICINE

Profits over patients

- PE seeks short term high profits for investors
- Physicians swear an oath to put the patient first
- PE core methods can cause harm
  - Maximizing revenue
  - Minimizing expenses

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PE issues in Medicine

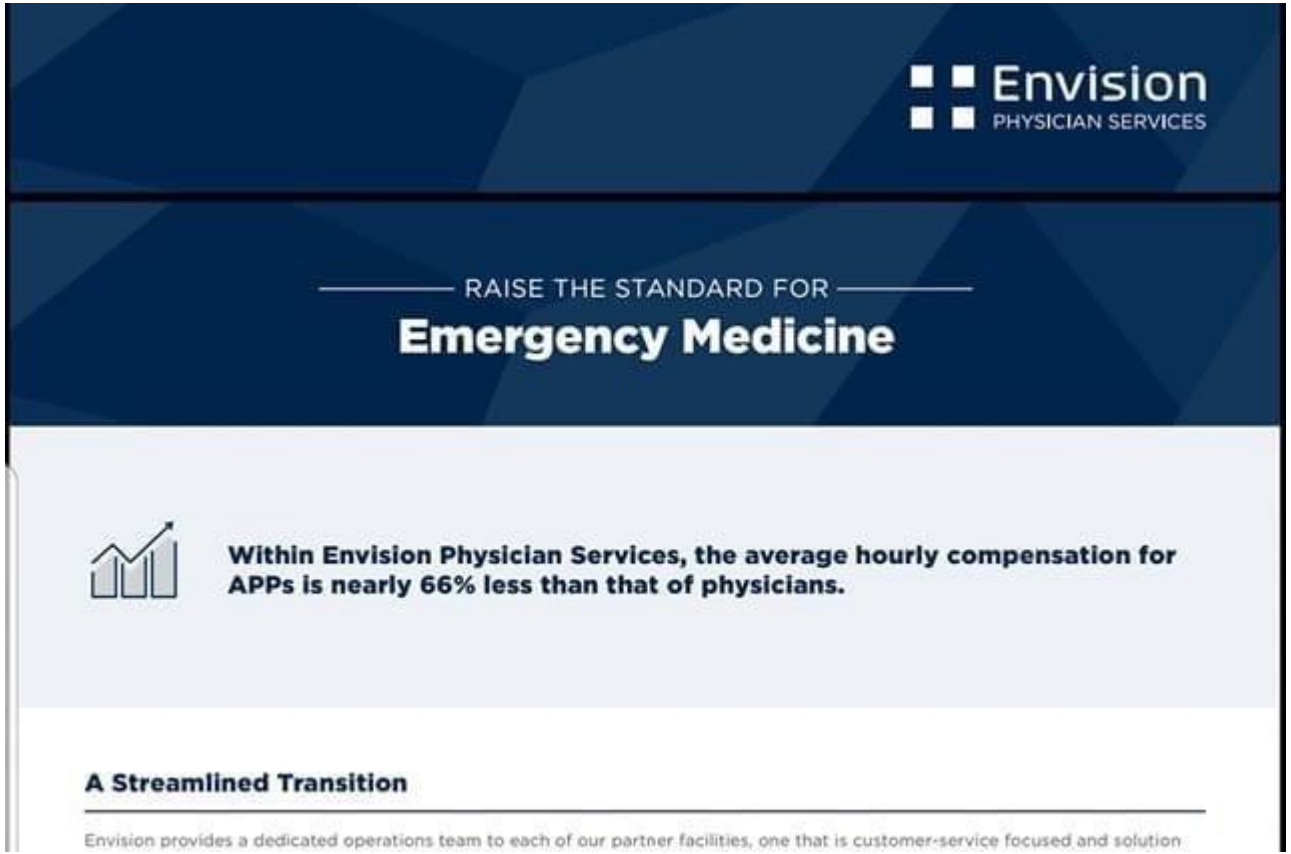
Revenue side

- Maximize charges
- Pursue the patients: TeamHealth sued the poor in TN
- Pressure the caregivers
  - Patients per hour/test ordering/metrics, charting
- “Surprise billing” crisis
  - An EM business strategy: Cooper’s research

PE issues in Medicine

Expense side

- Minimize staffing
- Replace “expensive” staff: #1 = BC physician
  - Non-physician providers
  - Eliminate “costly” senior physicians
  - Use non-specialists
- Create unsafe arrangements
  - Notional supervision



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envisionphysicianservices.com Done

Leveraging Your Available Talent Pool:

- Employ **the least expensive resource** to accomplish the mission.
- **APPs** - In many EDs, up to 25-35% of the cases can often be effectively and successfully seen independently by APPs.
- **Family practitioners or internists** can see up to 75% or more of the cases that emergency physicians see in some EDs (for a lower staffing cost…).
- Optimize your use of **scribes and techs**
- **SOPs and advanced treatment protocols,** developed and implemented with nursing's participation, can drive efficiency and reduce variation .
- On average, the use of **residents** in the ED is only a net gain when you are using senior-level residents (final year). In general, new residents only add complexity and slowness to the EM clinician's day.

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PE issues in Medicine

- Physicians cannot speak on behalf of the patient
  - Can be fired at will, no due process
  - McNamara RM. J Emerg Med 2013: 111-6
  - Hospital administrators like this power over docs
- EM “Heroes” fired during the pandemic

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PE issues in Medicine

- Physician burn out: EM is #1
- EM is a difficult specialty, one cannot survive long term if they feel taken advantage of
- The burned out doc is not giving the best care
  - It affects the patients
  - It affects the physician and their family

Fighting back: AAEMPG vs Envision

- CPOM: “A business cannot employ a physician”
- Most states have some form
  - CA suit, where strong prohibitions exist
- Envision uses a sham PA/PC structure
  - Paper owners
  - Brovont vs Envision: 1 doc “owned” 300 practices

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Fighting back

- Investigative Reporters shining the light
- FTC/DOJ
  - Investigation of US Anesthesia Partners
- State Attorney Generals and Boards of Medicine
- Legislative efforts
  - Rep. Bill Pascrell, D-New Jersey, chair of the House Ways and Means Committee's Subcommittee on Oversight calls out HCA/Envision

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“Private Equity cannot be an accepted part of Medicine”

Thanks for your attention

Contact the AAEM at info@aaem.org or (800) 884-2236

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- **Calls To Action**
- **Q&A**

Private Investment's Impact on Nursing Home Residents & Families

Richard Mollot

Long Term Care Community Coalition

October 18, 2022

www.nursinghome411.org

The Long Term Care Community Coalition

- **LTCCC**: Nonprofit, nonpartisan organization dedicated to improving care & quality of life for the elderly & adult disabled in long-term care (LTC).
- **Our focus**: People who live in nursing homes & assisted living.
- **What we do**:
  - Policy analysis and systems advocacy;
  - Data collection, analysis, and reporting;
  - Education of consumers and families, LTC Ombudsmen, and other stakeholders.
- **Richard Mollot**: Executive Director
- **Website**: www.nursinghome411.org.

Outline of my discussion

How the nursing home system works… or doesn't.

Myths vs. realities of nursing home financing & accountability.

Resources to support better care & program integrity

The Nursing Home Reform Law

- The law passed in 1987.
- ***Every*** nursing home that participates in Medicaid/Medicare agrees to meet or exceed the standards laid out in the Reform Law and its implementing regulations.
- Participation in Medicaid/Medicare is voluntary. Nursing homes that do not wish to meet these standards are free to run private facilities.

The Nursing Home Reform Law

- The federal law requires that every nursing home resident is provided the care and quality of life services sufficient to attain and maintain their highest practicable physical, emotional, & psycho-social well-being.
- The law emphasizes individualized, patient-centered care.
- Importantly, the law lays out specific resident rights, from good care and monitoring to a quality of life that maximizes choice, dignity, & autonomy.
- "Effective" infection control and sufficient staffing have been required since the beginning.

The Nursing Home Reform Law

Question: If the law and standards are so strong, why aren't nursing homes decent and safe places to live and work?

Answer: Laws and standards can only make a difference if they are enforced.

The Problem(s)

Federal data, our studies, and countless federal reports indicate that baseline requirements are largely unenforced.

Long-term care continues to be understaffed, poorly regulated and vulnerable to predation by for-profit conglomerates and private-equity firms.

E. Tammy Kim, “This Is Why Nursing Homes Failed So Badly,” The New York Times (Dec. 31, 2020)

- Over the years, the nursing home industry has become increasingly sophisticated and opaque.

- These mechanisms were originally employed as a means to escape legal and financial accountability for death and suffering caused by substandard care.

- In addition, 75% of nursing homes use related-party transactions, a mechanism that can be used to hide profits and funnel money away from resident care.*

*Rau, Jordan, "Care Suffers as More Nursing Homes Feed Money Into Corporate Webs," *The New York Times* (January 2, 2018). https://www.nytimes.com/2018/01/02/business/nursing-homes-care-corporate.html

In the absence of meaningful enforcement, nursing home operators can largely provide any level of staffing and any quality of care & quality of life services that they choose.

Example: Staffing

The typical resident needs at least 4.1 hours per day (HPRD) of nursing care just to meet clinical needs

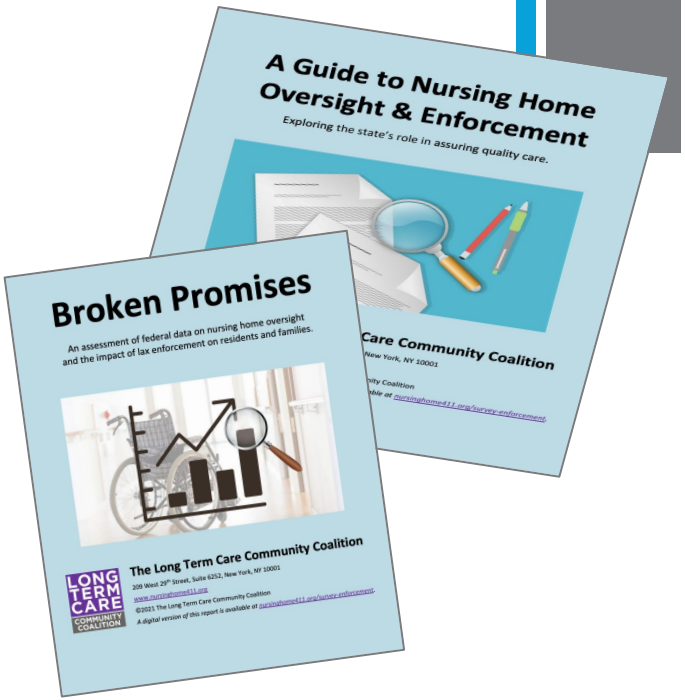
The average nursing home provides 3.62 HPRD

Though short staffing is pervasive, it is rarely cited and almost never identified by surveyors as harmful to residents

As a result, there are virtually no financial penalties for short staffing.

LTCCC's 2021 Project

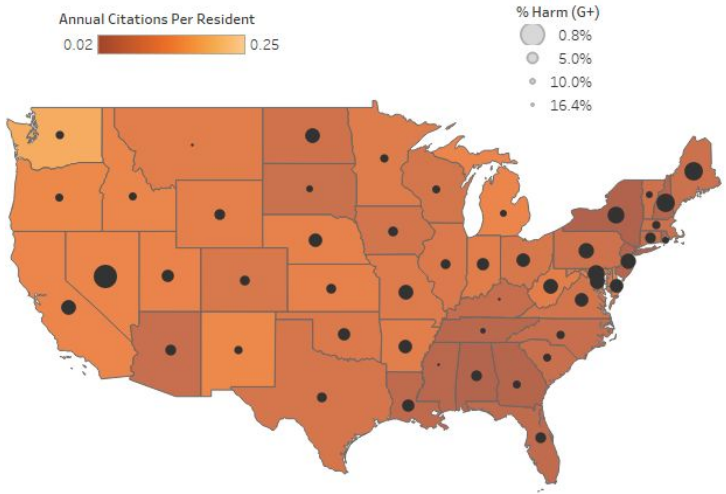
- What can we **expect from those responsible** for ensuring that nursing home residents are safe and treated with dignity?
- To what extent are **requirements for nursing homes – and the agencies responsible for overseeing them – being realized** in the lives of nursing home residents?



This study was conducted with the generous support of **The New York Community Trust**. To view or download, visit **https://nursinghome411.org/survey-enforcement/**

Summary of findings

- **States do a poor job identifying substandard care, abuse, and neglect.**
- **Harm (G or above) citations are rare.** Of the 290,000 citations, 5.0% were categorized as Harm. 1.8% were categorized as Immediate Jeopardy (J or above).
- **Citations by Category**
  - Infection Prevention & Control (F880) citations accounted for 7.8% of all deficiencies.
  - Antipsychotics (F758), Pressure Ulcers (F686), and Resident Rights (F550) each accounted for roughly 2%.
  - Sufficient Staffing (F725) accounted for 1%.
  - Quality of Life (F675) accounted for 0.1%.



Darker □ lower citation rate.

Larger circles □ lower % of Harm citations.

Myth

Nursing homes are underpaid

Myth: Nursing home payment is insufficient to provide good care.

Reality: Most nursing homes are run for-profit and are seen as attractive investments.

- The industry's longstanding argument that it does not get paid enough to provide sufficient staffing, baseline infection control protocols, etc… is unsubstantiated.
- In fact, nursing homes are increasingly operated by for-profit entities.
- Private equity and REITs have increasing, substantial investment in the sector.
- There are virtually no limitations on the use of public funds to pay for administrative staff or siphon off into profits.
- As noted above, operators commonly use related party transactions to hide profits (and perpetuate the myth of "razor-thin margins").

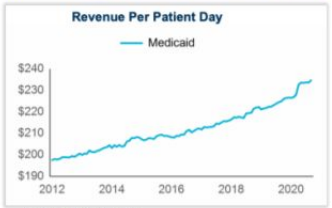
Medicaid Funding

LTCCC POLICY BRIEF

NURSING HOME MEDICAID FUNDING: SEPARATING FACT FROM FICTION

Background. Medicaid is the primary funding source for the majority of nursing home services in the US. Managed by states using a mix of state and federal funding, Medicaid covers more than 60% of residents nationwide. Each state has broad flexibility to determine eligibility standards and payment methods and design reimbursement rates.

Industry Claims vs. Facts. Nursing home providers and trade associations claim that Medicaid rates are inadequate and less than the cost of actual care, which then leads providers to leverage other payor sources, such as Medicare and private pay. The industry also blames low Medicaid rates for substandard care. However, recent studies suggest that for-profit facilities have maximized profits for owners and investors while skimping on resident care.



Source: NIC MAP Data Service

- Medicaid rates have steadily increased in the past decade, rising 12.6% since 2012, according to the National Investment Center for Seniors Housing & Care (NIC)
- Nursing homes received an average of $214 per resident per day in Medicaid funding in 2019, a 2.2% increase from 2018
- An NIC report with data through September 2020 shows a national average reimbursement rate of $235, though this $21 increase from 2019 is likely a COVID-related boost
- Although industry leaders claim that nursing homes are losing money on Medicaid residents and blame closures and financial struggles on low reimbursement rates, typical nursing home profits are in the 3 to 4 percent range, according to Bill Ulrich, a nursing home financial consultant
- In fact, most nursing homes "outsource a wide variety of goods and services to companies in which they have a financial interest or that they control." This practice, called related-party transactions, can be used to "siphon off higher profits, which are not recorded on the nursing home's accounts," giving the false impression that a nursing home has low profits or is losing

One Penn Plaza, Suite 6252, New York, NY 10119 | P: 212-385-0355 | E: info@ltccc.org
www.NursingHome411.org

Medicaid rates have steadily increased in the past decade…

nursinghome411.org/ltc-medicaid-funding/

Medicare Funding

According to the Medicare Payment Advisory Commission…

- The marginal profit from Medicare nursing home patients in 2020 was about 16.5%.
- The average Medicare profit margin has been above 10% for over 20 years.

Unfortunately, the focus of Medicare rate setting has been almost entirely on controlling costs rather than ensuring quality. Medicare prospective payments are based on estimated costs and not on actual expenditures. This system allows nursing homes to keep staffing and operating expenses low in order to maximize profits.

* Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy,* March 2022.

NOTE: These profit margins do not take into account profits hidden in administrative costs or related-party transactions.

Funding is NOT the Problem

OIG: *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries*

- OIG found that **one-third of residents who were in a nursing home for short-term care were harmed** w/in an average of 15.5 days.
- **Almost 60 percent of the injuries were preventable and attributable to poor care**.
- Much of the **preventable harm was due to substandard care**, inadequate resident monitoring, and failure or delay of necessary care.
- As a result, six percent of those who were harmed died, and more than half were rehospitalized.
- "Because many of the events that we identified were preventable, our study confirms the need and opportunity for SNFs to significantly reduce the incidence of resident harm events."

Even when profits are high, nursing homes fail to provide adequate care, safety, or treat residents humanely.

Recommendations

Ownership Transparency & Accountability

Increase ownership reporting for private companies including the parent, property, management, and all related-party organizations/entities

Establish & implement

- Minimum criteria for NH ownership & management
- Transparency in ownership reporting and audit reports
- Prevent disreputable owners from buying, owning, or managing facilities
- Conduct oversight of chains, not just individual facilities
- Surety bonds

Recommendations

Set Direct Care Spending Requirements & Limit Administration Profits

Direct care legislation was enacted in NJ, MA, and NY in 2020-21

NY requires 70% of reimbursement be spent on resident care with 40% on direct care staff and a 5% limit on profits

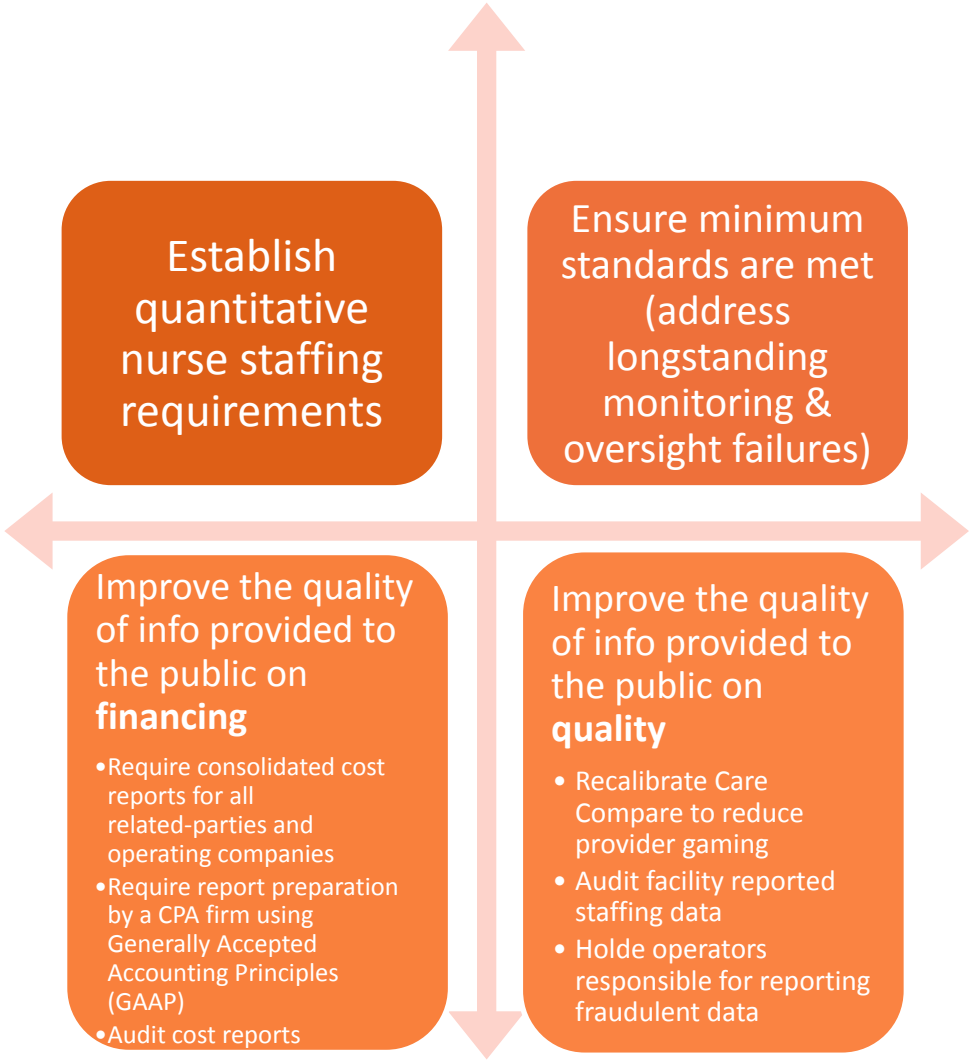
Legal complaint was filed by 238 NHs (out of 615) that they would have to give up $824 million in profits based on 2019 cost reports

NJ established a direct care ratio of 90% of a facility's aggregate revenue on direct care of residents in 2021

MA established a direct care cost quotient of at least 75% and are subject to downward rate adjustments for failure in 2021

Recommendations

Quality & Accountability



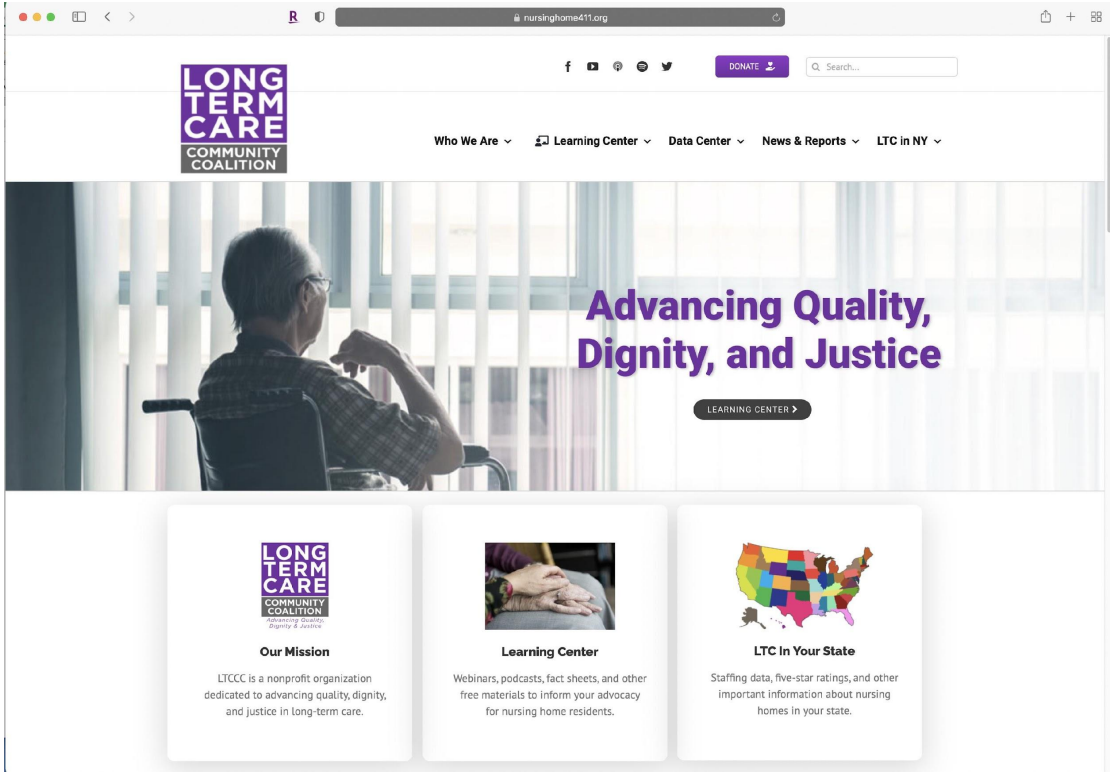
Conclusions

Federal data and numerous study clearly indicate that…

- The U.S. nursing home industry is increasingly run by for-profit entities.
- Operators have become increasingly sophisticated in obscuring information about ownership, related-parties, and where public funds allocated for care actually go.
- Oversight mechanisms, always weak, have not kept up.
- Industry arguments in defense of longstanding problems – insufficient staffing, poor infection control, degrading conditions – are….
  - → ***Unsubstantiated*** and
  - → ***Irrelevant***… nursing homes are not warehouses or gerbil farms (!!).
- Access to good data and information can make a difference on individual, community, and systemic bases.

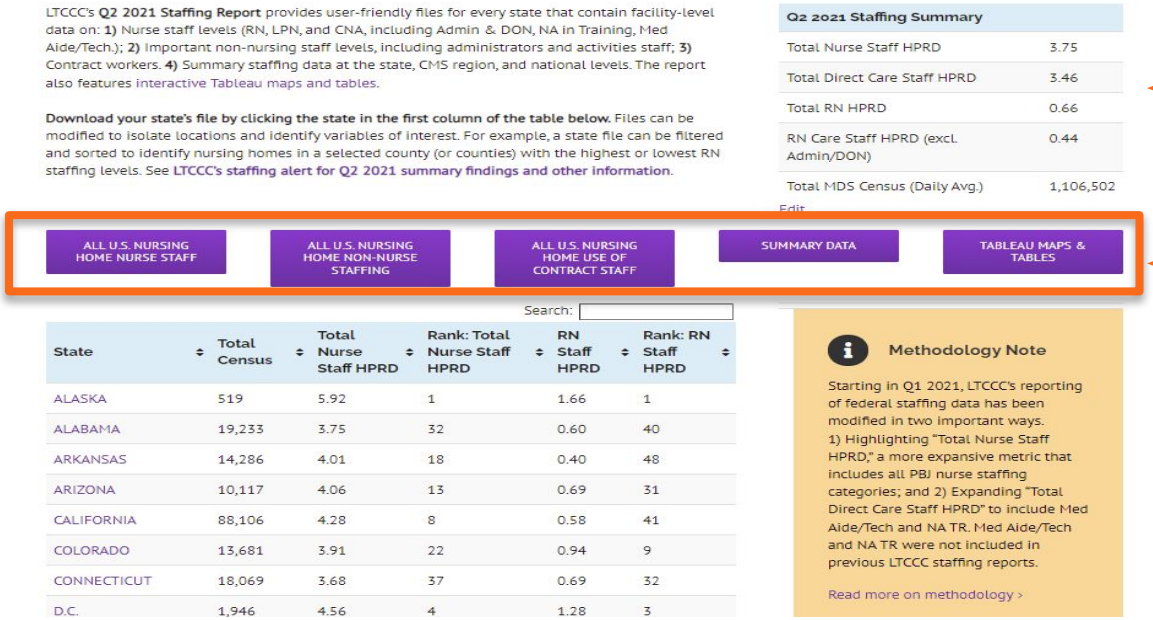
LTCCC Resources

www.nursinghome411.org



www.nursinghome411.org

+ LTCCC Staffing Data (Q2 2021)



LTCCC's **Q2 2021 Staffing Report** provides user-friendly files for every state that contain facility-level data on: **1)** Nurse staff levels (RN, LPN, and CNA, including Admin & DON, NA in Training, Med Aide/Tech.); **2)** Important non-nursing staff levels, including administrators and activities staff; **3)** Contract workers. **4)** Summary staffing data at the state, CMS region, and national levels. The report also features interactive Tableau maps and tables.

Download your state's file by clicking the state in the first column of the table below. Files can be modified to isolate locations and identify variables of interest. For example, a state file can be filtered and sorted to identify nursing homes in a selected county (or counties) with the highest or lowest RN staffing levels. See LTCCC's staffing alert for Q2 2021 summary findings and other information.

Q2 2021 Staffing Summary	
Total Nurse Staff HPRD	3.75
Total Direct Care Staff HPRD	3.46
Total RN HPRD	0.66
RN Care Staff HPRD (excl. Admin/DON)	0.44
Total MDS Census (Daily Avg.)	1,106,502

Edit

ALL U.S. NURSING HOME NURSE STAFF | ALL U.S. NURSING HOME NON-NURSE STAFFING | ALL U.S. NURSING HOME USE OF CONTRACT STAFF | SUMMARY DATA | TABLEAU MAPS & TABLES

Search:

State	Total Census	Total Nurse Staff HPRD	Rank: Total Nurse Staff HPRD	RN Staff HPRD	Rank: RN Staff HPRD
ALASKA	519	5.92	1	1.66	1
ALABAMA	19,233	3.75	32	0.60	40
ARKANSAS	14,286	4.01	18	0.40	48
ARIZONA	10,117	4.06	13	0.69	31
CALIFORNIA	88,106	4.28	8	0.58	41
COLORADO	13,681	3.91	22	0.94	9
CONNECTICUT	18,069	3.68	37	0.69	32
D.C.	1,946	4.56	4	1.28	3

Methodology Note

Starting in Q1 2021, LTCCC's reporting of federal staffing data has been modified in two important ways. 1) Highlighting "Total Nurse Staff HPRD," a more expansive metric that includes all PBJ nurse staffing categories; and 2) Expanding "Total Direct Care Staff HPRD" to include Med Aide/Tech and NA TR. Med Aide/Tech and NA TR were not included in previous LTCCC staffing reports.

Read more on methodology ›

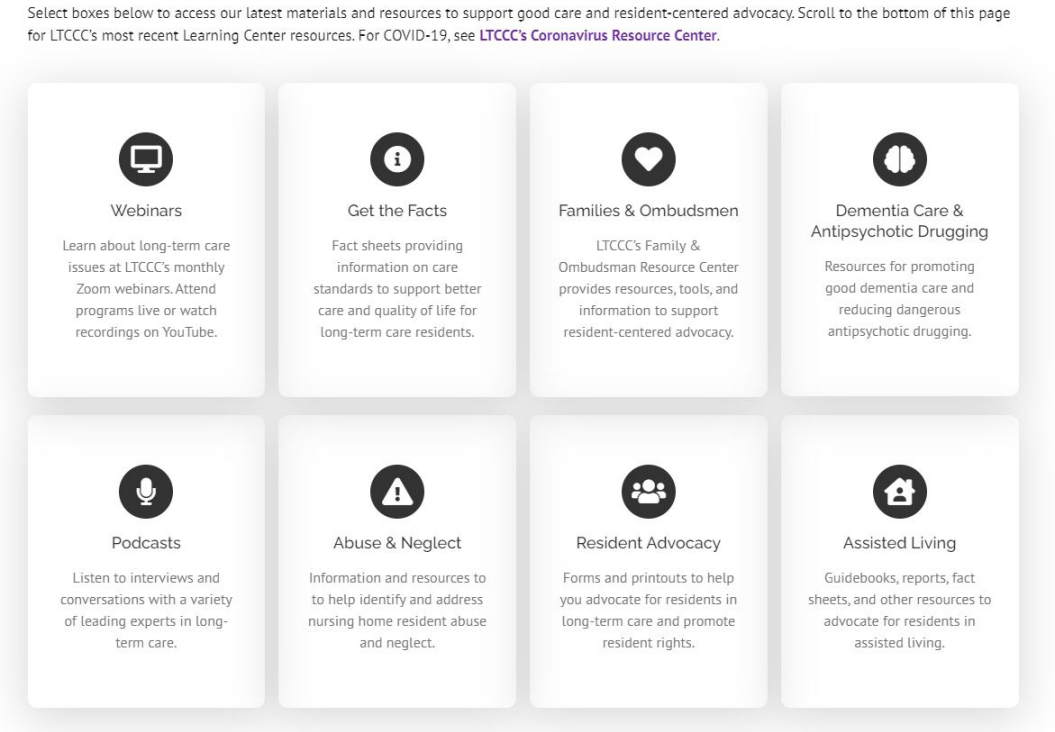
Summary Data

National Staffing Data:
- Nursing staff
- Non-nursing
- Contract
- State Comparisons
- Tableau

State files

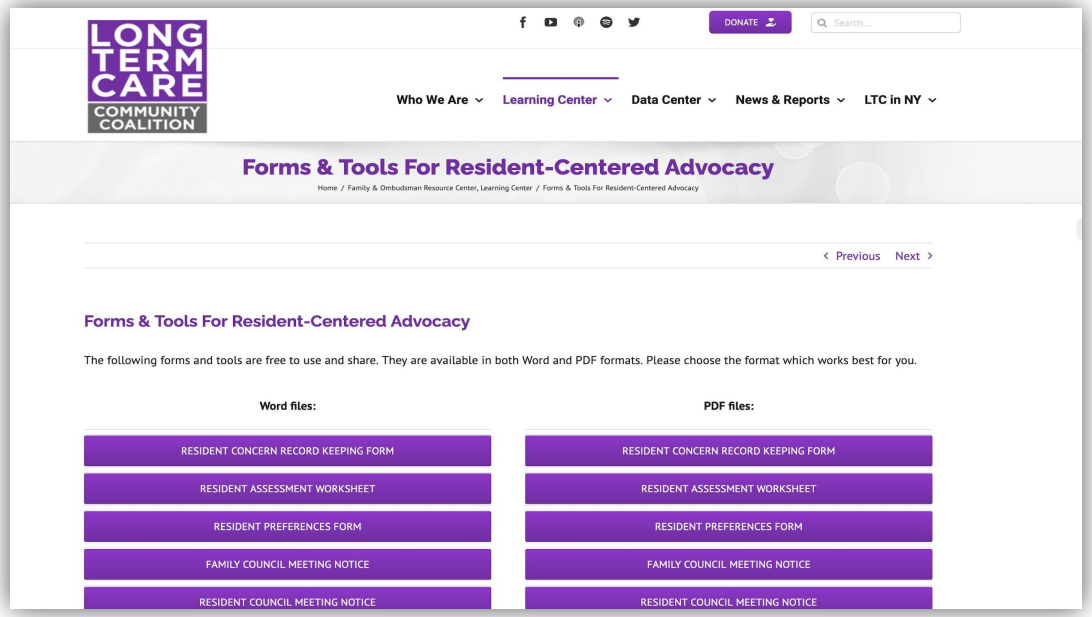
nursinghome411.org/staffing-q2-2021/

+ Learning Center



www.nursinghome411.org/learning-center/

Forms & Tools for Resident-Centered Advocacy



www.nursinghome411.org/forms-advocacy/

Sign up for alerts at https://nursinghome411.org/join/

Visit

www.nursinghome411.org

for

- Staffing and quality info for every U.S. nursing home,
- Guides & fact sheets on important resident care standards,
- Webinars and podcasts with useful information and insights; and
- Tools for resident-centered advocacy, including the Dementia Care Advocacy Toolkit.

How Private Equity Makes US Sicker

- Rosemary Batt, Ph.D.— Private Equity in Healthcare
- Robert McNamara, M.D., MAAEM — PE: A Danger to Patients & Caregivers
- Richard Mollot, J.D. — Impact on Nursing Home Residents & Families
- **Calls To Action**
- Q&A

FORWARD TOGETHER!

CALLS TO ACTION!

Senior AMA member Francis J. Crosson, MD says:

Private equity firms buy the practices and then their investors expect them to get their money back in roughly five to seven years at a 20% to 30% profit. That's not a situation which leads to an expectation of long-term relationships and with investments in making the practices better—it's quite the opposite."

Dr. Steve says:

Adding additional for-profit middlemen, cannot by definition, save money!

…and always worsens access to and quality of care.

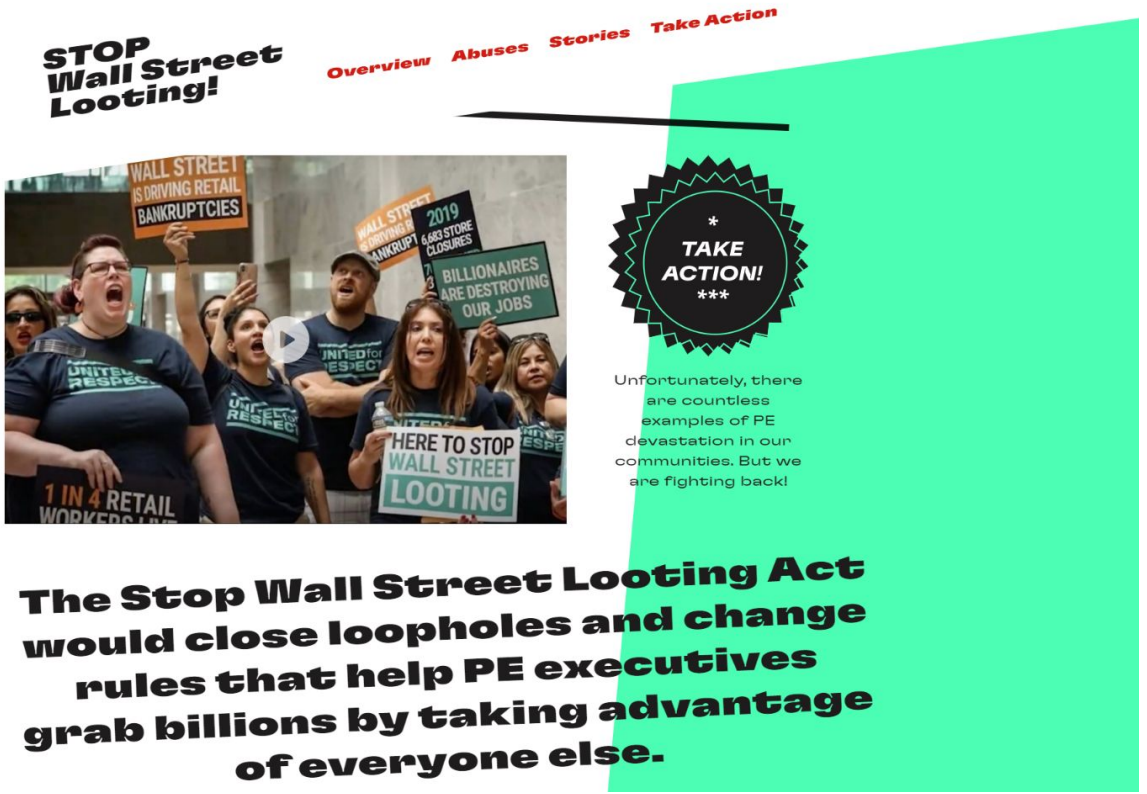
Campaign Against ACO-REACH and Medicare (dis)Advantage

Campaign to Pass The “Stop Wall Street Looting Act”

www.stopwallstreetlooting.org/#action-form

S. 3022 (Sen. Warren) & H.R. 5648 (Reps. Pocan and Jayapal)

- Make PE execs legally liable for the damage they cause
- Stop looting that enriches PE executives at the expense of workers, communities, and businesses
- Close tax loopholes and change rules that encourage predatory financial activities
- Protect workers if employers go bankrupt
- Require PE firms to be fair and transparent to investors in disclosing costs and returns



Healthcare Ownership Transparency Act

www.congress.gov/bill/117th-congress/house-bill/6885
H.R.6885 (Rep Jayapal)

The Healthcare Ownership Transparency Act will require private equity firms to disclose ownership stakes in nursing homes and other health care facilities

NY State Law Officially Prevents Most Types of For-Profit Health Care Facilities

…But Even Now, Too Many "Work Arounds"

Richard Gottfried - Retiring Longtime Health Committee Chair New York State:

"The incursion of private equity into NY health care, despite our laws against corporate practice of medicine, is profound danger. The danger is compounded by the growing trends of vertical and horizontal integration (which can come together in what I call "rectangular integration").

Publicly-traded corporations are doing more and more, getting around our corporate practice laws by not directly "owning" the health care provider. As in pharmacy-based "retail clinics," the private equity player doesn't need to own the provider, but rents it space (with all the power a commercial landlord has), provides financing for equipment, has a contract for "management services," etc."

NY State Legislation

The New York Health Act
2021-22 bill numbers A.6058 (Gottfried), S.5474 (Rivera):
The NY Health Act will provide comprehensive health care coverage for every New Yorker.

TAKE ACTION to #PassNYHealth at *www.p2a.co/sACwddj*

Chain Retail Medical Clinics [2021-22 Bill# A.216 (Gottfried), S.9276 (Rivera)]:
Defines chain clinics and restricts them to unscheduled episodic care.
Passed Assembly; no action in Senate.

For Profit Nursing Homes [2021-22 Bill numbers A.5842 (Gottfried), S.5269 (Rivera)]:
Prohibits new for-profit nursing homes; limits existing ones to their current bed capacity.
Passed Assembly; no action in Senate.

For-Profit Hospices 2021-2022 Bill Numbers A.8472 (Gottfried), S.9387 (Krueger):
Prohibits new for-profit hospices; limits existing ones to their current capacity.
Passed both houses; awaits Governor to sign.

NYS Assembly: Look-up www.assembly.state.ny.us/mem/search & Switchboard 518-455-4100
NYS Senate: Look-up www.nysenate.gov/registration/nojs/form/start/find-my-senator & 518-455-28001

Q&A!

Input questions in the chat

UPCOMING EVENTS

Amendment of City Administrative Code 12-126:

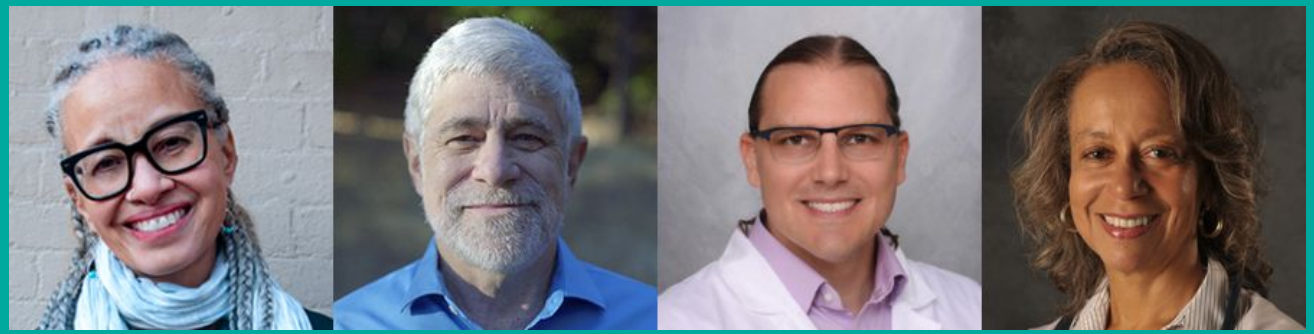
What is it & what can we do to stop it?

Tuesday, October 25
7:30-9:00 PM

PNHP National Annual Meeting and Leadership Training

Boston, November 4-5

www.pnhp.org/2022-annual-meeting



Speakers will include:

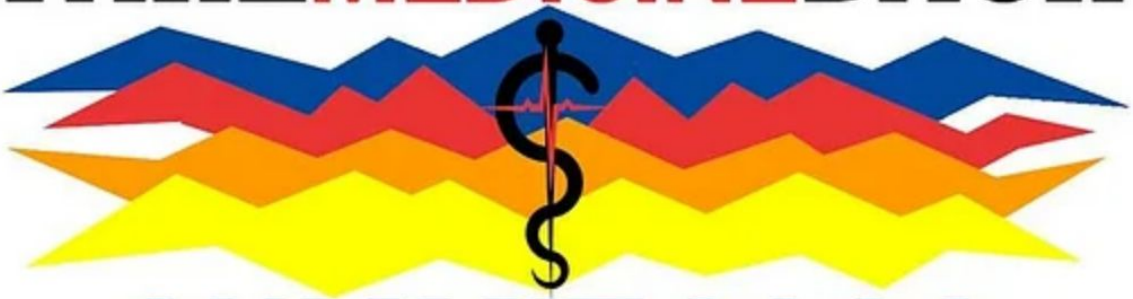
Linda Villarosa, contributor to The New York Times' 1619 Project and author of Under the Skin: The Hidden Toll of Racism on American Lives and the Health of Our Nation

Donald Cohen, executive director of In the Public Interest and co-author of The Privatization of Everything

Philip Verhoef, M.D., Ph.D., president-elect, PNHP

Susan Rogers, M.D., president, PNHP

TAKEMEDICINEBACK



SUMMIT 2022

PART 1: VIRTUAL - NOVEMBER 10th -Thursday

PART 2: ASHEVILLE, NC - NOVEMBER 11th-13th - Friday-Sunday

www.takemedicineback.org

PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM — NEW YORK METRO CHAPTER

www.pnhpnymetro.org

AMERICAN ECONOMIC LIBERTIES PROJECT

www.economicliberties.us

AFR EF Americans for Financial Reform Education Fund

www.ourfinancialsecurity.org

CEPR CENTER FOR ECONOMIC AND POLICY RESEARCH

www.cepr.net

ILR Worker Institute

www.ilr.cornell.edu/worker-institute

LONG TERM CARE COMMUNITY COALITION

www.nursinghome411.org

PRIVATE EQUITY STAKEHOLDER PROJECT

www.pestakeholder.org

TAKE MEDICINE BACK

www.takemedicineback.org

Thank you!

Legislation

National:

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www.stopwallstreetlooting.org
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Healthcare Ownership Transparency Act
www.congress.gov/bill/117th-congress/house-bill/6885
H.R.6885 (Rep Jayapal)

US Capitol switchboard: (202) 224-3121

New York State:

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The New York Health Act will provide comprehensive health care coverage for every New Yorker.

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