Dr. Terris King Written Testimony

U.S. House of Representatives, Committee on Ways and Means:

"Examining Private Equity's Role in the U.S. Health Care System."

March 25, 2020

Summary

Private equity firms use several strategies to raise the potential value of practices, such as reducing costs and improving efficiency by consolidating and internalizing previously outsourced processes like billing. Private equity firms typically purchase established group practices and acquire smaller practices to establish regional offices that exercise greater bargaining power with insurers and medical suppliers. As an owner shifts from physicians to private equity firms, more emphasis might be placed on extracting higher contracted payment rates, lowering overhead, and increasing volume and ancillary revenue streams. With health equity for vulnerable populations at the heart of my life's career goals, I wish to exam whether through increased transparency, improved accuracy of data, oversight and innovation can clinical quality of patients in all segments be assured and improved through private equity and chain ownership of healthcare institutions? Is there a way to balance the needs of patients and investors? How much control do investors have over clinical practices in private equity arrangements?

Introduction

At a convention of the Medical Committee for Human Rights in Chicago, in March of 1966, Dr. Martin Luther King declared, of all the forms of inequity, injustice in healthcare

is the most shocking and inhumane. For the past three decades, I have dedicated my life to reducing health inequities for vulnerable populations. First and foremost, I have served as the Senior Pastor of the Liberty Grace Church of God, in Baltimore, Maryland. I am a Doctor of Science in Occupational Science and Occupational Health and a former executive of the Centers for Medicare & Medicaid Services (CMS).

Situation

Private equity firms use capital from institutional investors to invest in private companies with potential to return a profit. My purpose in co-authoring the blog was to raise inquiry an understanding and begin to identify several relevant questions that start with whether through increased transparency, improved accuracy of data, oversight and innovation can clinical quality of patients in all segments be assured and improved within private equity and chain ownership of healthcare institutions? Is there a way to balance the needs of patients and investors? How much control do investors have over clinical practices in private equity arrangements?

For many consumers little is known about the role of private equity in today's health care delivery system. Given the increasing role of private equity financing, policy makers need to understand common strategies used by these firms, and the potential benefits and risk for patients.

The literature on private equity and nursing homes along with the information included in our blog provides a roadmap for research and reviews.

In addition, the potential of private equity firms in improving patient care should be explored. Among several domains the following potential improvement areas warrant examination:

- Overall innovation and increased use of technological advancements
- Impact of potential additional CMS incentives improve quality of care
- Improved quality of care consistency realized throughout private equity companies
- Improved patient experiences through Human Centered Design frameworks for optimum patient services
- Increased competition and customer choice through greater transparency of ownership and private equity identification on compare websites.

These and other key areas of improvement can and should be discussed with private equity firms as oversight responsibilities are simultaneously improved and increased from CMS.

One additional key concern for clinical quality is understanding the impact of private equity firms on quality and racial health disparities in the growth of this model. This is a particularly important issue because of the tremendous concentration of some minority groups. Ashish Jha wrote a ground-breaking article highlighting that only 222 hospitals in our country serve over 44% of African American elderly patients. It also highlights that 22% of physicians accounted for all outpatient primary care visits for the same group. Elderly African Americans. These numbers could have an impact on the market assessment and selection strategies of private equity ventures and racial concentration numbers may

be similar for Latinos and Asian Americans. We need to find the integration of private equity growth and minority population concentration.

What's wrong with private equity investments in nursing homes?

The increase in private equity investments in health care poses risks, including overutilization, practice instability, and patient safety concerns. Investment firms say these concerns are overblown. They point out that they are giving doctors financial shelter from ever a changing medical environment. They also argue that these investments benefit patients and bring more efficiency to a system burdened with waste. However, the current system makes it impossible to track private equity firms' impact. More research and reviews are needed to identify any positive and negative aspects of Private Equity growth in healthcare. The process should begin with a broad interagency review of hospital, home health and physician office review should be conducted by the Quality Improvement Organization, the Health and Human Services (HHS) Office of Inspector General (OIG) and the Government Accountability Office (GAO). This review should be led by the Centers for Medicaid & Medicare Services (CMS,) Center for Clinical Standards and Quality (CCSQ) and is needed to identify any positive effects of private equity in health care while mitigating the negative ones. Some doctors pushed ethical boundaries long before private equity appeared, but private equity firms currently may have an incentive to look the other way as long a medical practice is profitable.

Our nursing home blog exposed a potential failure to protect nursing home residents and staff during the COVID-19 pandemic. It asserted that the reason for the failure is growth in complex nursing-home ownerships structures, private equity practices, limited financial transparency and the subsequent. impact on direct resident care. We also noted that the

federal government does not have specific quality and financial standards for approving changes in ownership or management changes that meet a reasonable standard to ensure resident safety and quality of care. For example, CMS has not established a mechanism to audit the accuracy and completeness of the PECOS ownership reporting system and has not enforced its requirements to fully and accurately report the names of all the parent companies of the licensee and their related owners and corporations. This allows each facility to largely hide its chain ownership arrangements by individual owners or groups of owners as well as by parent companies.

Meanwhile, CMS has focused their regulatory and enforcement oversight on individual nursing facilities, even though the many are part of a chain and under the control of parent companies. CMS does not report, collect or examine the quality of care in nursing home chains on its "Care Compare" website.

Conclusion

Although it may seem premature to worry about the unintentional consequences of increased private equity ownership on the health care system in every sector, the concerns raised about the proliferation of private equity in health care deserve investigation. Evidence comparing the quality of private equity firm–owned practices with physician-owned practices is limited, due in part to nondisclosure agreements. However, the need for private equity firms to achieve high returns on investment may conflict with the need for investments in quality and safety. In addition, the need for generating returns may create pressure to increase utilization, direct referrals internally to capture revenue from additional services, and rely on care delivered by unsupervised allied or underqualified clinicians

Recommendations

To address these challenges, we made several of the following recommendations:

- HHS should create an interagency early detection task force that includes but is not limited to CMS, OIG, the Department of Justice (DOJ), and Centers for Disease Control & Prevention (CDC) to identify and monitor nursing homes that need focused attention. The task force would analyze and report on the quality, accuracy and completeness of PECOS data and provide a new lens on how ownership and financial investment in nursing homes impact quality of care and the stability of individual facilities and chains. The findings of this task force would be coordinated with states.

- CMS should augment PECOS reporting to include all parent, management, and property companies. Failure to provide complete and accurate data should result in specified financial penalties.

- CMS's Care Compare website should provide information that is searchable based on chain and common ownership and an annual report should be published that focuses on the quality of care in nursing home chains.

- CMS should provide minimum criteria for the purchase, ownership and management of any nursing home. If companies or chains have a history of owning or operating chronically low staffing and poor-quality of care facilities, they should not be allowed to purchase additional sites.

- CMS should establish a prior approval process for changes in ownership and establish a per-day minimum penalty for any licensee that did not receive prior approval.

- Cost reports should be amended to require each nursing home to provide annual consolidated financial reports that include data from all operating entities.

- Finally, a combined financial oversight system should be established by CMS to conduct annual, joint Medicare and Medicaid audits. As a part of the audit oversight, CMS should be given full access to Internal Revenue Service filings of entities involved in the nursing home operation.

One paradox of the COVID-19 pandemic has been that even as the virus has focused the entire country on health care, we may have an opportunity to improve the inadequacy of a system we already had.

Background on Terris King, ScD

I am currently the owner of a healthcare consulting company, the King Enterprise Group. We advise companies focused on the intersection of Health Information Technology, population health and infrastructure support for both the Department of Health and Human Services and local governments. Currently, my primary customer is Johns Hopkins University. We are assisting them in an effort to reduce COVID-19 Vaccine hesitancy in Baltimore City and increase the COVID-19 vaccine rates through a citywide mass vaccine interfaith effort. I am also on a number of boards promoting clinical quality, care coordination, health information technology and the reduction of social determinants of health.

Prior to my consultative role I served the federal government until my retirement in 2015 as the Deputy Chief Information Officer at the Centers for Medicare & Medicaid Services and as the Director of the Office of Minority Health. This is an Office that I had the opportunity to establish.

For six years, I also served as Deputy Director of the Office of Clinical Standards and Quality (OCSQ). I was the CMS executive lead for value-based purchasing that led to new payment models and innovation. Lastly, I designed an initiative called *Everyone with Diabetic Counts* (EDC), which remains the nation's largest federal health inequities reduction program.

My first article was published in 2014 with academia and clinical advisors and served to highlight the initial measurable potential of EDC. My second article explored the impact of the African American Church had on improving health outcomes through health education programs. In February 2021, I co-authored a blog that proposed administrative actions that highlighted the challenges of clinical quality adherence and patient safety as a result of the growth in private equity owners and practices in healthcare.

My next article, published in March 2021, provides a roadmap for institutions and government entities seeking measurable and sustainable engagement with vulnerable communities and their trusted sources. This article was co-authored with the Senior Vaccine Advisor for Johns Hopkins University's School of Public Health and was highlighted in the *Journal of Health Communications*.

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