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Toward a Preliminary Theory of Organizational Incentives: Addressing Incentive Misalignment in Private Equity-Owned Long-Term Care Facilities

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The COVID-19 pandemic brought critical debates regarding private equity ownership of long-term care facilities to the forefront of political, legal, and social landscapes. Like many of the historical concerns about long-term care, these debates center around low quality patient care. While the concerns present important challenges to overcome, this note theorizes the kinds of organizational incentives that may provide opportunities to align patient quality care with the financial goals of private equity investing. After a discussion of the historical context of long term care facilities and the more recent trends towards for-profit and private equity ownership of these facilities (Parts II and III), I engage with value-based models as a starting point to consider organizational level incentive possibilities (Part IV). In Part V, I consider an organizational-level pay for performance model, a time-bound incentive structure, and investor-specific incentives as three distinct possibilities for addressing the patient care issues identified.

I. INTRODUCTION

With more than 3,300 long-term care ("LTC") facilities receiving COVID-19 related fines between March and November of 2020, the pandemic brought longstanding concerns regarding these facilities into the public eye.[1] As of November 25, 2020, more

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[1]Press Release, Ctrs. for Medicare & Medicaid Servs., Trump Administration Has Issued More Than $15 Million in Fines to Nursing Homes During COVID-19 Pandemic (Aug. 14, 2020), https://www.cms.gov/newsroom/press-releases/trump-administration-has-issued-more-15-million-fines-nursing-homes-during-covid-19-pandemic [https://perma.cc/7MER-CNQ4] (reporting that 3,400 Long Term CareLTC facilities received COVID-related fines with 180 facilities over 22 states found to have put patients in immediate jeopardy. "Immediate jeopardy represents a situation in which a nursing home's noncompliance with CMS requirements of participation has caused or is likely to cause serious injury, serious harm, serious impairment, or death to a resident."); Tara Sklar, *Implementation and Enforcement of Quality and Safety in Long-Term Care*, *in* ASSESSING LEGAL RESPONSES TO COVID-19 (Scott Burris, Sarah de Guia, Lance Gable, Donna Levin, Wendy E. Parmet, &

than 100,000 staff and residents of LTC facilities had died from complications associated with COVID-19.[2] By February 4, 2021, there were over 162,268 LTC facility related COVID deaths accounting for around 36% of all U.S. deaths.[3]

Although researchers have not found an overall relationship between private equity-owned facilities and COVID deaths, anecdotal accounts suggest that facilities owned by private equity firms have fared worse than those that are not private equity-owned during the pandemic.[4] These accounts mirror a decades-long criticism that private equity ownership has a negative impact on LTC.[5] On the other hand, some have argued that any issues found in private equity ownership are also found in for-profit ownership in general.[6] In a Canadian study regarding outbreaks of COVID-19, for example, researchers found that non-profit and municipally-owned LTC facilities fared better and had less "extensive outbreaks" than those owned by for-profit companies.[7]

While this Note examines the debates around private equity ownership in some detail, its purpose is not to make a claim about whether private equity ownership is better or worse than other forms of ownership. Rather, this Note explores how strategic incentive structures can align the efficiency and profitability goals of private equity firms with

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Nicolas P. Terry eds., 2020) 143, 143-44 (examining the historical issues with quality of care in Long Term Care facilities); *see also* Charles Duhigg, *At Many Homes, More Profit and Less Nursing*, N.Y. Times (Sept. 23, 2007), https://www.nytimes.com/2007/09/23/business/23nursing.html [https://perma.cc/TG4K-PG84] (describing poor facilities and resident health outcomes in longer term care facilities acquired by private investors from 2000 to 2006).

[2]Priya Chidambaram, Rachel Garfield, and Tricia Neuman, *COVID-19 Has Claimed the Lives of 100,000 Long-Term Care Residents and Staff,* Kaiser Fam. Found. (Nov. 25, 2020), https://www.kff.org/policy-watch/covid-19-has-claimed-the-lives-of-100000-long-term-care-residents-and-staff/ [https://perma.cc/32DU-G9DY]; *see also* Priya Chidambaram & Rachel Garfield, *Despite Efforts to Slow the Spread of the Virus in Long-Term Care Facilities, KFF Analysis Finds Many States Experienced the Worst COVID-19 Outbreaks and Highest Number of Deaths in December,* Kaiser Fam. Found. (Jan. 14, 2021), https://www.kff.org/coronavirus-covid-19/press-release/despite-efforts-to-slow-the-spread-of-the-virus-in-long-term-care-facilities-kff-analysis-finds-many-states-experienced-the-worst-covid-19-outbreaks-and-highest-number-of-deaths-in-december/ [https://perma.cc/2YFM-QBU9] ("The new analysis finds that many states reported their highest average weekly number of new coronavirus cases in long-term care facilities in November or December 2020.")/.

[3]*Long-Term-Care COVID Tracker*, The COVID Tracking Project, https://covidtracking.com/nursing-homes-long-term-care-facilities [perma.cc/4RNN-8WSA] (last updated Mar. 7, 2021); *id.* at *Week-by-Week Summary Totals,* https://covidtracking.com/nursing-homes-long-term-care-facilities/history [perma.cc/HYT4-54H9]; *see also* Anna Wilde Mathews, *Covid-19 Delivers Financial Blow to Nursing Homes,* Wall St. J. (Nov. 9, 2020, 5:24 PM), https://www.wsj.com/articles/covid-19-delivers-financial-blow-to-nursing-homes-11604949454 [https://perma.cc/NDV5-FBQC] (reporting that deaths in Long Term Care facilities had accounted for over forty percent of all COVID deaths since the onset of the pandemic).

[4]Robert Tyler Braun et al., *Comparative Performance of Private Equity-Owned US Nursing Homes During the COVID-19 Pandemic*, 3 JAMA Network Open, Oct. 28, 2020, at 1, 7 (reporting that there were no differences between private equity owned facilities and other facilities in terms of how staff and residents have fared during the pandemic); Ams. for Fin. Reform Educ. Fund, The Deadly Combination of Private Equity and Nursing Homes During a Pandemic 13 (Aug. 2020), https://ourfinancialsecurity.org/wp-content/uploads/2020/08/AFREF-NJ-Private-Equity-Nursing-Homes-Covid.pdf [https://perma.cc/XFK9-G2FP].

[5]Alicia McElhaney, *Private Equity-Backed Nursing Homes Are Bad for Patients*, *Research Shows*, Inst. Inv. (Mar. 11, 2020), https://www.institutionalinvestor.com/article/b1kq79bp4nv79t/Private-Equity-Backed-Nursing-Homes-Are-Bad-for-Patients-Research-Shows [https://perma.cc/344Y-X9M5] (finding reductions in patient health and compliance in long term care homes acquired by private investors since 2004).; Danielle Brown, *Lawmakers Pepper Private Equity Firms on Nursing Home Investments, Quality Issues*, McKnights Long-Term Care News (Nov. 19, 2019), https://www.mcknights.com/news/lawmakers-pepper-private-equity-firms-on-nursing-home-investments-quality-issues/ [https://perma.cc/6SWE-CRT3].

[6]Nathan M. Stall et al., *For-Profit Long-Term Care Homes and the Risk of COVID-19 Outbreaks and Resident Deaths*, 192 Can. Med. Ass'n J. E946, E949-50 (Aug. 17, 2020). *See also* Margaret J. McGregor & Charlene Harrington, *COVID-19 and Long-Term Care Facilities: Does Ownership Matter?*, 192 Can. Med. Ass'n J. E961, E961 (Aug. 17, 2020) (finding that for-profit status of long-term care homes did not significantly increase COVID-19 incidence when factoring for multi-bed room design).

[7]McGregor & Harrington, *supra* note 6, at E961.

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facility goals of providing the best quality care for the growing elderly population in the United States.

In this Note, I use the term LTC facility as an umbrella term, capturing skilled nursing facilities ("SNFs"), assisted living facilities, and residential care facilities.[8] This Note will not discuss home health care, although further discussion of private equity ownership of these kinds of *elder-care* organizations is warranted in the future.[9]

This Note uses an organizational political economy framework, a sociological framework that examines "the complexity of organizational-community interactions [by taking] into account the effect of the external environment on how organizations shape themselves in response to market and regulatory incentives, constraints, and opportunities present in that environment."[10] This theory engages the historical and contemporary social context of organizations by analyzing the conditions under which certain behaviors occur or do not occur.[11] While this framework has been used to understand the behavior of corporations in industries such as banking, food manufacturing, steel, energy, and health care, it is also appropriate to analyze the LTC industry, a highly regulated but highly diversified industry.[12] This framework shapes the Note's overall questions: *What roles can organizational incentives play in addressing the apparent misalignment between the goals of private equity and the goals of patient quality of care in the LTC industry?* Further, *under what conditions can the goals of private equity-owned LTC facilities be aligned with patient quality of care?* These questions consider the role of both government and industry partners in promoting alignment between profit maximization and human-centered quality of care prioritization. In response to these questions, I posit three possibilities for incentive alignment: (1) organizational-level pay for performance geared towards performance-based metrics that provide facility-wide benefits; (2) time-bound incentives that include long-term sustainability metrics alongside short-term profit maximization; and (3) investor-specific incentives geared towards connecting investor priorities to the longer term health of the facility.

The next Section of the Note provides a brief background and historical context for LTC facilities within the United States. Section III delves into several important aspects

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[8] *See., e.g.*, Shuo Chen, *Caring for Mom: Establishing Statutory Rights for Elder Care Facilities,* 46 Am. J.L. & Med. 111, 1271-132 (2020) (defining "assisted living facility" and "skilled nursing home" to establish framework for standardized zoning laws for elder care facilities); *see also* Ronald J. Pawelski, Mass Ass'n of Residential Care Homes, Rest Homes: Their Value on the Massachusetts Healthcare Continuum 10 (2020), https://www.mass.gov/doc/january-10-2020-handout-rest-homes-their-value-on-the-health-care-continuum/download [https://perma.cc/43YX-LA94] (describing nursing facilities' "extensive range of services" that are distinguishable from other types of care, such as "rest homes")

[9] *See e.g.*, Greg Shulas, *Private Equity Poised to Reshape Home Health Care Industry?* HomeCare (Oct. 31, 2018), https://www.homecaremag.com/home-health/private-equity-poised-reshape-home-health-care-industry [https://perma.cc/P9A8-UE3W]; *see also* Charlene Harrington et al., *Marketization in Long-Term Care: A Cross-Country Comparison of Large For-Profit Nursing Home Chains,* 10 Health Servs. Insights, Jan.–Dec. 2017 at 1, 18 (From 2005 to 2015, the five largest for-profit nursing home chains in the United States both increased their beds and diversified into assisted living, rehabilitation, home health, and dialysis).

[10] *See e.g.,* Alesha T. (Istvan) Ignatius Brereton, The U.S. Food Manufacturing Industry and the Environmental Hazards of Toxic Emissions to Socially Vulnerable Populations 22 (Dec. 9, 2017) (Ph.D. dissertation, Texas A&M University) (OAKTrust). *See also*, Harland Prechel & Theresa Morris, *The Effects of Organizational and Political Embeddedness on Financial Malfeasance in the Largest U.S. Corporations: Dependence, Incentives, and Opportunities*, 75 Am. Socio. Rev. 331, 332 (2010) (describing Organizational-Political Embeddedness Theory); Theresa Morris, Cut It Out: The C-Section Epidemic in America 48 (2013) (in response to "economic, political, and legal" environmental factors, hospitals are more likely to change their organizational behavior and perform more c-sections than clinically required to avoid the threat of liability and protect organizational interests).

[11] Prechel & Morris, *supra* note 10, at 351.

[12] *See, e.g.*, *id.*; Ignatius Brereton, *supra* note 10; Morris, *supra* note 10.

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of private equity ownership of LTC facilities, both the development of the phenomenon as well as the implications as discussed in the research literature. Section IV discusses different value-based patient care models including pay for performance, bundled savings, and accountable care organizations. Section V builds on the same goals associated with value-based models by proposing a preliminary theory of incentive alignment focused not on individual provider incentives but organizational level financial incentives to promote an increased quality of care for LTC patients. Specifically, it posits that the COVID-19 crisis provides the opportunity to experiment with these incentive structures in ways that may be beneficial to private equity-owned LTC facilities in the future. Section VI makes concluding remarks about the implications of these ideas and describes their potential overall impact.

II. BACKGROUND AND HISTORICAL CONTEXT

A. The History of LTC and Statutory Provisions in the United States

LTC is "a set of health, personal care and social services delivered over a sustained period of time to persons who have lost or never acquired some degree of functional capacity."[13] These individuals include those with chronic conditions, those with permanent disabilities, and the elderly.[14] LTC facilities are becoming ubiquitous in our society as the population gets older and health care prolongs life but does not necessarily ease illness.[15] The number of facilities has risen gradually from 1,200 facilities with 22,000 licensed beds in 1939 to 15,600 facilities with 1.7 million licensed beds in 2016.[16] As of 2018, 14 million adults in the United States were in need of some form of LTC.[17] Some estimates suggest that by 2030, as many as 24 million Americans are expected to need LTC.[18]

In the United States, institutional care has a long history dating back to the colonial period. In the original colonies, English Poor Law required that families provide care for their elderly and infirmed family members.[19] However, those members of the community that needed support but did not have any family connections were left on their own.[20] Almshouses developed as a response to this issue.[21] First founded in Boston in

[13]Graham D. Rowles & Pamela B. Teaster, *The Long-Term Care Continuum in an Aging Society*, *in* Long-Term Care in an Aging Society: Theory and Practice 3, 9 (Graham D. Rowles & Pamela B. Teaster eds., 2015) (citing Rosalie A. Kane et al., Long Term Care: Principles, Programs, and Policies 4 (1987)).

[14]Rowles & Teaster, *supra* note 13, at 14.

[15]*See Prolonging Life at All Costs: Quantity Versus Quality*, 4 Lancet Respiratory Med.165 (2016) (discussing the clinical, emotional, and economic consequences of life-prolonging treatments in intensive care units).

[16]Louis Block & Halbert L. Dunn, Bureau of the Census, Vital Statistics – Special Report, Hospital and Other Institutional Facilities and Services 1939, at 547, 568 (13th vol. 1942); Lauren Harris-Kojetin et al., National Center for Health Statistics, Long-term Care Providers and Services Users in the United States, 2015–2016, at 73 (13th series, 2019).

[17]Edem Hado & Harriet Komisar, AARP Pub. Pol'y Inst., Long-Term Services and Supports 1 (Aug. 2019), https://www.aarp.org/content/dam/aarp/ppi/2019/08/long-term-services-and-supports.doi.10.26419-2Fppi.00079.001.pdf [https://perma.cc/3THM-EBC4].

[18]Tara O'Neill Hayes & Sara Kurtovic, *The Ballooning Costs of Long-Term Care*, Am. Action F. (Feb. 18, 2020), https://www.americanactionforum.org/research/the-ballooning-costs-of-longterm-care/ [https://perma.cc/G3V7-N5RS].

[19]Carole Haber, *History of Long-Term Care in* Long Term Care in an Aging Society: Theory and Practice, *supra* note 13, at 36.

[20]*See id.* at 37.

[21]*Id.* at 38.

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1664, almshouses were a catch-all space to house elderly, orphaned, and mentally ill individuals, whose only similarities were that they were poor and had no family to care for them.[22] Almshouse conditions were awful and inhospitable, meant to keep people from applying and, if accepted, to keep them from staying too long for services.[23] Over time, these institutions evolved into various new organizations including orphanages, mental asylums, and an early form of public LTC institutions primarily for housing the elderly and focusing on their medical care.[24] In response to the horrible conditions in and stigma around almshouses, "women's and church groups [established] special homes for the elderly"[25] while others worked to eradicate such institutions altogether.

In the first three decades of the twentieth century, proponents of old-age pensions argued that a radical shift was needed in order to really support individuals in old age who could no longer compete economically in society.[26] The Great Depression troubled historical notions of poverty as a moral failing, and news reports exposing almshouse conditions shifted public support away from these institutions and towards providing financial support so individuals could support themselves.[27] The federal government responded by developing Social Security.[28]

The Social Security Act of 1935 was enacted to institutionalize pensions for the elderly.[29] In a statement at the signing of the Act, President Roosevelt acknowledged:

> [w]e can never insure one hundred percent of the population against one hundred percent of the hazards and vicissitudes of life, but we have tried to frame a law which will give some measure of protection to the average citizen and to his family against the loss of a job and against poverty-ridden old age.[30]

Under this Act, states could receive financial support for the care of the elderly, but funds could not be used to support *public* old age institutions.[31] The statute specified that money would be provided to the state to support old age assistance only "with respect to each individual who at the time of such expenditure is sixty-five years of age or older and is not an inmate of a public institution."[32] These requirements were not without critique, but the Supreme Court supported the prohibition in a 7-2 decision.[33] However, this

[22] *See The History of Nursing Homes*, FOUND. AIDING THE ELDERLY, https://www.4fate.org/history.pdf [https://perma.cc/9A5T-UF7F] (last visited Oct. 17, 2021); *see also* Haber, *supra* note 19, at 38 ("First founded in Boston in 1664, the almshouse became a well-known and easily recognized institution in scores of cities throughout the 18th century").

[23] Haber, *supra* note 19, at 39. Almshouses were organized in such a way as to keep people from applying for residence and, if individuals were accepted, to keep them from staying for services unless it was their last option)

[24] *See id.* at 41 (describing how the "medical function … came to dominate" the character of the almshouse); Sidney D. Watson, *From Almshouses to Nursing Homes and Community Care: Lessons from Medicaid's History*, 26 GEORGIA ST. UNIV. L. REV. 937, 941 (2010).

[25] *The History of Nursing Homes*, *supra* note 23; *see also* Haber, *supra* note 19, at 42 (describing how the Second Great Awakening led religious groups to establish alternative institutions where residents could be reformed or cured).

[26] *History of Nursing Homes, supra* note 22.

[27] Watson supra note 24, at 941.

[28] *Id.*

[29] *See* Social Security Act of 1935, Pub. L. No. 74-271, 49 Stat. 620, 620-25 [hereinafter SSA].

[30] Franklin D. Roosevelt, Presidential Statement on Signing the Social Security Act (Aug. 14, 1935), https://www.ssa.gov/history/fdrstmts.html#signing [https://perma.cc/C2SU-BNVT].

[31] SSA § 3(a)(1), 49 Stat. at 621.

[32] *Id.*

[33] *See* Helvering v. Davis, No. 910, 1937 U.S. LEXIS 1200, at *43–45 (May 24, 1937). "The Court reasoned that with many people growing old and dependent, the Act was a protection and the only way for it to

requirement did not preclude individuals located in private institutions from receiving support.[34] This caveat facilitated a significant and rapid shift from public facilities to private facilities.[35] Over the next ten years, however, it became clear that direct pensions to beneficiaries did not ameliorate the need for institutional care for the elderly.

During the late 1940s and early 1950s, two major changes led to the proliferation of LTC facilities. First, the 1950 amendments to the Social Security Act allowed money to be allocated directly to LTC providers including public institutions.[36] This change was conditioned on funded states developing licensing programs for the facilities.[37] Second, the *Hospital Survey and Construction Act* ("Hill-Burton Act") supported building health care infrastructure including hospitals and public health centers.[38] The definition of public health center was to be determined on a state-by-state basis.[39] The 1954 amendments to the Hill-Burton Act included funding and support for non-profit organizations that built LTC facilities.[40] These amendments allocated matching funds from the federal government for states that built SNFs that conformed to the mandated regulations.[41] Although the two aforementioned changes led to increased development of LTC facilities, rules around licensing were not enforced or standardized.[42] Many facilities remained unregulated and by 1960, 44% of the beds in LTC facilities did not meet quality standards.[43]

The Social Security Act was amended to create Medicare and Medicaid, which provided more financial support for elder care.[44] President Johnson praised this development in his remarks regarding Medicare, saying, "[c]ompassion and reason dictate that this logical extension of our proven Social Security system will supply the prudent, feasible, and dignified way to free the aged from the fear of financial hardship in the event of illness."[45] The Medicare Program focused on doctor visits and hospital care, covering

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succeed was for Congress to exercise a power that was national so that it could serve the interests of all." *Id.* at *1. Justice Cardozo writes "the hope behind this statute is to save men and women from the rigors of the poorhouse as well as from the haunting fear that such a lot awaits them when journey's end is near." *Id.* at *38.

[34]*See* Jessica Dornin, Jamie Ferguson-Rome & Nicholas G. Castle, *Nursing Facilities*, *in* Long-Term Care in an Aging Society: Theory and Practice *supra* note 13, at 297 (though the stipulation intended to discourage use of overburdened public nursing homes, what followed was an increase in the number of private care homes).

[35]*Id.*

[36]Wilbur J. Cohen & Robert J. Myers, *Social Security Act Amendments of 1950: A Summary and Legislative History*, 13 Soc. Sec. Bull., (Soc. Sec. Admin.), Oct. 1950, at 3, 5, https://www.ssa.gov/policy/docs/ssb/v13n10/v13n10p3.pdf [https://perma.cc/N437-M9R8]; *see also* Haber, *supra* note 20, at 52.

[37]Inst. of Med. (U.S.) Comm. on Nursing Home Regul., Improving the Quality of Care in Nursing Homes 238 (1986) [hereinafter Improving Quality of Care].

[38]V.M. Hoge, *The Hospital Survey and Construction Act*, Soc. Sec. Bull. (Soc. Sec. Admin.), Oct. 1946, at 15, 17, https://www.ssa.gov/policy/docs/ssb/v9n10/v9n10p15.pdf [https://perma.cc/N75H-QABU]; John Henning Schumann, *A Bygone Era: When Bipartisanship Led to Health Care Transformation*, NPR (Oct. 2, 2016, 6:00 AM), https://www.npr.org/sections/health-shots/2016/10/02/495775518/a-bygone-era-when-bipartisanship-led-to-health-care-transformation [https://perma.cc/4MN8-8ZC7]; *see also* Haber, *supra* note 19, at 53.

[39]Hoge, *supra* note 38, at 15-16.

[40]Improving Quality of Care, *supra* note 37, at 239.

[41]*Id.; see also* Haber, *supra* note 19, at 53.

[42]Improving Quality of Care, *supra* note 37, at 240.

[43]*Id.*

[44]Kaiser Fam. Found., Long Term Care in the United States: A Timeline 1 (2015), https://www.kff.org/wp-content/uploads/2015/08/8773-long-term-care-in-the-united-states-a-timeline1.pdf [https://perma.cc/8LND-FG9V]; *see e.g.*, Soc. Sec. Admin., *Medicare is Signed into Law*, Soc. Sec. Hist., https://www.ssa.gov/history/lbjsm.html [https://perma.cc/J2P9-8KYC] (last visited Oct. 23, 2021).

[45]Soc. Sec. Admin., *Medicare & Other Changes,* in *Historical Background and Development of Social Security*, Soc. Sec. Hist., (quoting President Johnson regarding Medicare, (Jan. 7, 1965)), https://www.ssa.gov/history/briefhistory3.html [https://perma.cc/YB2C-CJCT] (last visited Oct. 23, 2021).

100 days of nursing home stays following a three-day or more hospital stay.[46] Medicaid, on the other hand, was an outgrowth of the Kerr-Mills Act, which was meant to primarily cover the poor in SNFs.[47] Medicaid covered longer stays in LTC facilities and became the largest payer for facility stays overall.[48]

Unlike Medicare which became primarily nationalized, Medicaid operated under a federalist structure prioritizing state rights in determining Medicaid eligibility.[49] "Under this legislation, the federal and state governments [became] the largest payers for Long Term Care: nursing home utilization increase[d] dramatically, along with government expenditures."[50] The Moss Amendments were passed in 1968 to standardize regulations associated with facilities that received Medicaid and Medicare funding.[51] In 1974, the federal government finalized regulations to enforce standards around LTC facility staffing, safety, and service delivery.[52] Finally, in 1977, the Health Care Financing Administration ("HCFA"), which would later be renamed The Centers for Medicare and Medicaid Services ("CMS"), was developed to promulgate certification standards and a certification process for LTC facilities.[53]

While statutory changes increased the number of LTC facilities, the industry continued to struggle with issues arising from low quality care. Fires from poorly maintained properties and ill-managed disease were only two of the many ways that patients and staff in LTC facilities lost their lives.[54] Furthermore, the Institute of Medicine found that many patients were "being abused, neglected, and given inadequate care."[55] In 1987, the *Federal Nursing Home Reform Act* ("Reform Act") mandated that institutions receiving Medicare or Medicaid had to guarantee that residents could maintain the "highest practicable, mental and psychosocial well-being."[56] The Reform Act required nursing homes to provide certain services to every resident, including periodic assessments, a comprehensive care plan, nursing services, social services, rehabilitation services, pharmaceutical services, dietary services, with additional requirements for larger facilities.[57] For example, the Reform Act required a full-time social worker to be employed by the facility if it had over 120 beds.[58] Furthermore, the Reform Act outlined a Bill of Rights for residents, developed a certification process, and instituted an enforcement system if the facility was not in compliance with the Reform Act's requirements.[59] Monitoring under the Reform

[46]Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286, 291-92, 317.

[47]Improving Quality of Care, *supra* note 37, at 239.

[48]Matthew Gritter, *The Kerr-Mills Act and the Puzzles of Health Care Reform*, 100 Soc. Sci. Q. 2209, 2220-2221 (2019); Improving Quality of Care, *supra* note 37, at 194.; *see also* Haber, *supra* note 19 at 54 ("Because of [Kerr-Mills], in the years between 1960 and 1975, the number of nursing homes grew from 9,582 to 23,000, whereas the number of patients ballooned from 290,000 to over 1,000,000.").

[49]Nicole Huberfeld, *Federalism in Health Care Reform*, *in* Holes in the Safety Net: Federalism and Poverty 197, 203-204 (2019).

[50]Kaiser Fam. Found., *supra* note 44, at 1.

[51]*Id.* at 2; Improving Quality of Care, *supra* note 37, at 242.

[52]Kaiser Fam. Found., *supra* note 44.

[53]Dornin et al., *supra* note 34, at 297-98; *see* Nicholas G. Castle et al., *Humanism in Nursing Homes: The Impact of Top Management*, 31 J. Health Hum. Serv. Admin. 4, 483-508 (2009).

[54]*See* Haber, *supra* note 19, at 54-6.

[55]Martin Klauber & Bernadette Wright, *The 1987 Nursing Home Reform Act*, AARP Public Policy Institute (Feb. 2001), https://www.aarp.org/home-garden/livable-communities/info-2001/the_1987_nursing_home_reform_act.html.

[56]Haber, *supra* note 19, at 56.

[57]Klauber & Wright, *supra* note 55.

[58]Requirements for, and assuring quality of care in, skilled nursing facilities, 42 U.S.C. § 1395i–3(b)(7); *See also*, Klauber & Wright, *supra* note 55.

[59]Klauber & Wright, *supra* note 55.

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Act is primarily a state-specific function, either directly or under contract with CMS, which inserts some variability in actual compliance enforcement.[60]

After a couple of decades of small changes to federal LTC facility quality standards, the *Affordable Care Act Nursing Home Transparency Provisions* ("ACA Nursing Home Provisions") provided a significant positive transition regarding quality care requirements and compliance.[61] The primary goal of these provisions has been to "increas[e] transparency throughout the healthcare system and [strengthen] consumer information systems."[62] Facilities affected by this statute are required to disclose information regarding, but not limited to, ownership and management, spending, staffing, and resident needs.[63] Furthermore, the ACA Nursing Home Provisions mandate the development of compliance programs, internal quality assurance, and performance improvement plans.[64] However, similar to previous efforts, the enforcement varies by state.[65]

B. LTC Facilities Today

Today, LTC facilities provide, among other things, significant nursing care services.[66] The majority of these facilities are certified through CMS.[67] However, because most LTC facilities receive Medicaid funding, and Medicaid funding and standards differ by state, they are subject to significant state variation as well.[68] At the same time, state laws govern licensure and certain standards of care.[69] Therefore, LTC facilities in some states fare better than others depending on the availability of state funding and varying compliance requirements.[70]

The vast majority of LTC facilities are private for-profit or non-profit corporate entities, while the remainder are government-owned.[71] Non-profit organizations reinvest their income towards the public benefit for which they are organized; for-profit organizations work to generate income, the excess of which is distributed to investors.[72]

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[60]Charlene Harrington, Joshua M. Wiener, Leslie Ross, & MaryBeth Musumeci, *Key Issues in Long-Term Services and Supports Quality* (Oct. 27, 2017), https://www.kff.org/medicaid/issue-brief/key-issues-in-long-term-services-and-supports-quality/.

[61]Kaiser Fam. Found., *supra* note 44.

[62]Catherine Hawes et al., *Nursing Homes and the Affordable Care Act: A Cease Fire in the Ongoing Struggle Over Quality Reform*, 24 J. Aging & Soc. Pol'y 2, 206-220 (2012); *See also*, Edward Alan Miller, *The Affordable Care Act and Long Term Care: Comprehensive Reform or Just Tinkering Around the Edges*, 24 J. of Aging & Soc. Pol'y 2, 101-117 (2012).

[63]*Hawes, supra* note 62, *at 214.*

[64]*Id.* at 215.

[65]Lindsay Wiley, *Health Care Federalism and Next Steps in Health Reform*, Digital Commons @ Am. Univ. Wash. Coll. L. (2018); *See also* Abbe R. Gluck & Nicole Huberfeld, *What is Federalism in Healthcare for*, 70 Stan. L. Rev. 1689, 1726-1728 (2018) (discussing the failed attempt of the ACA to nationalize Medicaid and its implications for continued enforcement variability by state).

[66]Adrienne Jones, *The National Nursing Home Survey: 1999 Summary*, 1 VITAL AND HEALTH STAT. 2, 3 (2002), https://perma.cc/T28M-Z7AG.

[67]T.J. Fairchild & J.A. Knebl, *Nursing Homes, in* 3 ENCYCLOPEDIA OF AGING 999, 999-1002 (D.J. Ekrderdt ed., 2002).

[68]Brendan Williams, *Failure to Thrive? Long Term Care's Tenuous Long Term Future*, 43 SETON HALL LEGIS. J. 285, 293 (2019).

[69]*See*, *e.g.*, Mass. Gen. L. Ch. 111 § 71 (Licensing of nursing and convalescent homes, infirmaries, etc.); 105 Code Mass. Reg. 150.00 (Standards for long-term care facilities); 105 Code Mass. Reg. 153.00 (Licensure procedure and suitability requirements for long-term care facilities).

[70]Williams, *supra* note 68, at 295.

[71]David C. Grabowski & David G. Stevenson, *Ownership Conversions and Nursing Home Performance*, 43 HEALTH SERV. RSCH. 1184, 1186 (2008); *see also* Dornin et al., *supra* note 35, at 301.

[72]Dornin et al., *supra* note 34, at 299.

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Government-owned organizations operate using tax revenues as well as other state and federal resources.[73] Some researchers who have studied the differences between ownership structure and quality of care identified lower quality of care in for-profit settings.[74] Regardless, it seems that for-profit entities in LTC continue to increase in number.[75] Chain ownership, i.e., ownership of two or more facilities under one entity, is also increasing, leading to further consolidation of the LTC industry.[76]

As discussed in the previous Section, the ACA Nursing Home Provisions, as well as the Reform Act, developed several requirements for nursing facilities, including maintaining enough nursing personnel on a 24-hour basis to provide the required care in accordance with patient care plans.[77] However, quality standards continue to be a significant problem. For example, while there are direct provisions requiring registered nurses to be available in the facility, in reality, much of the physical care in nursing facilities is administered by certified nursing assistants ("CNAs").[78] The majority of CNAs receive limited compensation, have limited education, and are expected to work long hours leading to burnout and eventual staff turnover.[79] Some states have attempted to compensate front line facility staff more equitably through targeted increases in state Medicaid funding, but there is still much to be done.[80]

Ongoing issues continue to be associated with quality of care in LTC facilities. Furthermore, many facilities perform poorly on metrics such as staffing levels, pain control, and patient infections.[81] This reality coupled with high staff turnover has caused significant issues in patient well-being generally and even more so during the current COVID-19 pandemic.[82] Further issues arise with the continued proliferation of private equity investment in the industry. The next Section delves further into this part of the LTC facility narrative. It describes, first, what is meant by private equity ownership and then moves into discussing some of the current implications of private equity ownership on LTC facilities.

III. PRIVATE EQUITY OWNERSHIP OF LTC FACILITIES

A. How is Private Equity Ownership of LTC Facilities Structured?

Private equity ownership in health care generally has increased dramatically in the last decade, rising from $41.5 billion in deals in 2010 to $119.9 billion in

[73]Grabowski & Stevenson, *supra* note 71, at 1200.

[74]*Id.*

[75]Ctr. for Medicare & Medicaid Serv., Nursing Home Data Compendium 1 (2015 ed.).

[76]Kaiser Family Foundation, Overview of Nursing facility capacity, financing, and ownership in the United States in 2011 (April 2018) (finding that over the 2009 through 2016 period, more than half of facilities were owned or leased by multi-facility organizations.); *see also* Dornin et al., *supra* note 35, at 299.

[77]*Hawes, supra* note 62, at 206-220*;* Klauber & Wright, *supra* note 55; *see also,* Dornin et al., *supra* note 34, at 300-301.

[78]Dornin et al., *supra* note 45, at 301.

[79]Eric Collier & Charlene Harrington, *Staffing Characteristics, Turnover Rates and Quality of Resident Care in Nursing Facilities*, 1 Rsch. Gerontological Nursing 3, at 161 (2008*).*; *see also* Dornin et al., *supra* note 34, at 302.

[80]Williams, *supra* note 68, at 302 (citing Brendan Williams, *NH Needs to Invest in Care for Seniors*, PORTSMOUTH HERALD (July 11, 2018), https://www.seacoastonline.com/news/20180711/nh-needs-to-invest-in-care-for-seniors (discussing a Massachusetts budget adopted in 2018, which provided for increases in wages and benefits for direct care staff and certified nurse's aides); *see* 2018 Mass. Acts 444.

[81]Nicholas G. Castle & Jamie C. Ferguson, *What is Nursing Home Quality and How is it Measured?*, 50 Gerontologist 4, 426-42 (2010).

[82]*Id.*; Chidambaram, Garfield, & Neuman, supra note 2.

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2019.[83] Private equity ownership in LTC has increased significantly over the same period.[84] With around 11% of LTC facilities across the country now owned by private equity firms, it is important to engage with the implications of this common ownership structure.[85] Furthermore, *the Private Equity Stakeholder Project* reported that "in 2020 there were 43 private equity driven nursing home acquisitions valued at $1.5 billion."[86] These numbers suggest that private equity acquisitions of LTC facilities have not slowed and there are no indications that they will slow in the near future.

Private equity firms are characterized by short term investments.[87] Unlike traditional corporate ownership, private equity ownership is set up for investors to make money within a short period of time, usually between three and ten years, after which the asset is liquidated.[88] In this structure, the longevity of the company is not the goal. Instead, the immediate profit benefits are the primary drivers of action.[89] This system can operate in multiple ways, but the most common process is the leveraged buyout ("LBO").[90] During the time of ownership, the private equity firm exerts management control of the company in order to maximize its profitability.[91] Once the time period for investment is completed, the portfolio company is sold and the profits realized are distributed between the investors of the original fund and the private equity firm itself.[92]

B. Benefits of Private Equity Ownership of LTC Facilities

Proponents of private equity ownership of LTC facilities argue that private equity ownership increases management efficiency, facilitates technological advances, and leads to more coordinated care for patients.[93] Additionally, private equity firms have the resources to infuse the facility with legal, health, and compliance expertise.[94] The managing firms

[83]Richard M. Scheffler, Laura M. Alexander, and James R. Godwin, Soaring Private Equity Investment in the Healthcare Sector: Consolidation Accelerated, Competition Undermined, and Patients at Risk 2 (American Antitrust Institute 2021).

[84]Atul Gupta, Sabrina T. Howell, Constantine Yannelis, and Abhinav Gupta, Does Private Equity Investment in HealthCare Benefit Patients? Evidence from Nursing Homes, 1 (Nat'l Bureau of Econ. Rsch., Working Paper No. 28474, 2021); Rohit Pradhan et al., *Private Equity Ownership of Nursing Homes: Implications for Quality*, 42 J. Health Care Fin. 2 (June-July 2014); Alex Spanko, *COVID-19 Brings Private Equity Investment in Nursing Homes into the Spotlight*, Skilled Nursing News (March 19, 2020), https://skillednursingnews.com/2020/03/covid-19-brings-private-equity-investment-in-nursing-homes-into-the-spotlight/.

[85]Spanko, *supra* note 83.

[86]Andrew Metrick & Ayako Yasuda, *The Economics of Private Equity Funds*, 23 The Rev. of Fin. Stud. 6, 2303-2341 (2010); Pradhan et al., *supra* note 83; Spanko, *supra* note 83.

[87]Eileen O'Grady, Priv. Equity Stakeholder Project, Pulling Back the Veil on Today's Private Equity Ownership of Nursing Homes (2021) https://pestakeholder.org/wp-content/uploads/2021/07/PESP_Report_NursingHomes_July2021.pdf.

[88]Metrick & Yasuda, *supra* note 86; Pradhan et al., *supra* note 83.

[89]Pradhan et al., *supra* note 83; Elizabeth De Fontenay, *Private Equity's Governance Advantage: A Requiem*, 99 B. U. L. Rev. 1095, 1104 (2019).

[90]Metrick & Yasuda, *supra* note 86; Gupta et al., *supra* note 83 at 8.; Pradhan et al., *supra* note 83; In an LBO, the private equity firm creates a fund by collecting investments from private investors. With the money raised, the fund seeks a secured loan from which to purchase a portfolio company. (Elisabeth De Fontenay, *Private Equity Firms as Gatekeepers,* 33 Rev. Banking & Fin. L. 115, 122-23 (2013)).

[91]De Fontenay, *supra* note 89, at 1104 ("Private equity firms do not pursue good governance for its own sake. The goal… is for private equity's governance advantage to translate into an advantage in firm value…").

[92]Aline Bos & Charlene Harrington, *What Happens to a Nursing Home Chain When Private Equity Takes Over? A Longitudinal Case Study*, 54 Inquiry: The J. of Healthcare Org., Provision, and Fin., 1-10 (2017); *see also* Gupta et al., *supra* note 83 at 9.

[93]Robert Tyler Braun et al., *Comparative Performance of Private Equity-owned US Nursing Homes During the COVID-19 Pandemic,* 3 JAMA Network 10 (2020); Gupta et al., *supra* note 83 at 10.

[94]Braun et al., *supra* note 93.

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may institute considerable organizational changes or continue to manage the facility as is. For example, while some cross-sectional research has shown that private equity-owned LTC facilities have lower staffing, some longitudinal studies show that, in fact, it might be that private equity firms are purchasing portfolio companies that already incorporate a strategy of low staffing levels.[95] This makes intuitive sense, given the goal of short-term profitability. The less time new management has to spend on changing operations toward profit maximization, the fewer resources need to be introduced into the facility to implement needed changes, and the faster a facility meets that goal. Overall, after private equity purchase, LTC facilities tend to expand and run more efficiently.[96]

Some research has shown that private equity efficiency models increase financial performance.[97] Specifically, increasing productivity has meant reducing costs for customers, which, from the consumer's perspective, is a significant benefit.[98] Additionally, researchers found that there was "no direct evidence of a decline in quality metrics for long-stay residents in private equity owned nursing homes in Ohio relative to other for-profit nursing homes in the state."[99] From this perspective, the effects of private equity ownership in health care are contingent on the extent to which profit maximization incentives are aligned with the social goals of quality care at a reasonable cost.[100] The organizational changes implicit in LBOs mean a company will likely improve its overall financial performance and maximize value when providing services.[101] This stream of research reports that private equity nursing homes "show better financial performance than other for-profit nursing homes."[102] Despite these reported benefits, there are substantial criticisms of private equity ownership of LTC facilities.

C. Criticisms of Private Equity Ownership of LTC Facilities

Strategies undertaken by private equity firms have a direct impact on the company itself and an indirect impact on the patients and staff. Private equity-owned LTC facilities tend to be located in urban markets as part of a larger chain of facilities.[103] Additionally, because profitability for the LTC facilities tends to be based on the facility's

[95]Bos & Harrington, *supra* note 92, at 8; *see also* De Fontenay, *supra* note 89, at 1104 ("[P]rivate equity firms may be more willing than typical management to make difficult decisions that improve operational efficiency, such as approving layoffs, spinning off underperforming divisions and even replacing top executives.").

[96]Gupta et al., *supra* note 83, at 7 (finding that private equity own facilities aggressively respond to Medicaid expansion as a profitable enterprise).

[97]Steven N. Kaplan & Antoinette Schoar, *Private Equity Performance: Returns, Persistence, and Capital Flows*, 60 J. of Fin. 4, 1791-1823 (2005).

[98]Gupta et al., *supra* note 83 at 8; *see also,* Quentin Boucly et al., *Growth LBOs*, 102 J. of Fin. Econ. 2, 432-53; Josh Lerner et al., *Private Equity and Long Run Investment: The Case of Innovation,* 66 J. of Fin. 2, 445-77 (2011); Steven J. Davis et al., *Private Equity, Jobs, and Productivity*, 104 Am. Econ. R.12, 3956-90 (2014); Charlie Eaton et al., *When Investor Incentives and Consumer Interests Diverge: Private Equity in Higher Education*, 33 R. of Fin. Stud. 9: 4024-60 (2019) (providing an alternative view that in another highly subsidized industry, there is evidence that private equity creates firms value at the consumers' expense).

[99]Erin Fuse Brown, Loren Adler, Erin Duffy, Paul B. Ginsburg, Mark Hall, and Samuel Valdez, Private Equity Investment as a Divining Rod for Market Failure: Policy Responses To Harmful Physician Practice Acquisitions, USC-Brookings Schaeffer Initiative for Health Policy, 2021) [hereinafter Brookings](citing Sean Shenghsiu Huang & John R. Bowblis, *Private Equity Ownership and Nursing Home Quality: An Instrumental Variables Approach*, 19 Int. J. Health Econ. Manag.. 273 (2019)).

[100]Gupta et al., *supra* note 83, at 6.

[101]Bos & Harrington, *supra* note 92, at 1.

[102]*Id.* at 1 (citing Rohit Pradhan, Robert Weech-Maldonado, Jeffrey S. Harman, Kathryn Hyer, *Private Equity Ownership of Nursing Homes: Implications for Quality*, 42 Journal of Health Care Finance 2 (June/July 2014)).

[103]Gupta et al., *supra* note 83, at 2.

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ability to extract as many funds as possible out of government subsidies, such as Medicare and Medicaid, private equity-owned facilities are often located in states with higher elderly populations.[104] For facilities more dependent on Medicare, which provides reimbursements for shorter time limits for patient stays, private equity firms may make management decisions that either institute or maintain previous strategies that promote shorter stays, which increase the amount of admissions for each bed.[105] Under these circumstances, the goals of profit maximization and human-centered patient care may not be aligned with the reimbursement and regulatory structure that creates perverse incentives for owners to deprioritize patient care.

In March 2021, The House Ways and Means Committee on Oversight held a hearing on "Private Equity's Expanded Role in the U.S. Health Care System."[106] During this hearing, speakers testified to some of the significant concerns around private equity in the health care industry.[107] These testimonies called attention to the ways that incentives in private equity ownership tend to be distinct from—and have distinct outcomes from—traditional corporate ownership.[108] While the private equity incentive structure might be successful in reducing cost inefficiencies and increasing productivity, it has also led to a deterioration in patient care while the firms continue to be able to capitalize on government subsidies.[109] For example, patients, especially in rural areas, have little to no choice between LTC providers, and, since the facilities are structured to retain government subsidies that are not tied to patient quality care, there is no incentive for the private equity firm to prioritize care.[110] Additionally, private equity ownership may result in less money for operations because the organization's ongoing increased debt from financing the purchase leads to less money earmarked for patient care.[111] This is especially the case if the strategies identified for maximizing profit are not aligned with the strategies identified for providing quality patient care.[112] Furthermore, there is limited business rationale for providing patient-centered care because the income does not come directly from the consumers/patients, but rather from external sources such as Medicare and Medicaid.[113]

An additional criticism of private equity ownership of LTC facilities flows from their structure as either LLCs or limited partnerships.[114] Unlike corporations, which must organize according to corporate rules within a given state, LLCs are primarily contractual entities with limited requirements outside of the private agreements between the parties involved.[115] These entity forms allow for maximum flexibility in management decision-making because there is very little, if any, reason for them to seek approval or explain their reasoning.[116] This means that decisions like staffing reductions and other cost-cutting

[104] *Id.* at 14.

[105] *Id.* at 34-35 (reporting that admissions in private equity firms "increase by 3.5%, or 6.5 patients per year for the average facility).

[106] *Private Equity in Healthcare: Hearing Before the H. Ways and Means Oversight Subcomm.*, 117th Cong. 1-10 (2021) (statement of Sabrina T. Howell, Assistant Professor, NYU Stern School of Business & NBER), https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/S.%20Howell%20Testimony.pdf.

[107] *Id.* at 3-4.

[108] *Id.* at 3.

[109] *Id.* at 4.

[110] *Id.*

[111] O'Grady, *supra* note 87, at 3.

[112] Gupta et al., *supra* note 83, at 4.

[113] *Id.* at 11.

[114] Joseph A. McCahery & Eric P. M. Vermeulen, *Private Equity Regulation: A Comparative Analysis*, 16 J. Mgmt. & Governance 197, 198 (2012).

[115] *Id.* at 210.

[116] O'Grady, *supra* note 87, at 2.

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strategies tend to occur without any accountability or transparency mechanisms in place and without regard for the actual needs of patients.[117] Furthermore, these LLCs or limited partnerships are embedded in multiple layers and complex matrices of other LLCs and limited partnerships that make it difficult for outsiders to understand who owns what.[118] This added complexity allows private equity firms to benefit from the financial investments without having to deal with the reputational risks associated with reductions in actual patient care.[119]

Private equity's profit maximizing incentives can be particularly detrimental to consumers because they can lead to a breach in the implicit contract to provide the best care possible.[120] In health care, patients have limited knowledge about their best care options while LTC staff themselves are positioned to make the best decisions for their patients. The asymmetry in knowledge and understanding means patients depend on providers to decide how they will be cared for and treated during their stay.[121] These contracts are not explicitly stated, "so profit maximizing incentives can lead firms to renege on implicit contracts to provide high quality care, creating value for the firms at the expense of patients."[122]

D. Current Implications on the State of the Research

In sum, although there continue to be strong sentiments on both sides of this debate around the risks, benefits, and consequences of private equity ownership of LTC facilities, the research literature continues to be mixed. Some researchers have asserted that it is unclear whether the detrimental impacts are a product of private equity specifically or "whether in the absence of private equity, other sources of capital—such as public equity, venture capital, health systems, and insurers—would similarly exploit existing market failures and legal loopholes in the health care system."[123] They argue that the issue is more upstream and that the majority of the policies should be focused on general market dysfunction.[124] Others have found that private equity ownership over and above general

[117]Martin B. Hackmann, *Incentivizing Better Quality of Care: The Role of Medicaid and Competition in the Nursing Home Industry*, 109 Am. Econ. Rev. 1684, *passim* (2019); Martin B. Hackmann & R. Vincent Pohl, *Patient vs. Provider Incentives in Long Term Care* 1, 3 (Nat'l Bureau of Econ. Rsch., Working Paper No. 25178, 2018); Gupta et al., *supra* note 83, at 3; David C. Grabowski & David G. Stevenson, *Ownership Conversions and Nursing Home Performance*, 43 Health Servs. Rsch. 1184, 1198-99 (2008); *see also,* David G. Stevenson & David C. Grabowski*, Private Equity Investment and Nursing Home Care: Is it a big deal?* 27 Health Affs. 1399, *passim* (2008); Charlene Harrington, Helen Carillo, Rachel Garfield, & Ellen Squires, *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 through 2016* (Apr. 3, 2018), https://www.kff.org/medicaid/report/nursing-facilities-staffing-residents-and-facility-deficiencies-2009-through-2016/ [https://perma.cc/DGQ6-ZX3Y]; Charlene Harrington, Brian Olney, Helen Carillo, & Taewoon Kang, *Nurse Staffing and Deficiencies in the Largest For-Profit Nursing Home Chains and Chains Owned By Private Equity Companies*, 47 Health Servs. Rsch. 106, 106 (2012); Charlene Harrington, Steffie Woolhandler, Joseph Mullan, Helen Carrillo, & David U. Himmelstein, *Does Investor Ownership of Nursing Homes Compromise the Quality of Care?*, 91 Am. J. Pub. Health 1452, 1454 (2001).

[118]*Id.* at 4.

[119]*Id.*

[120]Gupta et al., *supra* note 83, at 5; *see also* Bos & Harrington, *supra* note 92, at 5, 8.

[121]Mark A. Hall, *Law, Medicine and Trust*, 55 Stan. L. Rev. 463, 477-78 (2002); *See generally,* Hackmann & Pohl, *supra* note 117.

[122]Gretchen Morgenson and Emmanuelle Saliba, Private Equity Firms Now Control Many Hospitals, ERs and Nursing Homes. Is it Good for Healthcare?" NBC News (May 13, 2020), https://www.nbcnews.com/health/health-care/private-equity-firms-now-control-many-hospitals-ers-nursing-homes-n1203161.

[123]Brookings, supra note 99, at 1.

[124]*Id.* at 2 (recommending that policies: address "loopholes that raise costs for consumers and taxpayers; "[e]nhance enforcement under antitrust and employment laws;" "[i]ncrease fraud and abuse enforcement;" and to the extent that private equity raises specific risks, "explore policies" that would work).

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for-profit ownership leads to some of the most egregious negative effects.[125] These researchers have outlined some of the outcomes that tend to occur with private equity acquisitions.[126] While the business becomes more efficient, patient quality of care declines.[127] Overall, characterized by such issues as excessive bedsores on patients, unnecessary drug provision, and resident rights violations, "private equity ownership appears to be responsible for at least a large share of the negative effects that some studies have found following chain or other corporate acquisitions."[128]

The remainder of this Note will focus on some of the responses to concerns about private equity ownership of LTC facilities, a discussion on management-focused and patient-focused incentive strategies, and a theoretical discussion of incentive alignment strategies for and limitations of private equity ownership of LTC facilities.

IV. ALIGNING FINANCIAL AND PATIENT CARE INCENTIVES

Since the Affordable Care Act was passed in 2010, health care providers have been encouraged to form accountable care organizations, which are "clinically integrated organizations of primary care physicians and other providers that, through various payment mechanisms, are rewarded for both raising the quality and lowering the cost of care provided to their patients."[129] In the health care industry, there has been some significant movement toward value-based models for increasing patient care by linking financial incentives to patient quality of care.[130] This includes pay-for-performance strategies, bundled payments, and shared savings.[131]

In pay-for-performance strategies, "providers who perform well on selected quality and efficiency measures receive higher payment rates or bonuses while those who perform poorly often receive lower payments."[132] "Risk-based alternative payment models such as bundled payments and shared savings hold providers accountable for the cost of care by shifting financial risk to providers."[133] Accountable care organizations are health care organizations where providers "voluntarily come together to provide coordinated care and agree to be held accountable for the overall costs and quality of care for an assigned population of patients."[134]

There are two primary forms of incentive structures in these value-based models: relative attainment and absolute attainment.[135] A relative attainment incentive structure measures performance of a provider relative to others and is one way to account for the inability to determine an objective measure of patient outcomes. This is especially the case

[125]Gupta et al., *supra* note 83, at 3.
[126]Howell, *supra* note 106, *at 5.*
[127]*Id.*
[128]*Id.* at 2; *see also* Paul J. Eliason et al., *How Acquisitions Affect Firm Behavior and Performance: Evidence from the Dialysis Industry,* 135 Q. J. ECON. 221, 260-62 (2020).
[129]Jessica Mantel, *Accountable Care Organizations: Can we Have our Cake and Eat it Too*?, 42 SETON HALL L. REV. 1393, 1393 (2012).
[130]*Id.*; *see also* Danielle Pelfrey Duryea, Nicole Huberfeld, and Ruqaiijah Yearby, *Disparities in Health Care: The Pandemic's Lessons for Health Lawyers,* in AHLA HEALTH LAW WATCH, 31 (2021) (examining the significant proliferation of value-based models, [w]ith nearly 36 percent of total U.S. health care payments linked to value-based alternative payment models in 2018—up from 23 percent in 2015")
[131]Jessica Mantel, *An Unintended Consequence of Payment Reforms: Providers Avoiding Nonadherent Patients,* J. L., MED., & ETHICS 931, 931 (2018).
[132]*Id.* at 933.
[133]*Id.*
[134]*See* Cheryl L. Damberg et al., *Measuring Success in Health Care Value-Based Purchasing Programs*, 4 RAND HEALTH Q. 9, xx-xxi (2014).
[135]*See Id.* at xix.

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when some patients may be sicker than others and need different kinds of care.[136] However, a relative incentive structure "can promote a race to the top, creating perverse incentives for providers to allocate resources to improvement on a measure that may not yield the greatest clinical benefit and which may lead to overtreatment of patients."[137] Absolute attainment models provide clear thresholds and benchmarks for providers to hit to experience a benefit.[138] However, with absolute attainment thresholds, "some payers express concern that this approach removes the motivation for providers to continue to improve once the threshold has been attained."[139] This also "creates budgeting challenges for payers, who will not be able to estimate how many providers they will need to pay."[140]

In addition to the organizational challenges of incentive structures for individual providers, there are also agency considerations. Research on financial incentive impacts on professionals has emerged with two interesting findings:[141] (1) providers are generally responsive to incentive structures and adjust their actions to receive the highest benefit;[142] (2) however, providers' attitudes toward the incentive arrangement affects the strength of their response. [143] Specifically, "improved performance was substantially stronger among those physicians who … indicated relatively less concern about the incentive program as a threat to their autonomy."[144] Therefore, as long as providers do not see an incentive scheme as a threat to their ability to make autonomous decisions, incentive structures can have a significant impact on provider performance. Additionally, "professionals will demonstrate greater responsiveness to the incentives if they believe that incentive-related performance targets are important to promote their professional goals."[145]

While value-based patient care has provided interesting ways to experiment with improving patient care by shifting the risk of health care from patients to providers, our common and statutory laws still furnish protections for providers in such a way that allows them to shift the burden back to patients.[146] Providers can choose and retain their clients based on the provider's chances of receiving financial incentives.[147] In LTC, this means that the riskiest patients in need of LTC will struggle to find a facility that will accept them.[148] Furthermore, while strategies that incentivize individual or groups of providers can be beneficial, these methods do not necessarily focus on the role of the larger organization where these providers operate (e.g. hospitals or care facilities) and its own risks and responsiveness to incentives.

In LTC, given that most of the individual providers are lower-status licensed or non-licensed workers and have limited decision-making power, individualized incentives

[136] *Id.* at xx.
[137] *Id.* at xix.
[138] *Id.* at xx.
[139] *Id.*
[140] Gary J. Young et al., *Financial incentives, professional values and performance: A study of pay-for-performance in a professional organization*, 33 J. Organizational Behav. 964, 980 (2012).
[141] *Id.* at 976-77.
[142] *Id* at 980.
[143] *Id.* at 980.
[144] *Id.* at 977.
[145] *Id.*
[146] *See e.g.,* Mantel, *supra* note 131; *see also,* Jessica Mantel, *How Efforts to Lower Health Care Costs are Putting Patients & Providers on a Collision Course*, 44 Ohio Northern U.L. Rev. 371 (2018).
[147] Mantel, *supra* note 132; *See also* Pelfrey Duryea et al., *supra* note 130, at 32 (writing that, "[l]ower socioeconomic status (SES) and BIPOC populations are overrepresented among the patients likeliest to be 'lemon-dropped' from provider groups participating in VBP programs, in significant part because of the influence of intermediary social determinants of health.").
[148] Mantel, *supra* note 131, at 932-33.

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may fall short of what is needed to make any significant changes in patient care.[149] Additionally, the ownership structure of private equity-owned facilities is particularly complex so it is difficult to determine which individuals actually have the power to impact structural shifts within the individual facility.[150] These are just some reasons why the individualized incentives associated with accountable care organizations may, on their own, have limited utility in improving patient care in private equity-owned LTC facilities. In response to these potential challenges, the next Section theorizes an organizational-level incentive structure.

V. PRELIMINARY THEORETICAL DISCUSSION OF REGULATORY-ORGANIZATIONAL INCENTIVES TO ALIGN PATIENT QUALITY CARE WITH FINANCIALLY EFFECTIVE PRIVATE EQUITY OWNERSHIP OF LTC FACILITIES

While much of the literature regarding health care performance incentives focuses on the individual professional,[151] individual incentives are insufficient and ignore the structural contexts under which professionals make decisions. In terms of private equity ownership of LTC facilities, an incentive structure that benefits the organization as corporate person may be more effective than one geared toward individual professionals. There are at least two important reasons for this shift.

First, while in general health care, physicians, licensed nurses, and nurse practitioners continue to be the dominant care providers, LTC facilities are staffed primarily by unlicensed aides and lower-status licensed workers, with only a small number of licensed professionals.[152] In 2016, 63.9% of all full-time nursing home staff were CNAs, with registered nurses making up only 11.9% of the full-time staff.[153] For LTC, this means that individual provider incentives are less applicable because aides, though providing the day-to-day care, are not the ultimate decision-makers around that care. A focus on individual incentives through value-based models is not necessarily effective if the caretakers are not the ultimate decision makers. If there is limited autonomy, as in the case of CNAs, individual incentives will not impact action.

Second, for LTC facilities, the goal is patient quality of life. While LTC facilities employ nurses and other medical professionals, the primary focus of LTC facilities is not actual medical care, but patient well-being. Patients are probably in the facility because positive outcomes are limited, whether their care is for end of life or recovery from a serious medical issue.[154] Therefore, a value-based model focused on patient outcomes would not necessarily be sensible.

Even given these critiques, there are two examples of value based models in the LTC arena. The first example is the *Skilled Nursing Facility Value-Based Purchasing Program* implemented by CMS.[155] For this program, the metric used for evaluation is hospital readmission. This metric does not account for differences in "patient social risk

[149]Harris-Kojetin et al. *supra* note 16.
[150]*See* discussion *supra* Section III.
[151]*See* discussion *supra* Section IV.
[152]Harris-Kojetin et al. *supra* note 16, at 11.
[153]*Id.*
[154]*Id.*
[155]*See* Maggie Flynn, *MedPAC: SNF Value-Based Purchasing Program Should "Be Eliminated and Replaced As Soon as Possible'* (June 21, 2021), https://skillednursingnews.com/2021/06/medpac-snf-value-based-purchasing-program-should-be-eliminated-and-replaced-as-soon-as-possible/.

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factors" and does not provide any real impact on actual patient quality care.[156] The second example is the LTC ACO launched by Genesis HealthCare.[157] There has been a lot of excitement regarding its potential and as of 2019, it had succeeded in significant savings for providers.[158] However, this model still focuses primarily on the associated physicians and has no impact on the internal operations of the given facility outside of the physician relationship. The facility takes on limited or no risk and patient quality of care is not necessarily increased.[159] The incentives are towards reducing patient stays and hospital readmissions, but not on patient quality of life per se.[160]

Overall, the goal of a private equity firm is to make money for their investors, not health care providers. If all the incentives are targeted at individual providers, there are limited reasons for a private equity-owned facility to promote this kind of structure. There is ultimately no benefit to the private equity firm at the level of the individual provider. It is for these reasons that an incentive approach should be on the organizational level.

A. Organizational-level Pay for Performance

One way to make an incentive structure more relevant is to shift the reimbursement rate incentives from individual providers to the private equity-owned facility or facility chain as a whole. Specifically, an organization—and not the workers—would receive a higher reimbursement rate if patient care metrics are within certain parameters. Some theorizing around value-based payments has suggested a similar idea, considering metrics such as improving staffing, maintaining infection control, and prioritizing services that benefit patient quality of life.[161] Furthermore, to account for the issues associated with absolute as well as relative measures, instead of creating one threshold, one could create a graduated reimbursement schedule where reaching the highest level of patient care results in the highest reimbursement from Medicaid and Medicare. Although this would not have an impact on organizations that primarily take on private paying patients, adding a secondary incentive of graduated substantial healthcare payments to providers of LTC services could fill this gap. For example, this could mean a simple incentive payment each year as long as patient quality of care remains high.

The Department of Health and Human Services ("HHS") plan under the Coronavirus Aid, Relief, and Economic Security ("CARES") Act in 2020 included a proposed structure similar to the one I suggest. The CARES Act planned to tie incentive payments to patient well-being in terms of COVID-19.[162] Specifically, HHS set aside $2 billion to

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[156] *Id.*

[157] Rod Baird, *First Long-Term Care Accountable Care Organization Unveiled at Society Meeting*, Practice Management (June 2017), https://www.caringfortheages.com/action/showPdf?pii=S1526-4114%2817%2930201-9.

[158] *Id.*; Alex Spanko, *Genesis's LTC ACO Pulls In $18.8M in Shared Savings for 2019* (Oct. 14, 2020), https://skillednursingnews.com/2020/10/genesiss-ltc-aco-pulls-in-18-8m-in-shared-savings-for-2019/

[159] Spanko *supra* note 158; Maggie Flynn, *Confessions of a Skilled Nursing Operator: "ACOs Have Been a Disaster for SNFs'* (June 23, 2019), https://skillednursingnews.com/2019/06/confessions-of-a-skilled-nursing-operator-acos-have-been-a-disaster-for-snfs/.

[160] Flynn *supra* note 159.

[161] See e.g. Thomas Rapp and Katherine Swartz, Implementing Value-Based Aging in our Long-Term Care Systems, Value &Outcomes Spotlight (2021), https://www.ispor.org/publications/journals/value-outcomes-spotlight/vos-archives/issue/view/the-benefits-and-challenges-of-aging-in-place/implementing-value-based-aging-in-our-long-term-care-systems; Jenna Libersky, Debra Lipson, and Denise Stone, To Address Long-Term Care Issues, Focus on Value, Mathematica (Mar. 24, 2021), https://www.mathematica.org/blogs/to-address-long-term-care-issues-focus-on-value.

[162] *See Past Targeted Distributions*, Health Res. & Servs. Admin. (last reviewed June 2021), https://www.hrsa.gov/provider-relief/past-payments/targeted-distribution [https://perma.cc/6ZYJ-LBVV].

provide nursing homes with incentive payments if their COVID-19 infection rates were below the infection rates in the county where they were located.[163] Thomas Engels, the previous administrator for the HHS Health Resources and Services Administration, said, "we anticipate that linking payment to performance will be an effective means of holding nursing homes accountable, stimulating innovation, and encouraging them to reach beyond their own walls for infection control expertise and support."[164]

This kind of organizational level reimbursement or grant for performance would have the additional benefit of adding more resources to facilities for operational improvements. More precisely, private equity-owned facilities are critiqued because they are often purchased using an LBO, and therefore tend to spend much of their resources paying interest on the accrued debt from the purchase.[165] This reduces the amount of money available for staffing and other technical improvements that could improve patient care. Incentivizing the facility with infusions of capital based on patient care may propel the structural changes needed to create conditions for the best possible care. This strategy would balance the managerial and financial efficiency motives of the private equity firm with the patient-care metrics for the facility itself.

Critics might argue that this approach rewards facilities for merely providing the services they should already be providing to patients. To this, I would respond that the graduated approach is a key component to this model. Specifically, the better the patient care, the higher the reimbursement or grant payment. This is a simplified response to a complicated issue, and it would take significant time to develop the appropriate metrics and measurements. Nevertheless, this would be a worthwhile endeavor. Additionally, others might argue that the funding required to make this organizational incentive worth it to facilities may be out of reach for federal and state governmental entities. This concern is valid given the amount of funding currently allocated to LTC.[166] However, the COVID-19 pandemic brought attention to the experiences of patients in U.S. elder care facilities and, created a significant opportunity for reassessing the governmental budgets to reallocate appropriate resources in this area.

B. Time-Bound Incentives

One of the issues with private equity ownership of LTC facilities is that they are only owned over a short period of time and are meant to maximize profit in the immediate term.[167] An incentive program to stretch out the amount of time LTC facilities are owned by private equity firms may be beneficial. One option is reducing tax burdens based on the longevity of the ownership. Another option is developing graduated incentive payments based on how long the company is owned by the same firm. Finally, it might be worth considering a schematic that weighs patient care over time. Instead of length of ownership alone being incentivized, length of ownership with increasing patient care benefits is

[163] *Trump Administration Announces $2 Billion Provider Relief Fund Nursing Home Incentive Payment Plans*, Ins. News Net (Sept. 3, 2020), https://insurancenewsnet.com/oarticle/trump-administration-announces-2-billion-provider-relief-fund-nursing-home-incentive-payment-plans [https://perma.cc/A3HH-22BU].

[164] *HRSA to Start Allocating Next CARES Act Relief for Nursing Homes in mid-August*, Am. Health Ass'n (Aug. 10, 2020, 3:00 PM) (internal quotations omitted), https://www.aha.org/news/headline/2020-08-10-hrsa-start-allocating-next-cares-act-relief-nursing-homes-mid-august [https://perma.cc/QJK8-DRA2].

[165] *See* O'Grady, *supra* note 87, at 3.

[166] *Compare* Who Pays for Long-Term Services and Supports? Congressional Research Service In Focus (August 5, 2021) (reporting that public expenditures for long-term services and supports is currently calculated at $296 billion), *with* Defense Budget: Opportunities Exist to Improve DOD's Management of Defense Spending (Feb. 24, 2021) (reporting that the U.S. defense budget in 2020 was $714 billion).

[167] *See* discussion, *supra* Section III.B.

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incentivized. For example, the longer patient care continues to be at higher quality levels, the larger the incentive or tax benefit for the organization. These kinds of time-bound incentives prioritize stability and long-term strategy over short-term gains.

One criticism of this approach may be that it could have the unintended consequence of private equity firms retaining ownership of LTC facilities even longer than is actually beneficial for investors. The goal for firms is to hold investments long enough to realize profits (the harvest period), but not so long that the returns on the investments begin to flatten.[168] Furthermore, during the fund formation phase, private equity firms may have more difficulty navigating investment relationships without a distinct possibility of short-term gains. While these consequences present potential challenges, these concerns also assume that shifting to a long-term strategy is not in line with short-term gains. This is not necessarily true. In fact, this approach may allow for more innovative ideas around management strategies that take both short-term gains and long-term sustainability into account. For example, investors may take more seriously other options for acquisitions other than the LBO and all of its debt implications.[169]

C. Investor-Specific Incentives

A third theoretical incentive structure entails connecting the individual level to the organizational level by incentivizing the private equity investors as additional stakeholders in the process of LTC private equity ownership. Profit maximization in the short-term is the goal for private equity because these investments directly impact investors.[170] While the general partner in an investment fund has direct control over a firm's investments, the investors or limited partners have indirect control through financing power.[171] Thus, an engaged investor has the opportunity to request certain management practices especially if they align with the potential for higher returns.[172] To this end, structuring an incentive process where both the facility and the investors receive financial incentives for patient quality of care can make a difference. This can occur through slightly increasing the investor percentages on their returns or even delivering direct cash to investors. This structure aligns investor goals with the goals of the LTC providers and brings divergent interests together.

There is one significant challenge to this theoretical approach. The process of engaging directly with private investors may not be simple because of the complexities around the structure of private equity investments.[173] Many times, it can be difficult to even figure out which facilities are owned by private equity firms, so it may be particularly difficult, if not impossible, to determine who the actual investors might be.[174] While this may be the case, if an investor-incentive process is well-drafted and codified, it is less

[168]The Life Cycle of Private Equity: Private Equity managers aim to create value by providing investment capital to a wide range of businesses, https://pws.blackstone.com/wp-content/uploads/sites/5/2020/09/the_life_cycle_of_private_equity_insights.pdf.

[169]*See* discussion, *supra* Section III.C.

[170]*See* discussion, *supra* Section III.

[171]*Id.*

[172]*See supra* note 161.

[173]*See* discussion, *supra* Section III.C.

[174]This may become easier in the future with the passage of the Corporate Transparency Act, that may make it more difficult for LLCs to operate without providing information about ownership. However, there is still uncertainty about how entity's may be impacted once the Act takes effect in January 2022. *See What You Need to Know about the Corporate Transparency Act,* https://www.natlawreview.com/article/what-you-need-to-know-about-corporate-transparency-act; *see also,* James J. Wheaton & Gustavo De la Cruz Reynozo, *We Have to Tell Them What?: The New Corporate Transparency Act and Forming Business Entities in Massachusetts.* (Unpublished Journal Article).

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important to determine who the investors are and more important to make sure that information about these structures are distributed to them when they are making investment decisions.

D. Overall Criticisms and Responses

Even though these theoretical musings for aligning incentives may be provocative, there are at least two criticisms that I can anticipate. First, an incentive structure does not appropriately deal with the criminal and civil infractions that are pervasive in the LTC industry in general. While this might be true, the current liability structure has not served to effectively curb these infractions either.[175] In fact, they create increased opportunities for developing loopholes.[176] Instead of reaching for the best, organizations are reaching for the bare minimum.[177] Furthermore, these ideas are not meant to and would likely not impact the behavior of those purely bad actors seeking to do harm. The incentive structure is focused on those organizations that are "neutral," i.e., their goal is profit maximization and is not human-centered. However, if a human-centered approach can be associated directly with profit maximization, then the theoretical strategies outlined above would be the most rational course of action.[178]

A second criticism is that any financial incentive would need to be substantial enough to actually impact decision-making within a private equity firm.[179] If they are not, then these kinds of incentives would only reach those facilities in need of extra financing and might create the unintended consequence of a larger gap between patient care in private equity-owned versus not private equity-owned facilities. While I agree that this is a real concern, it also depends on the incentive structure. If it is only tied to financial resources for the firm, then the federal and state governments will never have enough funding to properly incentivize the well-financed firms. However, if these financial incentives help support the private equity-owned facility's bottom line by increasing its profitability, this could have an impact on how the owning firms decide to do business.[180] The goal here would be to structure an incentive program that focuses on the owned organization itself and not on giving money directly to private equity.[181]

VI. CONCLUSION

The COVID-19 pandemic has brought significant concerns about patient care and safety within LTC facilities to the forefront of public discourse. This time has also exacerbated the debate around private equity-ownership of these facilities and the direct impact it has on patient care. The research is mixed on this, recognizing that it is not a

[175] *See* discussion, *supra* Section II.B.

[176] *See* discussion, *supra* Section III.C.

[177] *Id.*

[178] *See e.g,* Gary J. Young, Howard Beckman, & Errol Baker, *Financial incentives, professional values and performance: A study of pay-for-performance in a professional organization.* 33 J. Organizational Behav. 980 (2012).

[179] An added complexity are cases where private equity firms invest in companies that they may not necessarily have governance control over. These theoretical incentives only function based on an assumption that a private equity firms take complete control over the target company and works towards governance improvements; *See, e.g.,* De Fontenay, *supra* note 89, at 1113.

[180] *See* discussion, *supra* Section V.A. (suggesting that the organizational incentives be geared towards the facility or facility-chain).

[181] *Id.*

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foregone conclusion that private equity ownership has a negative impact on patient care. In fact, what the research seems to show is that if patient care is not aligned with private equity goals of short-term profit maximization, then patient care is subordinated to the larger profit motive. This means that aligning the financial goals of private equity ownership with the human-centered patient care goals can solve, some, if not most, of the patient care issues.

Value-based patient care models were developed in earnest based on requirements of the ACA Nursing Home Provisions and will continue to proliferate given the ongoing significant statutory incentives to do so.[182] However, these value-based models have been primarily focused on individual providers and patient outcomes based on curative care. In LTC, however, the patient care orientation is or at least should be palliative, which means incentives need be focused on the systems in place to facilitate this care as opposed to patient outcome measures.[183] With private equity owned facilities, these systems are not developed by the internal workers, but by the external management of the private equity owners. It is for this reason that I suggest that organizational level financial incentives would be a more effective way of incentivizing private equity-owned LTC facilities to focus on patient care.

In this Note, I posited three types of incentive structures. First, I suggest a pay-for-performance scheme geared toward the organization itself and not the individuals within the organization. Much of the management of these organizations remains outside of the facility itself, so targeting the actual facility-level structure set up by the private equity firm makes more sense. Second, an incentive structure that is time-bound and encourages longer term ownership of facilities, may provide an impetus for extended private equity LTC ownership. This facilitates a longer term orientation to profit maximization. Third, a structure that includes providing incentives directly to the investors would allow for alignment between those investing and patient care orientations. Even with these initial theoretical suggestions, there are significant potential pitfalls. Specifically, the suggestions do not necessarily alleviate the problems associated with the worst actors, and the incentives still need to be significant enough to have an impact on the decision-making of a private equity firm. Additionally, not all private equity firms are created equal, and they do not follow the same kinds of strategies.[184] Though one incentive structure might work for one firm, it may not work with all firms. For example, while an investor-specific incentive may be a good strategy for a firm with active or more socially conscious investors, it may be less effective if the investors of the firm are more passive. Further elaboration and theorizing about the details would help overcome these and other concerns.

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[182]Pelfrey Duryea et al., *supra* note 130, at 35-37. (describing the regulatory changes including Stark Law exceptions, safe harbors under the Anti-Kickback Statute, and HHS encouragement for states to use value-based models).

[183]Research has suggested that value-based models can successfully include metrics based on palliative care, however these metrics do not seem to be widely used. *See e.g.* Justin M. Glasgow, Zugui Zhang, Linsey D. O'Donnell, Roshni T Guerry, and Vinay Maheshwari, *Hospital Palliative Care Consult Improves Value-based Purchasing Outcomes in a Propensity Score-Matched Cohort*, 33 Palliative Medicine 456 (2019); *see also* Holly Vosell, Value-Based Models could Promote Palliative Care Integration https://hospicenews.com/2021/06/11/value-based-models-could-promote-palliative-care-integration/ (suggesting ways Hospice can integrate into value-based payment structures); Richard Bernstein and Laura Singh, *A Value-Based Payment Model for Palliative Care: An Analysis of Savings and Return on Investment*, 42 J. Ambulatory Care Manag., 66-73 (2019) (providing an example of how a value-based model for palliative care could make financial sense).

[184]Paul Gompers, Steven, and Vladimir Mukharlyamov, *What Private Equity Investors Think They Do For the Companies They Buy*, Harv. Bus. Rev. (June 18, 2015), https://hbr.org/2015/06/what-private-equity-investors-think-they-do-for-the-companies-they-buy.

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Overall, I conclude where I began. In the United States, for as long as LTC facilities and similar institutions have been in existence, they have struggled to provide the best care for those that seek their services. These patients are either members of a vulnerable population or are seeking help at a particularly vulnerable point in their lives. Focusing on whether private equity ownership is better or worse for LTC facilities and their patients misses opportunities to develop solutions. Instead, we can try to alleviate some of the negative consequences by creating a space to pursue better patient quality care. We can pursue this strategy even as our society continues to question whether private equity firms should be able to pursue these ownership opportunities at all.

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