What Steward Health Care’s bankruptcy means for patient care

Massachusetts lawmakers call on regulators to review Steward-UnitedHealth deal

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Lawmakers urge FTC, DOJ to scrutinize Steward Health, Optum deal

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Steward to sell physician group to UnitedHealth’s Optum Care

Steward’s legal battles offer insight into pattern of mismanagement

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Steward looks to transfer all 9 Massachusetts hospitals amid lawmaker backlash

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States Target Health Insurers’ ‘Prior Authorization’ Red Tape

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How Steward Health’s relationship with private equity soured

The Source Roundup: February 2024 Edition

Healthcare System Mergers and Investment

- **Models for Enhanced Health Care Market Oversight – State Attorneys General, Health Departments, and Independent Oversight Entities (*Milbank Memorial Fund*)**

Erin C. Fuse Brown, Katherine L. Gudiksen

The Source's own Katherine L. Gudiksen co-authored this report for the *Milbank Memorial Fund* with Eric C. Fuse Brown, which assesses the tools state policy makers are using to address harmful health care market consolidation. Specifically, the report focuses on how states have broadened review authority by expanding the existing authority of the Attorney General (or other state agencies) and providing supplementary oversight entities with an added authority to review health care transactions. The authors assessed applicable state statutes and regulations and interviewed state policy makers for their assessment. Based on their findings, the authors present a set of recommendations and considerations for policymakers that are aimed at strengthening the oversight authority of health care transactions.

- **Changes in Hospital Adverse Events and Patient Outcomes Associated with Private Equity Acquisition (*JAMA*)**

Sneha Kannan, Joseph Dov Bruch, Zirui Song

Researchers from Harvard University and the University of Chicago recently studied whether private equity acquisitions of hospitals had an impact on quality of care and patient outcomes. The group studied data from 100% Medicare Part A claims for over 660,000 hospitalizations at 51 private equity-acquired hospitals against data for over 4 million hospitalizations at 259 non-private equity acquired hospitals for the period of 2009 to 2019. Ultimately, the study found that private equity-acquired hospitals were generally associated with increased hospital-acquired adverse events, such as falls and infections, despite a likely lower-risk pool of admitted Medicare beneficiaries. These findings raise concerns about the implications of private equity acquisitions on the delivery of healthcare, suggesting that they may be correlated with poorer quality inpatient care.

Healthcare Coverage Alternatives

- **Looking AHEAD to State Global Budgets for Health Care (*The New England Journal of Medicine*)**

Suhas Gondi, Karen Joynt Maddox, Rishi K. Wadhera

Despite the Center for Medicare and Medicaid Innovation's (CMMI) projection that the Affordable Care Act (ACA) would result in a net savings of $3 billion over its first decade, the Congressional Budget Office (CBO) recently reported that the program actually increased federal healthcare spending by $5.4 billion. As we enter the ACA's second decade, the Centers for Medicare and Medicaid Services (CMS) have developed an ambitious plan to make improvements. The State Advancing All-Payer Health Equity Approaches and Development (AHEAD) model is a voluntary state model that is focused on curbing cost growth, improving population health, and advancing health equity over the next 10 years. This article examines the strengths and limitations of AHEAD's goals, assesses CMS' likeliness to meet their goals, and provides some policy and implementation recommendations. As the U.S. works towards payment-reform,

AHEAD could be a crucial strategy towards netting federal healthcare savings while improving population health.

- **Next Steps for Engaging Specialty Care in ACO Models (*Health Affairs Forefront*)**

Asher Wang, Katie Huber, Jonathan Gonzalez-Smith, Frank McStay, Mark B. McClellan, Robert S. Saunders

This article is the second in a two-part *Health Affairs* series on how differences in specialty care providers and practices should inform accountable care strategies. Picking up where they last left off, the authors of this article outline a set of recommendations that can help accountable care models achieve effective specialty care. Considerations and recommendations for achieving change are organized under three overarching strategic themes which include: providing data and facilitating data sharing for enhanced specialty and primary care coordination; expanding financial levers to support specialty care participation and collaboration in population-based and longitudinal models; and implementing non-financial reforms to increase support and reduce burdens for specialist engagement in accountable care.

- **Small Marketplace Premiums Pose Financial and Administrative Burdens: Evidence from Massachusetts, 2016-17 (*Health Affairs*)**

Adrianna McIntyre, Mark Shepard, Timothy J. Layton

While health insurance premiums have been widely thought to pose barriers to health coverage, the authors of this study assessed whether financially negligible monthly premium payments (<$10/month) also created administrative burdens that negatively impacted coverage. A study of 2016-17 health insurance marketplace data from Massachusetts found that introducing nominal monthly payments negatively affected enrollment for the following year when compared with plans that maintained a $0 premium. On average, plans

with nominal premiums saw enrollment decrease by 14% which was largely attributable to terminations for non-payment. Overall, even financially nominal premiums act as financial and administrative barriers to enrolment and could be addressed through policy changes.

- **Why Cost Sharing on Its Own Will Not Fix Health Care Costs (*JAMA Internal Medicine*)**

Anna D. Sinaiko, Benjamin D. Sommers

A new Viewpoint article in *JAMA Internal Medicine* has raised skepticism over whether high-cost sharing with high-deductible health plans (HDHPs) will fix the U.S.' recurring issue of high health care costs. Since the pandemic, health care utilization has largely returned to pre-pandemic levels as private sector health insurance costs have simultaneously increased. On average, premiums for employer-based family coverage have increased by 20% over the past 5 years. HDHPs, which can be linked to pretax health savings accounts, have been posited as a potential solution. The belief is that if patients have more skin in the game, they will avoid unnecessary care, shop for lower-priced services, and reduce health care inflation. The authors of this article are not convinced by such arguments and discuss how this approach will not meet its targets and may result in adverse harms for many high-need patients.

Quality and Price Transparency

- **Benchmark and Performance Progression: Examining the Roles of Market Competition and Focus (*Journal of Operations Management*)**

Xin (David) Ding

Despite spending almost 20% of its GDP on health care in 2020, the U.S. ranked last in administrative efficiency and healthcare outcomes among high-income countries. To address this situation, the Centers for Medicare and Medicaid

(CMS) brought forth value-based programs which tied medical reimbursements, in the way of penalties or incentives, to performance benchmarks. This study examined the effect of these benchmarks on healthcare delivery and patient outcomes by assessing hospital performance in terms of technical efficiency, clinical quality, and patient experience over time. Ultimately, the author found that while benchmarking does lead to hospital performance improvements, its effects diminish as hospitals approach performance frontiers. Moreover, they also found that technical efficiency was impacted by market competition and that focus had a curvilinear positive effect on progression rates.

- **Playing by the Rules? Tracking U.S. Hospitals' Responses to Federal Price Transparency Regulation (*Journal of Healthcare Management*)**

Sayeh Nikpay, Caitlin Carroll, Ezra Golberstein, Jean Marie Abraham

Beginning in 2021, most U.S. hospitals were required by the Centers for Medicare and Medicaid Services (CMS) to increase transparency for consumers by publishing pricing information on their websites at the risk of receiving noncompliance penalties. This study assessed hospital compliance with the new rule after the first year of enactment across a random sample of 470 hospitals. By early 2022, almost 90% of hospitals had complied with the consumer-shoppable data requirement and 46% of hospitals had posted both machine-readable and consumer-shoppable data. Generally, the study found a trend among hospitals towards compliance. Progressively increasing compliance can foster greater price transparency and has the potential to elevate future policy discussions on price variations, affordability, and the impacts of healthcare market regulation.

And with that, we conclude this month's roundup. If you find articles or reports that you think should be featured, please send them our way.

Steward aims to offload 4 hospitals