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# WHEN HEALTH CARE BECOMES WEALTH CARE: HOW CORPORATE GREED PUTS PATIENT CARE AND HEALTH WORKERS AT RISK

## HEARING

BEFORE THE

SUBCOMMITTEE ON PRIMARY HEALTH AND RETIREMENT SECURITY

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED EIGHTEENTH CONGRESS

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ON

EXAMINING WHEN HEALTH CARE BECOMES WEALTH CARE: HOW CORPORATE GREED PUTS PATIENT CARE AND HEALTH WORKERS AT RISK

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# C O N T E N T S

STATEMENTS

WEDNESDAY, APRIL 3, 2024

# WHEN HEALTH CARE BECOMES WEALTH CARE: HOW CORPORATE GREED PUTS PATIENT CARE AND HEALTH WORKERS AT RISK

**Wednesday, April 3, 2024**

U.S. SENATE,
SUBCOMMITTEE ON PRIMARY HEALTH AND RETIREMENT SECURITY,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
*Washington, DC.*

The Subcommittee met, pursuant to notice, at 11:10 a.m., at Gardner Auditorium, Massachusetts State House, 24 Beacon Street, Boston, MA 02133, Hon. Edward Markey, Chairman of the Subcommittee, presiding.

Present: Senators Markey [presiding], and Warren.

OPENING STATEMENT OF SENATOR MARKEY

Senator MARKEY. The Senate Health, Education, Labor, and Pensions Subcommittee on Primary Health and Retirement Security will come to order. Thank you for joining us today for the hearing, When Health Care Becomes Wealth Care, How Corporate Greed Puts Patient Care and Providers At Risk.

Thank you to HELP Committee Chair Bernie Sanders for the assistance in putting this hearing together. And thank you especially to my colleague and partner, Senator Warren, for all of her work on these issues. And we are very grateful to Senate President Spilka and to Speaker Mariano for hosting us here in this historic State House.

A special thank you to Senate President aide Jim Zambrano and Ayanna Clark for all their help with preparing the auditorium for this hearing. Thank you also to Governor Healey, Massachusetts Health and Human Services Secretary Kait Walsh, State legislators, local elected officials, the Massachusetts Nurses Association, SEIU 1199, AFSCME, Massachusetts Medical Society, the Massachusetts League of Community Health Centers, the Massachusetts Health and Hospital Association, Mass CARE, and the many health care leaders in Massachusetts for their ongoing partnership in the wake of the Steward crisis. Health care is a sacred trust, a sacred responsibility.

Health providers hold the trust of their patients in moments of fear and vulnerability. They are with us from our first days on Earth to the last, and the hospitals that providers work in should and must enable them to do this work well. But Steward Healthcare, led by Dr. Ralph De La Torre, Cerberus, and Medical Properties Trust, and greedy corporate executives like them are failing in their responsibility to patients, providers, and communities.

When Cerberus and Dr. De La Torre partnered to buy Caritas Cristi in 2010, they sold themselves as saviors. W. Brett Ingersoll, the then co-head of private equity and now managing director at Cerberus, said their investment would enable providers to, "deliver world class care to patients in the communities where they live." In 2014, Dr. De La Torre said his mission was to provide people with "really good health care."

Instead, Dr. De La Torre and Cerberus, like the mythological dog that it is named after that guards the gates of the underworld, trapped their hospitals in financial instability as the rot of their greed spread.

Cerberus and Dr. De La Torre stripped the hospitals of their assets and staff and forced these hospitals to pay rent to Medical Properties Trust on land they used to own, all while they extracted billions from Massachusetts institutions to expand globally. Steward and Cerberus made millions, rejoiced in their profits, and sailed away from their responsibility to workers and patients on their luxury yachts.

Meanwhile, their hospitals drowned. Steward owned hospitals in Massachusetts, from Methuen to Brockton, buckled under $50 million in unpaid rent to Medical Properties Trust. New England Sinai closed. In one hospital, Sungida Rashid, who had just given birth, bled to death when vendors went unpaid, and a medical device needed to stop the bleeding wasn't available.

Across the country in Utah, Ohio, Florida, Louisiana, Pennsylvania, and Texas, Steward owned hospitals are without needed supplies, cutting their services or closing their doors. Now we are forced to clean up Steward's mess without clear information. Just last week, Optum announced their intent to purchase Steward's physician group.

In order to protect patient care, we must guarantee that the Department of Justice and the Federal Trade Commission closely scrutinize the potential impacts of this deal. And despite our inquiries, Steward insists on hiding their finances, flouting requirements set by law. Dr. Ralph De La Torre was invited here today to answer to the public for the decisions he made not only as the Chairman and CEO of Steward, but also as a physician.

His expertise afforded him legitimacy, but it also carries a responsibility, a responsibility he was acutely aware of when Steward took on the care of 2.2 million patients in the United States, including 434,000 here in Massachusetts. The stakes for his success were high when Dr. De La Torre promised to deliver really good health care, but he failed.

He failed the health providers, he failed communities. He failed to show up here today to answer even the most basic questions about what he has done. Dr. De La Torre's chair is as empty as the promises he made to the public, and we are going to not stop until we get the answers from Dr. De La Torre for the people of Massachusetts. But this story goes far beyond Steward Health Care.

A $33 billion deal by Bain, Kohlberg Kravis Roberts, and Merrill Lynch to buy Hospital Corporation of America Healthcare in 2006 showed greedy corporate executives that there was money to be made off of hospitals. HCA, now a publicly traded company, laid the groundwork for a playbook that others have followed.

Joel Friedman, from Paladin Healthcare, a private equity firm, promised to "sustain and enhance clinical programs" when Paladin purchased Hahnemann Hospital in Philadelphia. Instead, they closed the hospital while private equity retained the valuable hospital real estate.

Dr. Mark Bell of Pipeline Health, a private equity backed health system, promised high quality care when they purchased Westlake Hospital and Weiss Memorial Hospital in Chicago. Weeks later, Pipeline closed Westlake Hospital and sold Weiss Memorial's parking lot to a real estate developer.

HCA's CEO Sam Hazen has said that HCA aims to "care for and improve human life." In a year when nearly 80 percent of health workers and staff said that they had seen patient care jeopardized by short staffing, HCA made $60 billion in revenue. Corporate executives like these deploy promises for a profit.

They believe their sacred responsibility is not to patients, it is to their bottom line. But health care isn't an oil change franchise or a coffee brand. A broken health care promise could cause communities their lives and livelihoods.

It is insufficient to simply replace one for-profit company with another, like Steward or Optum, without assurances. And that is why I am announcing a new agenda that provides for stronger oversight of corporate greed, building a system that guarantees health care for all, and preventing Stewards' failures from becoming America's health care standard.

This includes my new legislation, the Health Over Wealth Act, which would protect every patient and provider that private equity touches. First, the Health Over Wealth Act would protect patients and providers.

It would mandate that private equity companies set aside funding to protect access to care, remove tax breaks that incentivize companies to strip hospital assets, and give a bigger voice to workers and patients to review and block deals that would impact patient care, access, or safety. And second, the Health Over Wealth Act would guarantee transparency.

Steward's refusal to disclose their financial information maximized the harm they inflicted on communities. This bill would require that for-profit companies report on their finances, real estate deals, and how much their investors and shareholders are getting paid. They must also report on worker retention, staffing ratios, and how much their care is costing patients.

Third, the Health Over Wealth Act would demand accountability. Cerberus made more than $800 million in profit. Dr. De La Torre is still sailing on his yacht. Medical Properties Trust owns health property across the country.

The Health Over Wealth Act would give the Federal Department of Health and Human Services the tools to prohibit private equity investments by companies engaging in price gouging, understaffing, or creating barriers to care and to block real estate deals that destabilize health systems. And that is just the start.

The strongest protections will come from elevating the voices of patients, providers, and communities. And that is why I posted a discussion draft of my Health Over Wealth Act on my website, and we would appreciate any public comment on that legislation.

Little did Ralph Waldo Emerson know when he wrote in 1860, the first wealth is health, that a force as greedy and pernicious as Steward would take it literally, using our health care system as a cash cow to line their pockets and those of their investors. What they did was immoral, and we need to make sure that it becomes illegal.

Together, we will guarantee every American a health care system, not a wealth care system. That is what the hearing today is all about, and that is why I am so proud to be joined up with my great, partner and leader on this and so many other issues, Senator Warren.

## OPENING STATEMENT OF SENATOR WARREN

Senator WARREN. Thank you very much, Senator Markey. And a very special thank you to you for holding this hearing. I appreciate the work you are doing and the leadership on this. You are, as always, a wonderful partner here.

I have been warning about the dangers of private equity for years. In industry, after industry, after industry, when private equity marches in, a few wealthy investors see an opportunity to turn a quick buck. They buy a business, they load it up with debt, they strip out the assets, and then they sell it off.

They take the money and run, leaving a hollowed out shell behind. Stores get closed, consumers get cheated, workers get laid off, pensions get raided. When private equity gets hold of health care providers, it is literally a matter of life and death.

One example, when private equity firms buy up nursing homes, they cut costs to the bone, they reduce staff and suck money out the door to boost investor profits. Quality of care declines. During the pandemic, private equity owned nursing homes had a 40 percent higher COVID mortality rate than other nursing homes.

I will say it bluntly, turning private equity loose in our health care system kills people. Steward Healthcare is a clear cut case of private equity exploiting for profit health care. Investors looted the hospital and got rich, while nurses, doctors, and other workers tried hard to provide care, supplies ran out, and contractors walked away because they weren't getting paid.

Investors got rich while communities struggled with the reality that they might lose access to reliable health care. Steward was created when a private equity firm, Cerberus Capital Management, bought a small non-profit hospital system, Caritas Christi.

Six years later, Cerberus sold the land and hospital buildings, the operating rooms, the nursery for the babies, the gift shop, the parking lots to a real estate investment trust called Medical Properties Trust, or MPT, for $1.25 billion.

What did private equity do with the money from that sale? Did they upgrade the operating room equipment or modernize the nursery? Nope. Private equity paid themselves hundreds of millions of dollars.

Meanwhile, the hospitals now had to make huge rent payments to MPT. Not enough money was coming in and Steward fell behind on bills everywhere. Steward's fate was pretty much sealed at that point. It was economically dead, a zombie.

But that news wasn't public yet. The private equity guys knew it, of course, but they had their money, and they were off on their yachts, sipping pina coladas. Now the entire system could collapse. There is one and only one thing of value that private equity hasn't already taken, Steward's physician group.

Now, Optum, a subsidiary of the conglomerate UnitedHealth Group, wants to buy that last asset. Optum may be willing to pay steward hundreds of millions of dollars, but the deal provides no guarantee that the hospitals would stay open. None. In fact, the money could go into Steward and right back out the door again to corporate lenders or investors without a single penny used to help these hospitals.

Worse yet, this deal gives Optum, which has already bought up physician practices all across the country, a chance to buy an even bigger chunk of health care here in Massachusetts. Optum is already the largest employer of physicians in Massachusetts, counting more than 53,000 of our doctors in its network.

For comparison, Mass General Brigham has about 7,500 doctors. Now, Optum, with its more than 53,000 doctors, wants to get its hands on thousands more physicians in the Steward group. The net result could be a disaster. Optum isn't offering to pay hundreds of millions of dollars so that they can make health care better in Massachusetts.

Nope. This is all about making more money and Optum has run this same play in other states. Optum boosts its profits by overbilling Medicare and cutting care for the patients who need it most.

I do not understand how regulators can approve such a deal. I appreciate the work that Governor Healey and Secretary Walsh are doing to find a solution to a problem that they inherited. The blame for this crisis falls squarely on the private equity firm that bought the hospitals and stripped their assets, and on Steward's CEO Ralph De La Torre, who sold the deal both to regulators and to the health care community here in Massachusetts.

While we hold this hearing, Dr. De La Torre is hiding out. Shame on Dr. De La Torre. He owes the residents of Massachusetts an explanation for his part in looting Steward hospitals. His refusal to appear at today's hearing is cowardly. We need accountability here, and law enforcement authorities should carefully review every aspect of this fiasco.

We also need to change the law. Private equity should not be allowed to loot one business after another, and I have introduced the most comprehensive bill to overhaul the private equity industry. In addition, investors should face extra restrictions when they buy up hospitals and health care practices.

I have a bill to accomplish that as well. In the meantime, either of these laws could be put in place by our state legislature and protect the people of the Commonwealth of Massachusetts. This hearing is a good start, and I am grateful to Senator Markey for getting the ball rolling.

Senator MARKEY. Thank you.

Senator WARREN. Thank you.

Senator MARKEY. Thank you, Senator Warren. And we are joined by many health care leaders here in the Commonwealth. Senator Cindy Friedman is here. Senator Mark Pacheco, Senator Mike Brady, Representative Chris Flanagan, Representative Vanna Howard, Representative Carol Doherty, Representative Gerry Cassidy, Representative John Lawn, Representative Sean Garballey.

We thank all of you for all of the work which you do on these issues on a daily basis, and we are looking forward with the Federal delegation partnering with you in order to get the answers and find the solutions to this problem. So, now we will turn to our witnesses. Our first witness is Dr. Ellana Stinson Elena.

Dr. Stinson is a board certified emergency room physician at Boston Medical Center. She also serves as President of the New England Medical Association, and as a Massachusetts delegate to the American Medical Association.

Dr. Stinson previously served as Associate Medical Director at the Reggie Lewis mass vaccination site in Roxbury, at the height of the COVID–19 pandemic.

She earned her medical degree at Meharry Medical College, her Master of Public Health, with a focus on access to care in underserved communities from Harvard, and she has also received a Master's in Business Administration from Babson College, focusing on health care finance and her Bachelor's of Science degree from Spelman College. Dr. Stinson, you may proceed with your testimony.

**STATEMENT OF ELLANA STINSON, M.D., MPH, MBA, EMERGENCY MEDICINE PHYSICIAN, PRESIDENT, NEW ENGLAND MEDICAL ASSOCIATION, BOSTON, MA**

Dr. STINSON. Thank you, Senator Markey, Senator Warren, for having me this morning. My name is Ellana Stinson. I am a board certified emergency medicine physician and have practiced medicine for 15 years.

From 2013 to 2020, I was employed as an emergency medicine physician at Carney Hospital, and also worked at Good Samaritan in the former Quincy Hospital, all part of the Steward Health system. In addition, over the past 11 years——

Senator MARKEY. Could you move the microphone just in, a little bit closer? Yes, please.

Dr. STINSON. In addition, over the past 11 years I have worked intermittently throughout the country at various facilities run and operated by HCA, Envision, Tenet, Team Health, and CHS.

When I entered medicine, I deeply loved what I did, the caring for a patient in the most vulnerable moments and working in a beautifully orchestrated chaos, while bearing witness to many life changing moments filled me with pride at the end of each shift. Unfortunately, so much of what I loved about emergency medicine has changed drastically over the years.

Initially, my time at Carney felt very fresh and fulfilling. Being able to serve a very diverse population in the Dorchester neighborhood of Boston was essentially how I always imagined my career trajectory, serving the most vulnerable populations.

When I could no longer provide for my patients the way I would want my loved one, I had to make a decision to stay or go. Having spent time at several other Steward hospital—facilities briefly, I began to realize how resources were being dwindled down and pooled from each facility.

Most of the facilities no longer had certain specialty services, and Quincy Hospital eventually was taken down to bare bones before it ultimately closed. Not having blood products, respiratory therapy at times, or certain specialty services no longer felt like I was able to provide safe or quality care. What is happening here in the Commonwealth is happening all over the country.

We have now seen the buyouts and M and As led by private equity firms, over 30 percent of hospitals here in the U.S., and over 40 percent of emergency departments. Having spent time in other PE sites around the country, the level of deprivation was seemingly worse in some areas.

Increasing wait times, critical shortage of staff, leading to dangerous boarding levels and critical dangerous patient to nurse ratios in the emergency departments seeing upwards to 14 to 1 ratios at times. All of this only to be exacerbated by the pandemic, which resulted in increased cost of care, infection rates, mortality, and even death.

Practicing medicine in PE led places is no longer about patient safety or quality, but about making medical decisions and judgments due to corporate decision-making with profit motives at the expense of patients.

Forcing staff to see patients in waiting room in order to have it appear wait times were being reduced and improving door to doc time. Calling codes on sepsis and stroke in order to find innovative ways to make profits through up-coding. Increasingly daunting metrics required by physicians and other staff to meet were unattainable and unsafe in many instances, but very much expected.

In addition, many sites across the country began to remove emergency physicians from in-network, resulting in higher bills for patients known as surprise billing. This propagating practice not only harms patients, but also increases financial burdens on patients who do not have a choice where they go when they are experiencing that crushing chest pain or those stroke like symptoms.

Especially when facilities sometimes are not close, and you have to travel more than an hour away. Most of these facilities work—I have worked in very vulnerable populations that were mostly people of color, low income, and had limited access to other facilities or primary services, forcing them to only seek their care at a PE-VC site.

It's also known that most of these buyouts of hospitals and facilities are already struggling and have higher Medicaid and Medicare population, but ultimately affects our most vulnerable populations. It is critical that we consider not only the impact that facilities have on our healthcare system, but also on the worsening care, access, and quality being provided to those communities already harmed by historical injury.

The financialization of medicine will continue to exacerbate health disparities, despite the work that we are doing on the ground to close these gaps. In addition, these private equity backed facilities are where I typically ran into other physicians of color looking to serve the underserved communities.

As it pertains to myself and my colleagues, these practices oftentimes felt unsafe, which sparked many questions of medical legal risk, as well as the emotional toll it took on all of us to enter into a profession to do no harm. In addition, being on staff at PE-VC facilities also would not qualify a physician swimming in student debt for loan forgiveness.

A profession once competitive when I first began my medical journey is now one of the least competitive fields to enter as students bear witness to the destruction of the profession. In 2023, 554 of the residency spots went unfilled.

We also saw more PE-VC hospitals opening residency programs that were not adequately equipped to provide the proper training for emergency medicine trainees. We trained to do—deal with hard stuff, but we are running out of options on how to continue providing safe and adequate care to our patients.

[The prepared statement of Dr. Stinson follows.]

PREPARED STATEMENT OF ELLANA STINSON

Thank you, Senator Markey and Senator Warren for having me this morning.

My name is Ellana Stinson. I am a board-certified emergency medicine physician and have practiced emergency medicine for 15 years.

From 2013 to 2020, I worked on staff as an emergency medicine physician at Carney Hospital, Good Samaritan and the former Quincy Hospital, all part of the Steward Health System. In addition, over the past 11 years, I have worked intermittently throughout the country at various facilities run and operated by HCA, Envision, Tenant, Team Health and CHS.

When I entered medicine, I deeply loved what I did. Caring for patients in their most vulnerable moments and working in beautifully orchestrated chaos while bearing witness to so many life changing moments filled me with pride at the end of each shift. Unfortunately, so much of what I loved about Emergency Medicine has changed drastically over the years.

Initially, my time at Carney felt very fresh and fulfilling. Being able to serve a very diverse population in the Dorchester neighborhood of Boston was essentially how I always imagined my career trajectory, serving the most vulnerable populations. But when I could no longer care for my patients the way I would want a loved one treated, I had to make decisions to stay or go. Having spent time at several other Stewart facilities briefly, I began to realize how resources were being dwindled down and pulled from each facility. Most of the facilities no longer had certain speciality services and Quincy Hospital, eventually was taken down to bare bones before its ultimate closure. Not having blood products, respiratory therapy at times or certain specialty services no longer felt like I was able to provide safe or quality care. What is happening here in the Commonwealth is happening around the country.

We have now seen the buyouts, mergers and acquisitions led by private equity firms of over 30 percent of hospitals in the U.S. Having spent time at other PE sites around the country the level of deprivation was seemingly worse in some areas. Increased wait times and critical shortage of staff leading to dangerous boarding levels and critically dangerous patient to nurse ratios in the emergency department, seeing upwards to 14 to 1 ratios at times. All of this only to be exacerbated by the pandemic which resulted in increased cost of care, infection rates, mortality and even death.

Practicing medicine in many PE led places is no longer about patient safety and quality, but about making medical decisions and judgment due to corporate decision-making with profit motives at the expense of patients. Forcing staff to see patients in the waiting room in order to have it appear wait times were being reduced and improving door to doc times, calling codes for sepsis and strokes in order to find innovative ways to make profits. Increasingly daunting metrics required of physicians and other staff to meet were nearly unattainable and unsafe in many instances, but very much expected. In addition, many sites across the country began to remove emergency physicians from in-network, resulting in higher bills for patients known as surprise billing. These profit gaining practices not only harm patients but also increase financial burdens on patients who do not have a choice of where they will go when they are experiencing crushing chest pain or stroke-like symptoms. Especially when the next closest facility has been in some of my experiences, upwards to an hour away.

Most of the facilities I worked in were in very vulnerable populations that were mostly people of color, low income, or had limited access to other facilities or primary care services. Forcing them to only seek their care at a PE backed site. It is also known that most of the buyouts are of hospitals and facilities already struggling or with higher Medicaid and Medicare populations which ultimately affects our most vulnerable populations. It is critical we consider not only the impact these facilities have on our health care system, but also on the worsening care access and quality being provided to those communities already harmed by historical injury. The financialization of medicine will continue to exacerbate health disparities despite work being done on the ground to close these gaps.

In addition, these Private Equity backed facilities are where I typically run into other emergency physicians of color. As it pertains to myself and my colleagues, these practices often felt unsafe, which sparked many questions of medical legal risk as well as the emotional toll it takes on all of us who enter this profession to do no harm. In addition, being on staff at a PE backed facility also would not qualify physicians swimming in student debt for loan forgiveness. A profession once competitive when I first began my medical journey is now one of the least competitive fields to enter as students bear witness to the destruction of the profession. In 2023, 554 of the residency spots went unfilled. We also saw more PE backed hospitals opening residency programs that were not adequately equipped to provide the proper training for an emergency medicine trainee.

We train to deal with hard stuff, but we are running out of options on how to continue providing safe and adequate care at these PE run facilities.

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Senator MARKEY. Thank you, Dr. Stinson. Next we are going to hear from, Eileen O'Grady. She is the Health Care Research and Campaigns Director for the Private Equity Shareholder Project. She has written extensively on the topic of private equity investments in the United States health care system.

She has published nationally. Ms. O'Grady previously worked for Unite Here and the Center for Economic and Policy Research. Ms. O'Grady, thank you for being here today. Whenever you feel comfortable, please begin.

**STATEMENT OF EILEEN O'GRADY, RESEARCH AND CAMPAIGN DIRECTOR, HEALTHCARE, PRIVATE EQUITY STAKEHOLDER PROJECT, WASHINGTON, DC**

Ms. O'GRADY. Thank you, Chairman Markey, and thank you, Senator Warren. I am Director of Health Care Research at the Private Equity Stakeholder Project. We are a nonprofit watchdog organization dedicated to understanding the impacts—the increasing influence of private equity in our economy and its impact on people.

Our mission is to empower communities, working families, and others impacted by private equity in the broader financial industry. And because private equity industry is so huge, those impacts are widely felt, even if we don't always recognize when a private equity firm is behind them.

In fact, we have seen private equity investing in virtually every aspect of the health care industry, from buying up mental health and addiction treatment clinics to almost completely dominating the market for motorized wheelchair parts and supplies. As the Private Equity Stakeholder Project, we found that almost 1 in 10 private hospitals in the U.S. are owned by a private equity firm.

About a third of those hospitals serve rural communities, and many of them are safety net hospitals serving poor and uninsured patients. And this is really troubling because we have seen time and time again that the private equity business model, which is intensely focused on maximizing profit at all costs, is often at odds with providing quality care.

We have seen that private equity health care profiteering has resulted in dangerous conditions, declining quality, Medicare and Medicaid fraud, increased costs, and closures, and those consequences have been borne by health care workers and the communities they serve.

To better understand how this happens, it is important to understand the private equity business model in health care. Private equity firms are short term investors. They usually try to own companies for around 4 to 7 years.

During that time, they have to generate as much cash-flow as possible, often with a goal of doubling or tripling their investment. There are a few financial tactics central to this business model. The first is debt.

Private equity firms routinely use much higher levels of debt than other companies, and they do it differently than I think a lot of people understand. Firms typically buy companies through leveraged buyouts, where private equity firm finance is a substantial part of the purchase price by taking out a loan secured by the company they are buying.

That means that the company is on the hook to pay down the debt that the PE firm took out. That kind of high leverage can divert cash away from operations to paying interest on the debt and leave companies more at risk for restructuring or bankruptcy. We are acutely seeing the effects of this now, as private equity owned companies are struggling under mountains of debt in a high interest rate environment.

We found that over 20 percent, the health care bankruptcies that happened last year, were private equity owned companies, and 90 percent of the health care companies that are considered most at risk for bankruptcy now are owned by private equity firms. Bankruptcies in healthcare are more than just legal or financial events.

They can lead to closures, disruption, or cessation of critical health care services, layoffs, and those outcomes have ripple effects on the broader health care infrastructure, like overburdening health care providers that need to fill the gaps left by those closures.

Another financial tactic we have seen private equity firms use with hospitals, sale lease back transactions, where a private equity firm will sell a hospital's underlying real estate and lease it back from the new owner.

PE firms will do this because it provides a quick and easy way to monetize the real estate and generate cash for investors, but they often leave hospitals with higher monthly lease payments and beholden to a landlord.

This is obviously the lesson we have learned with Steward Healthcare. There are a few other ways we have seen private equity firms blatantly extracting wealth from health care companies. Private equity firms have taken out new debt on the companies they own, and then use the proceeds from that debt to give themselves a cash payout, which is known as a dividend recapitalization, and somehow that kind of deal is completely legal.

On top of all of these tactics, debt stripping out real estate, extracting fees, dividends, we have seen private equity firms cutting costs. This might mean cutting staffing, skimping on medical supplies, failing to maintain equipment, cutting charity care.

I am going to give you another example of how all of these financial strategies have played out at a hospital system. Prospect Medical Holdings is a safety net hospital chain that was for 10 years owned by a private equity firm called Leonard Green and Partners.

Over the course of its ownership, Leonard Green loaded the hospitals with debt to pay itself hundreds of millions of dollars in dividends and fees. And then, in order to pay down some of that debt, it sold off the hospital's real estate and leased it back, saddling it with expensive rent payments to a new hospital landlord, you might know the name, Medical Properties Trust, which now own Steward.

All the while its hospitals suffered atrocious conditions, holes in the ceiling where the rain came through, failing to pay for medical supplies or gas for ambulances, shuttered a hospital in San Antonio and sold the real estate to a luxury hotel developer. Leonard Green sold its stake, but now it appears Leonard Green's chickens are coming home to roost.

Prospects hospitals are in poor financial shape, shutting down services, laying off hundreds of workers. Leonard Green, meanwhile, lined its pockets and left the communities Prospect serves holding the bag. I am worried that what we have seen about private equities profiteering in health care is just the tip of the iceberg.

It has been nearly impossible to hold private equity firms accountable, even when it is clear that their financial tactics harmed patients and workers, and that is because private equity firms largely operate in the shadows. They rely on the fact that there is very little oversight over what they do.

I want to be clear, we know the intense focus on profit isn't unique to private equity. We see this in all kinds of companies, including, unfortunately, at nonprofit providers. But private equity amplifies and exacerbates these kinds of extractive tendencies, and it gets away with it because complex corporate structures shield these firms from transparency and accountability.

It is therefore critical for policymakers to pass legislation and for regulators to propose rules that increase transparency and accountability for corporate actors in health care. This hearing is a critical step for creating the tools necessary to shed light on the impacts of corporate health care profiteering and give stakeholders the tools to hold Wall Street accountable. Thank you so much for the opportunity to speak, and I look forward to your questions.

[The prepared statement of Ms. O'Grady follows.]

PREPARED STATEMENT OF EILEEN O'GRADY

Chairman Markey, Ranking Member Marshall, and Members of the Subcommittee, thank you for the opportunity to provide a statement regarding the April 3, 2024 hearing "When Health Care Becomes Wealth Care: How Corporate Greed Puts Patient Care and Health Workers at Risk," by the Subcommittee on Primary Health and Retirement Security.

My name is Eileen O'Grady, and I am the Healthcare Research and Campaigns Director for the Private Equity Stakeholder Project. The Private Equity Stakeholder Project is a non-profit organization whose mission is to identify, engage, and connect stakeholders affected by private equity with the goal of engaging investors and empowering communities, working families, and others impacted by private equity investments.

This hearing could not come at a more critical time. The private equity industry has grown dramatically in recent years. Private equity and other private funds firms had less than $1 trillion in assets under management in 2004. They now manage more than $13.1 trillion, and are growing quickly. [1]

Private equity increasingly makes up a substantial portion of investment in U.S. healthcare companies, and reached an all-time high in 2021 of 515 deals valued at $151 billion. [2] These investments touch virtually every aspect of the healthcare industry, including *hospitals*, physician specialties such as *gastroenterology* and *anesthesiology*, *emergency medicine*, *dentistry*, *travel nursing*, *durable medical equipment*, *behavioral health*, *disability services*, and *healthcare services for people in prisons and jails*.

The growing presence of private equity in healthcare raises concern. The private equity business model, which is characterized by the pursuit of outsized profits over short periods of time and a reliance on high levels of debt, is in many ways incompatible with providing quality affordable healthcare.

Right now, hospitals in Massachusetts owned by Steward Healthcare are facing an existential threat following ownership by private equity firm Cerberus Capital Management. The experience of Steward is unfortunately not unique; there have

[1] "A routinely exceptional year," McKinsey, Feb 2017. *https://www.mckinsey.com/-/media/mckinsey/industries/private%20equity%20and%20principal%20investors/our%20insights/a%20routinely%20exceptional%20year%20for%20private%20equity/mckinsey-global-private-markets-review-february-2017.pdf*; "Private markets: A slower era," McKinsey, February 20, 2024. *https://www.mckinsey.com/industries/private-equity-and-principal-investors/our-insights/mckinseys-private-markets-annual-review*.

[2] "Healthcare Private Equity Market 2021: The Year in Review" (Bain and Company, March 16, 2022), *bain.com/insights/year-in-review-global-healthcare-private-equity-and-ma-report–2022/*.

been many stories of private equity firms looting healthcare companies at the cost of patient care.

Given the backdrop of Steward's acute financial distress, my testimony will focus on the risks of private equity hospital ownership. I will include at the end a list of resources for additional research on the impact of private equity in other aspects of the healthcare industry.

As private equity ownership of healthcare companies grows and continues to benefit from taxpayer funded healthcare spending, it is essential for lawmakers to understand the risks associated with private equity investment in the industry and create policy that protects patients and supports healthcare workers.

**The Impacts of Private Equity Investment on Hospitals**

Private equity ownership of hospitals has drawn scrutiny in recent years as some private equity hospital acquisitions have produced troubling impacts for patients and workers across the country. We have seen private equity firms *aggressively loot safety net hospitals*, *strip out valuable real estate*, *cut critical but less profitable services*, and *exploit government funding programs* designed to *support and stabilize healthcare access*.

The consequences have been borne by healthcare workers and the communities they serve. Private equity's hospital profiteering has resulted in dangerous conditions, closures and reduced access to services, declining quality, and fraud.

Private equity firms often seek to double or triple their investment over 4–7 years. The pursuit of outsized returns over relatively short time horizons can lead to cost-cutting that hurts care. In addition, use of high levels of debt can divert cash from operations to interest payments and dividends paid out to private equity owners.

Below are some financial tactics characteristic of private equity investment:

- *High leverage*: Private equity firms often utilize significant amounts of debt when buying companies. Firms typically buy companies through leveraged buyouts, whereby a private equity firm finances a substantial portion of an acquisition by taking out a loan secured by the company it is buying. High leverage can divert cash away from operations to paying interest on debt and leave companies more at risk for restructuring or bankruptcy.
- *Sale-leaseback of real estate*: Private equity firms that own hospitals sometimes conduct sale-leaseback transactions, where the firm will sell the hospital's real estate to a third party and lease it back. While these transactions provide a quick way to monetize real estate and generate cash, they can leave hospitals with fewer assets and higher monthly lease payments. [3]
- *Debt-Funded Dividends*: Some private equity firms siphon money out of companies they own through dividend recapitalizations, where a private equity firm directs its portfolio company to take on new debt and use the proceeds to pay the private equity owner a cash payout. These transactions can unnecessarily load healthcare providers with debt. While the private equity firm in these situations makes money, the healthcare provider often does not receive proceeds from the loan and still must pay it back, leaving it more vulnerable to market conditions and with fewer resources to support operations as it pays its monthly debt service payments. [4]
- *Roll-ups*: Private equity companies often conduct "roll-ups" by buying up multiple companies in the same industry segment and merging them under the same corporate umbrella. These transactions can allow firms to take advantage of economies of scale. However, a wide body of research

[3] Brian Spegele, "How a Small Alabama Company Fueled Private Equity's Push Into Hospitals," *Wall Street Journal*, February 14, 2022, sec. Markets, *https://www.wsj.com/articles/hospitals-private-equity-reit-mpt-steward-11644849598*.

[4] Eileen O'Grady, "Dividend Recapitalizations in Health Care: How Private Equity Raids Critical Health Care Infrastructure for Short Term Profit" (Private Equity Stakeholder Project, October 2020), *https://pestakeholder.org/reports/dividend-recapitalizations-in-health-care-how-private-equity-raids-critical-health-care-infrastructure-for-short-term-profit/*.

has shown that provider consolidation leads to higher healthcare prices for private insurance and public healthcare programs like Medicare.[5]

- *Fees*: Private equity firms often charge management or advisory fees to the companies they own, which can cost companies millions of dollars each year. Fees are typically stipulated in a management services agreement between the private equity firm and a company that it controls. In some cases, companies must pay fees to the private equity firm even for services never rendered ("accelerated monitoring fees"). These fees can further drain a company's cash away from hospital operations into the pockets of investors.[6]

The case studies below provide examples of private equity firms employing these financial tactics and others, and will demonstrate how investors' unbridled profit-seeking can harm patient care.

### 1. Steward Healthcare—Cerberus Capital Management

In 2010, private equity firm Cerberus Capital purchased Caritas Christi Health in a $420 million leveraged buyout through its affiliate Steward Healthcare, converting the nonprofit health system to for-profit.[7] Steward also assumed $475 million of debt and pension liabilities in the transaction, putting the value of the overall deal at $895 million.[8]

Because of the conversion to for-profit status, the deal required approval from the state Attorney General's office, which imposed conditions on the transaction and a 5-year monitoring period.[9]

These conditions included a requirement for the new owners to invest $400 million into the system's infrastructure.[10] Despite Cerberus Capitals's deep pockets, these "investments" would come from debt loaded onto Steward as well as sale-leasebacks of some of its medical office buildings.[11] Another condition of the deal was that the system could not take additional debt to pay investor dividends for the first 3 years following the transaction.[12]

After its 5-year monitoring period with the Attorney General expired,[13] Steward Health Care executed a $1.2 billion sale-leaseback transaction in 2016 with real estate investment trust (REIT) Medical Properties Trust (MPT). MPT made an additional $50 million equity investment in Steward.[14] Many Steward hospitals were then on the hook for rent payments and no longer owned their most valuable asset.

[5] Karyn Schwartz et al., "What We Know About Provider Consolidation," *KFF (blog)*, September 2, 2020, *https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/*.

[6] Eileen Appelbaum and Rosemary Batt, "Fees, Fees and More Fees: How Private Equity Abuses Its Limited Partners and U.S. Taxpayers" (Center for Economic and Policy Research), accessed March 24, 2023, *https://www.cepr.net/report/private-equity-fees-2016-05/*.

[7] *FierceHealthcare*. "Acquisition of Caritas Christi Now Complete." November 9, 2010. *https://www.fiercehealthcare.com/healthcare/acquisition-caritas-christi-now-complete*.

[8] Pg. 38 of Batt, Rosemary, Eileen Appelbaum, and Tamar Katz. "The Role of Public REITs in Financialization and Industry Restructuring—Working Paper No. 189." Center for Economic and Policy Research, July 9, 2022. *https://www.ineteconomics.org/uploads/papers/WP-189-Batt-Appelbaum-Public-REITS-2.pdf*.

[9] "Interim Reports on Steward Health Care System Pursuant to 2010 and 2011 Assessment and Monitoring Agreements," Office of the Massachusetts Attorney General, January 30, 2023. *https://www.mass.gov/doc/interim-reports-on-steward-health-care-system-pursuant-to-2010-and-2011-assessment-monitoring/download*.

[10] Pg. 39 of Batt, Rosemary, Eileen Appelbaum, and Tamar Katz. "The Role of Public REITs in Financialization and Industry Restructuring—Working Paper No. 189." Center for Economic and Policy Research, July 9, 2022. *https://www.ineteconomics.org/uploads/papers/WP—189-Batt-Appelbaum-Public-REITS-2.pdf*

[11] Pg. 39 of Batt, Rosemary, Eileen Appelbaum, and Tamar Katz. "The Role of Public REITs in Financialization and Industry Restructuring—Working Paper No. 189." Center for Economic and Policy Research, July 9, 2022. *https://www.ineteconomics.org/uploads/papers/WP—189-Batt-Appelbaum-Public-REITS-2.pdf*.

[12] Pg. 20 of La France, Aimee, Rosemary Batt, and Eileen Appelbaum. "Hospital Ownership and Financial Stability: A Matched Case Comparison of a Non-Profit and Private Equity Owned Health System." Center for Economic and Policy Research, March 22, 2021. *https://cepr.net/wp-content/uploads/2022/03/LBA-Advances-Chapter-Final-03-24-21.pdf*.

[13] Pg. 5 of La France, Aimee, Rosemary Batt, and Eileen Appelbaum. "Hospital Ownership and Financial Stability: A Matched Case Comparison of a Non-Profit and Private Equity Owned Health System." Center for Economic and Policy Research, March 22, 2021. *https://cepr.net/wp-content/uploads/2022/03/LBA-Advances-Chapter-Final032421.pdf*.

[14] Steward Health Care System. "Steward Receives $1.25 Billion Investment from Medical Properties Trust, Setting Stage for National Growth." Accessed March 14, 2024. *https://*

This sale-leaseback deal was used to pay nearly $500 million in dividends to investors as well as fund a rapid expansion strategy for Steward that also relied heavily on debt.[15] Steward eventually grew to be the largest private for-profit hospital system in the U.S. in 2017.

During its ownership under Cerberus Capital, Steward also:

- Took on millions more in debt;[16]
- Saw poor financial performance;[17]
- Broke commitments to regulators by failing to share financial information with regulators in a timely manner[18] and attempting to close hospitals or cut services at hospitals it had acquired;[19]
- Cited the pandemic in March 2020 in order to collect $8 million from the Pennsylvania state government to keep an Easton, PA hospital open and then sold it in May 2020.[20]
- Collected $675 million in Federal loans and grants money during the pandemic;[21]
- Was sued under the False Claims Act (ultimately the system would reach a $4.7 million settlement with the Department of Justice in 2022).[22]
- Saw higher than average patient hospital-acquired infections, falls, and readmissions at its Massachusetts hospitals.[23]

As Cerberus began its exit in fall of 2020, Steward Health was struggling, reporting a net loss of more than $400 million in 2020. The private equity firm reportedly made $800 million in the decade it owned Steward.[24] Cerberus Capital's exit was made possible by Medical Properties Trust, which provided a $335 million loan to a new set of physician owners.[25]

The role of Medical Properties Trust in the pillaging of Steward cannot be overstated. Without a willing REIT like MPT to abet Steward's asset-stripping, Steward would not have been able to generate so easily the more than a billion dollars it

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*www.prnewswire.com/news-releases/steward-receives-125-billion-investment-from-medical-properties-trust-setting-stage-for-national-growth-300334227.html.*

[15] Pg. 2 of La France, Aimee, Rosemary Batt, and Eileen Appelbaum. "Hospital Ownership and Financial Stability: A Matched Case Comparison of a Non-Profit and Private Equity Owned Health System." Center for Economic and Policy Research, March 22, 2021. *https://cepr.net/wp-content/uploads/2022/03/LBA-Advances-Chapter-Final-03-24-21.pdf.*

[16] See pg. 40 of Batt, Rosemary, Eileen Appelbaum, and Tamar Katz. "The Role of Public REITs in Financialization and Industry Restructuring—Working Paper No. 189." Center for Economic and Policy Research, July 9, 2022. *https://www.ineteconomics.org/uploads/papers/WP-189-Batt-Appelbaum-Public-REITS-2.pdf.*

[17] See pgs. 39–40 of Batt, Rosemary, Eileen Appelbaum, and Tamar Katz. "The Role of Public REITs in Financialization and Industry Restructuring—Working Paper No. 189." Center for Economic and Policy Research, July 9, 2022. *https://www.ineteconomics.org/uploads/papers/WP-189-Batt-Appelbaum-Public-REITS-2.pdf.*

[18] Torrieri, Marisa. "MA State Imposes $1,000-per-Week Penalty on Steward Health Care System." *Healthcare Dive*, December 19, 2014. *https://www.healthcaredive.com/news/ma-state-imposes-1000-per-week-penalty-on-steward-health-care-system/345671/.*

[19] Primack, Dan. "Hospital Debacle Puts Focus on Private Equity." *Axios*, March 6, 2024. *https://www.axios.com/2024/03/06/hospital-debacle-private-equity-cerberus-steward*; Bartlett, Jessica. "On Steward's Path to Financial Ruin, a Series of Missed Opportunities." *The Boston Globe*, March 25, 2024. https://www.bostonglobe.com/2024/03/25/business/steward-financial-ruin-state-intervention-massachusetts/.

[20] Spegele, Brian, and Laura Cooper. "As Coronavirus Cases Climbed, Private-Equity-Owned Hospital Demanded Bailout." *WSJ*, April 26, 2020, sec. Markets. *https://www.wsj.com/articles/as-coronavirus-cases-climbed-private-equity-owned-hospital-faced-closure-11587893400.*

[21] Willmer, Sabrina. "A Wall Street Giant Tapped $1.5 Billion in Federal Aid for Its Hospitals." *Bloomberg.Com*, September 14, 2020. *https://www.bloomberg.com/news/articles/2020-09-14/a-wall-street-giant-tapped-1-5-billion-in-Federal-aid-for-its-hospitals.*

[22] Bartlett, Jessica. "Steward Health Care to Pay $4.7M to Resolve Anti-Kickback Allegations—The Boston Globe." *BostonGlobe.Com*, June 9, 2022. *https://www.bostonglobe.com/2022/06/09/metro/steward-health-care-pay-47m-resolve-anti-kickback-allegations/.*

[23] See pg. 40 of Batt, Rosemary, Eileen Appelbaum, and Tamar Katz. "The Role of Public REITs in Financialization and Industry Restructuring—Working Paper No. 189." Center for Economic and Policy Research, July 9, 2022. *https://www.ineteconomics.org/uploads/papers/WP-189-Batt-Appelbaum-Public-REITS-2.pdf.*

[24] Sabrina Willmer, "Cerberus Quadruples Money After Unusual Exit From Hospital Giant," Bloomberg, May 27, 2021. *https://www.bloomberg.com/news/articles/2021-05-27/cerberus-quadruples-money-after-unusual-exit-from-hospital-giant.*

[25] For a description of the complicated transaction, see pg. 41 of Batt, Rosemary, Eileen Appelbaum, and Tamar Katz. "The Role of Public REITs in Financialization and Industry Restructuring—Working Paper No. 189." Center for Economic and Policy Research, July 9, 2022. *https://www.ineteconomics.org/uploads/papers/WP-189-Batt-Appelbaum-Public-REITS-2.pdf.*

ultimately used to pay millions to investors. The rent payments for those hospitals would ultimately burden the system's finances at the expense of operational costs.

Even though Cerberus exited its investment in 2020, its pillaging continues to have an impact on the system.

In September 2023, state and Federal officials declared that patients were in immediate jeopardy at Steward's Good Samaritan Medical Center in Brockton, MA. The Massachusetts Nurses Association had been warning state and Federal officials since 2021 about major issues in the Emergency Department at Good Samaritan. [26]

In December 2023, the U.S. Attorney's Office filed another False Claims Act lawsuit against Steward regarding allegations spanning from 2012 to 2022. [27] Earlier that month, Steward notified state healthcare officials of its plans to close New England Sinai Acute Long-Term Care and Rehabilitation Hospital, a 182 bed-hospital. [28]

In January 2024, MPT announced that as of December 31, 2023, Steward Health Care was $50 million behind in rent payments. [29]

Steward's hospitals currently face a dire financial situation. Vendors are suing over nonpayment [30] and staffing and patient quality of care issues have been mounting. [31] In January 2024, the Boston Globe reported that a new mother died after the embolization coil needed to treat her post-birth bleeding was unavailable. It had been repossessed weeks before by the medical device company that owned it due to Steward's nonpayment. [32]

As of February 2024, Steward had not complied with the Massachusetts Attorney General's office to provide audited financial statements. [33]

### 2 Prospect Medical Holdings—Leonard Green and Partners

Between 2010 and 2021, private equity firm Leonard Green and Partners owned Prospect Medical Holdings, a safety net hospital company with 17 hospitals in 5 states. [34]

After Leonard Green acquired Prospect in 2010, it used the hospital chain as a platform to raise debt so it could siphon off hundreds of millions of dollars in dividends and fees. According to Prospect's own financial statements, the owners collected at least $658 million from the hospitals—despite dramatic operating challenges, substantially underfunded pensions, and increasing regulatory scrutiny. [35]

The largest dividend that Prospect's owners collected in 2018 directly contradicted a commitment Prospect had made to state regulators. When it bought several hospitals in Rhode Island in 2014, it told regulators It would not pay out any more divi-

[26] Kowalczyk, Liz, and Felice J. Freyer Globe Freyer. "Sick Patients Collapsed Waiting for Care in Overwhelmed Steward Hospital's Emergency Department—The Boston Globe." *The Boston Globe*, February 15, 2024. *https://www.bostonglobe.com/2024/02/14/metro/steward-health-care-emergency-department-overcrowding/*.

[27] "District of Massachusetts United States Files Complaint Against St. Elizabeth's Medical Center, Steward Medical Group and Steward Health Care System United States Department of Justice," December 18, 2023. *https://www.justice.gov/usao-ma/pr/united-states-files-complaint-against-st-elizabeths-medical-center-steward-medical-group*.

[28] Vogel, Susanna. "Steward Health Care to Close Massachusetts Hospital amid Financial Troubles." *Healthcare Dive*, December 6, 2023. *https://www.healthcaredive.com/news/steward-health-care-to-close-massachusetts-hospital-amid-financial-troubles/701695/*.

[29] "Medical Properties Trust Provides Update on Steward Health Care," January 4, 2024. *https://www.businesswire.com/news/home/20240104928323/en/Medical-Properties-Trust-Provides-Update-on-Steward-Health-Care*.

[30] Vogel, Susanna. "Steward's Legal Battles Offer Insight into Pattern of Mismanagement." *Healthcare Dive*, March 20, 2024. *https://www.healthcaredive.com/news/steward-health-care-mismanagement-lawsuits/710102/*.

[31] Niezgoda, Abbey. "Steward Health Care Patient Care Concerns Top of Mind." *NBC Boston*, February 21, 2024. *https://www.nbcboston.com/news/local/stewards-financial-woes-are-impacting-patient-care-workers-say/3286716/*; *Steward Health's Financial Woes Are Impacting Patient Care*, 2024. *https://www.youtube.com/watch'v=UE5u4VKC2zg*.

[32] Bartlett, Jessica. "Steward's Medical Devices Were Repossessed. Weeks Later, a New Mother Died." *The Boston Globe*, January 25, 2024. *https://www.bostonglobe.com/2024/01/25/business/steward-health-care-mother-death/*.

[33] Boston 25 News. "Deadline Passes without Steward Health Care Providing Financial Statements to State," February 24, 2024. *https://www.boston25news.com/news/local/deadline-passes-without-steward-health-care-providing-financial-statements-state/4HB4Z6MLKBGEDEWP37P526RMHY/*.

[34] *https://pmh.com/*. Accessed May 6, 2020.

[35] *https://www.propublica.org/article/rich-investors-stripped-millions-from-a-hospital-chain-and-want-to-leave-it-behind-a-tiny-state-stands-in-their-way*.

dends. Just 4 years later, it paid the ownership an almost $460 million dividend. That same year, Prospect generated a $244 million net loss.[36]

As a result of that dividend, Prospect ran out of cash by early 2019, forcing the owners to provide emergency cash infusion.

Prospect was eventually able to pay off the existing $1.1 billion in debt it had accrued in part to fund dividends, but only by selling off the bulk of Prospect's real estate to a REIT. The transaction replaced debt with lease liabilities and left Prospect with fewer assets.[37]

### *Leonard Green's Representations to Members of Congress, Regulators*

Leonard Green and Prospect misrepresented the financial condition of some of the hospitals when lawmakers and other stakeholders raised concerns.

Members of Congress with Prospect hospitals in their districts have *written to Leonard Green twice* raising concern about the firm's treatment of the safety net hospital company and asking it to return the fees and dividends it collected.[38] Leonard Green dismissed the lawmakers' concerns, writing: "We can assure you with firm, empirical confidence that Prospect remains well-capitalized with adequate liquidity and resources for its staff to address the current COVID–19 epidemic."[39]

In response to a letter my organization wrote to Rhode Island regulators, Prospect wrote: "Contrary to PESP's assertions, Prospect today remains extraordinarily well capitalized, faces no material financial challenges, and is at no risk of financial failure."

### *Hospitals Suffered While the Owners Lined Their Pockets*

Here is what was happening at the hospitals while Leonard Green was siphoning money from the company:

- Prospect's hospitals had some of the lowest quality ratings from the Centers for Medicare and Medicaid Services—all but one had received one or two stars, the lowest quality ratings from CMS.[40]
- In Connecticut, state regulators placed Prospect's three hospitals under review in 2019 for deteriorating conditions that placed patients in "immediate jeopardy."[41]
- Prospect completely shut down all of its facilities in San Antonio in 2019—laying off nearly 1,000 workers[42]—and sold its hospital building to a hotel developer.[43]
- The California Attorney General formally charged Prospect executives with "gross negligence" related to persistent mold contamination of a hospital pharmacy, including in equipment used to mix patient medications. In March 2021, the California Attorney General and State Pharmacy Board entered into a settlement with Prospect's Southern California subsidiary, placing its hospital pharmacy permit and sterile compounding on probation for 2 years.[44]

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[36] *https://pestakeholder.org/wp-content/uploads/2020/05/UPDATE-Leonard-Green-Prospect-Medical-Dividends-PESP-051420.pdf*.

[37] *https://pestakeholder.org/broken-promises-rhode-island-regulators-question-leonard-greens-investment-in-prospect-medical-holdings/*.

[38] Laura Cooper and Chris Cumming, "Lawmakers and Leonard Green Spar Over Hospital Operator," *Wall Street Journal*, July 6, 2020, sec. WSJ Pro, *https://www.wsj.com/articles/lawmakers-and-leonard-green-spar-over-hospital-operator-11594076954*.

[39] Goldberg, "Leonard Green and Partners Response Letter to Members of Congress," June 12, 2020.

[40] CMS Hospital Compare, accessed March 2020. *https://www.Medicare.gov/hospitalcompare/search.html*.

[41] *https://www.courant.com/news/connecticut/hc-news-waterbury-hospital-prospect-medical-protests-20190602-hqc3yulngngwnd6qftmeiogdsq-story.html*.

[42] Ayla Ellison, "Texas Health System Closes Hospital, Lays off 972," *Becker's Hospital Review*, November 26, 2019, *https://www.beckershospitalreview.com/finance/texas-health-system-closes-hospital-lays-off-972.html*.

[43] Sanford Nowlin, "Hotel Company Purchases Downtown San Antonio's Historic Nix Hospital Building," *San Antonio Current*, January 3, 2020, *https://www.sacurrent.com/news/hotel-company-purchases-downtown-san-antonios-historic-nix-hospital-building-22709799*.

[44] Peter Elkind, "Investors Extracted $400 Million From a Hospital Chain That Sometimes Couldn't Pay for Medical Supplies or Gas for Ambulances," *ProPublica*, September 30, 2020,

Continued

- In Rhode Island, poor infection control led to COVID–19 infection of 19 of the 21 geriatric psychiatric ward residents: six of them died. Six housekeeping staff also got COVID due to limited access to PPE. The head of the department died.[45]
- Workers have complained of inadequate staffing. When Leonard Green first tried to sell Prospect in 2015, the company's prospectus touted its "cost-effective care" model, daily "flex" management of hospital staffing, and use of low-cost sources for medical supplies. In Pennsylvania, workers reported in September 2020 that staffing shortages forced scheduling delays for medical procedures.[46]

Despite what happened to Prospect and its hospitals, Leonard Green is off the hook—in June 2021 *Leonard Green sold its majority stake in Prospect* to the minority shareholders after a contentious year-long investigation by state regulators into the company's finances.[47]

For more on Prospect Medical Holdings, see our report: "*How Private Equity Raided Safety Net Hospitals and Left Communities Holding the Bag*" (November 2022) and *here* for a November 2023 update.

### 3. Lifepoint Health, ScionHealth—Apollo Global Management

Lifepoint Health and ScionHealth are two of the largest hospital systems in the U.S.[48] They are both owned by private equity firm Apollo Global Management.[49]

The two companies are the result of a series of hospital acquisitions by Apollo, which in 2018 bought Lifepoint and merged it with another hospital chain, RegionalCare Hospital Partners.[50] Then, in December 2021 Lifepoint acquired the large long term acute care hospital chain Kindred Healthcare. As part of the transaction, Lifepoint shifted some of the acquired facilities and some of its existing hospitals into a new company called ScionHealth,[51] which is also controlled by Apollo.[52]

Through Lifepoint and Scion together, Apollo has an extensive hospital footprint, owning approximately 220 hospitals across 36 states.[53] As of December 2021, Lifepoint employed 50,000 workers,[54] and Scion reportedly employs approximately 25,000 workers as of 2023.[55]

As healthcare consolidation continues to accelerate and drive up healthcare costs,[56] Apollo's merger of Lifepoint and Kindred and creation of ScionHealth merits scrutiny for potentially anti-competitive impacts. Though Lifepoint and Scion now

*https://www.propublica.org/article/investors-extracted-400-million-from-a-hospital-chain-that-sometimes-couldnt-pay-for-medical-supplies-or-gas-for-ambulances*.

[45] Elkind.

[46] Elkind.

[47] Laura Cooper, "Rhode Island Regulator Approves Hospital Sale," *Wall Street Journal*, June 1, 2021, *https://www.wsj.com/articles/rhode-island-regulator-approves-hospital-sale-11622591539*.

[48] Definitive Healthcare. "Largest Health Systems in the U.S. Biggest Healthcare Systems." Accessed October 31, 2023. *https://www.definitivehc.com/blog/top-10-largest-health-systems*.

[49] David Muoio, "Lifepoint Health to create new 79-hospital company upon close of Kindred Healthcare acquisition," Fierce Healthcare, October 27, 2021. *https://www.fiercehealthcare.com/hospitals/scionhealth-Lifepoint-health-to-create-new-79-hospital-company-upon-close-kindred*.

[50] Prang, Allison. "Lifepoint Health Agrees to Apollo Buyout." *WSJ*, July 23, 2018. *https://www.wsj.com/articles/Lifepoint-health-agrees-to-apollo-buyout-1532347207?mod=article-inline*.

[51] "Lifepoint Health Completes Kindred Healthcare Transaction," December 23, 2021, *https://Lifepointhealth.net/news/2021/12/23/Lifepoint-health-completes-kindred-healthcare-transaction*.

[52] See pg. 15 of "Form 10-K (Filed February 25, 2022), Apollo Global Management." United States Securities and Exchange Commission, December 31, 2021. *https://www.sec.gov/Archives/edgar/data/1411494/000141149422000014/apo-20211231.htm*.

[53] See Lifepoint's list of hospitals *here*. Scion's list of hospitals is *here*. Accessed September 2023.

[54] Kacik, Alex. "Lifepoint Health and Kindred Healthcare Close Deal, Form New Company." *Modern Healthcare*, December 22, 2021, sec. Mergers and Acquisitions. *https://www.modernhealthcare.com/mergers-acquisitions/Lifepoint-health-and-kindred-healthcare-close-deal-form-new-company*.

[55] ScionHealth. "Employees." Accessed September 8, 2023. *https://www.scionhealth.com/employees*.

[56] Jamie Godwin, Zachary Levinson, and Scott Hulver, "Understanding Mergers Between Hospitals and Health Systems in Different Markets," Kaiser Family Foundation, August 23, 2023. *https://www.kff.org/health-costs/issue-brief/understanding-mergers-between-hospitals-and-health-systems-in-different-markets/*.

position themselves as entirely separate businesses, they are both owned and controlled by Apollo.[57]

Press reports and regulatory investigations describe operating challenges that pose a threat to quality care and access to medical services at Apollo's Lifepoint and ScionHealth hospitals around the country.

- Lifepoint's Wilson Medical Center in North Carolina faced regulatory scrutiny in 2022 and 2023, including threats by CMS to revoke its Medicare payments and an investigation by the state's attorney general. On three separate occasions in under a year, compliance surveys by state regulators found that quality deficiencies warranted an "immediate jeopardy" designation for the hospital. Wilson is the only hospital in Wilson County, located about an hour east of Raleigh.[58]
- In 2020 the *Wall Street Journal* reported on how in Wyoming Lifepoint chipped away at staffing and services at its hospital in working-class Riverton until most services were transferred to another Lifepoint hospital in Lander, 30 miles away. Riverton residents reported that the consolidation severely reduced access to medical services and the transfer led to increased utilization of air ambulances, from 155 in 2014 to 937 in 2019.[59]
- According to *The Lown Institute Hospital Index*, which ranks hospitals and health systems based on health equity, value, and outcomes, multiple Lifepoint facilities rank among the worst hospitals in their states., including in Virginia, New Mexico, and North Carolina.[60]

Lifepoint hospitals have notably high readmission rates; in 2022 Lifepoint's North Alabama Medical Center, National Park Medical Center in Arkansas, and Fauquier Hospital in Virginia each had the highest readmission rate in their respective states.[61] Fauquier Hospital and Lifepoint's Nason Hospital in Pennsylvania each faced the maximum Medicare payment cut for fiscal year 2022 as a penalty for their high readmission rates.[62]

For more on Apollo's ownership of Lifepoint Health and ScionHealth, see our report: "*Apollo's Stranglehold on Hospitals Harms Patients and Healthcare Workers*" (January 2024)

**Pipeline Health—Stanton Road Capital, Davidson Kempner Capital Management, and Deerfield Management**

Pipeline Health is an operator of safety net hospitals in California and Texas, and previously in Illinois. It is backed by private equity and investment firms Stanton Road Capital, Davidson Kempner Capital Management, and Deerfield Management.

In 2019, Pipeline broke promises to state regulators when it purchased, and then promptly moved to close, a safety net hospital that served a predominantly Black and Latino population near Chicago. The hospital chain purchased Westlake Hospital in Melrose Park, IL before announcing its intentions of shutting down the hos-

[57] Lifepoint itself also has an ownership stake in ScionHealth. To support the acquisition of the Kindred hospitals, Lifepoint made a $350 million preferred equity contribution to ScionHealth, in addition to ScionHealth raising $550 million in debt. See here: "ScionHealth Completes $450M Term Loan Wide of Talk; Terms," S and P Global Intelligence, December 20, 2021, *https://www.spglobal.com/marketintelligence/en/news-insights/latest-news-headlines/scionhealth-completes-450m-term-loan-wide-of-talk-terms-68148901*.

[58] Mariah Taylor, "Duke LifePoint hospital at risk of losing Medicare funding for 3rd time in 1 year," *Becker's Hospital Review*, March 31, 2023. *https://www.beckershospitalreview.com/hospital-physician-relationships/duke-lifepoint-hospital-at-risk-of-losing-Medicare-funding-for-3rd-time-in-1-year.html*; Tyler Dukes, "Wilson hospital again facing Federal threat to end Medicare contract," *News and Observer*, November 5, 2022. *https://www.newsobserver.com/news/local/article268249967.html*.

[59] Brian Speegle, "A City's Only Hospital Cut Services. How Locals Fought Back.," *Wall Street Journal*, April 11, 2021, sec. Markets, *https://www.wsj.com/articles/a-citys-only-hospital-cut-services-how-locals-fought-back-11618133400*.

[60] "Apollo's Stranglehold on Hospitals Harms Patients and Healthcare Workers," Private Equity Stakeholder Project, AFT, IAMAW, January 2024. *https://pestakeholder.org/news/new-report-details-harm-caused-to-healthcare-industry-by-apollo/*.

[61] Schwartz, Noah. "Hospitals with the Highest CMS Readmission Penalties in Each State." *Becker's Hospital Review*, November 11, 2022. *https://www.beckershospitalreview.com/finance/hospitals-with-the-highest-cms-readmission-penalties-in-each-state.html*.

[62] Ellison, Ayla. "The 39 Hospitals Facing Maximum Medicare Readmission Penalties." *Becker's Hospital Review*, October 29, 2021. *https://www.beckershospitalreview.com/finance/the-39-hospitals-facing-maximum-Medicare-readmission-penalties.html*.

pital mere weeks after its acquisition. Pipeline and its private equity owners bought Westlake, alongside two other Chicago-area hospitals in 2019 for a mere $5 million. After the bankruptcy and closure of Westlake, they were able to then sell the remaining two hospitals for a monumental $92 million—over 18 times what they paid for all three hospitals.

In regulatory filings before the purchase of Westlake, Pipeline had committed to keeping the hospital open for at least 2 years. The local community fought back with a legal challenge to save Westlake after Pipeline received regulatory approval to close it, but Pipeline was able to close the hospital by having the hospital's holding company declare bankruptcy. In the following bankruptcy proceedings, it was revealed that the hospital's closure had been a condition of Pipeline's acquisition agreement with the seller.

Pipeline's activities in Chicago resulted in the bankruptcy and closure of a safety net hospital, mass layoffs of over 500 workers, and the sale of property zoned for hospital use to be converted into luxury housing despite heavy opposition. Through its use of over two dozen subsidiaries and holding companies, Pipeline's investors were able to hide in the shadows and protect their assets from losses.

Pipeline continues to own and operate five hospitals in Texas and California. Pipeline's investors also have faced, to date, few consequences for their business practices that shuttered a safety net hospital and harmed communities.

For more information on Pipeline Health, see our report: "*How private equity raided safety net hospitals: Volume 2—Pipeline Health*" (July 2023).

## Additional Information

### ***Private equity in wheelchairs and other DME***

Private equity firms have increasingly bought up durable medical equipment (DME) manufacturers and suppliers and consolidated them. DME includes wheelchairs and other mobility aids, respiratory equipment, infusion pumps and supplies, and other equipment used to manage disabilities.

Through aggressive debt-funded growth strategies, a handful of private equity-owned DME companies have grown from nonexistence to industry giants over the last decade. The resulting companies are highly indebted, and are now seeking ways to cut costs to achieve the outsized returns demanded by their private equity owners.

This profit seeking has been linked to cuts to staffing that exacerbates long delays for repairs and billing practices that have resulted in Federal lawsuits.

The two largest suppliers of customized (manual and motorized) wheelchairs are owned by private equity firms. Cost cutting at these companies has been linked to slow response times for repairs that harm wheelchair users.

For more information, see the report we co-authored with the National Disability Rights Network: "*How Private Equity Profits Off of Disabled and Chronically Ill Americans*" (November 2023)

### ***Private equity and healthcare fraud***

There is substantial overlap between the risks associated with private equity ownership of healthcare companies and the activities targeted by the False Claims Act (FCA), a Federal law that establishes liability for individuals or companies that defraud governmental programs.

The FCA is commonly used to prosecute healthcare companies that defraud Medicaid, Medicare, and related programs by submitting false claims for a variety of activities. Fraudulent activities may include providing substandard care, providing medically unnecessary services, receiving kick-backs for services provided, filing claims for services not provided, and providing services by unlicensed or improperly licensed providers.

In an effort to achieve the high returns often expected by private equity investors, companies' aggressive profit-seeking may result in fraudulent activity.

See our report "*Money for Nothing: How private equity has defrauded government health programs*" (February 2021)

### ***Private equity in behavioral health and disability services***

Private equity firms made significant investments in the behavioral health and disability services industries, including mental health, addiction treatment, services for people with intellectual and developmental disabilities, and therapeutic foster care.

**See our reports**:

"*The Kids Are Not Alright: How Private Equity Profits Off of Behavioral Health Services for Vulnerable and At-Risk Youth*" (February 2022)

"*Understaffed, Unlicensed, and Untrained: Behavioral Health Under Private Equity*" (September 2020)

***Private equity in dentistry***

In recent years, private equity has increasingly carved out a substantial portion of the U.S. dental industry, primarily through ownership of Dental Services Organizations (DSOs). DSOs are companies that handle the business side of dental practices, such as administrative, marketing, bookkeeping, and financial services.

While DSO-affiliated practices currently make up a relatively small portion of the broader dental industry, the number is rapidly increasing. As of 2021, private equity firms have near-complete control of the DSO market. Nine of the top 10 DSOs are owned by private equity firms, and 27 of the top 30 DSOs are private-equity-owned. This amounts to approximately 84 percent of practice locations that contract with the top 30 DSOs.

See our report "*Deceptive Marketing, Medicaid Fraud, and Unnecessary Root Canals on Babies: Private Equity Drills into the Dental Care Industry*" (July 2021)

**Conclusion**

Many of the tactics used to strip wealth out of the hospital systems profiled above are common among private equity ownership of healthcare providers: high levels of debt, extracting dividends and fees, and selling off the real estate to lease it back all come straight from the typical private equity playbook. There are no laws prohibiting these kinds of financial maneuvers, even in a sector as critical as healthcare.

It is thus essential to pursue policies at the state and Federal level that prevent this kind of looting of healthcare companies from occurring again—through expanding regulatory oversight of for-profit hospital mergers and acquisitions, prevention of exploitative real estate plays and extractive fees and dividends, and protections for workers against mass layoffs.

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Senator MARKEY. Thank you so much for your—thank you so much for your testimony. Next, we are going to hear from Hannah Drummond. Ms. Drummond has been a registered nurse for over a decade and currently works in the emergency department at Mission Hospital in Asheville, North Carolina.

Ms. Drummond currently serves as Chief Nurse Representative for the National Nurses Organizing Committee and the National Nurses United. She organized her colleagues to the largest union victory at any nonunion hospital in the South in almost 50 years. Ms. Drummond, thank you for being here today. You may proceed with your testimony.

**STATEMENT OF HANNAH DRUMMOND, RN, EMERGENCY DEPARTMENT, MISSION HOSPITAL, NATIONAL NURSES ORGANIZING COMMITTEE (NNOC), NATIONAL NURSES UNITED (NNU), ASHEVILLE, NC**

[Technical problems.]

Senator MARKEY. Can you turn on your microphone, please.

Ms. DRUMMOND. Good morning, Chairman Markey and Senator Warren. Thank you for inviting me to testify at today's important hearing.

My name is Hannah Drummond, and I am a registered nurse in the emergency department at Mission Hospital in Asheville, North Carolina. I have been a nurse for over a decade, and I am the chief nurse rep at Mission for National Nurses Organizing Committee, an affiliate of National Nurses United, the largest union and professional association of registered nurses in the country, representing 225,000 registered nurses.

My reason for becoming a nurse is not unique. I want to heal people and provide quality health care to my community. I joined Mission because it was known for providing excellent care to residents of Asheville and considered the health care hub for Western North Carolina, which includes the rural Appalachian region.

In the same year, our entire hospital system was bought out by HCA Healthcare, the largest health care corporation in the country. I quickly began seeing concerning changes in our hospital after HCA's purpose—purchase. Every time I went into the supply closet, there were shoddy supplies that often didn't work.

Hospital managers began cutting staff, including short staffing registered nurses to unsafe levels. When we brought these concerns to management, we were ignored. So, we decided to organize our workplace to help protect our community.

When we began our union organizing drive, we were met with an onslaught of union busting tactics from hospital management. This was happening in the midst of the COVID pandemic. The hospital was more focused on fighting the union than fighting COVID and protecting our workers.

We had to fight to get the appropriate PPE and the Federally required fit testing to ensure N95 respirators adequately protect individuals wearing them. Due to management's failure to provide fit test to every health care worker, one of my nurse colleagues died.

The pandemic exacerbated the issues nurses have been facing for decades, but the severe nurse staffing crisis we are experiencing now is due to the intentional policies and neglect of hospital management. Nurses are constantly directed to care for more patients with higher acuity and less staff and resources.

Management's intentional short staffing is so pervasive that they refuse to staff the sterile processing department at Mission, which often means nurses and doctors in the operating room struggle to find sterile and safe equipment for surgery.

There are decades of evidence to confirm that when registered nurses are forced to care for too many patients at one time, patients are at a higher risk of preventable medical errors, avoidable complications, falls and injuries, and death.

I have seen patients die because they didn't receive the care they needed and deserved. HCA staffing cuts have particularly impacted the emergency and oncology departments at Mission. And due to the closures of labor and delivery departments across the Mission hospital system, anyone who needs to deliver their baby has to travel to Asheville, a drive upwards of 2 hours for some rural communities.

My experience at Mission is representative of the decisions being made at HCA owned hospitals across the country, which are being stripped of staff and essential services like nurseries, behavioral health and trauma centers, leaving vulnerable communities without access to critical health services. This isn't just happening at HCA.

Ascension, one of the Nation's largest Catholic, nonprofit health care systems, is using its market dominance to shut down its labor and delivery units. There are countless examples across the country that I could point to. Our profit driven health care system is broken. Nurses know that you cannot serve the interests of profits and patients at the same time.

Health care should not be a business. That is why nurses across this country support a single payer, Medicare for all system that will transform our profit driven health care system into one that prioritizes patient care.

On behalf of the 225,000 registered nurses represented by National Nurses United, we urge the Subcommittee to work with us to rein in profit driven hospital corporations and private equity investors, and build a sustainable, guaranteed health care system for all.

Doing so is critical to improve working conditions in hospitals and the quality of patient care across the country.

[The prepared statement of Ms. Drummond follows.]

PREPARED STATEMENT OF HANNAH DRUMMOND

Good morning and thank you, Chairman Markey, Senator Warren, and Members of the Subcommittee, for giving me the opportunity to testify here today. My name is Hannah Drummond, and I am a registered nurse in the Emergency Department at Mission Hospital in Asheville, North Carolina. I have been a nurse for over a decade, and I am the Chief Nurse Representative at Mission Hospital for National Nurses Organizing Committee, an affiliate of National Nurses United.

National Nurses United is the largest union and professional association of registered nurses (RNs) in the United States, representing nearly 225,000 nurses across the country. Nurses witness in real time the repercussions that our flawed for-profit health care system gives rise to, including the severe nurse staffing crisis the United States is facing today and the negative impact on patient care.

In my testimony today, I will be illustrating the impacts of poor hospital conditions, including understaffing of nurses and other hospital staff, the reduction of essential health care services, and the role that hospital management plays in perpetuating these issues through profit-driven decisions.

I started working at Mission Hospital in Asheville, North Carolina, in 2019 as a travel nurse, and I loved it so much I decided to join the full-time staff. Mission Health was formerly a non-profit community hospital system and considered the hub for the entire Western half of the state to access health care, including the rural Appalachian region. In the same year I joined Mission, our six-hospital system, with nearly 12,000 workers, was bought out by Healthcare Corporation of America (HCA) Healthcare. [1]

HCA Healthcare is the largest health care corporation in the United States, which as of 2020 operates 186 hospitals in twenty-one states. [2] HCA has consistently acquired more hospitals, clinics, and other health facilities across the country. Before the acquisition was approved by regulatory authorities, an asset purchase agreement was negotiated by the North Carolina Attorney General to include safeguards surrounding the health care services HCA would be required to provide to the community, including maintaining services offered in Mission's rural hospitals for five-to-ten years. [3]

However, I quickly began to see concerning changes in our hospital after HCA's purchase, which were validated by the frustrations shared with me from other

[1] Citizen Times. "*Today's the day: Asheville's Mission Health, HCA Healthcare finalize $1.5B deal*." Published Feb. 1, 2019. Accessed Mar. 28, 2024: *https://www.citizen-times.com/story/news/local/2019/02/01/ashevilles-mission-health-hca-healthcare-finalize-1-5-billion-deal/2721743002/*.

[2] HCA Healthcare Fact sheet. June 30, 2020. Available at: *https://hcahealthcare.com/util/forms/press-kit/2020-healthcare-fact-sheet-a.pdf*.

[3] Amended and Restated Asset Purchase Agreement. Available at: *https://searchwnc.files.wordpress.com/2020/02/amended-and-restated-apa-main-text-public.pdf*.

nurses. I started to notice a decrease in the quality of supplies—every time I went into the supply closet, there were shoddier supplies that often did not work. As time went on, hospital managers began cutting staff. For registered nurses, our staffing levels were reduced to unsafe levels, and we noticed cuts in other hospital staff, including translators and security personnel. When we brought these concerns to management, they ignored us. It became clear that HCA management would interact with health care workers in a way that ignored our clinical education and expertise.

As nurses, we quickly understood the danger our community faced after HCA Healthcare, a for-profit health care conglomerate, bought our hospital system. That prompted our decision to organize our workplace and join a union just weeks before the onset of the Covid–19 pandemic.

When we began our union organizing drive, we were met with an onslaught of union-busting tactics from hospital management. Meanwhile, the working conditions and patient care in our hospital continued to deteriorate because management refused to address critical issues.

Despite a global pandemic demonstrating the need for health care systems to invest resources in better equipping hospitals to protect patients and health care workers, HCA management continued to cut staff, services, and supplies at Mission. We had to fight tooth and nail to get the appropriate Personal Protective Equipment (PPE) and for management to provide the federally required fit testing to ensure N95 respirators adequately fit and protect individuals wearing them. As registered nurses, we are at high risk for Covid exposure and illness. Due to management's failure to provide fit tests to every health care worker, one of my nurse colleagues died. The Occupational Safety and Health Administration (OSHA) of North Carolina Department of Labor (DOL) cited and penalized HCA Mission Hospital nearly $30,000 for failing to conduct annual fit tests and failing to notify the DOL of the death of an employee due to Covid–19 in a timely manner.[4]

We have consistently had a crisis in our nurse staffing levels since HCA purchased our hospitals. Nurses are constantly directed to care for more patients with higher acuity. The levels of available staff and clinical resources are consistently decreasing. Management has moved and expanded units without increasing the number of nurses working on those units. Management's intentional short staffing is so pervasive that they refuse to staff the sterile processing department, which often means nurses and doctors in the operating room struggle to find sterile and safe equipment for surgery.

There are decades of scientific evidence confirming that when registered nurses are forced to care for too many patients at one time, patients are at higher risk of preventable medical errors, avoidable complications, falls and injuries,[5] pressure ulcers,[6] increased length of hospital stay, higher numbers of hospital readmissions, and death.[7] Because of HCA's intentional decisions to short staff our hospital, I have watched patients die because they did not receive the care they needed and deserved. As a nurse, we experience deep moral injury when we are not able to provide that care that we are trained to provide because we are stretched too thin by hospital management. It is devastating.

HCA's staffing cuts have particularly impacted the emergency department and the oncology department at our hospital, and labor and delivery departments in the

[4] National Nurses United. Press Release, "HCA's Mission Hospital penalized nearly $30,000 for failing to protect nurses and other health care workers from Covid–19." Available at: *https://www.nationalnursesunited.org/press/hca-mission-hospital-penalized-for-failing-to-protect-nurses*.

[5] Kim J, Lee E, Jung Y, Kwon H, Lee S. Patient-level and organizational-level factors influencing in-hospital falls. J Adv Nurs. 2022. Nov;78(11):3641–3651. doi: 10.1111/jan.15254. Epub 2022 Apr 20. PMID: 35441709; PMCID: PMC9790490.

[6] Kim J, Lee JY, Lee E. Risk factors for newly acquired pressure ulcer and the impact of nurse staffing on pressure ulcer incidence. J Nurs Manag. 2022 Jul;30(5):O1-O9. doi: 10.1111/jonm.12928. Epub 2020 Feb 25. PMID: 31811735; PMCID: PMC9545092.

[7] Increased LOS, Mortality and Readmission: Dierkes, A. M., Aiken, L. H., Sloane, D. M., Cimiotti, J. P., Riman, K. A., and McHugh, M. D. (2022). Hospital nurse staffing and sepsis protocol compliance and outcomes among patients with sepsis in the USA: a multistate cross-sectional analysis. BMJ Open, 12(3), e056802. *https://doi.org/10.1136/bmjopen-2021-056802*.

other Mission hospitals.[8], [9], [10] As a result of the Labor and Delivery department closures across the Mission hospital system, anyone who needs to deliver their baby has to travel to Asheville, a drive upwards of 2 hours for some rural communities.

With our union, nurses began to blow the whistle on the dangerous working conditions at Mission and to report the many actions HCA Healthcare had taken to reduce essential services. On December 14, 2023, North Carolina's Attorney General Josh Stein filed a lawsuit against HCA Healthcare for violating its contractual agreement to maintain essential services effectively at the same levels.[11] Our reports to the Department of Health and Human Services (HHS) and the legal action by Attorney General Stein led to a Centers for Medicare and Medicaid Services (CMS) investigation that resulted in CMS issuing HCA Healthcare a notice on February 6th, 2024, that Mission hospital was in "immediate jeopardy" related to deficiencies in care, which posed a risk to patients' health and safety. HCA was given twenty-four days to rectify those issues or lose Federal funding.[12]

HCA Healthcare has since been removed from immediate jeopardy status after announcing "a plan of correction" to address issues. That plan was developed without the input of Mission's health care workers and fails to address the severe understaffing throughout the hospital.

**My experiences at Mission Hospital are just one example of how HCA Healthcare, the largest for-profit hospital system in the world, harms patients and workers by prioritizing its profits at the expense of people. HCA-owned hospitals across the country are being stripped of staff and essential services like labor and delivery units, nurseries, behavioral health, and trauma centers are being closed, leaving vulnerable communities without access to critical health services**. In Live Oak, Florida, HCA Healthcare bought two hospitals just to close them down and turn them into urgent care centers,[13] and similarly, HCA purchased Cypress Fairbanks Medical Center in the suburbs of Houston, Texas, only to lay off nearly 600 workers and convert the building into a free-standing emergency center.[14] From trauma and stroke centers in San Jose, California,[15] to nurseries that serve a large number of high-risk patients in Osceola, Florida,[16] and more,[17] HCA is attempting to shutdown lifelines for our communities.

It is not just HCA that is prioritizing profits over patients. This is a national problem with countless hospital systems actively harming communities by closing critical hospitals and hospital units.

[8] NC Health News. "*Mountain Maternity Wards Closing, WNC Women's Lives on the Line*." Published Sept. 29, 2017. Accessed Apr. 1, 2024. Available at Mountain Maternity Wards Closing, WNC Women's Lives on the Line.

[9] ABC News. "*Mission Health votes to close Blue Ridge Hospital's labor and delivery department*." Published Jun. 5, 2017. Accessed Apr. 1, 2024. Available at *https://wlos.com/news/local/protesters-rally-to-save-labor-and-delivery-at-blue-ridge-hospital*.

[10] The Transylvania Times. "Hospital Closing Birthing Unit-Brevard NC." Published Feb. 4, 2015. Accessed Apr. 1, 2024. Available at *https://www.transylvaniatimes.com/news/hospital-closing-birthing-unit-brevard-nc/article-2725dc6c-9c83-5e0e-9a6c-f33ee3f2e144.html*.

[11] Stein v. HCA Management Services, (North Carolina Superior Court). *https://ncdoj.sharefile.com/share/view/s7aa4a4b30bc34a168b691be7b053f932*.

[12] NC health News. "Feds cite Asheville's Mission Hospital for 'immediate jeopardy,' HCA division president tells staff." Published Feb. 6, 2024. Available at: *https://www.northcarolinahealthnews.org/2024/02/06/feds-cite-ashevilles-mission-hospital-for-immediate-jeopardy-hca-division-president-tells-staff/*.

[13] First Coast ABC News. "*Hospitals in Live Oak, Starke shutting down inpatient, non-emergency services*." Feb. 28, 2020. Accessed Mar. 31, 2024. *https://www.firstcoastnews.com/article/news/local/hospitals-in-live-oak-starke-shutting-down-inpatient-non-emergency-services/77-8a96fbd4-0bf2-4a5d-93db-1a5908e6461a*.

[14] Houston Chronicle. "*Hundreds laid off or reassigned as Cypress Fairbanks Med Center converts to free-standing ER*." Mar. 28, 2019. Accessed Mar. 31, 2024. *https://www.houstonchronicle.com/business/article/Hundreds-laid-off-or-reassigned-as-Cypress-13722031.php*.

[15] National Nurses United. Press Release, "*RNs rally to demand HCA maintain life-saving trauma, stroke, and heart attack services at Regional Medical Center*." March 25, 2024. Available at: *https://www.nationalnursesunited.org/press/rmc-rns-rally-to-demand-hca-maintain-life-saving-trauma-stroke-and-heart-attack-services*.

[16] National Nurses United. National Nurse Magazine, Oct, Nov, Dec 2022 Issue. "*RNs at HCA Florida Osceola Hospital protest shutdown*." Available at: *https://www.nationalnursesunited.org/article/nurses-condemn-closure-of-nursery-unit*.

[17] National Nurses United. Press Release, "*Trinity nurses to hold press conference condemning behavioral health unit shutdown*." Available at: *https://www.nationalnursesunited.org/press/trinity-nurses-to-hold-press-conference-condemning-behavioral-health-unit-shutdown*.

Hospital consolidation has skyrocketed over the past two decades. More than 67 percent of hospitals belong to a larger system, compared to just 45 percent of hospitals in 2000.[18] We have seen large health care corporations and their private equity investors buy up local community hospitals across the country, drastically reducing the number of public community hospitals operating today.

There has been a dangerous trend in which profit-driven health care corporations have reduced services, cut staffing levels, refuse to purchase essential medical supplies and equipment, closed departments or units within a hospital, or have fully closed hospitals in critical access areas, leaving patients, the community, and workers to deal with the consequences. These health care disruptions often follow decisions to sell the hospital's physical property and other assets to the highest bidder and pleas to the Federal or state governments for financial assistance, citing that a critical access hospital is in financial distress.

Hospital corporations consistently make these decisions because their main goal is to cut costs to maximize revenue for hospital executives and investors, without regard for the impact on the quality of care patients in the community receive. Numerous studies have found highly consolidated health care markets lead to an increase in prices and worse patient care outcomes. The elimination of obstetric services, the branch of medicine that provides care during pregnancy and childbirth, has emerged as a major casualty of hospitals in highly concentrated markets that want to cut costs.[19]

For example, Ascension, one of the Nation's largest Catholic, nonprofit health care systems with 140 hospitals in 19 states, is using its market dominance to shut down its labor and delivery units, forcing patients to travel further for obstetrics care.[20] A report released by National Nurses United in January 2024 showed that Ascension is closing obstetrics services at higher rates than the national average and that closures are disproportionately in Black and Latino communities, counties with higher infant mortality rates than the national average, and in low-income neighborhoods reliant on Medicaid.[21] Ascension also has a partnership worth approximately $1 billion with Towerbrook Partners, a private equity firm.[22]

In southern California, union nurses at Hazel Hawkins Memorial Hospital have been fighting the hospital's attempts to close its intensive care unit and claim bankruptcy, despite the fact that the hospital's own financial reports show them to be in a strong financial position.[23] Union nurses in the California Nurses Association worked tirelessly to alert their community to the false claims Hazel Hawkins management was presenting before the bankruptcy courts. On March 21, 2024, the U.S. Bankruptcy Court for Northern California District of California agreed with nurses and dismissed the case.[24]

Across the country, nurses have been taking collective action through their unions, both at the bargaining table and through legislative advocacy, to improve staffing levels in their hospitals and prevent reduction of services or hospital closures. But we should not have to spend this amount of time and energy fighting greedy health care organizations to provide the care our community needs.

Our profit-driven health care system is deeply broken, and it endangers patients and health care workers. It prioritizes short-term financial returns rather than long-term investments in our health. Health care should not be a business; it is a human right. The resulting problems can only be addressed by removing the profit motive

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[18] National Nurses United Report, "Dangerous Descent: How Ascension Betrays its Mission by Gutting Care for Pregnant Patients and Babies." January 2024. Available at: *https://www.nationalnursesunited.org/sites/default/files/nnu/documents/1223—AscensionSeton—Obstetrics-DangerousDescent-Report.pdf*.

[19] Ibid.

[20] Obstetrics refers to a wide range of units and services for pregnant patients, while labor and delivery refers to a patient in labor and who gives birth. We use obstetrics and labor and delivery interchangeably in this report.

[21] National Nurses United Report, "Dangerous Descent: How Ascension Betrays its Mission by Gutting Care for Pregnant Patients and Babies." January 2024. Available at: *https://www.nationalnursesunited.org/sites/default/files/nnu/documents/1223-AscensionSeton-Obstetrics-DangerousDescent-Report.pdf*.

[22] Ibid.

[23] National Nurses United. Press Release, "*Hazel Hawkins nurses to host town hall meeting following hospital's bankruptcy filing and RNs no confidence vote in the health district*." Available at: *https://www.nationalnursesunited.org/press/hazel-hawkins-nurses-host-town-hall-meeting-following-hospitals-bankruptcy-filing*.

[24] National Nurses United. Press Release, "*Registered nurses are deeply gratified after court dismisses Hazel Hawkins bankruptcy claim*." Available at: *https://www.nationalnursesunited.org/press/rns-are-deeply-gratified-after-court-dismisses-hazel-hawkins-bankruptcy-claim*.

from health care. That is why nurses across this country support a single-payer Medicare for All system that will transform our profit-driven health care system into a health care system that prioritizes patient care and, by extension, the nursing profession.

On behalf of the 225,000 registered nurses represented by National Nurses United, we look forward to working with your Subcommittee to improve patient care, protect the health and safety of nurses, improve staffing levels and nurse retention, and build a sustainable public health care system for all. Congress must take action to reign in profit-driven hospital corporations and private equity investors. Doing so is critical to improve hospital working conditions and the quality of patient care across the country.

ATTACHMENTS

1.National Nurses United Report, "Dangerous Descent: How Ascension Betrays its Mission by Gutting Care for Pregnant Patients and Babies." January 2024. Available at: *https://www.nationalnursesunited.org/sites/default/files/nnu/documents/1223-AscensionSeton-Obstetrics-DangerousDescent-Report.pdf*.

2. National Nurses United. Press Release, "Hazel Hawkins nurses to host town hall meeting following hospital's bankruptcy filing and RNs no confidence vote in the health district." Available at: *https://www.nationalnursesunited.org/press/hazel-hawkins-nurses-host-town-hall-meeting-following-hospitals-bankruptcy-filing*.

3. National Nurses United. Press Release, "Registered nurses are deeply gratified after court dismisses Hazel Hawkins bankruptcy claim." Available at: *https://www.nationalnursesunited.org/press/rns-are-deeply-gratified-after-court-dismisses-hazel-hawkins-bankruptcy-claim*.

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5. National Nurses United. National Nurse Magazine, Oct, Nov, Dec 2022 Issue. "RNs at HCA Florida Osceola Hospital protest shutdown." Available at: *https://www.nationalnursesunited.org/article/nurses-condemn-closure-of-nursery-unit*.

6. National Nurses United. Press Release, "Trinity nurses to hold press conference condemning behavioral health unit shutdown." Available at: *https://www.nationalnursesunited.org/press/trinity-nurses-to-hold-press-conference-condemning-behavioral-health-unit-shutdown*.

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Senator MARKEY. Thank you, Ms. Drummond, very much. And our final witness is Dr. Donald Berwick. Dr. Berwick is President Emeritus, Co-Founder, and Senior Fellow at the Institute for Health Care Improvement.

Dr. Berwick served as President Obama's Administrator for the Centers for Medicare and Medicaid Services under President Obama, and on President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

Dr. Berwick serves as a lecturer at Harvard's Medical School Department of Health Care Policy, and he has served on the staffs of Boston Children's Hospital Medical Center, Mass General Hospital, and the Brigham and Women's Hospital.

He brings a wealth of knowledge in our home state as to what is happening. So, we thank you, Dr. Berwick, for being here. Whenever you are comfortable, please begin.

**STATEMENT OF DONALD M. BERWICK, M.D., MPP, PRESIDENT EMERITUS AND SENIOR FELLOW, INSTITUTE FOR HEALTHCARE IMPROVEMENT, NEWTON, MA**

Dr. BERWICK. Thank you, Senator Markey and Senator Warren. It is really an honor to be with you and I am very grateful. I would like to request that the full text of my remarks be on the record.

Senator MARKEY. Without objection, so ordered.

Dr. BERWICK. I really want to speak first as a physician, a pediatrician. I trained for 7 years to become a doctor, and one message was drilled into me every single day of my professional formation. That message is that the needs of the patient come first. I was taught to be proud of that commitment and to let it become part of me, and it did.

My career has wandered far from the bedside, but that imprint has never—has never left me. And I think that principle, the needs of the patient come first, should apply to and be enforced by law in every single agent in the world of care, not just clinicians, but also organizations, payers, entrepreneurs, and investors.

At the moment we are dropping that ball. The patient today, as you have heard from my colleagues on the panel, is at risk as never before in my memory. At risk of being demoted, forgotten, and harmed. And always, as always in America, it is people of disadvantage, marginalized, poor, who are at greatest risk.

But make no mistake, the threat affects us all. We ranked 69th among all nations in the world in our health and health care system performance, despite spending twice as much on health care as anyone else. That is an astonishing failure. The causes are many, but I think the cause we are focusing on today is a main one.

It is this, we are allowing the accumulation of wealth, not health, to become the aim and that is causing harm at a phenomenal cost. Unchecked, and this is mostly unchecked so far, greed is going to cause disastrous, and I think irreversible harm.

The Steward debacle is born of unleashing gaming and profiteering and greed among private equity investors whose aim is to accumulate wealth, and whose method is to layer vulnerable health care organizations with debt and rental burdens too great to bear no matter what happens to patients and communities.

The needs of the patient, far from coming first, are nowhere in sight. Steward is by no means alone in this. Putting money above the healing mission, we see the unmoderated pursuit of wealth in drug prices, in hospital consolidation, and in Medicare Advantage, my own recent interest, where annual overpayments now amount to over $80 billion a year.

Pointedly today we see it in the behaviors of the majority of private equity investors whose sole aim is return on equity. They care little if that return comes from peanut butter or health care. For them, it is the needs of the investor come first. And the evidence is accumulating.

As you have heard that private equity and private enterprise more generally, ownership of health care delivery brings harms to patient. We see it in autism care, with significant declines in staffing and increases in use of cookie cutter care for kids that need customized care. Private equity ownership of nursing homes is associated with a 10 percent increase in mortality, 10 percent, lower patient mobility, and 11 percent increase in costs.

After PE purchase of hospitals, avoidable patient injuries like falls and infections increased 25 percent. The power of money in politics makes it difficult to rein in this wealth accumulation, like in the Steward case, because wealth has the power to stop statutory attempts to rein in wealth accumulation.

It is a vicious cycle that requires exceptional political courage to reverse. If that courage were available, and you see it in this room in Senator Markey and Senator Warren, then we know at least where to begin to prevent other Steward like disasters and to restore patients' needs to the forefront of our priorities.

We need statutory changes that allow, they have to allow private sources of capital to support authentic innovation in health and health care. We have to have capital formation, but that—we have to preclude private equity entities and private enterprise, I think, from non-value added ownership of health care delivery, where they have typically relied on raising prices and decreasing costs, threatening adequacy and quality of care.

We should forbid the typical private equity approach of loading health care organizations with debt, extracting capital, and leaving stripped down organizations in bankruptcy or worse. Personally, I would forbid private equity firms from owning or controlling health care delivery.

No matter what, an entirely new level of transparency is called for, much as is kind of plated in Senator Markey's Health Not Wealth draft bill. That transparency must extend to real estate investment trusts that the private equity firms use to extract—to free up cash for them to pocket.

I would favor strengthening corporate practice of medicine restrictions. I commend Senator Warren for her proposed Stop Wall Street Looting Act, which would close many of the loopholes used in the private equity—by the private equity players, including unfair tax advantages.

I would recommend that—governance requirements change. I think 50 percent of directors of for profit entities in health care should be unrelated to the investors and representative of patients and communities. Board meetings should be public.

I took oath as a physician, and I believe those oaths should extend by law to organizations and investors who want to get involved in health care. The needs of the patient have to come first. Thank you.

[The prepared statement of Dr. Berwick follows.]

PREPARED STATEMENT OF DONALD BERWICK

My name is Donald Mark Berwick. I am President Emeritus and Senior Fellow at the Institute for Healthcare Improvement, a Boston-based non-profit that I co-founded in 1991. I served as Administrator of the Centers for Medicare and Medicaid Services under President Obama in 2010 and 2011. I am a pediatrician by training, practicing at the Harvard Community Health Plan for 19 years.

It is first as a physician that I wish to share my thoughts with you. I trained for 7 years to become a doctor, and one message was drilled into me every day of my professional formation. It is this: "The needs of the patient come first." Day after day, night after night, I was schooled to show up, invest every iota of my mind and skill, accompany the patient through their journey, however harrowing. I was taught to be proud of that commitment, and to let it become part of me. It did.

My career has wandered far from the bedside, but that imprint has never left me. Nor, I believe, should it leave any aspect of our health care system as—not just "a" guiding principle—but as "the" guiding principle for action, policy, investment, accountability, and system design. I believe that principle—"the needs of the patient come first"—should apply to and be enforced in every single agent in the world of care—not just clinicians, but also organizations, payers, entrepreneurs, and investors. What does not help patients and community health, we should not do.

At the moment, we are dropping that ball. The patient today is at risk as never before in my memory. At risk of being demoted, forgotten, and harmed. As always in America, it is people at disadvantage, marginalized, poor, who are at greatest risk, but the threat is even bigger than that. It affects us all. We rank 69th among all nations on the planet in our health and health system performance, despite spending twice as much per capita as anyone else. That is an astonishing failure, and we owe it to ourselves to find and correct the causes.

Some of the threats are global—climate change, future pandemics, violence among people and among nations; but the threat we are focused on at this hearing is of a special nature—it is the threat of greed, profiteering, and financialization of health care in America. We are allowing the accumulation of wealth, not health, to become the aim, and that is causing harm, and at a phenomenal cost. Unchecked—and it is mostly unchecked so far—greed will cause disastrous and irreversible harm.

The Steward debacle is borne of unleashed gaming and profiteering—greed—among private equity investors, interested only in accumulating wealth and layering vulnerable health care organizations with debt and rental burdens too great to bear, no mater what the consequences for patients and communities. The needs of the patient, far from coming first, are nowhere in sight.

The Steward architects are by no means alone in this—putting money above the healing mission. We see the unmoderated pursuit of wealth in the confiscatory pricing of far too many pharmaceuticals. We see it in the consolidation of hospitals allowing them to jack up their prices. We see it in the behavior of the majority of large insurance companies, most especially in the world of Medicare Advantage, where the Medicare Payment Advisory Commission recently estimated that annual overpayments now total over $80 billion a year. And, pointedly today, we see it in the behaviors of the majority of private equity investors whose sole aim is return on equity, who seem to care little if that return comes from peanut butter or health care, and for whom the pledge, "The needs of the patient come first," has no meaning at all. Instead, the needs of the investor come first.

We have allowed American health care to become too much the servant of the profit motive, and we have too much lost the trail of duty to health care—excellent health care—equitable health care—as a human right. To overstate only slightly, the unmoderated pursuit of profit has only two fundamental mechanisms: charge as much as you can and spend as little as you can. That hurts patients. And it hurts the morale and effectiveness of clinicians who care for parents. [1]

Academic evidence is accumulating about the types and degree of harm that private equity ownership of health care delivery brings to patients. Recent studies of private equity acquisitions of autism care programs show significant declines in staffing and increases in the use of "cookie cuter" care, rather than customizing care to individual patients' need. [2] The result is worse quality of care. Similarly, private equity ownership of nursing homes is associated with a 10 percent increase in mortality, lower patient mobility, and an 11 percent increase in costs. [3] An important study by colleagues at Harvard last year comparing patient safety before and after private equity acquisition of hospitals showed major increases in important forms of avoidable and serious patient injuries. After PE purchase of hospitals, avoidable patient injuries increased 25.4 percent compared with hospitals not bought by PE. [4]

[1] *https://www.youtube.com/watch?v=8KZkEv1CHgE.*

[2] Bat R, Appelbaum E, Nguyen QT. Pocketing money meant for kids: private equity in autism services. 2023 (Jun 21) Center for Economic and Policy Research: Washington, DC.

[3] Gupta A, Howell ST, Yannelis C, Gupta A. Does private equity investment in healthcare benefit patents? Evidence from nursing homes. Working Paper 2021–20. 2021(Feb); Becker Friedman Institute: Chicago, IL.

[4] Kannan S, Bruch JD, Song Z. Changes in hospital adverse events and patient outcomes associated with private equity acquisition. JAMA. 2023; 330(24): 2365–2375.

For example, patient falls rose by 27.3 percent, central intravenous line infections rose by 37.7 percent, and surgical infections doubled, from 10.8 per 10,000 hospitalizations to 21.6. And, anecdotally, my email inbox is full of disturbing reports from physicians and other clinicians about the changing circumstances of their practices as profit-seeking overtakes patient protection.

I am not a lawyer, but I believe that the vast majority of these wealth-seeking practices, though morally offensive and harmful to patients and communities, are not illegal. And therein lies our failure and our opportunity. The power of money in politics makes it difficult to rein in wealth accumulation, like that in the Steward case, because wealth has the power to stop statutory attempts to rein in wealth accumulation. It is a vicious cycle that requires exception political courage to reverse. If that courage were available—and I think you see it in this room in Senator Markey and Senator Warren—then we know at least where to begin to prevent other Steward-like disasters and to restore patients' needs to the front of our priorities.

We need statutory changes that continue to allow private sources of capital to support authentic innovation in health and health care, but that preclude private equity entities from non-value-added ownership of health care delivery, where they have typically relied on raising prices and decreasing costs to the point of threatening the adequacy and quality of care. We should forbid the typical private equity approach of buying health care organizations, loading those health care entities with debt, extracting capital, and ultimately leaving stripped down organizations at the verge of bankruptcy or worse.

To be clear, I would forbid private equity firms from owning or controlling health care delivery. To the extent that private equity does own health care delivery, an entirely new level of transparency is called for, much as contemplated in Senator Markey's "Health, Not Wealth" draft bill. That transparency should extend to the Real Estate Investment Trusts that private equity firms use to free cash up for them to pocket. Reporting should include leading indicators from the owned health care entities to reveal staffing levels, access levels, care program changes, and patient experiences. I would favor strengthening Corporate Practice of Medicine restrictions, as counseled by Professor Erin Fuse Brown in her March 25, 2024, testimony to the Massachusetts Joint Committee on Health Care Financing and in a recent New England Journal of Medicine publication.[5] I commend Senator Warren for her proposed "Stop Wall Street Looting Act," which would close many of the loopholes used by the private equity players, including unfair tax advantage.

It would be my recommendation that governance requirements change, such that at least 50 percent of Directors of for-profit entities be unrelated to the investors, and representative of patients and community members. Board meetings should be required to be public.

In 2023, Professors Naomi Oreskes and Eric Conway published a landmark book called, "The Big Myth," which I think should be required reading among health care policymakers.[6] The myth of which they speak is that markets and competition, not government action, provide the best solutions to meeting social needs. They trace the history of that myth, which was sold to us by big business and which took over the American zeitgeist in the last century despite the overwhelming evidence that it is not true. Their exploration of its consequences ranges largely in maters outside health care—into climate change, smoking, poverty alleviation, and more. But in seeking a case study of the failure of competition and pursuit of private self-interest to meet dire social needs, they could not have done better than to study the Steward debacle to show how the unmitigated pursuit of wealth enriches a few and makes our community far worse off. As I see the trends, I am coming to believe that the pursuit of profit ought to have, at most, a very, very limited role to play in navigating our way to the health and health care system we need and can afford, where the patient truly comes first.

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Senator MARKEY. Thank you, Dr. Berwick, so much. And, adding to the list, we are joined by Representative Kate Donaghue, Representative Sam Montaño, Representative Chris Worrell, Representative Estela Reyes, Representative Francisco Paulino, Rep-

[5] Zhu JM, Rooke-Ley H, Brown EF. A Doctrine in Name Only: Strengthening Prohibitions Against the Corporate Practice of Medicine. 2023 N Engl J Med 389(11); 965–968.

[6] Conway EM, Oreskes N. The Big Myth: How American Business Taught Us to Loathe Government and Love the Free Market. (New York: Bloomsbury Publishing, 2023.)

resentative Joan Meschino, Representative Paul DiNardo, Representative Dawn Shand, Representative Dylan Fernandez. Thank you all for being here.

Thank you for your leadership on these issues. Now we will turn to a round of questions. We will have a minimum of three rounds of questions for the panel. So, I have heard from health care workers at Steward hospitals that they don't have tubes to draw blood or seeing their patients surgeries canceled because of unpaid vendors or understaffing.

According to the Center of Medicare and Medicaid Services, from 2022 to 2023, compared to the state average, more patients visiting Steward hospitals in Massachusetts left emergency departments without care. Patients in need of mental health or psychiatric care stayed at the emergency department for 172 minutes, nearly 3 hours longer than the state average.

At HCA Mission, patients in the emergency departments are waiting for 16 hours. There are reports of a cancer patient waiting over 30 hours in the emergency department waiting for hospital admission.

Dr. Stinson, what is the emotional impact of trying to provide care without the staff or the supplies that you need, knowing that corporate greed played a big role in the conditions that made it difficult to provide the care?

Dr. STINSON. As you have probably heard from my other colleagues, we go into this profession to care for people. We all take an oath to do no harm. When we are stripped of all of our resources and our ability to provide the care that we have been trained to provide, it is a huge moral injury that a lot of my colleagues, including myself, have to bear.

Seeing patients die in front of us with not having the proper equipment, seeing people in the waiting room having heart attacks where we can't get access to them quickly is a challenge, and it strips us from our ability to practice at the top of our license. And these are traumas and injuries that live with us forever.

Senator MARKEY. Ms. Drummond, how does that resonate with your experience in the hospitals that you have worked?

Ms. DRUMMOND. It really closely reflects Dr. Stinson's experience. At my hospital specifically, we have seen a loss of our senior staff in both our physicians and our registered nurses. And when you get into the medical field, when I was a new nurse 10 years ago, it was so key to me to have my mentors to look forward to help process what was happening and to ask questions when I ran across something that I didn't have the knowledge to do on my own yet.

What we see is high attrition rates across the board. We have seen nurses leave after just a year in the profession because they are being pushed out of their training faster and then they are being put in charge of training other new nurses when they don't even have a year of experience yet under their belt. And it is not humanly possible to do that. And like Dr. Stinson said, it leads to moral injury.

Senator MARKEY. Okay. Thank you. And Dr. Stinson, could you expand on how these for profit hospitals interfere in—operationally with the delivery of equity and justice, especially for Black and Brown and immigrant communities that are most in need of health care?

Dr. STINSON. It is a complex question. But there is so many different ways. I think the first thing that come—that the first thing I think about when I hear that question is the removal of access to basic services, especially here in Boston how the city is set up.

Once a specialty or service leaves a neighborhood, it is oftentimes challenging for people within a community to get the transportation to another facility that they can seek the care. So, it oftentimes delays care in like cancer care or nephrology care or various specialties if they don't have it in their certain community or neighborhoods.

One, delayed care, which leads to poor outcomes and widens those gaps and health disparities that I mentioned earlier. So, communities of color typically are already disenfranchised, and these facilities worsen those access to care and quality care issues.

Senator MARKEY. Thank you. And, Dr. Berwick, could you talk about that frame where there is pressure to extract revenues out of for profit hospitals that we have seen in the Steward case, then ultimately wind up harming those who are the most vulnerable in the community.

Dr. BERWICK. Well, the for profit plan is charge as much as you can and spend as little as you can. And when clinicians are forced to practice in conditions in which the resources are not there to support what they want in their hearts to do, it produces demoralization and has all sorts of cascade effects, in terms of longevity, the relationships between doctors and patients.

One other thing I will mention is that there is another cascade, and that is to the not for profit sector. When private equity and for profit are establishing behaviors around costs and profit that change the dynamics in a market, the not for profits are hurt.

They have—in fact, they have to follow suit. And so, we are distorting the, I think the goodwill of not for profits to actually do—to perform their mission.

Senator MARKEY. Okay. And let's just expand upon that for a second. When Saint Elizabeth's and Carney are in trouble in Boston, if they don't have the revenues to provide the services, that then impacts the remaining hospitals within the greater Boston area.

Dr. BERWICK. Absolutely. It is one system, and those patients end up going somewhere. But also, when Steward changes the rules, when they act in ways, in cutting costs, for example, by reducing staff, that changes the market so that now you have the not for profits in a market where they have to compete against those kinds of behaviors. And it hurts their—it hurts their commitment to patients also.

I also must say in governance, in health care generally in the country, if you look at the makeup of governance, for profit or not for profit, a recent study showed only 14 percent of the members of boards of large systems in this country have any—have had anything to do with patient care.

They have never been near a patient. 14 percent have been near a patient. Who else is sitting in those seats? Guess what, private equity investors, real estate investors. So, we are changing the whole game here through these behaviors and it has got to stop.

Senator MARKEY. Instead of health care experts, you do have wealth care experts.

Dr. BERWICK. Yes. They seek their mission, and they are good hearted people, but they think the mission is to accumulate. And that is not the mission. The mission is to do whatever it takes to help patients. And so, something has got to change.

Senator MARKEY. Thank you, doctor.

Senator Warren.

Senator WARREN. Thank you, Senator Markey. So, I want to focus on another part of the—what is unfolding right now. Last week, after weeks of radio silence on Steward space, the news broke that UnitedHealth Group subsidiary Optum plans to acquire Steward's physician group, which is called Stewardship Health.

Now, as far as anyone can tell, that is the last asset of any value left at Steward. The sale has been spun as a way out of the financial crisis for Steward's Massachusetts hospitals, but I would like to take a closer look at that, if we can.

The deal is likely valued at hundreds of millions of dollars. So, Dr. Berwick, is there anything in the deal as reported so far that requires Steward to put that money back into the Massachusetts hospitals?

Dr. BERWICK. I don't know for sure, but not to my knowledge. They will be—it is another way to line their pockets, including the purchase of the—by Optum, another for profit, aggressive for profit company, worries me a lot. I don't know what is going to happen to the culture of physicians.

Senator WARREN. Okay. So, we are talking about potentially millions of dollars going into Steward's hands, but the money may not actually go into the hospitals. It could just roll right back out to another group of investors like Dr. De La Torre before, right?

Dr. BERWICK. That is my fear.

Senator WARREN. Okay. Is there anything in this deal, Dr. Berwick, that would require Steward to keep its Massachusetts hospitals open if the deal goes through?

Dr. BERWICK. I don't know the content of the deal, but my guess is no. And let me—one of—the thing here is a lot of this we don't know, because both Steward and Optum operate under conditions of lack of transparency that make it very, very difficult to know what is going on.

Senator WARREN. I am going to put it this way, I think if it were beneficial for the hospitals or beneficial for the people of the Commonwealth, we would hear about all of those elements. Instead, what we are hearing is that Steward gets hundreds of millions of dollars, full stop, without any additional guarantee that a single penny of this money goes to the hospitals that need it and nothing to ensure that the hospitals stay open, if this deal goes through.

Once again, without oversight, this means the money can just flow out the door to the likes of Dr. De La Torre. Second, I want to focus on another part of this though, and that is pause to think why a company would offer to pay hundreds of millions of dollars for the Steward doctor practice group. One answer is that UnitedHealth is coming to town hunting for profits, not trying to figure out high quality care.

How do they think they are going to make tens of millions, hundreds of millions of dollars in return on their investment? Remember, earlier, the first private equity group that came in paid $246 million, evidently to the dioceses, and reaped a benefit of $800 million.

How are they planning to make money, tens of millions or hundreds of millions more, from the medical services that are already owned by the—that are already practiced by the Steward doctors? Dr. Berwick.

Dr. BERWICK. Again, transparency is a problem. We don't know the answer to that question because we lack access to information on what is going on in Optum. My guess is they will raise prices—they will increase physician fees and——

Senator WARREN. Drive up the costs. They are going to charge everybody who comes in the door more, which means either the taxpayers, the insurance companies, or private individuals, right?

Dr. BERWICK. Medicare. They are absolutely the world's experts on up-coding. So, they actually own companies for the purpose of upcoding. That is Optum.

Senator WARREN. Just so everyone understands, upcoding means charging more, right?

Dr. BERWICK. Charging more in that case to Medicare, the Government, and to beneficiaries. And they have done that all over the country, and I suspect we are going to see costs rise.

Senator WARREN. All right. So, part of it is going to be that they are going to raise the cost of health care for everybody in the Commonwealth. I want to ask you about another part, and that is the vertical integration.

Optum is not a company just off on its own. It is related to another set of companies that are all trying to make profits. Can you talk to us a little bit about that, Dr. Berwick?

Dr. BERWICK. Well, Optum is—I don't know, Optum's plan inside, but they are buying up a lot of different components of health care, ambulatory surgery centers, physician practices. And so, they are——

Senator WARREN. Billing practices, insurance companies.

Dr. BERWICK. Yes. So, they are playing the whole game, and they are experts, again, in pricing and upcoding pricing.

Senator WARREN. Why does it matter when you have this kind of vertical integration? Why is that important?

Dr. BERWICK. Well, you lose—first of all you don't have any market really at work. You have deep concentration. So, they are not accountable to anyone.

Senator WARREN. Every patient, every doctor who refers a patient to the hospital is already effectively tied to an entire group, right. So that everything has to stay in sync to maximize profits for the entire group. Is that a fair description, Dr. Berwick?

Dr. BERWICK. It could be. I must say, and honestly, I don't really know what the deal is, whether they are requiring that kind of in-network behavior.

Senator WARREN. Okay, but you have got the opportunity here of creating in-network control.

Dr. BERWICK. Yes. They are the largest employer of doctors in the Nation. I think it is—they are probably approaching 100,000 now with this purchase at Steward. That is a tremendous amount of heft in a market, so they kind of can call the shots.

Senator WARREN. There is the problem, right? It is a huge conglomerate that will have even more market power if it is able to buy the Steward doctor practice. We have a real problem with Steward hospitals, but we need a solution, not an opportunity to make things worse.

We need to keep the doors open. We need to protect workers. And we need to provide quality care for our communities. A quick sale to another outside investor could do more harm here than good. Regulators led the original sale to private equity investors go through and permitted a nonprofit hospital that—to become a for profit corporation that answered to investors that were hungry for profits.

Regulators put conditions on the sale, but the private equity firm found the loopholes, and we had a confluence of failures. As the Globe put it last week, regulators lacked the legal tools to hold Steward to account and were handcuffed by a fragmented oversight system and a lack of political will to take a tougher approach.

They stood by as more than $1 billion in assets were quietly stripped out of the hospital system. Federal and state regulators should think once and think twice, and think three times, before they let another corporate investor suck more money out of the Steward system. Thank you.

Senator MARKEY. Let me turn to you, Ms. O'Grady. The Private Equity Stakeholder Project has done several reports of instances of private equity firms hollowing out healthcare for profit.

Please describe how these firms exploit a lack of transparency and complicated financial schemes to extract the maximum profit for their investors, but at the expense of the health care then provided at those hospitals.

Can you walk through the scheme, walk through the play, which is happening here in Massachusetts, but as you have studied it across the country?

Ms. O'GRADY. Yes. There is very little transparency for private equity firms, and particularly for the companies they own and their finances. As I mentioned in my testimony, private equity firms have, for example, extracted debt funded dividends and fees from the companies they own, and in most cases, they don't have to report that anywhere, especially to the public.

In my own research, I have been able to track down some of this information, but on a really piecemeal basis. So, for example, one of the ways that I have been able to dig into these finances is when private equity firms load their companies with debt, they have to report that to the lenders and what they are going to use that debt for. Credit rating agencies will then rate that debt.

I am able to at least get a glimpse into these companies' finances because they have to report this to another financial institution, the banks. So really, the only disclosures that I end up seeing are only available to me because they are meant to protect the banks. You mentioned in your opening statement another hospital company, Pipeline Health, outside of Chicago.

It was only revealed after Pipeline closed the hospital and filed for bankruptcy. In the bankruptcy filings, it was disclosed that it was owned by a group of private equity investors. And to make matters worse, they had been intending to close the hospital since before they purchased it.

That was only available in the bankruptcy filings. So, we, in a sort of perverse sense, got lucky that we were able to see that, but it was all post-mortem, too late to do anything about it.

Senator MARKEY. Right. So going in, they would want you to think that if anything went wrong, it was because of benign neglect. We didn't want to really harm it one way or the other. But what you are saying is the plan is actually designed neglect.

It is an actual financial plan to go in to strip out needed revenues to provide services, to privatize that wealth, and then to leave these institutions without the revenues, without the resources they need in order to provide services.

It is an actual plan that you can put on a three by five card out of business school in terms of what you should do. And it is one thing to do it to a widget company, or a coffee company, or to a muffler change company across the country. It is another thing to do it to a hospital that is central to the well-being of a community.

From your perspective, what is their mentality? Is it, as Dr. Berwick said, to just turn this entire area into one for financial profit without any real regard for what the impact is on hundreds and thousands and millions of families across our Country?

Ms. O'GRADY. Yes. And like you said, health care over wealth care. But I think more broadly, it is important to understand that these aren't—I don't think that these investors are setting out to drive these companies into bankruptcy. Is that their interests are misaligned, and it is a broken business model that fully relies on extracting profit out of these hospital systems. They have everything to gain and very little to lose.

Senator MARKEY. Yes. And thank you, Ms. O'Grady. And I saw you nodding your head, Dr. Berwick. And in response to Senator Warren's questions, you were saying, well, I can't be exactly specific because I don't know all the details as to what is going on.

Can we really have accountability of corporate greed without greater transparency in this one sector, the health care sector, that affects every family in our Country?

Dr. BERWICK. I don't think we can. I served on the Massachusetts Health Policy Commission. Steward refused to give the health information to the agency, the information. They just refused with no consequences that I could see.

I don't know if that has changed since I was on the commission, but it had no requirements to actually open, to turn on the lights. Later, when Optum bought HS Health, I felt there were some risks in that. And as a Commissioner, I asked that we do a far deeper investigation to predict what would happen.

We didn't. We couldn't. There was no information available, even on the national effects of Optum purchase of physician practices. So, this is a system that operates in the dark. And so, we—our hands are tied.

Senator MARKEY. They kept the State of Massachusetts in the dark. They refused to provide the information necessary for the state to be able to make——

Dr. BERWICK. Yes. Again, I don't know what has happened——

Senator MARKEY [continuing]. A determination as to the financial condition of Steward.

Dr. BERWICK. Yes. It just was, no we won't. What has happened since I left the Commission, I can't say, but that was the situation then.

Senator MARKEY. No, I think it is all part of designed neglect. I think it is all part of a plan for them to be able to continue to loot, continue to drain the revenues out of the health care system, the Steward system, for personal gain. And meanwhile, to hide their shenanigans, to hide the plot, to hide the scam which they have put in place.

That is really what we are confronted with right now because of the lack of transparency, because of the lack of records that the state can have early on in order to prevent that cascading impact on the entire medical system.

Dr. BERWICK. That is my belief. Greed thrives in the dark. And turning on the lights will help.

Senator MARKEY. Do you agree with that, Ms. O'Grady?

Ms. O'GRADY. Absolutely.

Senator MARKEY. Absolutely. Thank you. Let me turn again to Senator Warren for another round of questions.

Senator WARREN. Thank you, Senator Markey. So, let's spend some time talking about how we got here. Dr. Ralph De La Torre, the CEO of Steward Healthcare, was invited to today's hearing as the head of the hospital system since 2006.

Dr. De La Torre has been involved in every major decision made by the company to sell off assets and leave behind a zombie hospital system. He is the No. 1 person who needs to show up and account for what he has done. Failure to appear is cowardice. I appreciate our witnesses coming today. I hope we can unravel as much of this as possible, given that the hospital system has been opaque and refused to follow the law in terms of its disclosures.

But let's focus on a critical moment that brought us to today's crisis. It occurred in 2016, when Steward's private equity owner, Cerberus, sold the land under its hospitals and its hospital buildings to a real estate investment trust, MPT.

MPT paid $1.25 billion to buy those buildings, that land, the nurseries, the operating rooms, the parking lots, the whole thing. Dr. Stinson, you used to work at Carney Hospital, one of the Steward owned properties.

When Cerberus sold Carney's hospital building, they got $260 million for that particular hospital's real estate. So, did the workers get a raise and pay? Did working conditions improve? What benefits came to the hospital from that $260 billion—million dollars that they received?

Dr. STINSON. I did not receive any increase in pay other than what I negotiated, so no. I can only speak for the emergency department. There were no infrastructure things that I saw going on. I know the emergency department may be got five extra ER rooms, but that was about it.

Senator WARREN. All right, so you got five rooms. With the curtains, right?

Dr. STINSON. These had doors. We got doors this time. We got doors.

Senator WARREN. You got doors. I stand corrected. Okay. $260 million and you got five rooms, but no better working conditions for the staff. And the patients, did you see any evidence that Cerberus was reinvesting this money back in Carney and patient care?

Dr. STINSON. Not that I saw, no.

Senator WARREN. Okay. So, Cerberus sells, or Steward sells its hospital buildings for a total, for all of them they sold more than $1.25 billion, and yet none of the money, or very little of the money, seems to have been used to support the doctors, the nurses, the other workers, patient care. Ms. O'Grady, if Cerberus didn't use this windfall to increase wages or invest money back into Steward's hospitals, where did it go? It is a lot of money.

Ms. O'GRADY. It went to Cerberus. Almost $500 million went straight to Cerberus and its investors.

Senator WARREN. Straight through.

Ms. O'GRADY. Yes. The rest of it was used to fund a rapid, massive expansion strategy by Steward.

Senator WARREN. Okay. So, it goes to investors basically—it is where the money goes. And once the deal goes through and service is sold off Steward's buildings and land, MPT, where does that leave a hospital that doesn't own its own operating room and nursery and gift shop?

Ms. O'GRADY. The hospitals were stuck with really hefty rent payments. They no longer had their most valuable asset. They were beholden to a corporate hospital landlord. By 2020, they were reporting on almost $400 million net loss. By the time Steward was ready to exit—or Cerberus was ready to exit Steward, they had made around $800 million in profits.

Senator WARREN. In profits. That means they got—their money back——

Ms. O'GRADY. In profit. No, they quadrupled their investment on Steward. Fast forward to today, Steward hospitals are in dire straits.

Senator WARREN. This is a prime example of the danger of private equity. The private equity firms walk away with hundreds of millions of dollars. They leave behind the shell of a business that often fails.

There is a lot of conversation right now about people saying, well, but the hospitals were in trouble when they were first bought. Remember, the whole idea was Cerberus was going to come in and be a rescuer. However we evaluate what had happened to the hospitals back then, keep in mind, they had $1.25 billion drained out of them, and still managed to keep providing patient care.

If that money had stayed in the hospitals, if they had not had to pay the kind of rent that they had to pay after they lost access to all of their real estate, the financial condition of the Steward hospitals today would be very different.

We need to hold these executives accountable. We need to rein in private equity's influence over the health care system, and we need to make sure that we are providing the people who deliver health care with the resources they need to deliver that care for our patients. Thank you—thank you.

Senator MARKEY. Did you ever, Dr. Stinson, in the hospitals in which you worked, ever see corporate executives held accountable for reducing health access at safety net hospitals?

Dr. STINSON. I never saw or witnessed that at all, no.

Senator MARKEY. Yes. And I think that no resounds throughout the room in terms of this balance of power at the corporate boards. Is there anything stopping Ms. O'Grady, medical properties trusts from continuing to buy hospital property or Cerberus from buying another hospital?

Ms. O'GRADY. No, not yet anyway. But I think at a more positive note, we are seeing states across the country starting to consider legislation that would put more oversight over these kinds of transactions. And I think us being here today and your agenda will also be a critical step at the Federal level.

Senator MARKEY. Yes. Thank you. Ms. Drummond, did private equity exiting HCA stop them from understaffing the hospital and restricting access to trauma or cancer care?

Ms. DRUMMOND. Absolutely not. I have only worked for HCA since they have been a publicly traded company. And at the end of the day, their No. 1 priority is their shareholders and their profits, which is in direct, direct conflict with patient care.

We are the second most profitable hospital system in HCA across the country, and yet they refuse to staff us properly and give us the resources we need. And ultimately, patients suffer, and they die.

Senator MARKEY. Dr. Berwick, this is a practice the private equity has that can be extended over to any part of the health care system, over to hospice care, nursing home care, over to fertility care, over to behavioral health care.

Can you expand upon what your greatest concerns are in terms of what this practice is today, but what it portends for the future if equity—if private equity goes unchecked?

Dr. BERWICK. I think serious, serious damage to the mission and capability of health care systems. I defer to Ms. O'Grady for the particulars, but you are absolutely right. Private equity—and remember, private equity is only one form of private investment in health care.

We should be extending our view more toward private entrepreneurship as the—as an area of inquiry. But we know what happens. Nursing homes are now owned 70 percent by private—for profit forces. The private equity share in nursing home has gone down. It was 11 percent a few years ago.

Now at 7 percent. But that doesn't mean the for profit motive has left nursing. On the contrary, we have absolute clear scientific data showing deterioration in care with private ownership of nursing homes. They underperform in staffing. They underperform in patient outcomes and higher costs. The same is true, as I have said in autism care.

I think it is—I think, and check me on it, it is over 90 percent of autism care is now privately owned, and it is all migrating toward decreasing staffing. Autism care depends a lot on customized, intensive intervention with kids, which does work. When private equity gets control of autism care, that goes down.

You name the sector, and I don't personally have a single example of private equity ownership of any component of health care where the health care gets better. It just doesn't seem to be what happens.

Senator MARKEY. Yes. So, I think—what we have got on our hands right now is something that is only going to grow as the years go by. Massachusetts is largely a nonprofit system, but Steward is the—is the beginning of something here in Massachusetts, but also across the whole country. It is an example that we have to learn from, because ultimately their collapse impacts the nonprofit health care system.

As they attempt to expand into other areas in the health care sector, it clearly would ultimately wind up harming the nonprofit sector that provides the very same services. So, corporate executives, they make profit, but when COVID hit, Massachusetts provided $54 million to Steward during the COVID–19 pandemic.

Pennsylvania provided $8 million to Steward to prevent Eastern Hospital from closing. And when for profit hospitals drown, surrounding hospitals and community health centers have to pick up the slack.

Dr. Stinson, what would it mean for the patients you served at Steward Carney in Dorchester if that hospital cannot make it without—additional revenues that go into it? What would it mean for those people?

Dr. STINSON. I think this would be devastating. I know there are a lot of hospitals around the city, but I think having easy access to care is critical to maintaining health of communities for generations.

When you remove a facility from a community, they no longer will maintain that ability to live prosperous lives, be able to contribute to the economy, continue to be driving economic force in the Commonwealth.

But in addition to that, it also would reduce employment opportunities for so many that live in the communities as well. Steward is a huge employer here. And I think a lot of people that work in these communities, in Dorchester and in Brockton, would also lose employment and then also contribute in other ways that I don't think we have fully realized.

Senator MARKEY. Okay. Ms. Drummond, what would it mean for the hospitals that you have worked in?

Ms. DRUMMOND. As I stated in my testimony, Mission is the hub for Western North Carolina, so it would wreak havoc on our community. We are the only health system in Western North Carolina. There is a couple of other smaller hospitals, but as far as cardiac, neuro, and trauma emergencies, Mission's hospital campus is it. We are the only option.

If we close our doors, there is nowhere for people to go, nowhere.

Senator MARKEY. Dr. Berwick, I will give you the final word on that subject, the impact on patients.

Dr. BERWICK. It is a cascade of effects as you have heard described. The—I knew Mission, and Mission was an amazing health care organization 20 years ago, so this is a real loss of a community asset, and I think we can see that repeated over and over again. And one final comment on the not for profit.

You are right, we are a not for profit system. But if there is a Steward in town and they are cutting nurse ratios and they are cutting resources and lowering their production costs, and you are a not for profit, you have got to compete against that, which deteriorates—causes your own care to deteriorate.

We are one system, and so you can't damage one component of it without seeing damage downstream.

Senator MARKEY. No, thank you. Thank you, doctor. And we are also joined by Representative Andy Vargas, Representative Jessica Giannino, Representative Marjorie Decker, Representative Ryan Hamilton. Thank you all so much for your participation and your leadership. Let me turn again to Senator Warren.

Senator WARREN. Thank you very much. And Ms. Drummond, I just want to say, you really hit it exactly right when you said, there is nowhere else to go. We need these hospitals, and we need them to be open and functioning, and functioning at a high level. People need this care.

Thank you for the work you do. Thank you for the work that all of our health care professionals do. Let's talk for just a minute as we wrap this up about changes we could make in the laws, so this doesn't happen again. The first one I want to start with is I got a general, law to deal with private equity. It is called the Stop Wall

Street Looting Act, and it is the most comprehensive legislation to fundamentally reform the private equity industry.

It would make private equity funds liable for the debt that they settle on portfolio companies. It would ban dividends to investors after a firm is acquired. And it would protect workers in the bankruptcy process if the target company eventually fails.

It also deals with some of the tax breaks right now where taxpayers are subsidizing private equity, which is a terrible mistake. But tell me, Ms. O'Grady, how might the Steward crisis have turned out differently if these provisions had been enacted?

Ms. O'GRADY. I think it would have been completely different. I mean, one of the things that you mentioned was the concept of joint liability. So right now, private equity funds are structured in a way that they are completely protected from the liabilities of the companies they own, which makes them take on incredible risks that they don't have to pay the price for.

They get away with so much with impunity because they are not liable for the companies they own. And so, I think just by one example, the Stop Wall Street Looting Act's joint liability provisions would create actual accountability for that kind of corporate profiteering.

Senator WARREN. Okay. So, this is not a case where we just have to throw up our hands and say, there is nothing we can do about this. We can change the rules. We can put some regulations in place and stop this kind of looting. I would argue, though, that it is not enough just to do it across the board.

We need special protections in health care because we are literally talking about life and death. We are talking about hospitals that we cannot let close. So, let's talk about that for just a second. Steward is in shambles, but its private equity owners walked away with hundreds of millions of dollars in profits, $400 million from the sale lease back alone.

Dr. De La Torre refuses to tell us how much he has made off the deal, but at least it was enough to support a couple of yachts.

Ms. O'Grady, does the Federal Government have any authority to claw back the profits Dr. De La Torre or the private equity executives made from selling Steward hospitals' assets out from underneath them and then hollowing out the hospitals while they ran away with the profits?

Ms. O'GRADY. No, not that I know of, but it should.

Senator WARREN. But it should. And that is really the point here. So, I am also introducing new legislation to change that.

I want to make the point there are two things that would do. It would ban health entities that receive Federal funding from selling or mortgaging their assets to real estate investment trusts, so that Wall Street investors can no longer strip hospitals of their land and property and operating rooms and nurseries.

We need to put an end to that, and we can. And second, it would give the Federal Government new authority to claw back compensation from both the health care executives and Wall Street investors, whose predatory financial engineering endangers the viability of a hospital.

The potential collapse of Steward Healthcare threatens access to health care for communities all across our Commonwealth. The first thing we need to do is to keep those hospitals open and able to deliver high quality care.

We also need to hold these executives accountable though, because failure to do so now just invites them to come back and do this to another part of the health care system, and another part of the health care system, and another part of the health care system.

The fact that this happens is because of choices that we have made. We have failed to step up and change the law to protect the delivery of health care system in America. It is now on us to make those changes. Thank you all for being here today. Thank you.

Senator MARKEY. Do you have any other questions?

[Technical problems.]

Senator MARKEY. Do you have a concluding statement? Beautiful. So, thank you. And, thanks to everyone who has joined us today. We heard clearly that the Steward Healthcare crisis is the rule and not the exception.

Whatever the financial strategy or company type, patients and communities suffer when companies freely put corporate greed over community needs. Frustratingly, our system allows, even rewards this strategy. Private equity companies across the country are quietly making profits while infiltrating everything from fertility care to hospice care.

HCA Healthcare made $65 billion, billion, in revenues last year. Cerberus walked away from Steward with over $800 million in profit. Medical Property Trust CEO reported in February that the land they owned from Steward would start making them money again soon, but that money will not be going to the health care system.

Meanwhile, it is communities that continue to experience the consequences. And without reform, we simply risk creating one problem for another. Instead of private equity cutting deals, we have Optum exerting its potentially monopolistic power over our health care system by buying Steward's physician practice group. Like the hydra, cut one for profit company's head off and more will take its place.

We need to change our strategy, and that is what I am proposing in a path forward. We need a health care system for everyone, supported by Medicare for all and the Green New Deal. The Green New Deal for our health care. We need to continue aggressive oversight on corporate greed. I was on the Committee in 2009. We fought, we fought, but we could not get the votes for a single payer system.

But we know that ultimately, that was the flaw in the Affordable Care Act, that we did not have in that provision. And we need the Health Over Wealth Act to require protections for patients and providers, transparency from corporate executives, and accountability from companies that put their wealth over America's health.

The discussion draft for that bill that I am introducing is posted at *markey.senate.gov/healthoverwealth*. Fighting against corporate greed is going to be an uphill battle, but it is what Senator Warren, and I are promising you here today that we are going to conduct on a national basis. And it is what we have seen in the face of the Steward crisis that is uniting people in the face of the greed which we can see here in our home state.

Doctors, nurses, lab techs, hospital administrators, professors, advocates, and elected officials are all saying clearly it is long past time to make sure patient health comes before shareholder wealth in Massachusetts and across our Country.

Before we close, I would like to thank the many stakeholders and experts who have contributed to this hearing, the Massachusetts Health Policy Commission, the Center for Health Information and Analysis, Dr. Zirui Song, Rosemary Bach, public citizen, the American Federation of Teachers, Americans for Financial Reform, National Nurses United, Mass Care, and the many, many Massachusetts elected leaders, health providers, and experts who have made their voices heard through conversations with me, with my staff, and through written testimony, which will all be put into the Senate permanent record.

On that note, I ask unanimous consent to enter into the record 23 statements from stakeholders outlining priorities regarding reducing the harms of for-profit entities, including private equity in our health care system. Without objection, so ordered.

[The following information can be found on page 45 in Additional Material:]

Senator MARKEY. Finally, we want to thank our esteemed witnesses today. You did a fantastic job. Your testimony——[Technical problems.]

Senator MARKEY. Your testimony today and the events at Steward and HCA facilities that necessitated your participation are a stark reminder that we owe it to our patients in Massachusetts and across the country to not only learn from you, but to act.

We will leave the record open for any other Senators who wish to ask questions. The record would be open until April 17th of this year. We thank you. We thank everyone who has participated in this.

We—failure is not an option. We have to fix the system. We have to protect it against the predators who are looking at this, our health care system as just another way of making themselves more wealthy, but again, it will come at the expense of the health of ordinary families. We thank all of you for your participation today.

With that, this hearing is adjourned. Thank you all so much.

## ADDITIONAL MATERIAL

My name is Tamara Bedard and I am a RN that has practiced in the field of nursing for over 30 years. My nursing career has included work at large, city trauma hospitals, small community hospitals, outpatient city clinics, home health care and, for the last 18 years, community and public health at a local regional health department. I have lived in North Central, MA my entire life, raised my family here, worked in these and surrounding communities, have mentored and precepted nursing students from various local colleges, and have cared for its residents passionately. Clearly, I have both personal and professional interest in the state of health care here.

I have always been proud to be a nurse, and especially a nurse in Massachusetts. Massachusetts is not only known for its extraordinary medical providers and cutting-edge health care technology, it also hosts some of the best hospitals, colleges and universities to support the very best minds and healthcare artistry in the field throughout the world. At least, I always thought so.

Words cannot truly express my devastation over the state of healthcare at all levels today. As a nurse primarily working with and advocating for the underserved and at-risk populations in our region, I am frequently appalled by the poor quality of the healthcare interactions people are now forced to have. It is a Sisyphean task to secure healthcare for those in need every day, and I am repeatedly faced with the complete and utter lack of access people have to basic health care needs.

Dramatic increases in medication and insurance costs are massive barriers to good health, but even when 'adequate' insurance support is present, there are not enough facilities or providers available to administer care. Given this increased social awareness and our mass of brilliant minds and dedicated clinicians acknowledging the increased need for services, I truly don't understand how health care agencies and hospitals are closing. Consider the recent examples of the Leominster Hospital's Birthing Center and, even a branch of my own non-profit, public agency, the Nashoba Nursing Service Home Health and Hospice that had been taking care of this community since 1966! Now, with the impending Steward Health Care closings, our region is directly impacted again.

These hospital/agency closings are a symptom of greater health care system failures (including privatization/for-profit models) that are traumatizing not only the health of our individuals and communities, but also the dedicated healthcare workers that are trying to survive this storm. It has to stop. Efforts should be focused on recruitment, retention and support for clinicians AND their *practice environments* to increase health care access/services. Yet, many providers, like myself, feel betrayed because we are not supported, on any level, to continue practicing nursing, medicine, psychiatry, social work, etc. with competence, compassion, professionalism, and integrity within this broken healthcare system. In addition to more providers, we need MORE facilities to improve equity and access, NOT less. Our healthcare system needs life support in the form of excellent stewardship and better accountability to preserve and grow the amazing resources Massachusetts and its citizens have to offer.

Your very tired and heartbroken neighborhood nurse,

TAMARA BEDARD,
RN.

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AFSCME COUNCIL 93,
*April 1, 2024.*

Hon. ED MARKEY, *Chairman,*
U.S. Senate Subcommittee on Primary Health and Retirement Security,
*Washington, DC.*

RE: Impact of Private Equity Ownership of Hospitals

On behalf of the more than 45,000 public and private sector workers represented by AFSCME Council 93, I am writing to express our concerns regarding the increasing trend of private equity (PE) ownership of hospitals and its potential impacts on workers, patient care, and the cost of health care.

I thank you for the opportunity to present our views at the field hearing entitled "When Health Care Becomes Wealth Care: How Corporate Greed Puts Patient Care and Health Care Workers at Risk." Please include this testimony in the record for the field hearing scheduled on April 3.

As you are aware, private equity acquisitions in health care have grown rapidly over the past decade, and hospitals are no exception. *As of January 2024*, at least 460 hospitals are now owned by private equity firms, comprising 30 percent of for-profit hospitals in the U.S. Evidence increasingly suggests there are far-reaching dangers associated with private equity PE takeovers of hospitals, nursing homes and other health care facilities. A notable example is *Steward Health Care*, a for-profit health care system previously under PE ownership, which is currently in the process of selling nine hospitals in Massachusetts due to financial insufficiency in managing these facilities.

As a union representing front-line health care workers who are committed to high quality patient care, we are deeply concerned that there is strong evidence indicating that patient care suffers when PE takes over a hospital. A *2023 study* conducted by Harvard Medical School found a decline in patient care at hospitals acquired by PE. This study revealed that after a hospital is bought by a PE firm, admitted Medicare patients had a 25 percent increase in hospital-acquired complications, compared with patients admitted before acquisition. Patients also had 27 percent more falls and 38 percent more bloodstream infections. Researchers argue that patient care is jeopardized due to the private equity business model's emphasis on short-term objectives geared toward maximizing profitability and investment returns. PE often utilizes cost-cutting measures such as layoffs, wage freezes, replacing higher paid and higher skilled workers with less skilled workers, and benefit reductions for health care workers. These measures exacerbate workforce challenges in an already strained health care system and have a direct impact on quality of patient care.

Additionally, there are direct linkages between PE ownership and *higher health care costs*. Research suggests that PE-owned hospitals tend to charge higher prices for services compared to their nonprofit counterparts, leading to increased health care expenditures for patients and insurers alike. This financial burden disproportionately affects vulnerable populations and undermines efforts to achieve equitable access to health care.

With the strong support of Council 93, AFSCME International has consistently advocated for Federal policies to make health care more affordable and accessible with the passage of the Affordable Care Act (ACA) and more recently, the passage of the prescription drug reforms under the Inflation Reduction Act (IRA). These legislative victories are crucial steps toward addressing the systemic issues contributing to rising health care costs and ensuring that all individuals have access to quality care without undue financial strain. By and large, private equity acquisition of health care facilities leads to higher prices for patients and other stakeholders, which goes against the principles of equity, access and affordability that AFSCME stands for.

As a union that provides health care to vulnerable populations in a range of health care settings, we are also alarmed about PE's acquisition of nursing homes. A *widely referenced study* examining nursing homes acquired by PE owners revealed a 10 percent rise in mortality among Medicare patients. This same study also cited higher patient mortality rates, fewer caregivers, higher management fees, and a decline in patient mobility when PE acquires elder home facilities.

In summary, we are pleased that the Committee is delving into the matters surrounding private equity acquisitions of health care facilities. Drawing from the experience of Steward Health Systems in Massachusetts and insights gleaned from thorough research, we strongly encourage the Committee to enact measures aimed at protecting the welfare of patients, health care professionals and the wider community. This may include measures to increase transparency and accountability in health care financing, strengthen regulations governing PE investments in health care, and promote alternative models of hospital ownership that prioritize patient care and community needs.

Thank you for your attention to this important issue. We look forward to your leadership in addressing the challenges posed by PE ownership of hospitals and advancing policies that promote affordable, high-quality health care for all Americans.

JAMES DURKIN,
LEGISLATIVE DIRECTOR,
AFSCME COUNCIL 93.

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My name is Barbara Pearson. I live in Amherst, and am addressing you as an active member of One Payer States, Mass-Care, and the Poor People's Campaign.

Thank you, Senator Markey, for stepping up to champion the state-based Universal Health Care Act, SBUHCA (or "suh-boo-kuh"). It is not a sexy bill, and doesn't reduce easily to a sound bite. But it will provide a firmer foundation for going forward, allowing us to be proactive in a larger context. In this case, the context is the bills to establish Single Payer/Medicare for All in our Commonwealth, the Green New Deal for Health, and other state-based efforts to address the Social Determinants of Health.

With the theme of this hearing, "Health Care, Not Wealth Care," you are helping us connect the dots between procedural health policy and our lives. Thank you for highlighting the consequences of using money set aside for health care to create profit for investors instead of healing and keeping us well: Wealth over Health. While peer countries were developing successful non-profit universal healthcare, the U.S., with the HMO (Health Maintenance Organization) Act of 1973, opened the door to the Corporate Practice of Medicine (despite laws against it). Now under the guise of a "free market," profit-seekers are running roughshod over our health care infrastructure and we are suffering the consequences.

The free market is no match for financial engineers with dark money who operate outside our regulatory constraints and who see nothing immoral or illegal in leveraging hospital assets for yachts and leaving patients without an emergency room, or foregoing maintenance and safety standards in our operating rooms (LaFrance, Applebaum, 2021). Companies like Steward Health (and Welsh-Carson) have stifled competition and doubled prices throughout whole specialties in a region, bringing care out of reach for even larger numbers of Americans (*FTC*). Yet another Private Equity game-plan involves people on kidney dialysis, a truly captive and vulnerable audience (*Stoller*).

With these forces dominant in our health care, is it any surprise that Poverty is the 4th leading cause of death (*Brady*). Our health care is broken. Corporate greed continues to break it. We need to break corporate greed.

The SBUHCA bill will help states be laboratories for democracy, as the PSA "*Unbreaking America*" from RepresentUS shows. Progressive reforms at the state level—like Women getting the vote or interracial marriage—provide a model for other states to follow. Together, states build up the pressure for change from below.

Senator Markey, throughout your career, you have worked to make government serve the common good. Such contributions to build the welfare of the Commonwealth from the bottom up do more to stimulate economic growth than giving to billionaires or corporations, who buy back their own stock rather than create jobs and build communities.

I hope the **Joint Committee on Health Care Financing** in our state legislature is paying attention to what you are proposing. The Committee's *own hearing last month* (3/25/24) also shone a light on the excesses of Steward Health. Their experts offered several feasible solutions: among them, Unified Health Planning, laws to increase transparency, laws to hold wrong-doers accountable, and mechanisms for public input and public oversight. They were describing Single Payer/Medicare for All but no one made the connection to the bills we have (and which the committee just let die in committee, again). Your bill helps us make that connection.

We have the framework; now to find the political will. Markey and Khanna's bills (to ensure the continuance of Federal money already flowing into the state) would give Massachusetts the chance to lead the country again in health care. The bills offer us a path to bring state-based universal health care within reach—a way to achieve the solutions our experts are recommending, Unified Health Planning to shield against the excesses of corporate power, and using existing laws, currently not being enforced, to bring us back from corporate disasters. How bad do the corporations have to behave before we take the business of health care back from them. It's time to *Take Medicine Back*. Thank you, Senator Markey, for giving us a powerful tool for the job.

BARBARA PEARSON,
AMHERST MA.
ONE PAYER STATES, MASSCARE.
POOR PEOPLE'S CAMPAIGN, OUTREACH VOLUNTEER.

**References**: (Most are hyperlinked in the text, but I list the URLS in case they don't open.)

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***FTC***: *https://www.ftc.gov/system/files/ftc—gov/pdf/2010031usapcomplaintpublic.pdf*.

***Stoller***: *https://www.thebignewsletter.com/p/the-dirty-business-of-clean-blood*.

***Brady***: *https://www.vox.com/future-perfect/23792854/poverty-mortality-study-public-health-antipoverty-america-deaths-poor-life-expectancy*.

*https://represent.us/unbreaking-america/*.

**Hearing**: *https://malegislature.gov/Events/Hearings/Detail/4903*.

*https://www.takemedicineback.org/*.

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Dear Ms. Wilson and Ms. Bravo.

I want to express my gratitude for Sen. Markey's plan to introduce a companion bill in the Senate to Rep. Khanna's State Based Universal Health Care Act, his coauthoring the Green New Deal and the Green New Deal for Health. I have received a ticket and am excited to attend the hearing on the 3rd. As a volunteer and member of several organizations (see below) I have been advocating for transformational health care reform, grounded in the belief that the universal right to health is fundamental to the ability for human beings to enjoy all other rights, for 22 years.

The hearing's focus "When Health Care Becomes Wealth Care" addresses one of the key threats to health and impediments to fundamental reform—relying on the provision of health care as a wealth-generating investment ultimately means that the investor's financial interests take precedence over the health of the individual patient and the health of the public. By its very nature it sets up a conflict of interests. This even occurs when non-profit healthcare systems grow to dominate a market and, sometimes, develop an integrated monopoly structure that includes hospitals, physician practices, and insurance subsidiaries. Too much centralized power corrupts.

The result includes the hollowing out of our public health infrastructure, primary care doctors burning out and leaving the field, even well insured patients having difficulty obtaining primary care, patients held in hallways because ER's are overwhelmed when admitting beds are unavailable due to other patients awaiting discharge to a nursing home that doesn't have capacity because it, in turn, is short-staffed, and short-staffed nursing homes having unsafe conditions, etc.

I have witnessed a number of these situations as a professional social worker, have heard from colleagues about these problems, and have family members who have suffered due to these issues.

An Expanded and Improved Medicare for All system, which SBUHCA would support, won't solve all of these problems, but would go a long way to addressing them. I count on the Senator's years of congressional experience and stature in moving this legislation to the forefront. Please let me know how I, in turn, can support him in this effort.

Regards,

BOB MASON,
CLINICAL SOCIAL WORKER (RET.)

Member: Mass-Care. National Association of Social Workers—MA Chapter. One Payer States, Naumkeag/Beverly, MA.

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Dear SENATOR MARKEY and Staff:

I am writing to urge you to take immediate action on the Steward Healthcare crisis so that healthcare access can be maintained for thousands of Massachusetts residents and physicians and healthcare employees can be protected. For-profit and private equity healthcare models that sell off local hospital assets to real estate investment trusts and then hollow out and destroy the institutions that communities rely on for healthcare is a local and national travesty. Private equity has been plundering The United States for years, and nowhere is this more damaging than in the healthcare field. The corporate practice of medicine puts profits before people. America is the No. 1 country in the world for medical bankruptcies many are driven by greed. Steward currently owns the hospitals and the physician groups of the previous Caritas Christi group. They do not own the land as that was sold to the real estate investment trust MPT (Medical Properties Trust), another part of this Ponzi scheme to siphon off value and line the pockets of these self-serving individuals. The current proposal to help ameliorate the financial issues with Steward is to sell the Steward physician group to Optum.

This is a terrible idea.

Optum is currently engaging in the corporate practice of corporate medicine, driving down quality, harming patients and causing moral injury for physicians and other healthcare providers as they struggle to take care of patients, but are put in difficult to untenable positions trying to do so under the auspices of Optum.

Massachusetts has always been a leader in medicine. It's time for us to retake that mantle and take bold steps to stop the corporate practice of medicine, which extracts value from healthcare delivery in our communities while providing substandard care.

The Commonwealth must take immediate action including oversight of Steward hospitals, not only forcing Steward to pay its bills but making sure that state regulators or other overseers guarantee that Steward still provides care until they can be transitioned to reliable owner(s). They must be placed into receivership and a plan must be formulated that all of their holdings are parceled out to reliable healthcare systems who can operate these hospitals for the good of the community. Additionally Steward cannot be allowed to sell physicians practices to an entity that engages in the corporate practice of medicine. The Commonwealth also needs to take the land that these hospitals sit on and was sold to the real estate investment trust MPT and needs to do so by eminent domain. Again this is another part of this Ponzi scheme and these other entities have already been made more than whole by the value that they've stolen from the land and from the hospitals and the healthcare professionals who work in them. The cost has been to the care and safety of the local communities. This is no time for half measures, there is no question who has the moral high ground here and what the right path forward is, the Commonwealth of Massachusetts simply needs to take it.

BRAD JUDSON MD,
MASSACHUSETTS EMERGENCY MEDICINE PHYSICIAN,
FOUNDING MEMBER TAKE MEDICINE BACK.

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COALITION FOR PATIENT-CENTERED CARE,
*April 3, 2024.*

Hon. ED MARKEY, *Chairman,*
Hon. ROGER MARSHALL, MD, *Ranking Member*,
U.S. Senate Subcommittee on Primary Health and Retirement Security,
*Washington, DC.*

DEAR CHAIRMAN MARKEY AND RANKING MEMBER MARSHALL:

The Coalition of Patient-Centered Care (CPCC) appreciates the Committee holding this hearing about how corporate greed negatively affects patient care and health workers. We strongly believe that any discussion about patient care and health workers' well-being must consider the harmful impact of private equity firms' acquisitions of physicians and other healthcare providers.

The CPCC represents a diverse group of healthcare industry stakeholders who stand together in opposition to private equity's acquisition and influence over independent physicians that can result in an emphasis on profits and revenue growth over patient interests.

The CPCC is comprised of over 5,000 physicians from across the country who are on the front lines of providing patient-centered care. Our membership has first-hand experience with the negative impact of these deals. Overall, our members have observed that often, after a private equity firm takes over an independent physician group, the quality of care for patients goes down, the cost of care to public and private payors goes up, and employee working conditions worsen. The bottom line is that private equity interferes with the social contract between a doctor and their patient.

**Impact of Private Equity Acquisitions of Independent Healthcare Providers**

We believe that everyone benefits when physicians have the freedom to exercise their best judgment as to the delivery of care and can work directly with their patients to make medical decisions and deliver patient-centered care. Private equity firms do not share this ideal. They seem to be more concerned with maximizing investor profits than advocating for patients. Unfortunately, current U.S. tax law incentivizes private equity firms to acquire healthcare providers and gives them an advantage over other would-be acquisition partners by providing the firms with substantial tax breaks.

Private equity firms have been particularly active in acquiring independent physician groups. More than half of all specialists in several U.S. markets are owned by private equity firms, according to a recent study by the American Antitrust Institute, the Petris Center at the University of California, Berkeley, and the Washington Center for Equitable Growth.[1] As the *New York Times* summarized, the study found that "[i]n more than a quarter of local markets—in places like Tucson, Arizona; Columbus, Ohio; and Providence, R.I.—a single private equity firm owned more than 30 percent of practices in a given specialty in 2021."[2] The article added,

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[1] **Richard M. Scheffler et al., Monetizing Medicine: Private Equity and Competition in Physician Practice Markets (July 10, 2023)**, *https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG-Private-Equity-I-Physician-Practice-Report-FINAL.pdf*.

[2] **Reed Abelson and Margot Sanger-Katz**, *Who Employs Your Doctor? Increasingly, a Private Equity Firm.*, **The New York Times (July 10, 2023)**, *https://www.nytimes.com/2023/07/10/upshot/private-equity-doctors-offices.html?auth=login-google1tap*.

"In 13 percent of the markets, the firms owned groups employing more than half the local specialists."[3]

CPCC members' experience—consistent with independent research, public reports, and even a recent investigation by the Federal Trade Commission (FTC)[4]—is that, after a private equity firm takes over an independent physician group, there are generally adverse effects. These effects often include decreased quality of care for patients, increased cost of care for public and private payors, and deteriorating working conditions for employees.

Regarding higher costs, there is significant evidence that private equity acquisitions of healthcare providers result in higher prices without any evidence of an increase in quality or access to care. For example, a recent study concluded that, after hospital outpatient departments and ambulatory surgery centers contracted with a physician management company (PMC), prices paid to anesthesiologists increased, and were substantially higher if the PMC received private equity investment.[5] Consistent with the study's findings, the FTC recently brought a lawsuit against private equity firm Welsh Carson, highlighting the harmful price effects of private equity acquisitions of independent physician groups. According to FTC Chair Lina Khan, "private equity firm Welsh Carson spearheaded a roll-up strategy and created [U.S. Anesthesia Partners (USAP)] to buy out nearly every large anesthesiology practice in Texas. . . . [T]hese tactics enabled USAP and Welsh Carson to raise prices for anesthesia services-raking in tens of millions of extra dollars for these executives at the expense of Texas patients and businesses."[6]

As for decreased quality and access to care, while there are many examples, the 2021 sale of an independent physician group at Dartmouth College to private equity backed One Medical, is instructive. In 2012, Dartmouth Health Connect, a primary care physicians office, was opened by the college in connection with Boston startup Iora Health. The office was originally intended to offer accessible and affordable healthcare to college students and the surrounding area. It began with two full-time physicians, a nurse, and other health professionals. After the private equity-backed takeover of the group, however, all that remains is one physician assistant with responsibility for approximately 1,300 patients.[7] In our experience, aggressive cuts in staff-to-patient ratios result in decreased quality of and access to care for patients. Furthermore, they result in job losses and increase stress for healthcare sector workers, contributing to burnout, among other negative impacts.

Steward Health Care's downfall is a powerful example of how private equity owners of healthcare providers often abrogate the inherent responsibility such businesses have to their patients, their employees, and their communities. In the case of Steward Health, the consequences of private equity putting profits above all else are nothing short of tragic. Senators Markey and Warren described the current situation in their March letter to Steward Health Care CEO Ralph de la Torre as follows: "[A]s a result of years of failures by you and the private equity ownership at Steward, access to health care is at risk for Massachusetts communities, and thousands of health care workers' jobs could be lost."[8] The CPCC strongly agrees that this case highlights ″the perils of private equity investment and corporate greed."[9]

We commend the Committee for holding this important hearing and urge you to continue to work on addressing these critical policy issues related to the cost and quality of patient care.

Sincerely,

THE COALITION FOR PATIENT-CENTERED CARE

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[3] *Id*.

[4] **Press Release, Federal Trade Commission, FTC Challenges Private Equity Firm's Scheme to Suppress Competition in Anesthesiology Practices Across Texas (Sept. 21, 2023)**, *https://www.ftc.gov/news-events/news/press-releases/2023/09/ftc-challenges-private-equity-firms-scheme-suppress-competition-anesthesiology-practices-across*.

[5] **Ambar La Forgia et al**., *Association of Physician Management Companies and Private Equity Investment With Commercial Health Care Prices Paid to Anesthesia Practitioners*, **182 JAMA Intern Med. 396, (2022)**, *https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2789280*.

[6] **Federal Trade Commission**, *supra* **note 4**.

[7] **Douglas Farrago**, *The Metamorphosis and Transformation of a DINO*, **DPC News (Oct. 6, 2023)**, *https://dpcnews.com/uncategorized/the-metamorphosis-and-transformation-of-a-dino/*.

[8] *See* **Letter, Elizabeth Warren, Senator, Warren, Markey to Steward Health CEO: Years of Mismanagement, Scheming, and Profiteering Now Pose Urgent Threat to Hospitals in Massachusetts (March 7, 2024)**, https://www.warren.senate.gov/imo/media/doc/2024.03.06%20Letter%20to%20Steward%20CEO.pdf.

[9] *Id*.

MASSACHUSETTS EMERGENCY NURSES ASSOCIATION,
QUINCY MA.,
*April 3rd, 2024.*

Chairman Sanders, Ranking Member Cassidy, Senator Markey, and Members of the Committee and those taking part in the Subcommittee hearing today. Thank you for holding this critically important hearing and allowing me to submit this testimony. My name is Dan Nadworny and I am the President of the Massachusetts Emergency Nurses Association (ENA). I have been involved with emergency nursing for over 20 years, working in large academic and community hospitals during that time. In my role in the ENA, I come with collective concerns regarding the accessibility of emergency care in the region from our members. The actions taken to date from the Steward system have already harmed our communities and furthering a prioritizing of profits over care will undoubtedly cause more harm.

Access to emergency care is a vital link in the healthcare system. From the serious events of trauma, cardiac arrest, and stroke care to the needs of mental health and emotionally dysregulated patients our emergency departments must be an option for our communities. The demand for emergency care is driven by several reasons such as lack of access to primary care providers, the inability of patients to obtain follow-up care, and cultural changes demanding immediate resolutions to concerns. Regarding the cause, the number of emergency care visits has risen over 60 percent since 1997. Those additional visits have only added to the burden of boarding and crowding that is seen across the Nation and here in Massachusetts. When emergency departments are overcrowded it is more than an inconvenience. Increased ED crowding is associated with negative patient outcomes including increased patient mortality and morbidity; delayed or missed care opportunities such as antibiotic and pain control as well as increased rates of patients leaving without being seen.

The high risk to patient safety associated with hospital crowding is recognized by the state with the continued classification of regions 3, 4, and 5 to Tier 3 capacity alert. That level on the 0–4 scale expects significant delays in care. Recent articles have shown that Massachusetts has the 2nd highest average wait times for emergency care in the country. These delays in emergency care will only increase if there are service impacts with any further dysfunction of the Steward healthcare systems even without full closures. According to the Massachusetts Hospital Association patient care data, the 8 emergency departments (not including Norwood) see over 260,000 patients annually (according to 2023 plans). To distribute those patients within the regions that are already saturated could lead to catastrophic impacts on healthcare in Metro Boston and the region.

The impacts are not only directly to our patients and communities but also indirect with EMS access. In early 2024 Good Samaritan Hospital had increased wait times for EMS to offload their patients. During this time, EMS agencies including Norfolk Fire Control published the delays on social media and open-source radio traffic. The result was EMS diverted patients away from the hospital, resulting in an unofficial diversion to EMS. By all accounts, the hospital is having substantial dysfunction in the organization and the leaders are allowing that dysfunction to directly impact the region's ability to have adequate access to emergency care.

While the state must have a response, there is a disproportionate impact on the population of Norfolk County and the rest of Region 4 and 5 compared to the rest of the state. This region is still recovering from the losses of Quincy, and Norwood, New England Sinani, and the temporary closure of Brockton Hospitals over the last 4 years. Any further loss of healthcare settings will only further the issues described above leading to increased boarding and crowding and an unfortunate reality of likely harm to our patients.

This hearing is called to look at the role of private equity in healthcare, but the focus of the hearing should be as much on the impact on the health of our communities. Massachusetts healthcare functions in a hub and spoke structure with community hospitals providing first-level care to triage and escalate to the tertiary care centers as needed. However, over the last 3 years, this goal has not been a reality, and often community hospitals are left with no option for transfer to the State's Tertiary care centers at Capacity daily. Any group working in the state must be responsible to the communities they serve. That responsibility includes understanding the consequences of choices such as hospital service reductions, closures, or failure to ensure safe environments for patients and staff. If the leadership of for-profit agencies cannot recognize the impacts, then there is a role for stronger oversight with accountability for these groups.

In closing it is the position of the Massachusetts ENA that either the reduction or closure of any emergency care centers will harm the overall health status of the state. There is a need for oversight, planning, and risk reduction on the local, state, and Federal levels to ensure timely access to emergency care for all.

Thank you for the time and attention to this matter.

DANIEL NADWORNY RN, DNP, FAEN,
PRESIDENT,
MASSACHUSETTS EMERGENCY NURSES ASSOCIATION,
QUINCY MA.

**Disability Law Center**
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April 3, 2024

Senator Edward J, Markey, Chair
United States Senate Committee on Health, Education, Labor and
Pensions Subcommittee on Primary Health and Retirement Security
428 Senate Dirksen Office Building
Washington, DC

Re: Written Testimony of the Disability Law Center (Boston, MA) for the April 3, 2024 Field Hearing (*When Health Care Becomes Wealth Care: How Corporate Greed Puts Patient Care and Health Workers at Risk*) **Related to Private Equity and Wheelchair Repair**

Dear Senator Markey and Members of the Subcommittee:

The Disability Law Center (DLC) is a nonprofit public interest law organization that also functions under federal law as the Commonwealth's Protection and Advocacy system, advocating for people with disabilities, protecting civil rights, investigating abuse and neglect, and advising lawmakers. It also includes work under the federal Protection and Advocacy for Assistive Technology (PAAT) Program to assist clients in obtaining wheelchairs and other durable medical equipment, and repairs to this equipment.

In this letter, one of three being submitted by DLC as written testimony for this hearing, we are commenting upon **the role of private equity (PE) as durable medical equipment providers**, particularly the sales of and services to wheelchairs paid for through Medicaid (MassHealth) and/or Medicare.

We are writing specifically to highlight essential safeguards needed for our clients, and your constituents, who are wheelchair users. Currently, the lack of proper warranty protections leaves consumers vulnerable when wheelchairs malfunction, causing significant disruptions to daily life. This issue is not only about access to healthcare. It is about ensuring the rights and dignity of individuals with disabilities and holding corporations accountable for their products.

A consolidation of the marketplace, unchecked by antitrust regulators[1], has resulted in **a "duopoly," virtually only two national providers** for wheelchairs for Medicaid recipients, **both controlled by private equity (PE).** These companies are National Seating and Mobility (NSM)[2] and Numotion.[3] Together, they dominate a $70 billion dollar market for durable medical equipment serving roughly 5.5 million wheelchair users.

Under pressure from their private equity owner-investors, these providers follow the money, which means pursuing sales of wheelchairs, and spending as little as possible on repairs and service technicians.[4] For years, DLC has represented individuals stuck in

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[1] See Paul Roberts, *"Two Behemoths Dominate the Motorized Wheelchair Industry. Disabled Customers Pay the Price,"* Mother Jones, May-June 2022, (available at https://www.motherjones.com/politics/2022/05/motorized-wheelchairs-numotion-national-seating-mobility/):

> To understand this sudden transformation in the $56 billion durable medical equipment market, of which complex rehabilitation technology (CRT) is one part, experts and advocates point to a decade-old decision by Medicare to abandon set prices in favor of ones set by competitive bidding. By one estimate, the move reduced the federal government's costs by 35 percent. But at the same time, locally owned wheelchair shops quickly began to disappear as large corporations offered rock-bottom bids to Medicare and private insurers.
>
> Numotion, based in Brentwood, Tennessee, was one of the winners to emerge from the new system. Formed by the union of two PE-backed companies, Numotion spent the last decade **buying up dozens of smaller suppliers from coast to coast,** now employing about 3,000 people in 47 states. National Seating and Mobility, based outside Nashville and owned by the PE firm Cinven, is Numotion's biggest competitor; it has **acquired more than 50 suppliers i**n the United States and Canada since 2014 and now has 2,600 employees in 174 locations. Brendan Schroeder, a senior analyst at the health care advisory firm Provident, estimated that Numotion and NSM together control more than half the CRT industry. "They're the two behemoths," he said. (Neither company was willing to disclose revenue figures or other financial information when asked.)

(emphasis supplied)

[2] https://www.nsm-seating.com/content/uploads/2020/03/National-Seating-Mobility-Announces-Purchase-Agreement-with-Cinven-FINAL-V3-10.3.1941.pdf

[3] https://www.numotion.com/about-us/news/aea-investors-lp-acquires-numotion-the-nation-s-l

[4] As the then Executive Director of NCART, the industry's trade association candidly explained in an interview, "[W]hen you look at the current environment for CRT [complex rehabilitation technology], there is no incentive for competition" and "Repair is a money loser." https://publicinterestnetwork.org/wp-content/uploads/2022/05/USPIRGEF_Stranded_June2022.pdf, p. 11-12

For more detail, please see:

- https://pestakeholder.org/reports/private-equity-in-durable-medical-equipment/
- https://www.health.harvard.edu/blog/millions-rely-on-wheelchairs-for-mobility-but-repair-delays-are-hurting-users-202207212785

their homes with broken wheelchairs, and **unable to get to work, school, medical appointments or the grocery store.**[5] Wheelchair users are commonly stranded at home with broken wheelchairs for **weeks or months at a time**[6], with no effective or efficient way to get repairs.

Providers attempt **to coerce, or at least incentivize customers to bring their broken wheelchairs to the repair shop**, rather than service the broken wheelchair in the customer's home or arrange for pick-up and delivery. In-home service was provided to wheelchair users for decades by local small businesses. However, since providers were consolidated into two PE-owned entities, the business model appears to be to quote much longer waits for in-home service, thereby pressuring customers to bring their broken wheelchairs to the provider. This saves billable time for technical service representatives, and fuel costs, as well as the need for trucks. The obvious problem is that low-income individuals with severe disabilities and broken power wheelchairs rarely have adaptive vans and the ability to bring a power wheelchair to the provider.[7]

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- https://www.bostonglobe.com/2023/10/22/metro/wheelchair-repairs-can-drag-out-months-mass-people-with-disabilities-seek-solution/
- The Secretive Industry Devouring the U.S. Economy - The Atlantic

[5] Among people who have waited for wheelchair repairs, 42 percent experienced a negative consequence, including missing an event or being unable to get out of bed. Worobey, Lynn A, Allen W Heinemann, Kim A Anderson, Denise Fyffe, Trevor A Dyson-Hudson, Theresa Berner, and Michael L Boninger. 2022. "Factors Influencing Incidence of Wheelchair Repairs and Consequences among Individuals with Spinal Cord Injury" 103 (4): 779–89. https://doi.org/10.1016/j.apmr.2021.01.094.

[6] Informal surveys presented to a wheelchair repair task force in Connecticut found that, of 73 manual and power wheelchair users surveyed between last November and January, 76 percent said it took an average of at least one month to repair or replace equipment after they contacted their vendor.

A 2016 survey of Massachusetts consumers by the Disability Law Center showed that 45% of respondents experienced delays in repairs; 40% could not get a status report; 55% unable to leave their house during repairs and 31% unable to get to work during repairs.

The industry attempts to deflect attention away from itself to explain away delays, blaming insurance companies, Medicaid and Medicare prior authorization requirements and other payer policies, as well as parts suppliers' delays and the workforce shortage. However, recent data provided by the industry to the wheelchair task force in Connecticut shows that between 60% and 82% of the total delay days are, on average, due entirely to the industries' own lack of staff to timely conduct in-home assessments and in-home repairs, after all prior authorization had been obtained and all parts had been received. In addition, delays related to the supply chain are partly attributable to business decisions in recent years to minimize warehouse storage and keep fewer parts on hand, even when otherwise required by law. Finally, any shortage of applicants is likely influenced by starting salaries for technician positions (for which only a GED is required) which are as low as, or lower than, many unskilled jobs in the service sector. See e.g., https://www.indeed.com/jobs?q=numotion&l=Massachusetts&vjk=240c6b541985fea9 ($20.per hour at Numotion for Service Technician and Wheelchair Technician).

[7] Here again, private equity is pursuing a well-worn strategy: to shift all possible costs away from itself and onto public payors. MassHealth has just launched a program to use its medical transportation services to help customers transport their broken wheelchairs for repairs to the facilities of the two PE providers.

The level of customer service has been terrible and is only getting worse over time. Since competition and free enterprise are no longer working, federal and state governments need to level the playing field and provide basic consumer protections for wheelchair users. The federal government must also intervene to rein in the conduct of private equity and to break apart these companies and restore competition to the marketplace.

## Recommendations:

*A. Address Consolidation of the Market*

1. CMS must **investigate and report on the role of Medicare competitive bidding** in creating market consolidation among wheelchair providers.

2. The Federal Trade Commission and the U.S. Department of Justice must **investigate roll-ups and horizontal consolidation in the wheelchair industry and enforce antitrust laws** to break apart the duopoly of two Medicaid wheelchair providers.

*B. Lower the Volume of Repairs for the Wheelchair Industry*

1. CMS must investigate and report on the secondary effects of its rule covering only **"in home" use** of Medicare-funded wheelchairs, particularly whether this has led to cheaper parts in both Medicare and Medicaid funded wheelchairs and a greater need for wheelchair repairs.[8]

2. For Medicaid and Medicare funded wheelchairs, CMS must **encourage development of lower-cost community-based or decentralized alternatives to industry repairs**, such as local bicycle repairs shops for tire repairs and online sourcing of batteries, armrests, footrests and basic parts (screws, bolts etc.). Consumers must be permitted to handle very

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[8] In response to this issue, the Disability Rights Education & Defense Fund (DREDF) recently urged the following:

> Congress should amend the Social Security Act to clarify that the Medicare DME benefit is intended to enable disabled beneficiaries to function at home and in the community. CMS should internally evaluate the extent to which its Medicare DME policies violate Section 504 of the Rehabilitation Act as it applies to federally conducted programs. CMS should also issue regulations indicating that healthcare practitioners should evaluate Medicare beneficiaries requiring mobility devices for the best device to meet their functional needs in their homes and the community. CMS should also review its mobility device repair policies and revise them to ensure Medicare beneficiaries have timely access to repairs. Additional evaluation by CMS is needed to determine the durability and reliability of currently approved mobility devices."

https://dredf.org/2024/03/12/mdus-summary/?mc_cid=73ccc1ab62&mc_eid=fff57b8f29

basic repairs (tires, batteries, securing armrests, etc.) themselves or through local repair shops, without voiding the wheelchair warranty.

*C. Strengthen Accountability to Public Payors and Consumer Rights and Bargaining Power*

1. To manage the effects of past market consolidation from private equity, CMS and states must restore equilibrium to the market by protecting consumer rights. Specifically, CMS must require states administering Medicaid-funded wheelchairs **to develop and enforce standards for Medicaid funded wheelchair repairs**, **requiring (a) minimum staffing; (b) timely in-home assessments; (c) offering loaner chairs when needed for longer repairs; (d) standards for timely completion of repairs; and (e) minimum warranty periods.** Standards should also include electronic real-time tracking of the progress of repairs, and data reporting on average response times to Medicaid and Medicare customers, available to both consumers and state and federal regulators.

2. For Medicaid and Medicare funded wheelchairs, CMS must also require (a) **minimum coverage** though a wheelchair warranty and a minimum warranty period; (b) **coverage for preventative maintenance**; (c) a **prohibition on prior approval** for repairs below a specified cost (e.g. $2000., tied to an inflation adjustment;) (d) a **prohibition on prescriptions** for wheelchairs and wheelchair repairs, after an initial medical determination of a disability expected to last indefinitely; and (e) a requirement that providers **keep an inventory of parts available** locally, or have access to such parts through contractors offering, where practicable, **overnight shipping**.

*D. Promote Transparency*

1. **CMS must mandate public disclosure of all ownership arrangements** for health care entities owned by private equity and receiving Medicare and Medicaid funds, including DME providers, and must require:

   a) **a description of ownership structures and identification of all parties with ownership interest** and the amount(s) of their relative financial interests;
   b) a description of **transactions** associated with any acquired entity, including requirements of additional debt, restructured ownership; the leasing of real estate or physical facilities; or management or consulting contracts required by private equity of the acquired entity;

c) a description of **profits associated with acquisition** and whether such profits were reinvested, used to finance additional acquisitions or paid to shareholders in the form of dividends.
d) a **detailed and accessible accounting of revenue** for the health care entity, which allows regulators and members of the public to **distinguish between insufficient revenue relative to expenses versus the appearance of insufficient revenue** caused by its diversion to pay for acquired debt, sale/leaseback arrangements, management and consulting fees to PE controlled entities ("forced marriages") and dividend recapitalization.[9]

Thank you for the opportunity to comment. Please feel free to contact us if we may answer any questions concerning our testimony.

Sincerely yours,

Rick Glassman
Director of Advocacy

Tatum Pritchard
Director of Litigation

Barbara L'Italian
Executive Director

[9] During the proceedings of the Connecticut Wheelchair Task Force, the Vice President of Numotion was asked why the company cannot just hire more staff to do repairs in the field. He replied: "if we added more techs, we added more vehicles, that's more fuel costs, that's more other costs that we can't bear." (see 11/16/23 minutes, page 3, Wheelchair Repair Task Force - 11.16 Meeting Minutes.pdf (ct.gov), and https://www.youtube.com/live/RpcwoNHfpmk?si=cS24FhBYd5exdhhQ&t=2819 at 46:59-47:33).(November 16, 2023). Since PE companies are not publicly traded, do not publicly disclose earnings, and frequently employ tactics to siphon away revenue, these allegations are highly suspect and not subject to verification

**Disability Law Center**

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April 3, 2024

Senator Edward J, Markey, Chair
United States Senate Committee on Health, Education, Labor and Pensions Subcommittee on Primary Health and Retirement Security
428 Senate Dirksen Office Building
Washington, DC

Re: Written Testimony of the Disability Law Center (Boston, MA) for the April 3, 2024 Field Hearing (*When Health Care Becomes Wealth Care: How Corporate Greed Puts Patient Care and Health Workers at Risk*) **Related to Private Equity, Real Estate Investment Trusts and Nursing Homes.**

Dear Senator Markey and Members of the Subcommittee:

The Disability Law Center (DLC) is a nonprofit public interest law organization that also functions under federal law as the Commonwealth's Protection and Advocacy (P&A) system, advocating for people with disabilities, protecting civil rights, investigating abuse and neglect, and advising lawmakers. We regularly monitor abuse and neglect in nursing homes using our federal P&A authority. We also issue detailed public and private investigation reports, including a recent report on abuse and neglect in a real estate investment trust (REIT)-owned nursing home in Worcester, Massachusetts. https://www.dlc-ma.org/2024/01/31/investigation-at-bear-mountain-at-worcester/

We are writing to comment upon the role of private equity (PE) and REITs in nursing homes.

I. How Nursing Facilities Operate After Being Acquired by Private Equity Companies and REITs.

Nursing homes have been seen as attractive targets for private equity investors and real estate investment trusts: On average, 75% of business revenue comes from governmental sources. In addition to having reliable cash flow from public payors, traditionally nursing homes have physical assets, i.e., buildings and land. Nursing home residents are vulnerable and tend to go to the closest facility available, which limits competition in this sector. While profit margins of some facilities are narrow, they may be as high as 20%.

Typically, PE investors acquire the nursing facility relying mostly on borrowed or leveraged funds from investors such as pension funds, insurance companies, and sovereign wealth. Then, through tactics such as sale-leaseback arrangements and dividend recapitalization, they extract capital from the business to repay the acquisition costs and collect additional revenue. For example, PE may sell the real estate to another entity which PE controls and in a sale-leaseback arrangement, the nursing home will be forced to lease the facility it once owned. The PE entity then recovers its initial investment by receiving rental payments, often with the nursing home still saddled with the costs of insurance, upkeep and property taxes. Beyond this, PE will extract yet more through advisory, transaction and management fees.

The demands of the equity investors for payback and profits leads to programmatic cuts. Quality care comes at a financial cost. Caring and specialized staff consume time with patients. and therefore revenue. The core part of the business becomes the primary target for cost-cutting, leading to fewer staff on the floor and fewer specialized staff providing and overseeing necessary services and programming. Those cuts to direct care and clinical staff lead to more residents unattended, including people who may need help with eating, toileting and personal hygiene, and that may lead to a loss of personal dignity, infections, pressure ulcers, injuries, and even death. We also see higher incidents of behavioral challenges and higher rates of anti-psychotic medications to keep residents docile and easier to care for, using fewer staff.

II. Data on Health Implications for Residents in PE and REIT-Owned Nursing Facilities

In final regulations adopted last fall related to disclosure obligations, the Center for Medicare and Medicaid Services (CMS) described studies concluding that health quality measurements drop, often sharply, after nursing facilities are acquired by PE or REITs:

> As of 2021, roughly 70 percent of nursing homes were for-profit facilities; this includes those owned by PECs [private equity companies], which comprised approximately **11 percent of all nursing homes** (although estimates vary). Reports have circulated that nursing facility quality has declined under private

equity and similar owners. For example, in February 2021 the National Bureau of Economic Research (NBER) published an analysis titled ''Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes.'' The report stated: ''**Our estimates show that private equity (PE) ownership increases the short-term mortality of Medicare patients by 10%, implying 20,150 lives lost due to PE ownership over our twelve-year sample period. This is accompanied by declines in other measures of patient well-being, such as lower mobility, while taxpayer spending per patient episode increases by 11%.''** A November 2021 analysis published in the Journal of the American Medical Association contained similar findings concerning PEC-owned nursing facilities. Titled ''Association of Private Equity Investment in US Nursing Homes with the Quality and Cost of Care for Long-Stay Residents,'' the report stated that **PECs seek annual returns of 20% or more; with this pressure to generate high short-term profits, private-equity owned nursing homes might reduce staffing, services, supplies, or equipment, which could adversely affect quality of care.** The analysis concluded that: (1) private equity acquisition of nursing facilities was associated with higher costs and increases in emergency department visits and hospitalizations for ambulatory sensitive conditions; and (2) per the study's findings, more stringent oversight and reporting on private equity ownership of nursing homes may be warranted. The previously mentioned concerns about nursing home ownership are not limited to PECs. Other types of private ownership, such as REITs have generated similar concerns.

88 *Federal Register* 80141, 80144 (November 17, 2023) (footnotes omitted, emphasis supplied).[1]

## III. Recommendations:

### A. Staffing Levels

1. Given that nursing homes owned by private equity and REITs already control a substantial share of the market, the federal government must provide **additional protection to residents and health care workers in these settings.** CMS must require Medicare and Medicaid funded settings to strengthen quality of care by providing more rigorous licensing inspections and raising minimum staffing levels.

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[1] The NBER study also found that once a nursing home is acquired in by PE, patients in more likely to be given antipsychotic medications.

[2] https://www.federalregister.gov/documents/2023/11/17/2023-25408/medicare-and-medicaid-programs-disclosures-of-ownership-and-additional-disclosable-parties

2. In 2001, CMS provided Congress recommendations for the levels of staffing generally needed to care adequately for nursing home residents: 4.1 hours total care per long-term care resident per day, including 2.8 hours nurses' aide per resident and .75 Registered Nurse (RN) time. CMS contracted with Abt Associates, which produced the evaluation, "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes Report To Congress: Phase II Final, Volume I" (December 2001), available at https://theconsumervoice.org/uploads/files/issues/CMS-Staffing-Study-Phase-II.pdf. Abt determined that these are thresholds below which facilities are more likely to have quality of care problems. The threshold included combined 1.3 LPNs and RNs (or .55 LPN, utilizing the .75 RN threshold).

3. In February 2022, CMS proposed for public comment minimum staffing levels which are not as high as the 2001 recommended staffing levels, but which were proposed as minimum standards which could be implemented to raise staffing levels in a large number of facilities in the near-term. CMS, "Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency," *Federal Register*, Vol. 88 No. 171, September 6, 2023, 61352-61429. Based on facility assessments, if the acuity needs of residents in a facility require a higher level of care, a higher RN and NA staffing level will also be required. Id. at 61353.

4. **The majority of nursing homes fall short of federal recommendations, considered the "bare minimum,"** according to Charlene Harrington, a leading researcher on nursing home staffing levels and quality. State minimum staffing standards, including Massachusetts standards, are generally well below the staffing levels recommended by researchers and experts.

5. **Compensation must be linked to compliance with direct care staffing ratios, requirements of staffing hours per resident day, competencies, training, and services**. All require continuing governmental oversight.

B. Inspections and Quality of Care

1. CMS must ensure that states provide **adequate resources for surveying nursing homes** to enforce state and federal standards. DPH must supply surveyors who have the clinical expertise necessary

to review psychotropic medication practices as well as behavioral health treatment, neurobehavioral programs, and the focus areas of other specialized units.

2. CMS must require states to **promulgate detailed regulations** for long-term care facilities which must include minimum requirements for medical and nursing care; the keeping of proper medical and nursing records; uniform requirements for the handling of patient funds; minimum requirements relative to the prevention and reparation of lost or damaged patient possessions including personal clothing; minimum requirements relative to facility sanitation; and minimum clinical standards. These should address:

   - clinical expertise
   - staff licensing and certification
   - unit accreditation, staff training
   - staff ratios
   - community integration
   - use of psychotropic medications and non-pharmacological interventions
   - therapeutic and psychosocial programming to develop and maintain daily living skills and encourage socialization
   - use of behavior plans, and
   - other requirements of care and treatment.

C. Specialized Units

1. Many nursing homes operated by PE or REITs have sought to enhance revenue by opening specialized care units serving persons requiring treatment for infectious diseases, stroke, dementia, degenerative neurological conditions, geriatric psychiatry, traumatic brain injury, in-house dialysis treatment, behavioral health including serious mental illness, substance use disorder, bariatric patient care, or conditions requiring 24-hour or 1:1 monitoring and supervision (such as suicidal ideation, aggressive behavior toward other residents or staff, exit-seeking behavior, or treatment of registered sex offenders or medically paroled offenders.)

2. **CMS should permit compensation for specialized units or for residents of higher acuity only in facilities with best treatment practices in place**. Specifically, each such unit should be overseen by the state using surveyors with specialty training. Such units should be accredited in the specialty area by an outside accrediting agency approved by the state; or shall have a certification from the state in each specialty that they accept. Specialized care units must comply with standards for the type of unit to be set forth by the state through

promulgation of regulations, This may include demonstration of medical necessity for the service; use of a board-certified physician overseeing the specialty unit; and employment of certified staff, demonstrating competency in the specialized area. Specialized units with enhanced rates should also be limited to facilities with a current rating from the Center for Medicare and Medicaid services of at least four of five possible stars.

D. Discharge Advocacy

1. CMS must require that nursing home residents who may be capable of living in the community and desire to do so, are **appropriately assessed and supported through community-based alternatives to nursing facilities**. Residents and their representatives must be informed about community-based living and support options/

E. Limitations on Ownership Entities

1. **CMS must prohibit sale/leaseback arrangements**, through REITs or otherwise, where such transactions will undermine the financial viability of the nursing home or adversely affect residents.

F. Transparency and Public Disclosure

1. **CMS must require transparency and public disclosure** of what one expert called the corporate equivalent of Russian nesting dolls, in which assets are hidden or diverted through related party transactions or "tunneling" – to shell companies and management companies controlled by equity investors. That situation leads to at least two subsidiary problems:

   - Nursing homes appear poorer than they really are and demand more from public payors, funds that are not adequately allocated to resident care; and

   - When nursing homes engage in abuse or neglect, it is more difficult to provide accountability through the courts because assets have been diverted away from the business.

2. We support HHS' recent final rule requiring nursing homes enrolled in Medicare or Medicaid to disclose information regarding their owners, operators, and management, as well as the entities that exercise

financial control over the facility.[2] This rule requires disclosure of an interest of 5% or greater in the Medicare's Provider Enrollment, Chain, and Ownership System (PECOS). **CMS regulations should also require public disclosure of the parent entities of any investors and contractors**[3].

Thank you for the opportunity to comment. If we may be of any assistance to the Committee, please do not hesitate to contact us.

Sincerely yours,

Rick Glassman
Director of Advocacy

Tatum Pritchard
Director of Litigation

Barbara L'Italien
Executive Director

Disability Law Center
11 Beacon Street
Suite 925
Boston, MA

[2] https://www.federalregister.gov/documents/2023/11/17/2023-25408/medicare-and-medicaid-programs-disclosures-of-ownership-and-additional-disclosable-parties

3 See Health Affairs study published in March 2024, discussing deficiencies in CMS data, available at https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2023.01110:

> …[O]ur evaluation of the newly released data identified several gaps: One-third of PE and fewer than one-fifth of REIT investments identified in the proprietary Irving Levin Associates and S&P Capital IQ investment data were present in Centers for Medicare and Medicaid Services (CMS) publicly available ownership data. Similarly, we obtained different results when searching for the ten top common owners of nursing homes using CMS data and facility survey reports of chain ownership. Finally, ownership percentages were missing in the CMS data for 82.40 percent of owners in the top ten chains and 55.21 percent of owners across all US facilities.

The latest and most urgent crisis in our eroding healthcare "system" is what to do with Steward's 9 hospitals. We cannot afford to let these hospitals fail and devastate communities, patients and caregivers, and put more pressures on an already overburdened and chaotic system.

For profit healthcare does not work. The situation is exacerbated when the worst actors-hedge funds and private equity are involved-as they are with Steward. They strive to maximize profits at the expense of the caregiving mission of healthcare. Systemic failure is inevitable. We have already seen the disastrous results in other areas of society such as journalism and housing, as private equity takes over and leaves companies and communities "stripped for parts" as they walk away with mega profits.

The best way to resolve this situation is for the State to seize Steward's assets and establish a State Trust to manage these facilities for the public good. Healthcare is a human right and is treated as such in most industrialized countries, and many countries in the Global South. It is meant to serve communities and patients, not shareholders. Rising insurance rates, medical debt, worsening health indices (e.g. maternal mortality rising, while life expectancies are lowering),in addition to closing or failing of facilities, continues to negatively impact all of us.

Instead of running from crisis to crisis, we need to establish a universal, single payer system in Massachusetts as Mass Care has advocated for years. Medicare for all bills (S 744 & H 1239) have been filed and need to be passed now!

Bruce Fleischer, Mass Care, 1199SEIU Retiree, JP Progressives

ACOG
The American College of
Obstetricians and Gynecologists
Massachusetts Section

United States Senate Committee
on Health, Education, Labor, and Pensions
Subcommittee Field Hearing
Gardner Auditorium,
Massachusetts State House,
24 Beacon Street, Boston, MA

April 2, 2024

Thank you for holding this hearing regarding for-profit hospitals and their effect on health care.

I am submitting this testimony on behalf of the Massachusetts Section of the American College of Obstetricians and Gynecologists.

As a physician who has been caring for patients in Massachusetts for over thirty years, I have seen countless changes in healthcare – changes in advancements in medical knowledge and technology and changes in policy and legislation. Many of these changes have been positive, leading to better health and health care of our community.

More recently, a change in the distribution of healthcare has led to a frightening realization of the consequences of private equity firms gaining control of health care systems.

We see that the tribulations caused by the financial woes of Steward Health Care, a private equity firm, have apparently led to the threat of and actual harm to the health of our citizens, particularly in underserved communities.

As OB/GYN's, my colleagues and I were sickened to learn of a maternal death that might have been prevented had a necessary medical device been available; had it not been repossessed for nonpayment of bills. It is a disgrace.

The purported activities of this for-profit company – leading to medical equipment repossessed for non-payment while company officials harvested millions of dollars in profits - are detestable. The need for transparency in medicine is essential, especially in for-profit structures.

The fragility of our health care system is exposed when there are threats of hospital closures. Many of our hospitals routinely operate at a full census. The added volume of any hospital closure puts the safety of all patients at risk as surges in patient numbers overwhelm our already stressed hospitals.

There is a myriad of complexities in providing health care, and there are no simple solutions. However, in this instance, the facts are clear. The for-profit nature of this company has endangered the entire health care system in Massachusetts. It is essential that there are processes that ensure private companies are prioritizing patients over profit.

Respectfully,

James K.C. Wang, MD, FACOG
Past Chair, Massachusetts Section – American College of Obstetricians and Gynecologists

Written Testimony related to Steward Health System for
Hearings on April 3, 2024

By Mardge Cohen MD
Boston Health Care for the Homeless Program

I would like to begin by sharing an incident that my colleague Dr. Karen Klein, a Boston pediatrician reported to me. She writes the following:

I'm a pediatrician at Atrius Health. I saw a newborn in the office a few weeks ago who had a severe conjunctivitis. The baby had been born at St. Elizabeth's Hospital. The parents reported the baby did not receive erythromycin ophthalmic ointment because they were told it was 'unavailable' at the hospital. This treatment is part of the routine recommended protocol by neonatologists and the American Academy of Pediatrics. It is the long-recognized standard of care to prevent serious eye infections caused by gonorrhea and chlamydia. It also has the advantage of providing some protection from microorganisms the infant might come into contact with in the birth canal.

The parents were told that since they were a monogamous married couple, the risk of infection was low, and although there was an alternative option (likely with an injection), they could opt to 'just observe'. This is an inappropriate clinical decision for the hospital to consider - many cases of gonococcal ophthalmic infection in women are asymptomatic, and assuming there has been no exposure in a married couple is not sufficient to advise deferring prophylaxis. This is why universal prophylaxis is the standard of care.

This infant was seen several times in our office. We first treated with erythromycin ophthalmic ointment, which was easily available in our own pharmacy and the neighborhood pharmacies. This raises the question of why the hospital was unable to provide it or unwilling to buy it. Once the infection began, it worsened and there was concern for potential periorbital infection. A culture showed the infection was resistant and this necessitated a consultation with the ophthalmologist at Children's Hospital to ascertain whether the baby would need oral or intravenous antibiotics. Luckily a trial of an alternative ophthalmologic antibiotic was effective.

The experience was understandably upsetting and worrisome to the parents. It also interfered with their ability to be at home bonding, resting and establishing nursing.
I report this case because the baby was put at risk of serious infection due to what I would consider inadequate care received at St. Elizabeth's Hospital."

This incident reflects the deficiencies and poor quality of care at St. Elizabeth's for the most basic of procedures for well infant care (lack of availability of an inexpensive antibiotic prophylaxis for newborn infants).

In 2010, St. Elizabeth's was converted into a for-profit hospital when its parent organization, Caritas Christi Health Care, was purchased from the Archdiocese of Boston by private equity firm Cerberus Capital Management, becoming the flagship hospital of the newly-created Steward Health Care System. Steward sold much of their hospitals' real estate, including that of St. Elizabeth's, to Medical Properties Trust in 2016 in a sale-leaseback deal, providing the hospital system with $1.25 billion used both to pay hundreds of millions of dollars in dividends to investors and fund a nationwide expansion of the healthcare system. This deal, which imposed large lease payments on the affected hospitals, would largely be blamed for St. Elizabeth's - and the whole system's - financial crisis in the 2020s.

Health care should not be a giant Ponzi scheme for investors and people like Ralph de la Torre to buy 2 yachts and 2 private planes. Where were the state regulators when this was happening? Where was the oversight? These hearings are coming a bit late for the patients who have suffered and the ones who are going to suffer in the near future. Not to mention the whole chain reaction on the MA health care system—where people are finding it harder and harder to find a doctor, get appointments, and health care costs are rising with money leaving the system and going toward profits.

We should get profit and greed out of health care now and build a much needed reformed and high-quality national health care system.

MELINDA E. BARRETT
MAYOR

CITY OF HAVERHILL
MASSACHUSETTS

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April 3, 2024

Senator Edward Markey
JFK Federal Building
15 New Sudbury Street
Boston, MA

**RE Written Testimony on Impact of For-Profit Companies on Health Care**

Dear Senator Markey:

I am writing to you to share my thoughts on the impact of for-profit companies on health care, more specifically the negative impact Steward Health Care Systems has had on healthcare in Haverhill and the Merrimack Valley region.

I have said it before and I will say it again: our city has fallen victim to a ponzi scheme. Steward Health Care System does not care about their patients or employees. They care about profits. When they can't extract the profits they need to pay their creditors, they run hospitals like ours, Holy Family Haverhill, into the ground. It does not help that Steward has set themselves up to fail by entering sale-leaseback deals with Medical Properties Trust (MPT), a hospital real estate company. Steward is beholden to MPT because it owns the property their hospitals operate on, which is unusual for a healthcare system.

Steward owes Medical Properties Trust $50 million in back rent and that is what has sparked concern about hospital closures. In an interesting turn of events, Steward has been able to remain open because Medical Properties Trust gave them a $60 million bridge loan. It is also an unusual practice to see a landlord giving credit to a tenant who owes them rent, now more than doubling debt and potentially putting them in deeper financial crisis. Steward Health Care received $675 million in loans and grants from the federal government during the pandemic and I'd like to know where that money went if not towards rent and providing quality service to patients. Financial transparency is not what Steward is known for as they have resisted and failed at providing detailed financial information to the State for years as is required by every non-profit hospital in the Commonwealth.

The weight of Steward's financial crisis has been felt throughout the community of Haverhill. Residents have doubts about the quality of care they would receive if they went to Holy Family today. That troubles me because I don't want people to defer care or travel further than they need to receive care that is accessible, affordable, and high quality. I have spoken with Holy Family employees who have recounted to me the many ways in which the hospital has been mismanaged by Steward Health Care System, allowing the situation to get as dire as it has. They have departments, profitable ones, that have been closed without reason that the public knows of. Beds and resources are limited so we have nurses making some of the toughest decisions of their careers when it comes to who gets care first, especially as it concerns the emergency room, which is the only department that appears to be fully functioning. Staff morale is low as they have received minimal to no answers from Steward about how they plan to stabilize operations and staff are leaving. Filling those positions has proved difficult because, again, there is no confidence in Steward.

In Haverhill, we find ourselves in a challenging situation. As Mayor, I want to ensure that residents continue to receive the care that they need and deserve. Holy Family Haverhill is open for now and if it were left up to me, I'd like to see it remain an acute care hospital under non-profit ownership. Steward Healthcare Systems cannot continue operations, nor should another for-profit company be allowed to come in to operate Holy Family Haverhill From what we've seen in Haverhill, the for-profit model does not work.

Sincerely,

Melinda E Barrett

**Melinda E. Barrett**
Mayor

Good afternoon,
I was unable to call into to the meeting on Tuesday concerning what it's like working for Steward, but would like to you give you some insight on this matter
I have worked for Holy Family in Methuen for 29 years. For 23 of those years, I have been a cat scan technologist. I truly love what I do and love patient care, but working for Steward can be a challenge at times. One of the biggest problems in our department, besides the lack of being able to obtain supplies, is the cat scan techs being mandated to cover shifts. I am told that hospitals have the ability to mandate workers to work an extra 4 hours per day; there is no law stopping this from happening in Massachusetts. This system is used and abused all the time. Cat scan hasn't been fully staffed in years. Us techs are being mandated to cover vacant positions and vacation requests, adding an additional 4 hours on our 8-10 hour shifts. I can assure you that it is not safe for the staff or the patients to be continuously working these mandated shifts. How can we safely take care of patients when we are exhausted and can barely think straight? There needs to be a law put in place to stop hospitals from mandating healthcare workers to work an extra 4 hours per day.
To add on to this matter, there should also be 2 technologists per CT scanner for patient and staff safety. Unfortunately, this has not been happening for some time now. We are at risk for hurting ourselves and/or patients when moving patients on and off our table for their exams. You cannot safely slide a patient on and off our CT table safely by yourself.
I am concerned about the health and safety for both our staff and patients, and want to do something to improve this system

Thank you for your time,
Karen Lavertue

As a former employee of several Boston-area hospitals and as a healthcare consultant, I am writing to encourage you to recommend actions that will support the communities of those hospitals that are in danger of being closed or sold to a for-profit entity.

I suspect there are no public or non-profit hospitals that sell their buildings and are then required to pay rent to the new building owners. I suspect there are no public or non-profit hospitals whose goals are to make as much financial profit in the short term as possible, irrespective of the long-term consequences.

Community hospitals are important community resources that serve the people of their communities.

I encourage you to recommend actions to seize by eminent domain the hospitals in the Commonwealth that are owned by Steward and to create a Massachusetts trust to operate these hospitals for the benefit of the citizens of the Commonwealth served by these hospitals. This will ensure long-term benefits to the communities served by these hospitals.

Thank you for your consideration.

Norman Daoust

**Massachusetts Independent Pharmacists Association**

**2200 S. Ocean Blvd Unit 606**
**Delray Beach, FL**

**www.mipanet.org**

**April 3, 2024**

**Massachusetts Independent Pharmacists Association**
**Written Testimony**
**Senate Committee on Health, Education, Labor and Pensions**
**Field Hearing of the Primary Health and Retirement Security Subcommittee**

**U.S. Senator Ed Markey, Chairman**

Dear Senator Markey

The Massachusetts Independent Pharmacists Association represents the largest number of independently owned pharmacies in Massachusetts, and we agree the risks that private for-profit companies pose to both patients and health care workers is a serious issue. While it is clear based on recent headlines that Steward Health Care has had a direct and negative impact on patient care in the commonwealth independent pharmacies and the patients we serve have been suffering from a similar set of corporate greed for many years and continue to struggle with monopolistic for-profit corporations that indeed put profits first and patients second.

Large insurance companies have now combined with Pharmacy Benefits Managers (PBM) to dictate prescription services in such a way that neither doctors, pharmacists nor the patients who receive their care mean anything more than numbers.

While most people have probably never heard of them, PBMs play an outsized role in setting drug prices we all pay for at the pharmacy counter. Middlemen between drug manufacturers and health insurance plans, the job of PBMs is to develop and maintain a list of covered drugs ("formularies"), contract with pharmacies, and, most important of all, negotiate discounts and rebates on behalf of patients in those health plans.

Today three companies—Express Scripts, CVS Caremark, and OptumRx—control 80 percent of the PBM market, covering nearly 180 million prescription drug customers. In fact, PBMs have become so profitable that some rank even higher in the Fortune Top 25 than the drug manufacturers whose prices they are supposed to control. So drugmakers have a big incentive to offer steep rebates to PBMs. If they don't, they potentially can lose access to tens of millions of customers.

These for-profit corporations also use their enormous leverage over small independent pharmacy businesses to accept unrealistic rates of payments or be shut out of the prescription flow to those covered by these insurers. Pharmacies are forced to accept low payments and with little or no recourse other than to cut services, eliminate staff or simply close.

Reduced reimbursement to community pharmacies has resulted in significant consolidation among chain community pharmacies and the closure of many independent community pharmacies. The closure of independent community pharmacies affects all Massachusetts residents. A 2019 study showed that community pharmacy closings were associated with reduced adherence to cardiovascular medications. These medications are very effective and significantly decrease the need for more costly treatment. According to the study, the adherence impact was seen across all communities, was more significant with the closing of independent pharmacies, and was more significant among patients with the highest risk. In addition, a study investigated the impact of pharmacy closings in lower income and more diverse neighborhoods including Boston. This study identified communities with "pharmacy deserts," those with a lack of access to community pharmacies, and found that in Boston, diverse and black neighborhoods had a greater incidence of pharmacy deserts, and this can impact access to medications and other health services.

We have seen recent trends in the inner-city neighborhoods of Boston where even large chain stores such as Walgreens and CVS are closing their doors in places like Roxbury, Mattapan, and Dorchester because of lowered reimbursement rates. The Independent pharmacies in these areas are struggling to provide services but are barely surviving the aftereffects of the pandemic and the negative impact of PBM policies. These neighborhoods will likely see a rise in emergency room visits as residents struggle to find adequate care, further eroding the quality and accessibility of health care.

Over what … profits for big for-profit corporations. We ask the committee to consider the pharmacy market in its investigation into how health care is being driven by corporate interests and ensure that patients do not lose access to the high-quality care they deserve.

Americans for Financial Reform Education Fund

Senate Health, Education, Labor, and Pensions (HELP) Committee hearing
Sen. Markey, Chair of Primary Health and Retirement Security Subcommittee
April 3, 2024

Testimony for the record

**Robert Seifert, Senior Policy Fellow, Americans for Financial Reform**

The private equity industry's purchase of health care entities has grown dramatically over the last two decades, with health care takeovers accounting for 14 percent of all leveraged buyouts (LBOs) in 2021, there were 1,400 private equity healthcare deals with a combined value of over $208 billion in that year alone.[1] The growing presence of private equity in the health care sector poses new risks and harms a wide range of stakeholders. Entire communities' access to care can be threatened when private equity's business model strips medical facilities of the resources needed to provide safe, reliable care and leaves them at the brink of bankruptcy, as with the financial meltdown of Steward Health Care in Massachusetts.

Private equity's business model is fundamentally incompatible with health care's essential purpose. The private equity industry specializes in securing outsize financial returns by making debt-driven acquisitions that consolidate market power and using those acquisitions as financial instruments for extracting as much wealth as possible over a short period. Its standard playbook, when applied to health care, dangerously puts profits above patients and the health care professionals serving them. Medical professionals face immense risk and challenges when private equity's profit-driven business model demands new staffing practices, coding, and referrals. In nursing homes, hospitals, physician practices, and other health care settings, private equity takeovers lead to leaner staffing structures and a push to do more with less, contributing to physician burnout and compromising patient care. Recent peer-reviewed studies have found increased mortality in nursing homes owned by private equity, and increased falls and infections among patients in hospitals recently acquired by private equity.[2]

As these deals proliferate and the private equity industry's influence grows, state and federal policymakers face an increased urgency to remedy their ill effects. Public policy must stand

[1] Kerry Dooley Young, "The Impact of Private Equity Ownership in Health Care." *The Journalist's Resource* (blog), November 2, 2022.
https://journalistsresource.org/home/private-equity-ownership-in-health-care-research/

[2] Atul Gupta et al., "Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes," https://bfi.uchicago.edu/insight/finding/does-private-equity-investment-in-healthcare-benefit-patients-evidence- from-nursing-homes/; Kannan, S., Bruch, J. D., & Song, Z. (2023). Changes in hospital adverse events and patient outcomes associated with private equity acquisition. JAMA, 330(24), 2365. https://doi.org/10.1001/ jama.2023.23147

opposed to a degraded health care system and the increasing possibility of medical deserts that are the eventual outcome of a healthcare sector run largely by private equity firms. Policymakers must recognize health care entities' responsibility to the public's health, not just to investors' profits. Needed reforms would increase transparency of private equity owners' activities, and hold them accountable when they fail to meet their obligations.

Today's hearing is timely given the current crisis in Massachusetts health care driven by Steward Health Care, a crisis with its roots in the predatory practices of private equity. Steward was created by the private equity firm Cerberus Capital Management in 2010 when it gained control of the Caritas Christi system in an acquisition largely financed by debt, for which Steward was responsible. Cerberus then pursued various strategies that drained resources from the company, including selling its real estate, obligating the hospitals to pay $400 million a year in rent for properties they once owned. Cerberus paid dividends to its investors while closing facilities and depriving its hospitals. The company exited the ownership of Steward with an $800 million profit while leaving Steward in dire financial condition.

The Steward story retells a well-worn private equity tale. Similar takeovers and outcomes are well known in retail[3] and media and news companies.[4] The Steward case echoes other stories in health care as well, such as the bankruptcies of Envision Healthcare[5] and Philadelphia's Hahnemann Hospital.[6]

Americans for Financial Reform is committed to pushing back against the financialization of the economy that rewards the few at the expense of the many. In critical sectors like health care, we must ensure that investments serve to improve and not degrade the nation's health. AFR's policy strategies[7] to eliminate the harmful effects of the private equity industry's takeover of healthcare include:

- Shining a light on PE ownership of health care facilities and practices through regulatory actions requiring more extensive disclosure of ownership and financial relationships, and with greater public dissemination of this information.

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[3] Janet Nguyen, "A look back at KKR, the investment firm that bought out Toys R US … among others." *NPR Marketplace.* June 12, 2019. https://www.marketplace.org/2019/06/12/a-look-back-at-kkr-the-investment-firm-that-bought-out-toys-r-us-among-others/

[4] Anna Nicolaou and Sujeet Indap "The fall of Vice: private equity's ill-fated bet on media's future." *Financial Times.* May 25, 2023. https://www.ft.com/content/b8010767-8fe8-4ec0-aa40-676440b90f8d

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[7] Robert Seifert, "Doctored by Wall Street: Policy Solutions for Private Equity in Healthcare." Americans for Financial Reform. https://ourfinancialsecurity.org/wp-content/uploads/2023/07/AFREF-Doctored-by-Wall-Street-PRIMARY-final.pdf

- Increasing enforcement of existing anti-fraud laws by seeking maximum penalties for violations; identifying whistleblowers, such as physicians with negative experiences of PE ownership, to bring anti-fraud actions; increasing investigations of likely violations of laws prohibiting self-dealing; and better monitoring of individuals and entities barred from participation in Medicare and Medicaid because of past fraud convictions.
- Strengthening antitrust laws and enforcement to address the PE strategy of making small acquisitions that evade current federal merger guidelines.
- Reducing incentives to game Medicare payment rules through regulatory fixes that curb excessive overpayments in the Medicare Advantage program. Complementary legislative action could close payment loopholes that favor certain types of services, sites of care, and prescribing practices over others.

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March 29, 2024

The Honorable Edward Markey
Chairman
United States Senate
HELP Committee
Subcommittee on Primary Health and Retirement
Washington, DC

Chairman Markey:

On behalf of the 1.7 million AFT members, I want to thank you for organizing this important hearing on the impact of private equity on healthcare and for writing the Health Over Wealth Act. The AFT is a union of educators, public employees and more than 250,000 healthcare professionals who provide care to patients in an array of clinical settings. We can speak clearly about the detrimental impact private equity has on patient care.

Healthcare professionals at facilities across the country, from hospitals to physician practices, are calling out the failed private equity playbook of gutting patient care to maximize profits—a model that benefits owners and hurts patients, workers and the communities they serve. Healthcare services are essential for ensuring the vitality and productivity of people in our communities and should be affordable and accessible to all. But too many private equity firm managers view healthcare as just another industry to strip for assets and hawk to the highest bidder, while banking stratospheric fees.

Members of our union have witnessed many of these issues firsthand. At some hospitals, patients and staff have weathered deep service cuts, department closures and other cutbacks—an apparent result of the healthcare facility's high debt burden. Administrators have refused to repair or replace equipment needed for surgical procedures, resulting in unstable lighting, and conditions so hot and humid in the summer that surgeons are often sweating profusely over open incisions. In other hospitals, cutbacks have resulted in understaffing, at times putting the safety of patients and healthcare professionals at risk. The evolving world of healthcare requires investment and oversight to ensure that patients receive the care they deserve—and workers need employers that provide safe conditions and fair pay. I appreciate that the Health Over Wealth Act requires monitoring how private equity impacts staff ratios by position, staffing recruitment and retention, patient outcomes, and number of beds. This type of transparency is crucial for patients as well as for unions and other advocates. As important, this bill helps protect workers and patients during facility closures, by requiring closure timeframes and the approval of mitigation plans.

We know that much needs to be done to strengthen our healthcare system, from establishing safe staffing levels to ensuring that everyone has access to high-quality care without fear of implicit bias to making that treatment and medication affordable. While we move the nation forward on these goals, we must immediately act against those weakening our healthcare system, and the expiry date on the private equity model is long past due. AFT members—whether educators, public service workers or bedside clinicians—support your Health Over Wealth Act. We are ready to assist you in passing this crucial legislation.

Sincerely,

Randi Weingarten
President, AFT

RW : emc opeiu #2 afl-cio

Dear Senator MArkey,

As a Massachusetts primary care physician for 34 years at Atrius Health , now retired, and senior member of the MMS , I am STRONGLY OPPOSED to the possible purchase of the Steward physician group by Optum Health.

Optum Care is a subsidiary of UnitedHealth Group, one of the largest, and most profitable health care corporations in the US. They allege that the medical care arm is entirely separate from the insurance/pharmaceutical/ radiology/ laboratory division of the company. I must inquire, how can that POSSIBLY be correct , when the products sold by the for profit arm, are the products needed by the not-for-profit arm ?

It was my repeated experience that extracting prior approval for needed patient procedures, or for non-formulary medications, was obstructed by many insurers. Is it not probable that the charged COST of these needed evaluations and therapies (paid for by the insurer Optum wing) will be determined by the need for a profit ? When ordered by an Optum physician, this may well lead to increased billing. In turn to Medicare, Medicaid, & Mass Health, or the underinsured patients . Alternatively, the Optum physician will be DISCOURAGED or even PREVENTED from ordering appropriate evaluations.

The purchase of Atrius Health by Optum occured after my retirement. Nonetheless, I have innumerable examples of the ways that insurers OBSTRUCT patient care. I cannot simply "trust" that the common ownership of insurer-provider by a for- profit group will lead to better and less costly outcomes for patients.

Optum is seeking to enlarge its presence in Massachusetts. It is imperative that careful, independent analysis be performed BEFORE such a purchase proceeds. We cannot allow the health care of disenfranchised and vulnerable people to become a product sold to the highest bidder.

Thank you for your thoughtful consideration of this matter.

Best regards,

Sara Lennox MD

Commonwealth of Massachusetts
OFFICE OF SENATOR PAVEL M. PAYANO
STATE HOUSE ROOM 520 BOSTON, 02133-1053
Phone: 617-722-1604 Email: Pavel.Payano@masenate.gov

April 2, 2024

The Honorable Senator Edward Markey
225 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Markey,

I write today in opposition to private equity takeovers of Massachusetts hospitals and healthcare facilities. The people in my district have long suffered the injustice of health disparities caused by inequitable healthcare practices and limited access to quality care. For many of my constituents in the Merrimack Valley, Holy Family Hospital in Methuen and Haverhill serves as a critical safety net hospital, providing essential health services for many vulnerable low-income and migrant residents. However, since Steward Health Care's takeover of Holy Family Hospital in 2010, my constituents have not seen the improvements promised by the group. Instead, a concerning picture is emerging of hospitals that are less patient-focused, decreasingly accessible, and more demanding on healthcare workers.

Over the last few years, healthcare workers at the Holy Family facilities have voiced growing concerns over Steward's lack of investment into its hospitals. I spoke to nurses and physicians who attested to shortages of basic supplies needed for patient care, such as linens and medical supplies. In January 2023, these shortages manifested acutely when Mass General Brigham cancelled orthopedic and gastrointestinal procedures scheduled at Holy Family sites due to concerns over a lack of available surgical equipment. Since then, MGB physicians have returned to Holy Family, but equipment shortages remain, degrading the quality of care that workers can provide. Compounding the supply shortages are concerns over Steward's billing practices. In 2020, a court decision ruled against Steward for violating Medicare rules regarding false claims at its Holy Family sites, adding to a list of lawsuits Steward has faced over its billing. Moreover, after the Steward takeover, Holy Family nurses voted to unionize, citing inadequate staffing and high patient-to-worker ratios that put patients and healthcare workers alike at greater risk. These staffing shortages have only grown more pronounced, threatening the hospital's ability to safely provide services.

Now, many Merrimack Valley residents face the prospect of Holy Family Hospital closing its doors due to Steward's mismanagement and profit-seeking behavior. These closures would leave many in my communities without access to essential health services and further strain overburdened community hospitals such as Lawrence General. At every step, Steward's management of its Merrimack Valley hospitals suggests a desire to maximize profit instead of patient care, and it is our most vulnerable who suffer disproportionately from their decisions.

Thank you for the opportunity to provide testimony for this issue. Please, do not hesitate to contact me or my staff if you have any questions or would like additional information.

Sincerely,

Pavel M. Payano
State Senator
First Essex District

I'm Stephen Epstein, an emergency physician from Needham, Massachusetts. I am a member of the Department of Emergency Medicine at Beth Israel Deaconess Medical Center in Boston, Chair of the Board of Governors of the American College of Emergency Medicine's Emergency Medicine Data Institute, and Chair-Elect of the American Medical Association's Council on Medical Service, which has studied the issues surrounding private equity in health care. However, my comments are my own and do not necessarily reflect the positions of the organizations I am affiliated with.

While the primary purpose of today's hearing is the role of private equity in hospitals, focusing on the current situation with Steward, private equity is now widespread throughout health care. Multiple medical specialties, including my own, have seen private equity enter the health care marketplace. In 2019, Hahnemann Hospital in Philadelphia was shuttered just over a year after it was sold to a private equity firm. Last year, American Physician Partners, a medical staffing company with over 150 contracts to staff emergency departments across the country, abruptly filed for bankruptcy. In both circumstances, patients and caregivers suffered.

In and of itself, private equity is simply a financial tool. Private equity can be used to provide capital and business expertise for expansion, improving efficiency in the health care system. However, all too often, we have seen situations similar to what appears to be occurring with Steward, in which entities are over-leveraged, ultimately leaving someone else "holding the bag" at the end of the day. The FTC has studied health care mergers, many of which are funded with the help of private equity, and while each situation is different, on balance there appears to be a trend toward reduced access and increased costs. To the extent that private equity reduces staffing to purportedly increase efficiency, these practices often lead to the exact opposite of the quadruple aim and worsen access, costs, quality, and workforce satisfaction.

Indeed, data is now confirming these fears. A recent study in JAMA noted that "private equity acquisitions of hospitals, on average, was associated with increased hospital-acquired adverse events despite a likely lower-risk pool of admitted Medicare beneficiaries, suggesting poorer quality of inpatient care" (Kannan S, Bruch JD, Song Z. Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition. JAMA. 2023;330(24):2365–2375. doi:10.1001/jama.2023.23147).

I would suggest that a key issue in considering the use of private equity in healthcare is the control of the entity, in particular the clinical care, not just in name but in fact. The adverse effects of private equity are seen when corporate interests supersede clinician autonomy, when private equity prioritizes profits over patients, and when investors emphasize their coffers at the expense of the community. While clinician control is no guarantee of the appropriate use of private equity, clinicians have a duty to care for their patients, while corporations have a fiduciary duty to their investors. While some states have laws banning the corporate practice of medicine, enforcement has been a struggle. An ongoing lawsuit filed in California, American Academy of Emergency Medicine Physician Group, Inc. v. Envision Healthcare Corporation, is a case in point. In cases such as Steward, the focus of today's meeting, there seems to be little legal recourse at all. Given the national nature of large healthcare corporations, it would seem to make sense that national legislative and regulatory solutions for these corporate practices are called for while balancing the rights of states to regulate the actual practice of medicine.

Thank you for the opportunity to provide written testimony to the Committee.

Stephen K. Epstein, MD, MPP, FACEP

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Senator Markey and members of the Senate Health, Education, Labor, and Pension Subcommittee on Primary Health and Retirement Security.

Thank you for allowing me to submit testimony on the role of for-profit companies in healthcare. I want to start by admitting that I am not an expert on this subject, but that my testimony comes from my role in Connecticut healthcare and in the labor movement.

My name is John Brady, I am a Registered Nurse and Executive Vice President of AFT Connecticut. AFT Connecticut is a union of a little over 30,000 members in education, healthcare, and public service. We are part of AFT, which is 1.7 million members strong. In addition to being Executive Vice President of AFT Connecticut, I serve as cochair of the AFT Healthcare Council, which advises the AFT Executive Committee on healthcare issues. I am also very active in Connecticut's Certificate of Need (CoN) process because AFT Connecticut members staff eight acute care hospitals and one psychiatric hospital in Connecticut, which are part of Hartford Healthcare, Yale Healthcare, the University of Connecticut, Nuvance Healthcare, Trinity Healthcare, and Prospect Medical Holdings. I have served on several State of Connecticut task forces and committees on healthcare, including the Connecticut Certificate of Need Task Force, which issued a final report in January of 2023.

Connecticut's primary experience with private equity in healthcare dates to 2015 or 2016. Tenet Healthcare applied to acquire three Connecticut hospitals, Waterbury Hospital, Manchester Hospital, and Rockville Hospital. Manchester and Rockville hospitals are in eastern Connecticut and were known as Eastern Connecticut Health Network (ECHN). ECHN staff are mostly AFT Connecticut members. In 2016, Tenet withdrew from the proposed deal after the State Office of Health Care Access (OHCA) established acceptable conditions on the acquisition. (In 2018, OHCA was restructured into the Office of Health Strategy (OHS) which now administers the CoN process.) My knowledge on the events is centered on the experiences of our members at Manchester and Rockville hospitals, although I know Waterbury Hospital has had many of the same experiences.

In 2016, after Tenent withdrew, Prospect Medical Holdings expressed interest and eventually acquired all three hospitals. At the time, the hedge fund Leonard Green & Partners owned a majority share of Prospect Medical Holdings, divesting of those shares in 2021. Prospect pledged to invest $75 million in capitol improvements, which it later revised to $27 million.

In 2016, Rockville was a 102-bed hospital with full services, including emergency care, surgical care, labor & delivery, and an ICU. Rockville is a 20–25-minute drive from Manchester Hospital and many in the Rockville area lack reliable transportation. In 2019, before the pandemic, Rockville had decreased to 28 medical/surgical beds, an ICU, labor & delivery, and an emergency department, with more patients being transferred to Manchester Hospital.

In 2020, under a governor's executive order, Rockville suspended surgeries, as did many hospitals, to open beds for COVID patients. However, Prospect exceeded the limits of the executive order and closed its medical/surgical unit, labor & delivery unit, and its ICU at

Rockville, without seeking a CoN. Eventually, the state OHS would fine Prospect $118,000, which Prospect appealed, and the state withdrew because the state didn't feel they could prove Prospect "willfully" violated the CoN statute. As an aside, the 2023 CoN Task Force Report recommended several changes to tighten loopholes in the CoN process and OHS is currently seeking those changes through the General Assembly.

Rockville Hospital currently has an emergency department, outpatient labs and Xray, an inpatient behavioral health unit, and a small Progressive Care Unit (PCU).

In addition to the decreases in services at Rockville Hospital, many done without state approval, there is a financial story also, which has resulted in an ongoing investigation by the Connecticut Attorney General.

In 2014, Raymond F Damato bequeathed 20% of his estate, $9.24 million to Legacy ECHN, a non-profit entity. Legacy ECHN transferred these funds to Eastern Connecticut Foundation for Health, which was set up for this purpose, when Prospect acquired ECHN. In 2019, Prospect claimed it is entitled to that money and there is a pending court case.

Even though Rockville Hospital never cared for any COVID patients, which was the original reason for the governor's executive order, they received $7.4 million in federal COVID relief money and another $1.8 million from the state.

In 2018 Prospect took out a $1.1 billion loan and paid executives and shareholders $457 million. The Prospect CEO received $90 million. To finance the loan, Prospect sold its Connecticut hospital property, along with some of its hospital property in Pennsylvania and California, to a real estate trust company for 41.4 billion, and then started leasing back the property that their hospitals sit upon.

In 2021, Leonard Green & Partners divested its shares, and majority control, which it had held since 2011.

In 2022, Yale Healthcare agreed to purchase Prospect's Connecticut hospitals for $435 million, but after a cyberattack at the three hospitals, and reports that Prospect owes tens of millions of dollars to vendors, physicians, and the state for provider taxes, it renegotiated, asking for a lower sale price and $80 million from the state (which the state declined to provide).

Just recently a deal was announced. The state will give prospect a $12 million tax break, decreasing its debt to the state to $55 million, and imposing 46 conditions on Yale, including price caps on health care costs and local participation on the hospitals' boards.

The sale of Prospect to Yale will mean that Connecticut returns to having no for-profit hospitals and no hedge fund ownership. I think there is a collective sigh of relief to see this come to an end and I believe Connecticut will continue to work to ensure that Connecticut's patients and residents are better protected from those who see healthcare as an opportunity to make a quick buck. AFT Connecticut is certainly committed to this.

Thank you for allowing me to submit testimony and thank you for your work on this important issue.

John Brady RN

Executive Vice President AFT Connecticut

Dear Senator Markey,

During the past 24 years, I had the privilege of observing and writing about two exemplary medical systems that serve desperately impoverished people: Partners In Health and Boston Health Care for the Homeless Program. In the vast arena of American medicine, these systems are small and idiosyncratic, but they illustrate the obvious truth that in medicine, as in most things, intention matters. Both those organizations were founded and continue to be operated for the purpose of improving the health and general well-being of their patients. They pursue the efficient use of their limited resources, in order to improve their services to patients. In many quarters, American medicine is pursuing a purely financial kind of efficiency, efficiency defined as serving the interests of investors and, in some cases, administrators. The results include the spectacular failure of the Steward hospital system; dramatic declines in the quality of care at hospitals acquired by private equity firms; the well-documented unhappiness of health professionals and, to some degree, the current shortages of medical personnel.

Medicine should be a public investment, not a commodity bought and sold for private gain.

Sincerely, Tracy Kidder (winner of The Pulitzer Prize and The National Book Award, author of *The Soul of a New Machine*, *Mountains Beyound Mountains*, and *Rough Sleepers*).

[Whereupon, at 12:43 p.m., the hearing was adjourned.]

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