

## Private Equity and the Corporatization of Health Care

Erin C. Fuse Brown

Mark A. Hall\*

### ABSTRACT

Private equity has rapidly entered the health care sector, expanding its investment targets from hospitals and nursing facilities to physician practices. The incursion of private equity is the latest manifestation of a long trend toward the corporatization and financialization of medicine. Private equity pools investments from large, private investors to buy controlling stakes in companies through leveraged buyouts or similar arrangements that use the companies' own assets to finance debt. These investors seek to earn handsome profits by rapidly increasing revenues before selling off the investment. Private equity's incursion in other sectors is raising significant concern, but especially so in health care, where the drive for quick revenue generation threatens to increase costs and lower quality arising from consolidation, overutilization and up-coding, constraints on physicians' clinical autonomy, and compromises in patient care. Policymakers attempting to counter these threats can barely keep up. Like a cloud of locusts, private equity moves so quickly that by the time lawmakers become aware of the problem and researchers study the effects, private equity has moved on. Moreover, it remains unclear whether private equity investment is fundamentally more threatening to health policy than other forms of acquisition and financial investment—whether by publicly traded companies, conglomerate health systems, or health insurers. Even if private

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\* Erin C. Fuse Brown, J.D., M.P.H., is the Catherine C. Henson Professor of Law and Director of the Center for Law, Health & Society at Georgia State University College of Law. Mark A. Hall, J.D., is the Fred and Elizabeth Turnage Professor of Law and Public Health at Wake Forest University. Professors Fuse Brown and Hall acknowledge the contributions of collaborators from the USC-Brookings Schaeffer Initiative for Health Policy, Loren Adler, Erin Duffy, Paul Ginsburg, and Samuel Valdez, on a related publication, *Private Equity Investment as a Divining Rod for Market Failure: Policy Responses to Harmful Physician Practice Acquisitions*, BROOKINGS (Oct. 2021). That report and this work were supported by Arnold Ventures. The authors would like to thank Zack Buck, Jacob Elberg, Deborah Farringer, Brendan Maher, Michelle Mello, Ángel Oquendo, Govind Persad, Jessica Roberts, Christopher Robertson, and Gabriel Scheffler for their helpful comments and insights, and participants in law faculty workshops at the University of Connecticut, University of Miami, and Georgia State University. The authors extend special appreciation for the stellar analytic contributions and excellent research assistance from Jake Summerlin (Georgia State University J.D. 2022) and Greg Mercer (Georgia State University J.D. candidate 2023).

equity is not uniquely harmful, it is extremely adept at identifying and exploiting market failures and payment loopholes. Thus, the article's central claim is that the influx of private equity into health care poses sufficient risks to warrant an immediate legal and policy response. Public policy should be targeted primarily at correcting market failures and closing payment loopholes and only secondarily aimed at curbing private equity investment per se.

The good news is that we already have many legal tools under federal and state law with the potential to address the harms of commercialization. These can be used or sharpened to address the particular concerns raised by private equity's incursion into physician markets. Key tools include antitrust oversight, fraud and abuse enforcement, and state laws regulating the corporate practice of medicine and the terms of physician employment. In some instances, legislative or regulation action may be needed to adapt existing laws. In others, new laws may be needed to close payment loopholes or correct market distortions. A leading example is the recent enactment of the No Surprises Act, which curtails surprise out-of-network medical billing.

While the article lays out a roadmap for additional legal and policy actions to protect the health system from the acute risks of private equity, these are patches rather than systemic solutions. If the patches fail to stave off the incessant march toward commercialization of health care, we may see renewed calls to fundamentally rethink the market orientation of the U.S. health system.

## Table of Contents

PRIVATE EQUITY AND THE CORPORATIZATION OF HEALTH CARE .....	1
ABSTRACT .....	1
INTRODUCTION .....	1
I. THE PROBLEM OF PRIVATE EQUITY IN HEALTH CARE .....	7
A. <i>The Private Equity Model</i> .....	8
B. <i>History and Trends in Private Equity Investment in Health Care</i> ..	10
C. <i>The Risks of Private Equity Investment in Health Care</i> .....	12
II. REGULATING PRIVATE EQUITY IN HEALTH CARE: CURRENT LEGAL TOOLS .....	14
A. <i>Antitrust Law</i> .....	15
B. <i>Fraud and Abuse Enforcement</i> .....	19
1. Applying the False Claims Act to Private Equity Owners .....	20
2. Applying the Stark Law to Private Equity Owners .....	24
C. <i>Corporate Practice of Medicine and State Fee-Splitting Laws</i> .....	28
1. History and Current Application of the Corporate Practice of Medicine .....	28
2. Applying the Corporate Practice Prohibition to Private Equity ..	32
3. State Fee-Splitting Laws .....	37
D. <i>Physician Employment Laws</i> .....	40
III. TOWARD BETTER REGULATION OF PRIVATE EQUITY IN HEALTH CARE .....	44
A. <i>Better Use of the Laws We Have</i> .....	47
1. Sharpening Antitrust Enforcement Tools .....	47
2. Sharpening the Corporate Practice of Medicine Prohibition .....	49
B. <i>Where We Need New Laws</i> .....	51
1. Closing Payment Loopholes .....	52
2. Transparency in Ownership .....	55
3. Tax Treatment of Private Equity.....	56
C. <i>Past, Present, and Future of Corporatization and Financialization of Health Care</i> .....	58
IV. CONCLUSION .....	60
TABLE: POLICIES TO ADDRESS PRIVATE EQUITY INVESTMENT IN HEALTH CARE .....	1



## INTRODUCTION

Policymakers and policy advocates are growing increasingly alarmed at the influx of private equity (PE) investment into various sectors of the economy, but especially so for health care. The alarm bells started ringing two decades ago when private equity companies began purchasing and then selling hospitals and skilled nursing facilities. As PE has moved into physician practices, concerns have intensified about PE's effects on the quality and availability of patient care, physicians' clinical decisions, and rising health care costs.

Private equity differs from other forms of health services investment in three critical ways. First, the investment comes from lay entities or individuals, meaning they lack professional or institutional obligations to promote the higher ethical goals of medical care.<sup>1</sup> Second, PE investment is heavily debt-financed, in a "leveraged buyout" fashion, that uses an existing health services enterprise to secure much of its purchase price.<sup>2</sup> Third, PE investors typically aim to reap their profit rewards over a much shorter term than do start-up venture capitalists or public-market investors.<sup>3</sup> Accordingly, PE investors typically aim to generate substantial increases in the enterprise's operating profitability in just a few years before exiting the investment.<sup>4</sup>

Resulting from this combination of factors, PE investors in health services have a track record of finding and exploiting market vulnerabilities in a manner that raises significant public policy concerns. "Surprise medical billing" is a poster case. Surprise medical bills occur when patients unexpectedly and involuntarily see an out-of-network provider, which commonly occurs in emergencies and for hospital-based physicians, like anesthesiologists, where the hospital is in-network with the patient's health

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<sup>1</sup> Eileen Appelbaum & Rosemary Batt, *Private Equity Buyouts in Healthcare: Who Wins, Who Loses?* 5 (Ctr. for Econ. and Pol'y Rsch., Working Paper No. 118, 2020), <https://cepr.net/report/private-equity-buyouts-in-healthcare-who-wins-who-loses/>.

<sup>2</sup> *Id.* at 6.

<sup>3</sup> Umar Ikram, Khin-Keymon Aung & Zirui Song, *Private Equity and Primary Care: Lessons from the Field*, NEJM CATALYST INNOVATIONS IN CARE DELIVERY 2–3 (Nov. 19, 2021), <https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0276>.

<sup>4</sup> Appelbaum & Batt, *supra* note 1, at 7.

plan, but the physician is out-of-network.<sup>5</sup> What all these cases have in common is that the patient has no choice of provider due to the emergency or because they reasonably (but incorrectly) assume that the physicians at an in-network facility will also be in-network. Physician staffing companies owned by private equity and publicly traded firms strategically used this market failure to increase revenues, staying out-of-network to charge higher out-of-network rates, “balance billing” patients for the difference between their list charges and what insurance paid, or using the threat of surprise billing to demand higher in-network rates from health plans.<sup>6</sup>

Journalists drew attention to the phenomenon by extensively documenting stories of surprise medical bills and the financial burden they imposed on patients. Illustrative examples include Drew Calver, who received a \$108,951 surprise bill from an out-of-network hospital after suffering a massive heart attack,<sup>7</sup> the \$52,112 surprise bill from an out-of-network air ambulance provider who transported an intubated 60-year-old woman suffering from Covid-19,<sup>8</sup> and Peter Drier’s \$117,000 surprise bill from an out-of-network assistant surgeon whom he never met.<sup>9</sup>

Private equity’s exploitation of out-of-network surprise billing as a revenue strategy drew bipartisan ire, catapulting the issue to the top of the legislative agenda.<sup>10</sup> The effort to curb surprise medical bills took

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<sup>5</sup> Mark A. Hall, Paul B. Ginsburg, Steven M. Lieberman, Loren Adler, Caitlin Brandt & Margaret Darling, *Solving Surprise Medical Bills*, THE LEONARD D. SCHAEFFER INITIATIVE FOR INNOVATION IN HEALTH POL’Y 5 (Oct. 2016), <https://www.brookings.edu/research/solving-surprise-medical-bills/>.

<sup>6</sup> Zack Cooper, Fiona Scott Morton & Nathan Shekita, *Surprise! Out-of-Network Billing for Emergency Care in the United States*, 128 J. POLIT. ECON. 3626, 3634 (2020); see also Julie Creswell, Reed Abelson & Margot Sanger-Katz, *The Company Behind Many Surprise Emergency Room Bills*, N.Y. TIMES (July 24, 2017), <https://www.nytimes.com/2017/07/24/upshot/the-company-behind-many-surprise-emergency-room-bills.html>.

<sup>7</sup> Chad Terhune, *Life-Threatening Heart Attack Leaves Teacher with \$108,951 Bill*, NPR, (Aug. 27, 2018, 4:47 AM), <https://www.npr.org/sections/health-shots/2018/08/27/640891882/life-threatening-heart-attack-leaves-teacher-with-108-951-bill>.

<sup>8</sup> Sarah Kliff, *A \$52,112 Air Ambulance Ride: Coronavirus Patients Battle Surprise Bills*, N.Y. TIMES (Oct. 22, 2021), <https://www.nytimes.com/2020/10/13/upshot/coronavirus-surprise-medical-bills.html>.

<sup>9</sup> Elisabeth Rosenthal, *After Surgery, Surprise \$117,000 Medical Bill from Doctor He Didn’t Know*, N.Y. TIMES (Sept. 20, 2014), <https://www.nytimes.com/2014/09/21/us/drive-by-doctoring-surprise-medical-bills.html>.

<sup>10</sup> Erin C. Fuse Brown, *Stalled Federal Efforts to End Surprise Billing—The Role of Private Equity*, 382 NEW ENG. J. MED. 1189, 1189–90 (2020); Lunna Lopes, Audrey

considerable policy reform—starting with dozens of state laws and then culminating with the passage of the federal No Surprises Act at the end of 2020.<sup>11</sup> The saga continues as PE-backed physician staffing firms, air ambulances, and other industry groups fight the implementation of the law or aggressively use the law’s arbitration process to push for higher payments and preserve their profits.<sup>12</sup>

Policymakers are right to wonder what is the next “surprise billing” type of loophole PE will find to exploit and how to mount a preemptive policy response. Viewing PE firms’ investment activities as a sentinel, PE has recently moved beyond the hospital-based specialties that can use surprise out-of-network billing as a revenue strategy to procedural specialties (like gastroenterology, dermatology, ophthalmology, and orthopedics) that offer lucrative in-office procedures and “wraparound” services, and to primary care practices that can utilize aggressive risk-coding to profit from value-based and risk-adjusted payment policies.<sup>13</sup> Recent reports have noted PE’s

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Kearney, Liz Hamel & Mollyann Brodle, *Data Note: Public Worries About and Experience with Surprise Medical Bills*, KAISER FAM. FOUND. (Feb. 28, 2020), <https://www.kff.org/health-costs/poll-finding/data-note-public-worries-about-and-experience-with-surprise-medical-bills/>.

<sup>11</sup> Consolidated Appropriations Act of 2021, Pub. L. No. 116-260 (containing the No Surprises Act); *see also* Sarah Kliff & Margot Sanger-Katz, *Surprise Medical Bills Cost Americans Millions. Congress Finally Banned Most of Them*, N.Y. TIMES (Dec. 20, 2020), <https://www.nytimes.com/2020/12/20/upshot/surprise-medical-bills-congress-ban.html>; Maanasa Kona, *State Balance-Billing Protections*, COMMONWEALTH FUND (Feb. 5, 2021), <https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections>.

<sup>12</sup> Katie Keith, *Latest in No Surprises Act Litigation and New Guidance*, HEALTH AFFS. FOREFRONT (June 6, 2022), <https://www.healthaffairs.org/doi/10.1377/forefront.20220606.105571/>; Blake Farmer, *ER Staffing Firms Keep the Claims Flowing in Tennessee Even After Federal Ban on ‘Surprise’ Bills*, WPLN NEWS (Jan. 9, 2023), <https://wpln.org/post/er-staffing-firms-keep-the-surprise-bills-flowing-in-tennessee-even-after-federal-ban/>.

<sup>13</sup> Erin C. Fuse Brown, Loren Adler, Erin Duffy, Paul B. Ginsburg, Mark Hall & Samuel Valdez, *Private Equity Investment as a Divining Rod for Market Failure: Policy Responses to Harmful Physician Practice Acquisitions*, USC-BROOKINGS SCHAEFFER INITIATIVE FOR HEALTH POLICY 11-15 (Oct. 2021), <https://www.brookings.edu/essay/private-equity-investment-as-a-divining-rod-for-market-failure-policy-responses-to-harmful-physician-practice-acquisitions/>.

growing interest in other health care targets, including hospices<sup>14</sup> and behavioral health.<sup>15</sup>

While the revenue playbook for each health care market segment may differ, each taps into one or more of a core set of public policy concerns: consolidation and attendant price increases; overutilization, overbilling, and aggressive coding practices; shirking unprofitable services or patients; threats to physicians' clinical decisions and independence; and compromising the quality of patient care. In human terms, these threats manifest as unmanageable medical bills and harsh collection practices,<sup>16</sup> clinicians experiencing moral distress and burnout under pressure to put profits over patients,<sup>17</sup> and, in extreme cases, alarming declines in the quality of patient care.<sup>18</sup>

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<sup>14</sup> See, e.g., Joan M. Teno, *Hospice Acquisitions by Profit-Driven Private Equity Firms*, JAMA HEALTH F., 1–2 (Sept. 30, 2021); Markian Hawryluk, *Hospices Have Become Big Business for Private Equity Firms, Raising Concerns About End-of-Life Care*, KAISER HEALTH NEWS (July 29, 2022), <https://khn.org/news/article/hospices-private-equity-firms-end-of-life-care/>.

<sup>15</sup> See, e.g., Benjamin Brown, Eloise O'Donnell & Lawrence P. Casalino, *Private Equity Investment in Behavioral Health Treatment Centers*, 77 JAMA PSYCHIATRY 229, 230 (2020).

<sup>16</sup> See, e.g., Appelbaum & Batt, *supra* note 1, at 76 (describing private equity's entry into "revenue cycle management" – medical billing and collection); Wendi C. Thomas, Maya Miller, Beena Raghavendran & Doris Burke, *This Doctors Group Is Owned by a Private Equity Firm and Repeatedly Sued the Poor Until We Called Them*, PROPUBLICA (Nov. 27, 2019, 1:00 PM), <https://www.propublica.org/article/this-doctors-group-is-owned-by-a-private-equity-firm-and-repeatedly-sued-the-poor-until-we-called-them> (describing 4,800 lawsuits by PE-backed physician staffing firm TeamHealth).

<sup>17</sup> See, e.g., Ryan Crowley, Omar Atiq & David Hilden, *Financial Profit in Medicine: A Position Paper from the American College of Physicians*, 174 ANN. INTERN. MED. 1447, 1448-49 (Oct. 2021); Gretchen Morgenson, 'Get that money!' Dermatologist Says Patient Care Suffered After Private Equity-Backed Firm Bought Her Practice, NBC NEWS (Dec. 20, 2021, 8:55 AM), <https://www.nbcnews.com/health/health-care/get-money-dermatologist-says-patient-care-suffered-private-equity-back-rcna9152>; Tara Bannow, *Parents and Clinicians Say Private Equity's Profit Fixation is Short-Changing Kids with Autism*, STAT (Aug. 15, 2022), <https://www.statnews.com/2022/08/15/private-equity-autism-aba-therapy/>.

<sup>18</sup> See Yasmin Rafiei, *When Private Equity Takes Over a Nursing Home*, NEW YORKER (Aug. 25, 2022), <https://www.newyorker.com/news/dispatch/when-private-equity-takes-over-a-nursing-home> (describing abject conditions, minimal staffing, and deaths of residents at St. Joseph's Home for the Aged, following private equity acquisition); Atul Gupta, Sabrina T. Howell, Constantine Yannelis & Abhinav Gupta, *Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes* 7, 35 (Nat'l Bureau of Econ. Rsch., Working Paper No. 28474, 2021), <https://www.nber.org/papers/w28474> (finding that patients at private equity-owned nursing facilities suffered an 10% increase in 90-day mortality, compared with controls).



Health services research systematically quantifying the effects of PE investment in health care is only beginning to emerge. A real question remains whether the risks posed by PE are unique to PE or whether they are a feature of influence or control by any corporate investor, whether by publicly traded companies, conglomerate health systems, or health insurers, because at bottom, all these investors seek to maximize revenues. However, if policymakers wait for more definitive answers from studies, the PE investors will likely have entered, altered, and exited their health care investments, moving on to greener pastures and leaving behind a costlier, more concentrated, poorer quality, less accessible health care system.

Even if PE investment in health care poses risks that are not unique to PE, it appears to heighten those risks by being more adept or ruthless at identifying profit opportunities and economies of scale among previously fragmented providers, consolidating physician specialty markets and raising costs as they go. Thus, policymakers are searching for solutions to address the risks of PE's rapid incursion in health care.

The good news is that several legal and policy interventions already exist to address the risks posed by PE investment in health care. These include antitrust enforcement to address consolidation, fraud and abuse laws to go after improper billing and self-referrals, and the old (some would say moribund) state law doctrine prohibiting the corporate practice of medicine. In some cases, such as fraud and abuse enforcement, the tools are already capable of policing the risks of PE investment and simply need to be trained on this current target. But in other cases, the legal tools should be sharpened and strengthened to better address PE investment. A leading example is antitrust authorities' failure to review many PE health care acquisitions that occur incrementally and thus are too small to trigger reporting under the Hart-Scott-Rodino Act.<sup>19</sup> Some of this honing of legal tools can be done at the state level, which may be fertile ground for policy innovation. For example, state corporate practice of medicine laws can be used to require that licensed physicians, rather than corporate investors or managers, retain control over the clinical and financial operations of the practice.<sup>20</sup> Other policy tools would require new federal legislation—e.g., changing the federal tax treatment of PE investment income or closing Medicare payment loopholes being exploited to increase profits. Needing federal legislation raises the level of difficulty, but enactment is not impossible. A case in point

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<sup>19</sup> See discussion *infra* Part III.A.1.

<sup>20</sup> See discussion *infra* Part III.A.2.

is the passage of the No Surprises Act to correct the market failure exploited by PE in the form of aggressive out-of-network billing.<sup>21</sup>

The article's central claim is that the influx of PE into health care warrants an immediate legal and policy response, primarily targeting the payment loopholes and market failures adroitly (but not solely) leveraged by PE investors. Several existing legal tools can be used or strengthened with relatively minor legislative or regulatory modifications to quickly respond to PE's rapid incursion into physician practices: antitrust enforcement, fraud and abuse enforcement, and state laws restricting the corporate practice of medicine and physician employment. The second message is that state policymakers have a vital role to play. Many of the tools are creatures of state law or can be deployed by state enforcers. State law innovations can inform the slower, more difficult federal policy response.

PE's incursion into health care continues a decades-long trend toward corporatization, financialization, and commercialization, which all prioritize profit maximization and financial returns for owners and investors of health care entities.<sup>22</sup> The terms used to describe this general phenomenon can vary, depending on whether the emphasis is on corporate structure, sources of financing, or general business strategies. In this paper, all such concerns overlap, and so we use these and similar terms more or less interchangeably.

Concerns over the adverse effects of corporate financial incentives on patient care, professionalism in medical practice, and health care costs are as old as the U.S. health system.<sup>23</sup> Therefore, the legal tools that were developed to respond to these historical concerns, though antiquated, are still useful today. If the good news is that we already have several tools to respond to PE's threats to health care, the bad news is that none of these tools has held off the steady march toward commercialization to date. Regulators and enforcement authorities may only be learning about the risks of PE's incursion into health care and may be unaware of how to use the existing legal tools to address a problem. Thus, the challenge of PE in health care is both a call to dust off our existing legal tools to correct exploitable market dysfunctions and a recognition that, justifiably, some may see this development as signaling an end stage of capitalism in health care calling for more foundational renovation.

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<sup>21</sup> Kliff & Sanger-Katz, *supra* note 11.

<sup>22</sup> Appelbaum & Batt, *supra* note 1, at 4.

<sup>23</sup> See discussion *infra* Part II.C.1.

This article describes the risks posed by PE investment in health care and then analyzes legal and policy interventions to mitigate these risks. Part I sets forth the history of PE investment in health care and describes the problem posed by PE's recent focus on physician practice acquisitions. Part II highlights the existing legal tools to address the adverse effects of PE investment in health care and assesses their strengths and limitations. Included are antitrust enforcement, fraud and abuse laws, the state corporate practice of medicine doctrine and employment laws applicable to physicians. Part III identifies how existing tools may be sharpened and areas where additional policy reforms are needed, also depicted in a Table in the Appendix. The conclusion draws some lessons from this analysis for the larger effort to counter corporatization in medicine.

## I. THE PROBLEM OF PRIVATE EQUITY IN HEALTH CARE

Robbers rob banks because, as is famously said, that is where the money is.<sup>24</sup> Following that logic, PE investment has surged in the health care industry, which, at \$4 trillion, is the largest sector of the U.S. economy.<sup>25</sup> According to one estimate, PE capital investment in health care grew from \$5 billion in 2000 to \$100 billion in 2018.<sup>26</sup> After slowing somewhat during the first year of the Covid-19 pandemic, PE investment in U.S. health care services accelerated again, reaching \$77.5 billion and 733 deals in 2021.<sup>27</sup> In the past decade, PE investors have rapidly acquired physician practices, increasing from 39 to 221 deals annually between 2010-2019, totaling 1,283 deals over that decade.<sup>28</sup>

Private equity investment in health care is key driver of a larger trend toward the financialization of health care, in which the financial investors and intermediaries (including PE) have seen health care organizations as

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<sup>24</sup> See Willie Sutton, FED. BUREAU OF INVESTIGATION, <https://www.fbi.gov/history/famous-cases/willie-sutton#:~:text=When%20asked%20why%20he%20robbed,bank%20early%20in%20the%20morning>, (last visited Dec. 6, 2022) (attributing the quote to famed bank robber, Willie Sutton).

<sup>25</sup> CTRS. FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTH EXPENDITURES 2020 HIGHLIGHTS 1 (2021), <https://www.cms.gov/files/document/highlights.pdf>; Appelbaum & Batt, *supra* note 1, at 14.

<sup>26</sup> Appelbaum & Batt, *supra* note 1, at 15.

<sup>27</sup> PITCHBOOK, 2021 ANNUAL US PE BREAKDOWN 10 (2022), <https://pitchbook.com/news/reports/2021-annual-us-pe-breakdown>.

<sup>28</sup> Fuse Brown et al., *supra* note 13, at 5 tbl.1.

sources for extracting wealth.<sup>29</sup> In a financialized market, profit making is the primary end, and the quality of the product—patient care—is secondary.<sup>30</sup>

This paper focuses on PE investment in physician practices, though some of the regulatory channels and lessons apply to PE investment in hospitals, nursing homes, hospices, behavioral health, and other types of health care entities. This part describes the PE model, the history, and the risks posed by PE investment in health care.

### A. *The Private Equity Model*

Private equity leverages private funds to purchase target companies from a wide array of industries, usually established, fairly mature businesses in which the PE investor can substantially improve profitability through active management, aiming to sell the company for a large profit in a relatively short time, usually 3-7 years.<sup>31</sup> PE firms typically use a leveraged buy-out or similar model that finances the bulk of the purchase price with loans for which the business itself serves as security.<sup>32</sup> For the portion financed by equity, PE firms put in only a small percentage as a general partner, yet retain a controlling interest in the target company.<sup>33</sup> Thus, although the PE firm typically contributes only about 2% of the funds, it reaps approximately 20% of the profits.<sup>34</sup>

The general partner of the PE firm typically restructures or engages in active management of the target company to increase its profitability or liquidate its most valuable assets (e.g., surplus real estate) and typically looks to exit the investment in a short period of time rather than continue to

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<sup>29</sup> See LAURA KATZ OLSON, ETHICALLY CHALLENGED: PRIVATE EQUITY STORMS US HEALTH Care 2-3 (2022); Eileen Appelbaum & Rosemary Batt, *Financialization in Health Care: The Transformation of US Hospital Systems*, (Ctr. for Econ. and Pol’y Rsch., Working Paper No. 2022-1, 2021), <https://cepr.net/report/working-paper-financialization-in-health-care-the-transformation-of-us-hospital-systems/>; Benjamin M. Hunter & Susan F. Murray, *Deconstructing the Financialization of Healthcare*, 50 DEVELOPMENT & CHANGE 1263, 1268–72 (2019); Colleen Grogan & Miriam Laugesen, *Financialization of Health Politics* (forthcoming) (on file with authors).

<sup>30</sup> KATZ OLSON, *supra* note 29, at 3; Appelbaum & Batt, *supra* note 29, at 6-7.

<sup>31</sup> See Ikram et al., *supra* note 3; Chris Morran & Daniel Petty, *What Private Equity Firms Are and How They Operate*, PROPUBLICA (Aug. 3, 2022, 5:00 AM), <https://www.propublica.org/article/what-is-private-equity>.

<sup>32</sup> Appelbaum & Batt, *supra* note 1, at 6.

<sup>33</sup> *Id.*

<sup>34</sup> MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO THE CONGRESS: MEDICARE AND THE HEALTH CARE DELIVERY SYSTEM 80 (2021); Lawrence P. Casalino, Rayhan Saiani, Sami Bhidya, Druv Khullar & Eloise O’Donnell, *Private Equity Acquisition of Physician Practices*, 171 ANNALS INTERNAL MED. 78, 78 (2019).

hold or manage the acquired company.<sup>35</sup> Thus, the key distinguishing features are: private investors, highly leveraged, short-term investment.

Private equity is not the only type of corporate investor in health care. Public equity in the form of publicly traded companies may invest significant capital or engage in debt-financing of health care acquisitions.<sup>36</sup> Major differences are that these companies answer to their shareholders, are subject to more regulation and disclosure in offering securities to public investors, and while individual shareholders may come and go, the managers of publicly traded companies typically hold for longer periods of time.<sup>37</sup> Venture capital is a specific form of PE that typically focuses on pure equity investments in start-up or early-stage businesses, such as technology or biosciences companies, with an eye to establishing and growing the company to the point where it can either go public or be sold to a larger, more mature company.<sup>38</sup> The main difference between PE and venture capital is that the former tends to focus on more mature companies and is heavily debt-financed.<sup>39</sup> Nevertheless, all forms of corporate investment (whether PE, venture capital, public company) share similar risks of health care commercialization.<sup>40</sup> This paper focuses on PE because its short-term investment horizon, active management, and opacity make it a particularly aggressive form of corporate investment, heightening the risks that are shared by all.

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<sup>35</sup> Appelbaum & Batt, *supra* note 1, at 7.

<sup>36</sup> Prominent examples include Amazon's announcement it would purchase primary care practice One Medical for \$3.9 billion and CVS's announcement that it would purchase home health primary care provider Signify for \$8 billion. *See* Rebecca Springer, *Walmart, Amazon and CVS' Plan to Disrupt Healthcare Services Could Benefit PE and VC*, PITCHBOOK (Sept., 14, 2022), <https://pitchbook.com/news/articles/walmart-amazon-cvs-healthcare-services>. Also, private equity firms may sell their health care companies to publicly traded companies or take the companies public, such as Oak Street Health, which initially received VC funding, then PE funding in 2018, before going public in 2020. *Oak Street Health - Funding, Financials, Valuation & Investors*, CRUNCHBASE [https://www.crunchbase.com/organization/oak-street-health/company\\_financials](https://www.crunchbase.com/organization/oak-street-health/company_financials) (last visited Nov. 29, 2022).

<sup>37</sup> Appelbaum & Batt, *supra* note 1, at 7, 74.

<sup>38</sup> *See* Ikram et al., *supra* note 3, at 2.

<sup>39</sup> *Id.* at 3 tbl.1.

<sup>40</sup> Soleil Shah, Hayden Rooke-Ley & Erin C. Fuse Brown, *Corporate Investors in Primary Care—Profits, Progress, and Pitfalls*, 388 NEW ENG. J. MED. 99, 100 (2023).

### B. History and Trends in Private Equity Investment in Health Care

Private equity investment in health care initially focused on facilities such as nursing homes and hospitals.<sup>41</sup> In recent years, however, PE investment in physician practices has dramatically accelerated, as reduced returns from more conventional investment targets pushed private equity investors to seek more niche and specialized providers.<sup>42</sup> By one estimate, 2013 to 2016, PE acquired 355 physician practices involving 1,426 locations and 5,174 physicians.<sup>43</sup>

PE investors are attracted to the areas of physician practice that offer the greatest profit potential, based on market structures or reimbursement rules that allow rapid increases in revenues.<sup>44</sup> Physicians are receptive to these investors because they bring access to substantial capital and relieve physicians from practice management responsibilities.<sup>45</sup>

These investments typically employ what is known as a “platform and add-on” approach in which investors first purchase a large, established practice (the “platform practice”) and then acquire smaller “add-ons” to build market share and economies of scale and scope.<sup>46</sup> The PE firm typically contracts out management of the business aspects of the practice.<sup>47</sup> In exchange for selling the majority share of equity in their practices, physician owners receive a sizeable buyout payment.<sup>48</sup> After the PE firm has grown the company, it will typically sell to another investor.<sup>49</sup> The

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<sup>41</sup> Appelbaum & Batt, *supra* note 1, at 95.

<sup>42</sup> *Id.*; Fuse Brown et al., *supra* note 13, at 3; Suhas Gondi & Zirui Song, *Potential Implications of Private Equity Investments in Health Care Delivery*, 321 JAMA 1047, 1048 (2019).

<sup>43</sup> Jane M. Zhu, Lynn M. Hua, & Daniel Polsky, *Private Equity Acquisitions of Physician Medical Groups Across Specialties, 2013-2016*, 323 JAMA 663, 663 (2020).

<sup>44</sup> Appelbaum & Batt, *supra* note 1, at 53.

<sup>45</sup> Gondi & Song, *supra* note 42, at 1048; Appelbaum & Batt, *supra* note 1, at 4–5.

<sup>46</sup> Gondi & Song, *supra* note 42, at 1047; Jane Zhu & Daniel Polsky, *Private Equity and Physician Medical Practices—Navigating a Changing Ecosystem*, 384 NEW ENG. J. MED. 981, 981–82 (2021).

<sup>47</sup> Patrick D. Souter & Andrew N. Meyercord, *Private Equity Investment in the Physician Practice: Has Its Time Finally Come or Will the Mistakes of the Past Be Repeated?*, 13 J. HEALTH AND LIFE SCIS. L. (2020), <https://www.americanhealthlaw.org/content-library/journal-health-law/article/5a4d6c17-f1cb-4c1f-b233-24a6688ac674/Private-Equity-Investment-in-the-Physician-Practice>.

<sup>48</sup> Gondi & Song, *supra* note 42, at 1047.

<sup>49</sup> Zhu & Polsky, *supra* note 46, at 981–82.

original physician owners, however, usually have no continuing control over selecting subsequent buyers.<sup>50</sup>

This cycle of investment and divestiture echoes earlier forms of investment in the management of physician practices but differs in meaningful ways. The emergence and growth of managed care insurance a generation ago gave rise to the rapid birth and expansion of for-profit physician practice management companies (PPMCs).<sup>51</sup> The market value of these companies crashed spectacularly, however, only a few years after they emerged.<sup>52</sup> PPMCs typically were publicly traded and, thus, were financed through more conventional, less debt-leveraged equity capital, with physicians usually maintaining a majority equity stake.<sup>53</sup> Initial valuations ended up being far off the mark, however, because PPMCs failed to achieve anticipated cost reductions and lacked business strategies to substantially increase profit margins.<sup>54</sup> PPMCs, hungry for revenue growth, financed further acquisitions by diluting existing share values, ultimately leading to an implosion in the market that observers likened to the collapse of a pyramid scheme.<sup>55</sup>

So far, PE investors have avoided this fate for two key reasons. They have targeted areas of physician practice where substantially increased profits can be achieved and adjusted physician compensation to be tied to these profits rather than the flat salary approach often used by PPMCs.<sup>56</sup> And, they have assumed more control over business strategies by reducing physicians' ownership in management aspects to minority status.<sup>57</sup>

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<sup>50</sup> *Id.* at 982.

<sup>51</sup> See Lawton R. Burns, *Physician Practice Management Companies* 22 HEALTH CARE MGMT. REV. 32, 44 (1997); see also Souter & Meyercord, *supra* note 47.

<sup>52</sup> See Burns, *supra* note 51, at 41–42; Bill Frack & Nurry Hong, *Physician Practice Management* BECKERS HOSP. REV. (Feb. 19, 2014), [https://www.beckershospitalreview.com/hospital-physician-relationships/physician-practice-management-a-new-chapter.html?tmpl=component&print=1&layout=default.](https://www.beckershospitalreview.com/hospital-physician-relationships/physician-practice-management-a-new-chapter.html?tmpl=component&print=1&layout=default;); Uwe. E Reinhardt, *The Rise and Fall of the Physician Practice Management Industry*, 19 HEALTH AFFS. 42, 42–55 (2000); Souter & Meyercord, *supra* note 47.

<sup>53</sup> See Burns, *supra* note 51, at 33, 40 (1997).

<sup>54</sup> See Reinhardt, *supra* note 52, at 51–52.

<sup>55</sup> *Id.* at 46–50.

<sup>56</sup> Appelbaum & Batt, *supra* note 1, at 95.

<sup>57</sup> Fuse Brown et al., *supra* note 13, at 2, 6.



### C. *The Risks of Private Equity Investment in Health Care*

Many public policy analysts are worried that PE investment in health care contributes to the commercialization of health care, fuels consolidation and rising costs, and is bad for patient access, outcomes, and professional practice.<sup>58</sup>

Private equity is exceptionally adept at identifying and exploiting market failures that can be turned into profit for investors. PE investors may not be the only ones who can capitalize on these market failures. However, they are more likely to find these opportunities to profit from payment loopholes or market dysfunctions and move aggressively into that space. Hence, as we have argued elsewhere, PE functions as a divining rod for finding market failures—where PE has penetrated, it is a good bet that there is a profit opportunity ripe for exploitation.<sup>59</sup>

There are three main risks that PE investment appears to pose to patients, medical professionals, and the health care market overall. First, PE investment spurs health care consolidation, which increases prices and potentially reduces quality and access.<sup>60</sup> Second, the pressure from PE-investors to increase revenue can lead to exploitation of billing loopholes, overutilization, up-coding, aggressive risk-coding, harming patients through unnecessary care, excessive bills, and increasing overall health spending.<sup>61</sup> Third, physicians acquired by PE companies may be subject to onerous employment terms and lose autonomy over clinical decisions and their practice of medicine.<sup>62</sup>

Although the data are still being developed, early evidence supports several of these concerns. In the hospital context, PE acquisition has been

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<sup>58</sup> *Id.* at 1–2, 7.

<sup>59</sup> *Id.* at 16.13

<sup>60</sup> Claire E. O’Hanlon, Christopher M. Whaley & Deborah Freund. *Medical Practice Consolidation and Physician Shared Patient Network Size, Strength, and Stability*, 57 MED. CARE 680, 680–687 (2019); Jon B. Christianson, Caroline S. Carlin & Louise H. Warrick. *The Dynamics of Community Health Care Consolidation: Acquisition of Physician Practices*, 92 MILBANK Q. 542, 543–44 (2014).

<sup>61</sup> Appelbaum & Batt, *supra* note 1, at 5; Fuse Brown et al., *supra* note 13, at 2–3. See also, Harris Meyer, *More Orthopedic Physicians Sell Out to Private Equity Firms, Raising Alarms about Costs and Quality*, KAISER HEALTH NEWS (Jan. 6, 2023), <https://khn.org/news/article/more-orthopedic-physicians-sell-out-to-private-equity-firms-raising-alarms-about-costs-and-quality/> (describing PE investment in orthopedic practices and concerns over increased prices and utilization, unnecessary care, and quality concerns from increased reliance on non-physicians to provide care).

<sup>62</sup> Sally Tan, Kira Seiger, Peter Renehan & Arash Mostaghimi. *Trends in Private Equity Acquisition of Dermatology Practices in The United States*, 155 JAMA Dermatology 1013, 1019 (2019); Zhu & Polsky, *supra* note 46, at 982.



associated with increased net income, charges (the asking price), markups over costs, and the proportion of privately insured patients.<sup>63</sup> Among nursing homes, evidence of the impact of PE on patient outcomes is particularly troubling. Researchers found that Medicare patients in private equity-owned nursing facilities suffered a 10% increase in 90-day mortality between 2004-2016 (i.e., pre-pandemic), and that this increased risk of death could have been due to reduced staffing levels.<sup>64</sup> Other quality measures also declined following the acquisition, even as per-patient spending increased.<sup>65</sup>

The impact of PE investment in physician practices shows similar risks of higher prices, increased spending, and reduced staffing levels. One study, for instance, documented that when hospitals contracted with either of the two largest physician staffing companies for emergency services, both of which have PE investors, this led to substantially higher prices, increased testing and hospital admissions, and more aggressive billing practices.<sup>66</sup> Another study found that PE-acquired physician practices specializing in dermatology, gastroenterology, and ophthalmology increased health spending and utilization, compared with controls.<sup>67</sup> A separate study of dermatology practices found that PE targeted larger practices for acquisition and that PE acquisition led to higher prices and patient volumes compared to controls,<sup>68</sup> and similar results were found for PE investment in anesthesia practices.<sup>69</sup> In terms of staffing impacts, PE ownership of surgical

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<sup>63</sup> Joseph D. Bruch, Suhas Gondi & Zirui Song, *Changes in Hospital Income, Use, and Quality Associated with Private Equity Acquisition*, 180 JAMA INTERNAL MED. 1428, 1432-33 (2020).

<sup>64</sup> Atul Gupta, Sabrina T. Howell, Constantine Yannelis & Abhinav Gupta, *Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes*, NBER Working paper 28474, Baker Friedman Institute for Economics, University of Chicago, 2021, <https://www.nber.org/papers/w28474>.

<sup>65</sup> *Id.*

<sup>66</sup> Cooper et al., *supra* note 6, at 3626-77.

<sup>67</sup> Yashaswini Singh, Zirui Song, Daniel Polsky, Joseph D. Bruch, & Jane M. Zhu, *Association of Private Equity Acquisition of Physician Practices with Changes in Health Care Spending and Utilization*, JAMA HEALTH F. 5-7 (2022), <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2795946> (click "Download PDF").

<sup>68</sup> Robert Tyler Braun, Amelia Bond, Yuting Qian, Manyao Zhang & Lawrence Casalino, *Private Equity in Dermatology: Effect on Price, Utilization, and Spending*, 40 HEALTH AFFS. 727, 734 (2020).

<sup>69</sup> Ambar La Forgia, Amelia M. Bond, Robert Tyler Braun, Leah Z. Yao, Klaus Kjaer, Manyao Zhang & Lawrence P. Casalino, *Association of Physician Management Companies and Private Equity Investment with Commercial Health Care Prices Paid to Anesthesia Practitioners*, 182 JAMA INTERNAL MED. 396, 397, 402 (2022).

dermatology practices is associated with higher ratios of nonphysician providers to physicians and lower staffing levels overall, particularly for non-revenue generating staff.<sup>70</sup> Compared to non-PE-acquired practices, PE-owned dermatology, ophthalmology, and gastroenterology practices showed higher physician turnover and the addition of more mid-level staff, suggesting that physician satisfaction may be lower in PE-owned practices, and that additional PE-driven practice growth may be absorbed at a lower cost by a greater reliance on mid-level practitioners.<sup>71</sup>

To be sure, not all studies have shown clear adverse effects.<sup>72</sup> Moreover, there are some potential benefits to consider, such as: access to capital, efficiencies, allowing physicians graduating with medical debt to join practices, and offloading practice management burden from physicians.<sup>73</sup> Yet, regulators and policymakers must attend to the risks to patient care, health care spending, and physicians' clinical autonomy posed by rampant PE-investment in health care.

## II. REGULATING PRIVATE EQUITY IN HEALTH CARE: CURRENT LEGAL TOOLS

Private equity has shown a penchant for taking advantage of various market failures and payment loopholes. Although similar critiques could be levied against other acquirers of physician practices, such as health systems, public companies, or insurance companies, PE's entry into a physician specialty market may signal financial loopholes and market dysfunctions ripe for legal intervention. The problems of consolidation, overutilization and upcoding, corporate control over medical practice, and anticompetitive physician employment practices are not new nor unique to PE. Enforcement of existing laws can target this market consolidation or exploitation of

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<sup>70</sup> Alexander L. Fogel, Sara Hogan & Jeffrey Dover, *Surgical Dermatology and Private Equity: A Review of the Literature and Discussion*, 48 DERMATOLOGIC SURGERY 339, 339 (2022).

<sup>71</sup> Joseph Dov Bruch, Canyon Foot, Yashawani Singh, Zirui Song, Daniel Polsky, and Jane M. Zhu, *Workforce Composition in Private Equity-Acquired Versus Non-Private Equity-Acquired Physician Practices*, 42 HEALTH AFFS. 121, 126-27 (2023).

<sup>72</sup> See e.g., Marcelo Cerullo, Kelly Yang, Karen E. Joynt Maddox, Ryan C. McDevitt, James W. Roberts & Anaeze C. Offodile, *Association Between Hospital Private Equity Acquisition and Outcomes of Acute Medical Conditions Among Medicare Beneficiaries*, 5 JAMA NETWORK OPEN 1, 1 (2022) (reporting no increase in hospital mortality following private equity acquisition).

<sup>73</sup> Lawrence P. Casalino, *Private Equity, Women's Health, and the Corporate Transformation of American Medicine*, 180 JAMA INTERNAL MED. 1545, 1545 (2020) (summarizing conceptual arguments for an against PE acquisition of physician practices); Gondi & Song, *supra* note 42, at 1047 (describing why physicians may be attracted to private equity buyouts); Fuse Brown et al., *supra* note 13, at 6.

market dysfunction no matter by whom, although the aggressiveness of private equity adds urgency to honing and adapting these legal tools quickly to address old threats by new actors.

This Part reviews existing legal mechanisms to address the key harms posed by PE in health care: (A) antitrust enforcement to address consolidation; (B) fraud and abuse enforcement to address improper self-referrals, overbilling, and upcoding; (C) state corporate practice of medicine and fee-splitting prohibitions to address threats to professionalism from improper lay-control over physicians' practices; and (D) state employment laws to curb PE's use of restrictive covenants and gag clauses against physicians. Table 1, in the Appendix, summarizes these legal tools, the policy concerns they address, their source (state or federal), and what could be done to sharpen them to address the risks of PE investment in health care.

#### A. Antitrust Law

A significant concern is that PE investment in physician practices contributes to the horizontal market consolidation of these physician specialties.<sup>74</sup> This concern is particularly strong for the form of PE investment known as the “platform add-on” model, in which an existing practice with market clout grows substantially by acquiring smaller and less-recognized groups.<sup>75</sup> Regional dominance allows the combined practice to demand higher prices from payers and may reduce patients' access to providers by restricting insurance network participation.<sup>76</sup> Moreover, the highly leveraged PE business model contains strong incentives for consolidation because the availability of debt financing depends on the size of the company and because larger-sized portfolio companies generate higher valuations, measured in multiples of EBIDTA (earnings before interest, taxes, depreciation, and amortization)—a

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<sup>74</sup> Richard M. Scheffler, Laura M. Alexander & James R. Godwin, *Soaring Private Equity Investment in the Healthcare Sector: Consolidation Accelerated, Competition Undermined, and Patients at Risk*, AM. ANTITRUST INST. & PETRIS CTR. 34–35 (2021), <https://publichealth.berkeley.edu/wp-content/uploads/2021/05/Private-Equity-I-Healthcare-Report-FINAL.pdf>; Jack S. Resneck, *Dermatology Practice Consolidation Fueled by Private Equity Investment: Potential Consequences for the Specialty and Patients*, 154 JAMA DERMATOLOGY 13, 13–14 (2018); Zhu & Polsky, *supra* note 46, at 981–83.

<sup>75</sup> Fuse Brown et al., *supra* note 13, at 18–19; Scheffler et al., *supra* note 74, at 29; Resneck, *supra* note 74, at 13–14; Gondi & Song, *supra* note 42, at 1047; Zhu & Polsky, *supra* note 46, at 981–83.

<sup>76</sup> Scheffler et al., *supra* note 74, at 28, 42.

common measure of profitability that increases with greater leverage.<sup>77</sup> The literature shows that horizontal consolidation of physician practices leads to higher prices without corresponding improvements in the quality of care.<sup>78</sup> Emerging evidence also suggests horizontal physician consolidation is associated with worse patient outcomes in Medicare, where prices are set administratively.<sup>79</sup>

One legal solution to address PE's use of the platform add-on model to amass market power would be to increase antitrust scrutiny of these incremental acquisitions. Under Section 7 of the Clayton Act, federal antitrust authorities—the Federal Trade Commission (FTC) and the Department of Justice (DOJ)—can sue to block mergers and acquisitions where the effect of the transaction may be “substantially to lessen competition, or to tend to create a monopoly.”<sup>80</sup> To determine whether a transaction may threaten competition, antitrust agencies analyze whether the transaction will enhance the market power of the transacting parties in a given geographic and product market and thus increase prices to consumers or lead to nonprice effects in terms of diminished quality or access.<sup>81</sup> Typically, health care acquisitions (other than insurance) are overseen by the FTC.<sup>82</sup> This merger enforcement follows a series of steps, starting with pre-merger notification of the authorities, followed by a review period during which the transaction may not close; following review, the government may clear the deal to move ahead, request more information,

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<sup>77</sup> *Id.* at 30.

<sup>78</sup> Laurence C. Baker, M. Kate Bundorf, Anne B. Royalty & Zachary Levin, *Physician Practice Competition and Prices Paid by Private Insurers for Office Visits*, 312 JAMA 1653, 1653-62 (2014); Daniel R. Austin & Laurence C. Baker, *Less Physician Practice Competition Is Associated with Higher Prices Paid for Common Procedures*, 34 HEALTH AFFS. 1753, 1753-54 (2015); Eric Sun & Laurence C. Baker, *Concentration in Orthopedic Markets Was Associated with a 7 Percent Increase in Physician Fees for Total Knee Replacements*, 34 HEALTH AFFS. 916, 916 (2015); Thomas Koch & Shawn W. Ulrick, *Price Effects of a Merger: Evidence from a Physicians' Market*, 59 ECON. INQUIRY 790, 790-91 (2021).

<sup>79</sup> Thomas Koch, Brett Wendling & Nathan E. Wilson, *Physician Market Structure, Patient Outcomes, and Spending: An Examination of Medicare Beneficiaries*, 53 HEALTH SERVS. RSCH. 3549, 3551 (2018); Christopher S. Brunt, Joshua R. Hendrickson & John R. Bowblis, *Primary Care Competition and Quality of Care: Empirical Evidence from Medicare*, 29 HEALTH ECON. 1048, 1048-49 (2020).

<sup>80</sup> 15 U.S.C. § 18.

<sup>81</sup> U.S. DEP'T OF JUSTICE AND THE FEDERAL TRADE COMM'N, HORIZONTAL MERGER GUIDELINES 2-3 (Aug. 19, 2010), <https://www.justice.gov/atr/horizontal-merger-guidelines-08192010>.

<sup>82</sup> *Health Care Competition*, FED. TRADE COMM'N, <https://www.ftc.gov/news-events/topics/competition-enforcement/health-care-competition> (last visited Oct. 18, 2022).

or challenge the deal.<sup>83</sup> Most challenged transactions are resolved in a negotiated consent agreement, under which the agency agrees to let the transaction move ahead subject to certain conduct and structural remedies, such as agreeing not to raise prices, maintaining access to key services, and divestiture of assets to maintain or restore competition in the relevant market.<sup>84</sup> If the parties do not reach a settlement, the agency can seek an injunction to block the transaction in federal court.<sup>85</sup>

Although the market consolidation that results from PE acquisitions of health care entities could be slowed by antitrust review, there are two main barriers to effective enforcement: (1) these acquisitions go unreported and unreviewed because no single transaction exceeds the mandatory reporting threshold under the Hart-Scott-Rodino (HSR) Act;<sup>86</sup> and (2) merger guidelines and legal precedent do not contain models for assessing the collective market effects of serial platform and add-on acquisitions. Due to these barriers, whether driven by PE or otherwise, physician markets have been characterized by so-called “stealth consolidation.”<sup>87</sup>

Moreover, the incremental add-on approach of PE investment obscures the extent of consolidation over time and across a larger geographic

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<sup>83</sup> *Premerger Notification and the Merger Review Process*, FED. TRADE COMM’N, <https://www.ftc.gov/advice-guidance/competition-guidance/guide-antitrust-laws/mergers/premerger-notification-merger-review-process> (last visited Sept. 2, 2022).

<sup>84</sup> See DOUGLAS H. GINSBURG & JOSHUA D. WRIGHT, FED. TRADE COMM’N, ANTITRUST SETTLEMENTS: THE CULTURE OF CONSENT paras. 9–11 (Feb. 28, 2013), [https://www.ftc.gov/sites/default/files/documents/public\\_statements/antitrust-settlements-culture-consent/130228antitruststlmt.pdf](https://www.ftc.gov/sites/default/files/documents/public_statements/antitrust-settlements-culture-consent/130228antitruststlmt.pdf); *Frequently Asked Questions About Merger Consent Order Provisions*, FED. TRADE COMM’N, <https://www.ftc.gov/advice-guidance/competition-guidance/guide-antitrust-laws/mergers/frequently-asked-questions-about-merger-consent-order-provisions> (last visited Jan. 4, 2023).

<sup>85</sup> FED. TRADE COMM’N, *supra* note 83.

<sup>86</sup> 15 U.S.C. § 18a. The HSR reporting thresholds are updated annually, and in 2023 the reporting threshold was set at transactions valued at \$114 million or more. *FTC Announces 2023 Update of Size of Transaction Thresholds for Premerger Notification Filings and Interlocking Directorates*, FED. TRADE COMM’N (Jan. 23, 2023), <https://www.ftc.gov/news-events/news/press-releases/2023/01/ftc-announces-2023-update-size-transaction-thresholds-premerger-notification-filings-interlocking>.

<sup>87</sup> Thomas G. Wollman, *How to Get Away with Merger: Stealth Consolidation and its Real Effects on US Healthcare* 2–5 (Nat’l Bureau of Econ. Rsch., Working Paper No. 27274, 2020), [https://www.nber.org/system/files/working\\_papers/w27274/w27274.pdf](https://www.nber.org/system/files/working_papers/w27274/w27274.pdf); Cory Capps, David Dranove & Christopher Ody, *Physician Practice Consolidation Driven by Small Acquisitions, So Antitrust Agencies Have Few Tools to Intervene*, 36 HEALTH AFFS. 1556, 1561–62 (2017).

footprint.<sup>88</sup> As a result, some have called for federal antitrust enforcement agencies to update merger guidance to incorporate developing economic evidence to address forms of consolidation not traditionally targeted under the horizontal merger guidelines (involving a simple merger between two rivals in a single geographic area), including serial add-on acquisitions that accumulate market power for a platform practice across a broader geographic area.<sup>89</sup>

The FTC and DOJ have recently shown signs of receptivity to these concerns. In early 2022, the federal antitrust agencies announced that they were undertaking a review of their horizontal and vertical merger guidelines, specifically asking for comments on how the guidelines should address serial “roll-up” (i.e., add-on) acquisitions and whether such transactions, when aggregated, may violate the Clayton Act.<sup>90</sup> In another action to address the limitations of the HSR threshold, in 2021 the FTC voted 3-2 to revive a long-abandoned remedy that requires prior notice and approval of proposed transactions by parties to a merger consent agreement for a period of 10 years.<sup>91</sup> In 2022, the FTC applied this technique in a consent agreement with a PE-owned veterinary services provider, requiring notification and approval of future acquisitions that would otherwise not be reported under the HSR Act.<sup>92</sup> The FTC specifically tied the notice-and-approval remedy to the agency’s concerns that “[p]rivate equity firms

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<sup>88</sup> Scheffler et al., *supra* note 74, at 44.

<sup>89</sup> Aimee Cicchiello & Lovisa Gustafsson, *Federal Antitrust Tools Are Inadequate to Prevent Anticompetitive Health Care Consolidation, to the Point*, (May 13, 2021), <https://www.commonwealthfund.org/blog/2021/federal-antitrust-tools-are-inadequate-prevent-anticompetitive-health-care-consolidation>; Jaime S. King & Erin C. Fuse Brown, *The Anti-Competitive Potential of Cross-Market Mergers in Health Care*, 11 ST. LOUIS U. J. HEALTH L. & POL’Y 43, 61–67 (2017); Keith Brand & Ted Rosenbaum, *A Review of the Economic Literature on Cross-Market Health Care Mergers*, 82 ANTITRUST L. J. 533, 533 (2019); Leemore Dafny, Kate Ho & Robin S. Lee, (2019). *The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry*, 50 RAND J. ECON. 286, 315 (2019).

<sup>90</sup> U.S. DEP’T OF JUSTICE & U.S. FED. TRADE COMM’N, REQUEST FOR INFORMATION ON MERGER ENFORCEMENT 2 (2022), <https://www.regulations.gov/document/FTC-2022-0003-0001>.

<sup>91</sup> Press Release, Fed. Trade Comm’n, FTC Rescinds 1995 Policy Statement that Limited the Agency’s Ability to Deter Problematic Mergers (July 21, 2021), <https://www.ftc.gov/news-events/press-releases/2021/07/ftc-rescinds-1995-policy-statement-limited-agencys-ability-deter>; Notice and Request for Comment Regarding Statement of Policy Concerning Prior Approval and Prior Notice Provisions in Merger Cases, 60 Fed. Reg. 39745, 39745–47 (Aug. 3, 1995).

<sup>92</sup> JAB Consumer Partners/Ethos Veterinary Health; Analysis of Agreement Containing Consent Orders to Aid Public Comment, 87 Fed. Reg. 48026, 48027 (Aug. 5, 2022).

increasingly engage in roll up strategies that allow them to accrue market power off the Commission's radar."<sup>93</sup>

Despite the potential for existing antitrust enforcement tools to counteract the consolidation and competitive harms posed by PE's land-grab among health care entities, gaps remain. As discussed further below, antitrust enforcement tools can be sharpened with policy reform at the federal and state levels to better counteract PE's threats to health care competition.<sup>94</sup>

### *B. Fraud and Abuse Enforcement*

PE companies' emphasis on increasing the revenues of acquired portfolio practices may increase risks for overutilization, overbilling or upcoding, medically unnecessary care, and inappropriate self-referrals for ancillary services.<sup>95</sup> The same pressure to maximize revenues may also lead to stinting on less profitable services (or patients) or increased use of non-physicians without adequate supervision.<sup>96</sup> These threats to program spending and patient well-being stemming from providers' financial incentives are generally addressed by federal fraud and abuse laws, namely, the False Claims Act (FCA), Anti-Kickback Statute (AKS), and Stark Law.<sup>97</sup> In addition, most states have laws barring fee-splitting and self-referral that could be applied similarly.<sup>98</sup> Stepped-up enforcement under these laws by government and private whistleblowers could redress some of the fraud and abuse risks posed by PE investment in physician practices.

Liability under federal fraud and abuse laws can be extensive. Under the FCA, each improper claim for payment triggers up to a \$27,000 per-claim penalty and "treble damages," calculated as 3-times the amount the government improperly paid in claims.<sup>99</sup> Enforcement action could target

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<sup>93</sup> Press Release, Fed. Trade Comm'n, FTC Acts to Protect Pet Owners from Private Equity Firm's Anticompetitive Acquisition of Veterinary Services Clinics (June 13, 2022), <https://www.ftc.gov/news-events/news/press-releases/2022/06/ftc-acts-protect-pet-owners-private-equity-firms-anticompetitive-acquisition-veterinary-services>.

<sup>94</sup> See discussion *infra* Part III.A.1.

<sup>95</sup> Gondi & Song, *supra* note 42, at 1047–48; Zhu & Polsky, *supra* note 46, at 982.

<sup>96</sup> Resneck, *supra* note 74, at 13–14.

<sup>97</sup> Fuse Brown et al., *supra* note 13, at 22.

<sup>98</sup> See discussion *infra* Part II.D.

<sup>99</sup> FCA penalties are adjusted for inflation. The 2023 FCA minimum penalty per-claim is \$13,508 and the maximum is \$27,108. 88 Fed. Reg. 3, 4 (Jan. 3, 2023) (to be codified at 15 C.F.R. pt. 6).

deep-pocketed PE firms which, if they directed or encouraged their portfolio practices to engage in unlawful conduct, could face substantial liability or administrative exclusion from participating in Medicare or other federal programs.<sup>100</sup> Nevertheless, the government typically seeks significantly less than the maximum penalties in settlements (closer to double-damages than treble), which may not carry significant deterrent value for PE firms who see occasional settlements as the cost of doing business and lack the reputational incentives of long-term operators of health care entities.<sup>101</sup> Government enforcers may want to consider the nature of the defendant when determining damages multipliers in such cases.

Although each statute targets different types of conduct, they overlap in that payment claims in violation of the AKS or Stark Law are also considered false claims under the FCA, which imposes civil and criminal liability for those who present false or fraudulent claims for payment by the federal government.<sup>102</sup>

### 1. Applying the False Claims Act to Private Equity Owners

The FCA can be used to police nefarious billing practices, including upcoding, submitting claims for unnecessary care, or billing for services of mid-level practitioners without adequate supervision. In two recent cases, PE firms have been sued under the FCA for the alleged fraudulent conduct of one of their portfolio companies.<sup>103</sup> In both cases, the plaintiffs alleged that the PE owners knew of or acquiesced to fraudulent billing practices sufficient to render them liable under the FCA.<sup>104</sup>

To prove liability under the FCA, the plaintiff needs to show that the defendant had the requisite level of scienter or knowledge of the fraudulent conduct.<sup>105</sup> It, therefore, stands to reason that putative control over a medical practice may be imputed to the PE owner where the PE owner has a high level of knowledge of the acts underlying the fraud of its portfolio.

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<sup>100</sup> 42 U.S.C. § 1320-7.

<sup>101</sup> Jacob Elberg, *A Path to a Data-Driven Health Care Enforcement*, 2020 UTAH L. REV. 1169, 1194 (2020).

<sup>102</sup> 31 U.S.C. §§ 3729–3733.

<sup>103</sup> *United States ex rel. Martino-Fleming v. South Bay Mental Health Ctr., Inc.*, No. 15-13065-PBS, 2018 WL 4539684, at \*1 (D. Mass. Sept. 21, 2018); *United States ex rel. Carmen Medrano v. Diabetic Care RX, LLC*, NO. 15-CV-62617-BLOOM/VALLE, 2018 WL 6978633, at \*1 (S.D. Fla. Nov. 30, 2018).

<sup>104</sup> *Martino-Fleming*, 2018 WL 4539684, at \*1; *Medrano*, 2018 WL 6978633, at \*1.

<sup>105</sup> 31 U.S.C. § 3729(a)(1)(A).



Putative control can be established by examining scienter, causation, and third-party liability under the FCA.<sup>106</sup>

Defendants are liable under the FCA where they “knowingly present[], or cause[] to be presented, to an officer or employee of the United States Government ... a false or fraudulent claim for payment or approval[.]”<sup>107</sup> The FCA does not require the specific intent to defraud; rather, the scienter requirement is established where the defendant has actual knowledge of false information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information.<sup>108</sup> Closely related to scienter is the causation element, as a defendant can be liable only for claims that it “causes to be presented” to the government.<sup>109</sup> Although scienter and causation are technically distinct elements, they often overlap, such that proving one necessarily proves the other.<sup>110</sup> Proving that a person or entity caused false claims to be submitted satisfies at least the reckless disregard scienter standard.<sup>111</sup>

Scienter and causation are particularly important to proving FCA liability of PE owners of health care entities, who argue that they are passive third-party investors who cannot be held liable for the actions of medical professionals.<sup>112</sup> Under the FCA, merely being a parent corporation is not sufficient to establish liability for the conduct of a subsidiary.<sup>113</sup> In *United States ex rel. Hockett v. Columbia/HCA Healthcare Corp.*, the court considered two possible ways to hold a parent corporation liable under the FCA.<sup>114</sup> First, through traditional veil-piercing frameworks, a parent may be liable on behalf of its subsidiary where a “unity of interest and ownership” essentially destroys the separate personalities of the two entities.<sup>115</sup> In the

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<sup>106</sup> *Id.*

<sup>107</sup> *Id.*

<sup>108</sup> *Id.* § 3729(b)(1)(A).

<sup>109</sup> *Id.* § 3729(a)(1)(A).

<sup>110</sup> CLAIRE M. SYLVIA, THE FALSE CLAIMS ACT: FRAUD AGAINST THE GOVERNMENT § 4:3, Westlaw (database updated June 2022) (“The person or entity ‘causing’ the submission of the claim must have acted ‘knowingly’ within the meaning of the FCA.”).

<sup>111</sup> *Id.* (citing *Strom ex rel. United States v. Scios, Inc.*, 676 F. Supp. 2d 884, 890 (N.D. Cal. 2009)).

<sup>112</sup> *Martino-Fleming*, 2018 WL 4539684, at \*4–5.

<sup>113</sup> *United States ex rel. Hockett v. Columbia/HCA Healthcare Corp.*, 498 F. Supp. 2d 25, 59–60 (D.D.C. 2007) (citing *United States ex rel. Tillson v. Lockheed Martin Corp.*, 2004 WL 2403114 at \*33 (W.D. Ky. Sept. 30, 2004)).

<sup>114</sup> *Id.* at 60–62.

<sup>115</sup> *Id.* at 60.

PE context, traditional veil piercing would likely be difficult because of the carefully crafted relationship between the medical practice and the outside management and investment entity.

*Hockett* also held that parent liability may be established where the parent was “directly involved in submitting false claims or causing them to be submitted to the government.”<sup>116</sup> The parent company in *Hockett*, Columbia/HCA, was directly involved in submitting cost reports to the government that determined the amount of reimbursement the company received from government payers.<sup>117</sup> Due to the administrative control exerted by PE over acquired medical practices, this direct-involvement theory of parent liability seems more viable. Unlike other forms of capital investment, PE firms acquire a controlling share of their portfolio companies and assertively take steps to quickly increase revenues.<sup>118</sup> Thus, they are known for their high degree of involvement in the billing practices and procedures of the medical practice.<sup>119</sup> Various commentators have recognized that aggressive focus on revenue by the PE fund’s general partner can form a basis for establishing the requisite level of control.<sup>120</sup>

Two recent cases illustrate how scienter and causation can be established to hold PE parent companies liable for FCA violations of their portfolio companies. The PE firm in *United States ex rel. Carmen Medrano v. Diabetic Care RX, LLC* used a common organizational structure: acquisition of portfolio companies through a wholly owned management company, which owns and/or manages the acquired companies.<sup>121</sup> In *Medrano*, the PE firm acquired a controlling stake in a portfolio pharmacy via a management contract with the PE partners’ wholly owned management company.<sup>122</sup> The government alleged that the portfolio pharmacy violated the Anti-Kickback Statute by engaging marketing companies to refer beneficiaries to the pharmacy to purchase an expensive topical cream.<sup>123</sup> The management company argued that it could not be held liable under the FCA because it had no knowledge of the pharmacy’s scheme and did not cause the claims to be submitted to the government.<sup>124</sup>

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<sup>116</sup> *Id.* at 62.

<sup>117</sup> *Id.*

<sup>118</sup> Appelbaum & Batt, *supra* note 1, at 6–7.

<sup>119</sup> *Id.* at 65.

<sup>120</sup> Morgenson, *supra* note 17; Fuse Brown et al., *supra* note 13, at 24; Scheffler et al., *supra* note 74, at 34–35.

<sup>121</sup> *Medrano*, 2018 WL 6978633, at \*1 n.3.

<sup>122</sup> *Id.*

<sup>123</sup> *Id.* at \*3.

<sup>124</sup> *Id.* at \*11–14.

The court disagreed.<sup>125</sup> First, the court held that the PE owner had knowledge of the scheme because it approved the pharmacy's decision to use the marketers to generate referrals.<sup>126</sup> Second, the PE owner caused the violation when it provided \$2 million in commissions to the marketers for generating referrals.<sup>127</sup>

The PE firm in *United States ex rel. Martino-Fleming v. South Bay Mental Health Center, Inc.* acquired its ownership stake in a mental-health center through a holding company.<sup>128</sup> The plaintiff, a private whistleblower, alleged that the defendant mental-health facility employed unlicensed staff and provided inadequate supervision to employees providing care.<sup>129</sup> Submission of claims for payment in violation of these requirements constitutes a false claim.<sup>130</sup> The plaintiff alleged that the board of directors, many of whom were partners in the PE firm, rejected her recommendation to bring the facility into compliance.<sup>131</sup> The court found that the plaintiff adequately alleged causation because “knowingly [ratifying] the prior policy of submitting false claims by rejecting recommendations to bring [the facility] into regulatory compliance constitutes sufficient participation in the claims process to trigger FCA liability.”<sup>132</sup> In doing so, the court expressly relied on the *Hockett* case in holding that the PE firm may be liable because it was “directly involved in the operations” of the medical practice.<sup>133</sup>

*Medrano* and *Martino-Fleming* demonstrate that the substantial level of control PE owners exert over their acquired medical practices exposes them to FCA liability for acts of those practices.<sup>134</sup> Even where sophisticated contracting obscures formal control enough to evade the state corporate

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<sup>125</sup> *Id.* at \*11–13.

<sup>126</sup> *Id.* at \*11.

<sup>127</sup> *Id.* at \*13.

<sup>128</sup> Complaint at 8–9, *Martino-Fleming v. South Bay Mental Health Ctr., Inc.*, No. 15-13065-PBS (D. Mass. 2018). It appears that the subject transaction was not subject to the corporate practice prohibition because the portfolio company was a Massachusetts licensed for-profit corporation rather than a professional corporation. *Id.* at 5. Before acquisition, it was wholly owned by a licensed mental health care provider. *Martino-Fleming*, 2018 WL 4539684, at \*2.

<sup>129</sup> *Martino-Fleming*, 2018 WL 4539684, at \*2.

<sup>130</sup> *Id.* at \*1.

<sup>131</sup> *Id.* at \*3.

<sup>132</sup> *Id.* at \*4.

<sup>133</sup> *Id.* at \*5.

<sup>134</sup> *Medrano*, 2018 WL 6978633 at, \*11–13; *Martino-Fleming*, 2018 WL 4539684, at \*5.

practice of medicine doctrine,<sup>135</sup> various forms of influence and oversight can establish that private equity owners act with the requisite level of scienter and causation to be liable under the FCA.<sup>136</sup>

## 2. Applying the Stark Law to Private Equity Owners

Enforcement of the Stark Law can target another revenue strategy of PE-acquired physician practices: self-referrals for ancillary, wrap-around services within the PE's portfolio practices. This strategy seems to motivate PE's recent acquisition of office-based specialties like dermatology, ophthalmology, and gastroenterology that provide outpatient procedures and lucrative "wraparound" services such as physician-administered drugs or pathology laboratory services.<sup>137</sup>

The Stark Law prohibits physicians making referrals and entities from billing for "designated health services" payable by Medicare to entities with whom the referring physician has a financial relationship unless the arrangement satisfies one of a series of specific exceptions.<sup>138</sup> Stark is a strict liability statute, so unlike the FCA or AKS, the government does not have to prove the defendant's intent to violate the law, which may make it easier to establish a violation by PE investors or the PE-controlled managed company.<sup>139</sup>

The Stark Law requires all financial arrangements between the portfolio practice, management company, and the group's physicians to satisfy a Stark exception.<sup>140</sup> For PE-owned physician practices, this would include the physicians' ownership interests and revenue-sharing, the management services agreement with the practice, and physician employment compensation.<sup>141</sup> If all these financial arrangements do not strictly satisfy a Stark exception, the group's physicians may not refer for ancillary services within the group—a key source of revenue for the PE investors.<sup>142</sup>

The "in-office ancillary services" exception is the primary Stark Law exception that portfolio practices rely upon to capture referrals and share

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<sup>135</sup> See discussion *infra* Part II.C.

<sup>136</sup> *Medrano*, 2018 WL 6978633 at \*11–13; *Martino-Fleming*, 2018 WL 4539684, at \*5.

<sup>137</sup> *Fuse Brown et al.*, *supra* note 13, at 13.

<sup>138</sup> 42 U.S.C. § 1395nn.

<sup>139</sup> *Fuse Brown et al.*, *supra* note 13, at 23.

<sup>140</sup> 42 U.S.C. § 1395nn(a)–(b).

<sup>141</sup> *Fuse Brown et al.*, *supra* note 13, at 23.

<sup>142</sup> 42 U.S.C. § 1395nn(a)–(b); *Fuse Brown et al.*, *supra* note 13, at 23.

revenues for ancillary services within the practice.<sup>143</sup> The purpose of the exception was to permit physicians to provide rapid diagnostic or therapeutic services during a patient's office visit, such as imaging, laboratory, or physical therapy.<sup>144</sup> The in-office ancillary services exception permits physicians to engage in otherwise-prohibited revenue sharing and to profit from referrals for services within the referring physician's "group practice."<sup>145</sup>

To use the in-office ancillary services exception, the practice must meet the definition of a "group practice" under Stark for ancillary services within the practice.<sup>146</sup> To qualify as a group practice, a practice must meet a series of requirements, including that the practice is a single legal entity, each physician member must furnish substantially all of their patient services through the group practice; it must be a unified business with centralized decision-making, billing, and financial reporting; and physician members (rather than contractors) must personally provide at least 75% of the physician-patient services furnished by the group practice, and intricate requirements apply to physician compensation and profit-sharing.<sup>147</sup> PE-backed portfolio practices may struggle to meet some of these requirements. For instance, the "single legal entity" provision does not include "separate group practices under common ownership or control through a physician practice management company . . . or other entity or organization."<sup>148</sup> Each add-on practice in a portfolio would be considered its own entity and could not be considered a single group practice.<sup>149</sup> In addition, it may be difficult to meet the unified business and centralized decision-making requirements, where a representative body has effective control over the practice's billing and finances—often the PE-owned management company takes over administration and management for all the portfolio practices.<sup>150</sup> Thus, it may be legally difficult for the portfolio of practices to qualify as a single

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<sup>143</sup> 42 C.F.R. § 411.355(b) (2022); 42 U.S.C. § 1395nn(b)(2); Madeline E. DeWane, Eliot Mostow & Jane M. Grant-Kels, *The Corporatization of Care in Academic Dermatology*, 38 CLINICS IN DERMATOLOGY 289, 290 (2020).

<sup>144</sup> Fuse Brown et al., *supra* note 13, at 24.

<sup>145</sup> 42 U.S. § 1395nn(b)(2); 42 C.F.R. § 411.355(b).

<sup>146</sup> 42 C.F.R. § 411.352 (2022); *see also*, AM. MED. ASS'N, KEY CONSIDERATIONS IN PROVIDING ANCILLARY SERVICES IN YOUR PHYSICIAN PRACTICE 2 (2021), <https://www.ama-assn.org/system/files/private-practice-checklist-ancillary-services.pdf>.

<sup>147</sup> 42 C.F.R. § 411.352.

<sup>148</sup> 42 C.F.R. §§ 411.352(a), 411.355.

<sup>149</sup> *See* 42 C.F.R. § 411.352(a).

<sup>150</sup> 42 C.F.R. § 411.352(f).

group practice necessary to share revenues and to permit referrals across the practices.

Qualifying as a group practice is only one of the requirements of the in-office ancillary services exception.<sup>151</sup> Other requirements of the in-office ancillary services exception include restrictions on who may perform the services (only by the referring physician, another physician in the group practice, or someone supervised by them), the location where the services may be provided, and who may bill for the services.<sup>152</sup>

The intricate requirements of Stark's group practice definition and the in-office ancillary services exception increase the likelihood of noncompliance. Particularly for PE investments in procedural specialties, such as dermatology, gastroenterology, and ophthalmology that rely on in-office procedures and wraparound services as a revenue strategy, deeper investigations into the structure and revenue-sharing of these practices may reveal noncompliance. Although the Stark Law is a strict liability statute, for a Stark violation to constitute a false claims under the FCA, the government or qui tam relator would still need to prove the PE firm acted with the requisite intent (i.e., that it knowingly violated the Stark Law), which may be trickier to prove given the complicated requirements of the Stark Law. Nevertheless, the larger point is that PE-driven platform and management practices may be an area ripe for further enforcement scrutiny under available fraud and abuse laws.

In the fraud and abuse context, the key policy recommendation is to increase federal and state fraud and abuse enforcement to penalize and deter PE-owned companies from engaging in nefarious or inappropriate billing and referral practices. The existing laws provide ample authority to go after some of the most egregious practices—upcoding, billing for medically unnecessary care or unapproved treatments, kickback schemes, improper use of mid-level practitioners—and government enforcers and private whistleblowers have begun to hold PE companies liable under the FCA for the misconduct of their portfolio practices.<sup>153</sup> More targeted investigations

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<sup>151</sup> 42 C.F.R. § 411.355(b).

<sup>152</sup> 42 C.F.R. § 411.355(b)(1)–(3); *see also*, Victoria Vasckov Sheridan, Gary W. Herschman & Joseph E. Lynch, *Recent Settlements May Indicate Increased Government Focus on the Stark Law's "Group Practice" Requirements and Exception for "In-Office Ancillary Services,"* EPSTEIN BECKER GREEN (Feb. 26, 2018), <https://www.healthlawadvisor.com/2018/02/26/recent-settlements-may-indicate-increased-government-focus-on-the-stark-laws-group-practice-requirements-and-exception-for-in-office-ancillary-services/>.

<sup>153</sup> *See* Press Release, U.S. Dep't of Just., EEG Testing and Private Investment Companies Pay \$15.3 Million to Resolve Kickback and False Billing Allegations (July 21,

of PE-portfolio company practices, including by the cross-agency Health Care Fraud Prevention and Enforcement Action Team (HEAT), could yield more recoveries and deter bad behavior.

Curtailling overutilization of self-referred services is, however, more difficult to address with existing fraud and abuse laws.<sup>154</sup> To stem the overutilization of self-referred anatomic pathology services, the Government Accountability Office recommended that CMS add a self-referral “flag” to Part B claims to track in-office referrals and to identify potentially unnecessary services.<sup>155</sup> Thus far, the agency has not adopted this recommendation. The Medicare Payment Advisory Commission (MedPAC) also raised concerns that the in-office ancillary services exception creates incentives to increase utilization and recommended the agency take steps to limit the exception, reduce the payment rates for diagnostic services furnished under the exception, or counteract the incentives by using all-inclusive bundled payments.<sup>156</sup> Recent amendments to the Stark and AKS rules, however, have loosened rather than tightened the rules (or in the case of Medicare ACOs, waived the rules altogether), in

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2001), <https://www.justice.gov/opa/pr/eeg-testing-and-private-investment-companies-pay-153-million-resolve-kickback-and-false> (underscoring DOJ’s willingness to hold PE firms liable for FCA violations of their portfolio companies after PE firm, Ancor Holdings LP agreed to pay \$1.8 million for false claims resulting from an ongoing kickback scheme engineered by the portfolio company); Press Release, U.S. Att’y’s Off., E. Dist. of Pa., Former Owners of Therakos, Inc. Pay \$11.5 Million to Resolve False Claims Act Allegations of Promotion of Drug-Device System for Unapproved Uses to Pediatric Patients (Nov. 19, 2020), <https://www.justice.gov/usao-edpa/pr/former-owners-therakos-inc-pay-115-million-resolve-false-claims-act-allegations> (announcing decision by PE firm, The Gores Group (TGG), to pay \$1.5 million to settle a lawsuit filed under the FCA’s whistleblower provision after their portfolio company allegedly marketed a cancer treatment for pediatric patients that was not approved by the FDA, resulting in the submission of false claims to Medicaid, the Federal Employee Health Benefits Program, and Tricare); *Medrano*, 2018 WL 6978633, at \*1 (involving an action by relators against a pharmacy for allegedly violating the FCA); *see also Martino-Fleming*, 2018 WL 4539684, at \*1 (involving an action by a relator against a mental health center); *see also* U.S. ex rel. Cho v. H.I.G. Cap., LLC, 2020 WL 5076712, at \*1 (M.D. Fla. Aug. 26, 2020) (involving an action by relators against a surgery center).

<sup>154</sup> Laurence C. Baker, Scott W. Atlas & Christopher C. Afendulis, *Expanded Use of Imaging Technology and the Challenge of Measuring Value*, 27 HEALTH AFFS. 1467, 1467-1478 (2008).

<sup>155</sup> U.S. GOV’T ACCOUNTABILITY OFF., GAO-13-445, MEDICARE: ACTION NEEDED TO ADDRESS HIGHER USE OF ANATOMIC PATHOLOGY SERVICES BY PROVIDERS WHO SELF-REFER 3 (2013).

<sup>156</sup> MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO THE CONGRESS: ALIGNING INCENTIVES IN MEDICARE 213-34 (Jun. 2022), [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/Jun10\\_EntireReport.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/Jun10_EntireReport.pdf).

an effort to reduce providers' compliance burden and to promote value-based payment arrangements.<sup>157</sup> One way to address the risk of overutilization created by fee-for-service payments would be to shift physician practices that self-refer ancillary services to alternative payment models, such as capitation or bundled payments.

A further limitation of federal fraud and abuse laws is that some of the specialties targeted by PE firms are attractive because of their extensive cash-pay services that are not reimbursed by federal health care programs (e.g., cosmetic dermatology or refractive vision services).<sup>158</sup> Preventing overutilization of these non-federal cash-pay services would require changing federal laws to capture revenue sharing from non-federally reimbursed services or fall more naturally under state law enforcement.

### *C. Corporate Practice of Medicine and State Fee-Splitting Laws*

Courts traditionally have addressed many of the concerns over commercialization and profit-seeking in medicine through what is known as the "corporate practice of medicine" prohibition, which generally prohibits nonprofessionals from owning or controlling medical practices.<sup>159</sup> Similarly, state anti-fee splitting laws sought to prevent corporations from profiting from physicians' medical care.<sup>160</sup> These two historical doctrines prove useful to address the contemporary issues raised by PE investment in physician practices.

#### *1. History and Current Application of the Corporate Practice of Medicine*

The prohibition against the corporate practice of medicine has its roots in ethical guidelines promulgated by the American Medical Association (AMA) during the 1800s.<sup>161</sup> The guidelines, which prohibit corporations or lay-entities from employing physicians, set out to distinguish professionally

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<sup>157</sup> Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations, 85 Fed. Reg. 77492, 77503 (Dec. 2, 2020) (codified at 42 C.F.R. pt. 411); Medicare Program; Final Waivers in Connection With the Shared Savings Program, 76 Fed. Reg. 67992, 67994 (Nov. 2, 2011) (codified at 42 C.F.R. pts. Chapter IV, V).

<sup>158</sup> Fuse Brown et al., *supra* note 13, at 13.

<sup>159</sup> Andre Hampton, *Resurrection of the Prohibition on the Corporate Practice of Medicine: Teaching Old Dogma New Tricks*, 66 U. CIN. L. REV. 489, 497 (1998).

<sup>160</sup> Fuse Brown et al., *supra* note 13, at 22.

<sup>161</sup> Nicole Huberfeld, *Be Not Afraid of Change: Time to Eliminate the Corporate Practice of Medicine Doctrine*, 14 HEALTH MATRIX 243, 245–47 (2004).



trained doctors from “quacks” who offered substandard or fraudulent medical care to legitimize the profession in the eyes of the public.<sup>162</sup>

The AMA’s ban on the corporate practice of medicine reflected public policy concerns about the safety and legitimacy of the medical practice in the hands of for-profit or other non-professional entities.<sup>163</sup> The belief was that lay control over the medical profession would create perverse profit motives that would come at the expense of patients.<sup>164</sup> Additionally, corporate control over medicine would remove the physician’s autonomy in decision-making critical to the patient’s care.<sup>165</sup> Broadly, the corporate practice prohibition responded to a concern about the commercialization of the medical profession and the fear of conflicting interests between profit and patient care.<sup>166</sup>

Eventually, the AMA successfully turned these ethical guidelines into state laws by lobbying state legislatures to adopt strict medical practice acts incorporating much of the AMA’s framework.<sup>167</sup> Organized medicine maintained that prohibition of corporate control over physicians is implicit in that only natural persons, not corporations, could be licensed to practice medicine.<sup>168</sup> Many newly-adopted laws also prohibited fee-splitting between medical professionals and lay entities.<sup>169</sup> Finally, courts ratified the view that state medical practice acts barring the unlicensed practice of medicine implicitly prohibit corporate ownership or employment of physicians, cementing public policy against corporate control of the medical profession.<sup>170</sup>

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<sup>162</sup> *Id.*

<sup>163</sup> Mark Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 514–15 (1988); AM. MED. ASS’N, PRINCIPLES OF MEDICAL ETHICS, ch. 3, art. 6, sec. 5, *reprinted in* AM. MED. ASS’N, AM. MED. DIRECTORY 15 (15th ed. 1938).

<sup>164</sup> Hall, *supra* note 163, at 514; Hampton, *supra* note 159, at 497.

<sup>165</sup> Hall, *supra* note 163, at 514; Hampton, *supra* note 159, at 497.

<sup>166</sup> Hall, *supra* note 163, at 514.

<sup>167</sup> Kathrine Marous, *The Corporate Practice of Medicine Doctrine: An Anchor Holding America Back in the Modern and Evolving Healthcare Marketplace*, 70 DEPAUL L. REV. 157, 161 (2020).

<sup>168</sup> Hall, *supra* note 163, at 509–10; Huberfeld, *supra* note 161, at 250.

<sup>169</sup> Huberfeld, *supra* note 161, at 249; *see infra* Part II.C.3.

<sup>170</sup> *See, e.g.,* Neill v. Gimbel Bros., Inc., 199 A. 178, 182 (Pa. 1938) (holding department store could not employ an optometrist); Barton v. Codington, 2 N.W.2d 337, 346 (S.D. 1942) (concluding corporations’ engagement in the practice of medicine is against public policy because it reduces the quality of care); *see also*, Huberfeld, *supra* note 161, at 251.

Even at its inception, the corporate practice of medicine doctrine did not escape criticism.<sup>171</sup> Some critics argued that the AMA's guidelines were profit-seeking attempts at stifling competition.<sup>172</sup> A century after the ethical code was first passed, the FTC began challenging the doctrine as anticompetitive.<sup>173</sup> During the 1970s and 1980s, the FTC successfully argued that the AMA's ethical guidelines prevented physicians from adopting "more economically efficient business formats . . . ."<sup>174</sup>

An additional impetus to restrain medical practice acts was public policy endorsement of Health Maintenance Organizations, as manifested in the Health Maintenance Organization (HMO) Act of 1973.<sup>175</sup> The Act incentivized the creation of managed care entities where physicians could contract directly with corporate entities.<sup>176</sup> Most medical practice acts, however, were interpreted to prohibit physicians from associating with HMOs.<sup>177</sup> The corporate practice of medicine doctrine, therefore, stood in the way of innovation and reforms sought to control the skyrocketing price of health care in the 1970s and 1980s.<sup>178</sup>

Following the HMO Act and the managed care revolution, the corporate practice of medicine doctrine fell into disfavor among policymakers.<sup>179</sup> Just as exceptions were carved out for managed care entities, exceptions were increasingly recognized for other officially endorsed forms of corporate

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<sup>171</sup> See Hall, *supra* note 163, at 510 ("The doctrine has a long history of suppressing needed innovation in times of industry upheaval."); see also Marous, *supra* note 167, at 161 (noting that the American Medical Association, one of the main proponents of the corporate practice of medicine doctrine, was originally established to be an advocacy group for its members)

<sup>172</sup> See Hall, *supra* note 163, at 515 ("When courts enforce the corporate practice doctrine, they mistakenly suppose they are enforcing the legislature's *public* protection policies when in fact they are enforcing the profession's *economic* protection policies."); see also Marous, *supra* note 167, at 161 (explaining that the AMA sought to "control the healthcare market" by limiting the practice of medicine to people with formal medical training).

<sup>173</sup> Hall, *supra* note 163, at 515; Huberfeld, *supra* note 161, at 255.

<sup>174</sup> *In re Am. Med. Ass'n*, 94 F.T.C. 701, 1017–18 (1979); Hall, *supra* note 163, at 515; Huberfeld, *supra* note 161, at 255. The FTC based its conclusion in part on concerns over the AMA's statements that, "[i]t is unprofessional for a physician to dispose of his services under conditions . . . which interfere with reasonable competition among physicians of a community." *Id.* at 246 n.5.

<sup>175</sup> Huberfeld, *supra* note 161, at 255; Hampton, *supra* note 159, at 500.

<sup>176</sup> Huberfeld, *supra* note 161, at 255–56; Hampton, *supra* note 159, at 501.

<sup>177</sup> Huberfeld, *supra* note 161, at 255.

<sup>178</sup> Hall, *supra* note 163, at 510–11; Huberfeld, *supra* note 161, at 255.

<sup>179</sup> Marous, *supra* note 167, at 168–69.

practice.<sup>180</sup> For instance, hospitals and non-profit clinics were allowed to employ medical professionals.<sup>181</sup>

Despite its apparent diminution, the doctrine still persists in many states, leading some observers to question the doctrine's role in the modern health care economy.<sup>182</sup> These critiques broadly advance the belief that the doctrine's originating concerns are out of step with current realities.

First, managed care in various forms is now an industry norm and has become even more important since the passage of the Affordable Care Act and the shift away from fee-for-service reimbursement.<sup>183</sup> Payment reforms involving risk-sharing and value-based payment necessitate the need for coordination and efficiency among managed care entities, many of which exist as corporations.<sup>184</sup>

Second, physicians undeniably are motivated in part by financial concerns.<sup>185</sup> The presence of managed care forces physicians to contemplate reimbursement rates as a crucial aspect of the practice of medicine.<sup>186</sup> Anti-abuse laws discussed above are further evidence that physicians are motivated by financial gain, as is the decreasing participation in Medicaid due to low reimbursement.<sup>187</sup>

The rise of consumer-directed health insurance—which pairs high deductible health plans with health savings accounts to encourage the consumer to price-shop for health services—has furthered the notion that

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<sup>180</sup> Hall, *supra* note 163, at 517–18; Marous, *supra* note 167, at 168.

<sup>181</sup> Marous, *supra* note 167, at 168.

<sup>182</sup> Hall, *supra* note 163, at 509–18; *See* Marous, *supra* note 167, at 158 (arguing “[t]he justification behind barring corporate influence from medical practice overlooks the realities of the current healthcare marketplace.”).

<sup>183</sup> Marous, *supra* note 167, at 174.

<sup>184</sup> Huberfeld, *supra* note 161, at 257; Marous, *supra* note 167, at 173–75. In the context of health care payments, risk-sharing refers to the agreements to share financial risk between the payer and providers for the cost and quality of care provided to the health plan's enrollees. Value-based payments are a form of reimbursement where the payer ties payment to the quality and efficiency of health care provided, rather than paying based on volume. *See* Jacqueline LaPointe, *Understanding the Value-Based Reimbursement Model Landscape*, REVCYCLE INTELLIGENCE (Sept. 9, 2016), <https://revcycleintelligence.com/features/understanding-the-value-based-reimbursement-model-landscape>.

<sup>185</sup> Hall, *supra* note 163, at 515; Huberfeld, *supra* note 161, at 259.

<sup>186</sup> Huberfeld, *supra* note 161, at 259.

<sup>187</sup> Huberfeld, *supra* note 161, at 259–65; Marous, *supra* note 167, at 175–77.

health care is an ordinary consumer product.<sup>188</sup> Furthermore, managed care has created a reality in which insurance-like entities exercise control over the delivery of care.<sup>189</sup>

Accordingly, although a few states still vigorously enforce the doctrine, others have made it easier for corporations to employ medical professionals.<sup>190</sup> In addition to the carved-out exceptions previously noted, such states allow some form of corporate control over medicine as long as the physician retains the ultimate control over the delivery of care.<sup>191</sup>

## 2. Applying the Corporate Practice Prohibition to Private Equity

Despite its near demise and unpopularity, the prohibition against the corporate practice of medicine persists in nearly every state in some form.<sup>192</sup> States vary in the degree to which they enforce the doctrine, ranging from a nearly *per se* ban to practical non-enforcement.<sup>193</sup> Nevertheless, because the corporate practice prohibition remains “on the books” in most states, the doctrine can be revived to address the commercialization concerns over PE’s increasing investment in and influence over physician practices, including through legislation and litigation.

### a) *The MSO Model and California SB-642*

Even in states that strongly enforce the corporate practice of medicine doctrine, PE firms have successfully circumvented the prohibition using investment models that grant them sufficient control even though not outright owning the medical practice.<sup>194</sup>

The most common model involves a management services organization (MSO) owned and controlled by a PE firm that enters into a contract with a physician-owned professional corporation to provide administrative and other services.<sup>195</sup> This model is popular with investors and health care providers because it alleviates the physicians’ burdens of running the

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<sup>188</sup> TIMOTHY STOLTZFUS JOST, HEALTH CARE AT RISK: A CRITIQUE OF THE CONSUMER-DRIVEN MOVEMENT 17-19 (2007).

<sup>189</sup> Marous, *supra* note 167, at 174–75.

<sup>190</sup> Stuart I. Silverman, *In an Era of Healthcare Delivery Reforms, the Corporate Practice of Medicine Is a Matter That Requires Vigilance*, 9 HEALTH L. & POL’Y BRIEF 1, 2 (2015).

<sup>191</sup> *Id.* at 8.

<sup>192</sup> See AHLA, CORPORATE PRACTICE OF MEDICINE: A 50 STATE SURVEY 169 (Andrew G. Jack et al. eds., 2d Ed. 2019).

<sup>193</sup> Marous, *supra* note 167, at 163–67.

<sup>194</sup> *Id.* at 170–71.

<sup>195</sup> *Id.*

business while granting financial and operational control over the medical practice to the investor.<sup>196</sup>

In exchange for a management fee, the MSO provides the administrative services while leaving the clinical decisions to the physicians.<sup>197</sup> The MSO's administrative services may include purchasing office space and equipment, billing and collections, and hiring of non-professional staff.<sup>198</sup> Even though the relationship between the MSO and medical practice is not employment, the MSO can use various mechanisms to maintain effective control over the business.<sup>199</sup> For example, as part of the deal, some physician-owners of the PC are required to sign stock restriction agreements preventing them from selling their interests or exercising certain rights in the PC without the approval of the MSO.<sup>200</sup> Physician-owners are also obligated to sign tight restrictive covenants and nondisclosure agreements.<sup>201</sup>

In California, a state with a historically strong corporate practice prohibition, the state legislature recently introduced a bill that takes aim at the MSO investment model.<sup>202</sup> Senate Bill (SB) 642 would require the physician owners of the practice to exercise ultimate control over the business aspects of the medical practice:

(a) The shareholders, directors, and officers of a medical corporation . . . shall manage and have ultimate control over the *assets and business operations of the medical corporation and shall not be replaced, removed, or otherwise controlled by any lay entity* or individual, including, without limitation, through stock transfer restriction agreements or other contractual agreements and arrangements.

(b) For purposes of this section, “ultimate control” shall mean and be consistent with the definition provided by generally accepted accounting principles.<sup>203</sup>

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<sup>196</sup> Carol Lucas, *Corporate Practice of Medicine on Steroids*, JD SUPRA (May 11, 2021), <https://www.jdsupra.com/legalnews/corporate-practice-of-medicine-on-9931045/>.

<sup>197</sup> *Id.*

<sup>198</sup> *Id.*

<sup>199</sup> Marous, *supra* note 167, at 171.

<sup>200</sup> *Id.*

<sup>201</sup> *Id.*

<sup>202</sup> S.B. 642, 2021–2022 Reg. Sess. (Cal. 2021).

<sup>203</sup> *Id.* (emphasis added).

If passed, SB 642 would have severely curtailed the ability of PE and other lay-investors to use the MSO model to avoid the corporate practice of medicine prohibition in California. Unlike other states that permit lay investment into medical practices as long as physicians control the clinical decision-making, SB 642 further requires medical professionals to have control over the business aspects of the practice.<sup>204</sup>

*b) Litigation Over PE Investment Models*

The “friendly PC” model is similar to the MSO model and allows PE firms to control of physician practices without running afoul of the corporate practice prohibition.<sup>205</sup> In this model, PE firms appoint a licensed physician as the owner of a medical professional corporation (the “PC”).<sup>206</sup> This “friendly” physician owner then hires other physicians and enters into contracts for the delivery of care.<sup>207</sup>

The friendly PC model is at issue in the California case, *AAEMPG v. Envision*, involving one of the largest PE firms in the health care marketplace, Kohlberg Kravis Roberts (KKR).<sup>208</sup> In 2017, KKR bought Envision Physician Services, one of the largest multispecialty physician groups in the country.<sup>209</sup> The plaintiff is a physician management company that lost a contract with another emergency medical group after a hospital granted an exclusive contract with an Envision-owned emergency group.<sup>210</sup> The plaintiff alleges that Envision, through a friendly PC, exercises an impermissible level of control over the delivery of care by its subsidiary in violation of California’s corporate practice prohibition.<sup>211</sup>

Specifically, the plaintiff alleges that the subsidiary is owned by a California-licensed physician who is either directly employed by Envision or is under its substantial control.<sup>212</sup> The physician-owner must sign a stock

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<sup>204</sup> *Id.*

<sup>205</sup> Marous, *supra* note 167, at 170–71.

<sup>206</sup> *Id.*

<sup>207</sup> Michael Gawley, *A Friendly Reminder: Friendly PC Arrangements Are Subject to Scrutiny*, JD SUPRA (June 20, 2022), <https://www.jdsupra.com/legalnews/a-friendly-reminder-friendly-pc-9552891/>; Don’t Forget the “PC” in the “Friendly PC” Model, NOSSAMAN LLP (Feb. 15, 2022), <https://www.thehealthlawticker.com/dont-forget-the-pc-in-the-friendly-pc-model>.

<sup>208</sup> Complaint at 5, *Am. Acad. of Emergency Med. Physician Grp., Inc. v. Envision Healthcare Corp.*, No. 3:22-CV-00421 (N.D. Cal. 2021).

<sup>209</sup> *Id.*

<sup>210</sup> *Id.* at 6–7.

<sup>211</sup> *Id.* at 5–7.

<sup>212</sup> *Id.* at 5.

transfer agreement that prevents them from having actual control over the company, including restrictions on the ability to issue dividends, create additional stock, or sell the medical group.<sup>213</sup> Moreover, KKR-backed Envision retained control over several key aspects of the practice: physician employment, compensation, work schedules, and staffing levels; negotiating contracts with payers; and setting quality and performance metrics.<sup>214</sup>

Although the case is still pending, the federal District Court rejected Envision's motion to send the case first to the state medical board.<sup>215</sup> Though unresolved at this time, the case may affect the ability of PE firms to exercise control over their health care investments in California.<sup>216</sup>

Texas is another state with a strong prohibition against the corporate practice of medicine where courts have addressed what constitutes "control" over the medical practice.<sup>217</sup> In short, Texas courts indicated that control over a medical practice is a fact-intensive inquiry, requiring close review of individual MSO agreements at issue.

In *Flynn Brothers, Inc. v. First Medical Associates*, two business partners contracted with an emergency physician through various corporate entities and management agreements.<sup>218</sup> Because the investors were not licensed physicians, the emergency physician formed a professional corporation that could contract with a hospital to provide emergency services.<sup>219</sup> The management agreement between the two parties gave lay investors the following rights: to prevent the physician from selling his interest in the practice, to receive two-thirds of the practice's net profit, toto

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<sup>213</sup> *Id.* at 7.

<sup>214</sup> *Id.* at 8–10.

<sup>215</sup> Am. Acad. of Emergency Med. Physician Grp., Inc. v. Envision Healthcare Corp., No.3:22-CV-00421(N.D. Cal. 2021); Order Denying Motion to Dismiss, Am. Acad. of Emergency Med. Physician Grp., Inc. v. Envision Healthcare Corp., No.3:22-CV-00421(N.D. Cal. 2021).

<sup>216</sup> See, e.g., Gawley, *supra* note 205 (describing the implications of the *AAEMPG v. Envision* case for the corporate practice of medicine); Dan Weissmann, *Private Equity Might Run Your Local Emergency Room. Meet the Doctors Suing to Kick Them Out*, AN ARM AND A LEG (June 16, 2022), <https://armandalegshow.com/episode/docs-are-trying-to-kick-private-equity-out/> (discussing the plaintiff's legal strategy using state corporate practice of medicine laws to challenge private equity investment in physician practices).

<sup>217</sup> *Flynn Bros., Inc. v. First Med. Assocs.*, 715 S.W.2d 782, 785 (Tex. App. 1986); *Xenon Health, L.L.C. v. Baig*, 662 Fed. Appx. 270, 274 (5th Cir. 2016).

<sup>218</sup> *Flynn Bros., Inc.*, 715 S.W.2d at 783.

<sup>219</sup> *Id.*

encumber the practice's assets to raise capital and other financing, to trade on the physician's medical license, and to decide which of the PC's medical staff would work at the hospital.<sup>220</sup>

The court invalidated the agreement under the Texas Medical Practice Act because it found that the physician was essentially under the employ of the unlicensed investors.<sup>221</sup> The court reasoned that the "contractual scheme was developed to do indirectly that which they freely concede they could not do directly under the Medical Practices Act."<sup>222</sup> Relevant to the PE context, the court disallowed using a physician's emergency practice as an investment vehicle for those who could not practice medicine independently. Additionally, there are comparisons between the pledging of the PC's assets noted in this case and the leveraged buyout model utilized by most PE acquisitions.

The Fifth Circuit further weighed in on what contractual terms would constitute the unlicensed practice of medicine in violation of the Texas Medical Practice Act in *Xenon Health, L.L.C. v. Baig*.<sup>223</sup> Although the entity that violated the law was a California professional corporation and not a lay-corporation, the reasoning of the case could apply as well to a PE-backed MSO not licensed to practice medicine in Texas. In *Xenon*, a joint venture agreement between the California PC and the Texas PC gave the California PC (owned by a physician not licensed in Texas) the exclusive authority over many aspects of the practice in Texas, including: hiring, credentialing, and scheduling physicians in the Texas clinic; ordering supplies and equipment; billing and collection; monitoring regulatory compliance; financial reporting and management; and implementing quality assurance programs.<sup>224</sup> Additionally, the Texas PC was prevented from "paying any dividends or distributions, incurring any debt, or selling company assets" without the consent of the California PC.<sup>225</sup> The court concluded that the agreement violated the Texas Medical Practice Act.<sup>226</sup>

Although *Flynn Brothers* and *Xenon* provide examples of impermissible control by unlicensed entities over medical practices through the use of management agreements, other case law in Texas found no violation where the management agreements carefully separated the business and clinical

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<sup>220</sup> *Id.* at 783–85.

<sup>221</sup> *Id.* at 785.

<sup>222</sup> *Id.*

<sup>223</sup> *Xenon Health*, 662 Fed. Appx. at 271.

<sup>224</sup> *Id.* at 273.

<sup>225</sup> *Id.*

<sup>226</sup> *Id.* at 274.



sides of the medical practice.<sup>227</sup> Thus, whether or not a corporate investor or management firm exerts impermissible levels of control over a medical practice is highly fact-specific—even in a state like Texas with a vigorous corporate practice prohibition.<sup>228</sup> The nature of the PE investment model, with active management by the PE-general partner, might put pressure on the control structure. Because investors want a high return in a short period of time, management agreements between private equity firms and medical practices might edge towards those found to be impermissible in the *Flynn Bros.* and *Xenon* cases.

### 3. State Fee-Splitting Laws

As a corollary to the corporate practice of medicine doctrine, many states have adopted laws prohibiting the splitting of professional fees between medical professionals and lay entities.<sup>229</sup> These laws aim to prevent unlicensed corporations from profiting from physician's professional income and grew out of the same AMA lobbying efforts that convinced state legislatures to limit the practice of medicine to physicians.<sup>230</sup> The policy concern was that fee-splitting arrangements could divide physicians' loyalty to their patients with pressure to generate profits for corporate investors.<sup>231</sup>

Like with the corporate practice prohibition, states vary in the degree to which they enforce fee-splitting laws.<sup>232</sup> Where enforced, fee-splitting laws are used most often to invalidate agreements to share a percentage of professional revenue with outside entities, such as management companies.<sup>233</sup> In New York, the state fee-splitting law has been applied to invalidate management service arrangements between medical practices

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<sup>227</sup> *Gupta v. Eastern Idaho Tumor Inst., Inc.*, 140 S.W.3d 747, 754 (Tex. App. 2004); *McCoy v. FemPartners, Inc.*, 484 S.W.3d 201, 210 (Tex. App. 2015).

<sup>228</sup> *See Gupta*, 140 S.W.3d at 754 (distinguishing the instant case from *Flynn Bros.* because the physician retained authority over personnel and billing decisions); *McCoy* 484 S.W.3d at 212 (holding that lay persons only controlled “nonmedical functions and services,” leaving recruitment and oversight of physicians in the hands of physicians).

<sup>229</sup> Huberfeld, *supra* note 161, at 261–62.

<sup>230</sup> *Id.* at 249.

<sup>231</sup> *See* AHLA, CORPORATE PRACTICE OF MEDICINE: A 50 STATE SURVEY 169 (Andrew G. Jack et al. eds., 2d Ed. 2019).

<sup>232</sup> Silverman, *supra* note 190, at 20–23.

<sup>233</sup> *Id.* at 22.

and lay entities, where the non-licensed entity shares a percentage of the revenues generated by professional services.<sup>234</sup>

Nevertheless, in some instances, state legislatures have watered down their fee-splitting laws.<sup>235</sup> For example, the Illinois Supreme Court earlier had applied the state fee-splitting law<sup>236</sup> to invalidate percentage-of-revenue agreements in the case, *Vine Street Clinic v. HealthLink, Inc.*<sup>237</sup> At issue were two financial arrangements between the defendant corporation and physician groups: (1) an administrative fee equal to 5% of revenue; and (2) a flat fee based on the volume of claims submitted by the physicians in the preceding calendar year.<sup>238</sup> The court invalidated the percentage of revenue arrangement as against public policy but upheld the flat fee arrangement because it was not “based or linked to the physician’s revenue.”<sup>239</sup>

Following the *Vine Street* decision, however, the Illinois legislature amended the fee-splitting law to allow certain types of arrangements—even those where an unlicensed entity receives a percentage of professional fees—if certain requirements are met.<sup>240</sup> The new exception permits medical providers to pay fair market value to an unlicensed entity to perform “billing, administrative preparation, or collection services based upon a percentage of professional fees billed or collected” provided that: (1) the medical practice controls the amount of fees charged or collected; and (2) all charges collected are deposited into an account controlled by the medical practice or a held in trust by a licensed collection agency.<sup>241</sup> This exception, although requiring the medical practice to retain control over the fees it generates, seems to create room for the type of financial arrangements leveraged by PE.

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<sup>234</sup> *Necula v. Conroy*, No. 96 CIV 8990, 2000 WL 877009, at \*1–3, 7, 11 (S.D.N.Y. June 30, 2000), *aff’d* *Necula v. Conroy*, 13 F. App’x 24 (2d Cir. 2001) (striking down the agreement between a radiologist and an MSO because the physician agreed to pay the MSO a fixed percentage of the receipts for billing services).

<sup>235</sup> Silverman, *supra* note 190, at 21.

<sup>236</sup> 225 ILL. COMP. STAT. 60/22.2 (2019) (emphasis added) (providing that “[a] licensee under this Act may not directly or indirectly divide, share or split any professional fee or other form of compensation for professional services with anyone in exchange for a referral or otherwise[]”).

<sup>237</sup> *Vine St. Clinic v. HealthLink, Inc.*, 856 N.E.2d 422, 439 (Ill. 2006).

<sup>238</sup> *Id.* at 426–27; *see also* Silverman, *supra* note 190, at 21.

<sup>239</sup> *Id.* at 435.

<sup>240</sup> 225 ILL. COMP. STAT. 60/22.2(d); *see* Silverman, *supra* note 190, at 21.

<sup>241</sup> 225 ILL. COMP. STAT. 60/22.2(d).

California's fee-splitting law contains a similar exception, which appears to give even more leeway for private investment.<sup>242</sup> That law provides that "[t]he payment or receipt of consideration for services other than the referral of patients that is based on a percentage of gross revenue or similar type of contractual arrangement shall not be unlawful if the consideration is commensurate with the value of the services furnished or with the fair rental value of any premises or equipment leased or provided by the recipient to the payer."<sup>243</sup>

California courts have applied this exception to uphold at least one financial arrangement between a physician and MSO where the court concluded the management services fee was commensurate with fair market value.<sup>244</sup> Although not explicitly pled under the California fee-splitting statute, the plaintiff in the pending *AAEMPG v. Envision* case seems to allege an illegal fee-splitting scheme because Envision earns amounts in excess of fair market value for the administrative services provided.<sup>245</sup>

Not all states have adopted exceptions to their fee-splitting laws.<sup>246</sup> New York's law remains relatively strong, and explicitly prohibits the type of arrangement that California and Illinois amended their laws to allow.<sup>247</sup> In many states, however, lay corporations wishing to invest in or operate physician practices can avoid state fee-splitting laws with a carefully structured agreement. In states with stronger fee-splitting laws, the aggressive nature of the PE model might make such agreements vulnerable. By exerting aggressive control over its investment in the medical practice, private equity might be more prone to impermissible behavior, such as setting the fees billed by physicians, controlling the practice's revenue, or providing services to the medical practice at non-market rates. If the practice was set up to avoid sharing revenues from federally-reimbursed services to avoid entanglements of the Stark Law,<sup>248</sup> it may still may violate

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<sup>242</sup> CAL. BUS. & PROF. CODE § 650(b) (West 2022).

<sup>243</sup> *Id.*

<sup>244</sup> *Epic Med. Mgmt., LLC v. Paquette*, 244 Cal. App. 4th 504, 516 (2015).

<sup>245</sup> Complaint at 9, *Am. Acad. of Emergency Med. Physician Grp., Inc. v. Envision Healthcare Corp.*, No. 3:22-CV-00421 (N.D. Cal. 2021).

<sup>246</sup> See AHLA, *CORPORATE PRACTICE OF MEDICINE: A 50 STATE SURVEY* 169 (Andrew G. Jack et al. eds., 2d Ed. 2019).

<sup>247</sup> N.Y. EDUC. LAW § 6530 (McKinney 2021) (prohibiting "any arrangement or agreement whereby the amount received in payment for furnishing space, facilities, equipment or personnel services used by a licensee constitutes a percentage of, or is otherwise dependent upon, the income or receipts of the licensee from such practice . . .").

<sup>248</sup> See text accompanying notes 142-145, *supra*.

state fee-splitting laws, which do not discriminate based on the source of the revenue by payer or type of service. If the evidence of PE control over its acquired practices rings true, state fee-splitting laws might remain a viable oversight mechanism.

#### *D. Physician Employment Laws*

State and federal laws regulating the use of non-compete, anti-disparagement, and non-disclosure clauses in employment agreements could offer stronger protection for physicians' clinical and professional autonomy from control by PE investors. After acquisition, physicians must sign employment agreements with the PE-backed practice, which typically include restrictive covenants not-to-compete (a.k.a., non-competes), under which the physician is not permitted to work within a defined geographic radius of the employer for a certain period of time, sometimes years, after employment.<sup>249</sup> Such provisions are common in employment agreements to protect the value of the investment by retaining the physician's expertise, labor, and patient base.<sup>250</sup> Some physician contracts with PE, however, go further to include non-disclosure and anti-disparagement clauses which may prevent physicians from expressing concerns about the practice's operation, including concerns over billing practices, patient safety, or staffing.<sup>251</sup>

Although non-competes are common for executive contracts, they are controversial for physicians.<sup>252</sup> Regulation of non-competes is traditionally the realm of state law, but the FTC has recently stepped in with a proposed rule to bar non-compete clauses in employment contracts across all sectors, including for physicians.<sup>253</sup> The proposed rule would make existing and future employee non-competes an unfair method of competition.<sup>254</sup> While some question the applicability of the rule to nonprofit hospitals over which

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<sup>249</sup> Derek W Loeser, *The Legal, Ethical, and Practical Implications of Noncompetition Clauses: What Physicians Should Know Before They Sign*, 31 J.L. MED. & ETHICS 283, 283 (2003).

<sup>250</sup> Fuse Brown et al., *supra* note 13, at 21.

<sup>251</sup> Heather Perlberg, *How Private Equity is Ruining American Healthcare*, BLOOMBERG (May 20, 2020, 5:09 PM), <https://www.bloomberg.com/news/features/2020-05-20/private-equity-is-ruining-health-care-covid-is-making-it-worse>.

<sup>252</sup> Fuse Brown et al., *supra* note 13, at 21; Erik B. Smith, *Ending Physician Noncompete Agreements—Time for a National Solution*, 2 JAMA HEALTH FORUM e214018 (2021). 13

<sup>253</sup> Federal Trade Comm'n, *Non-Compete Clause Rule*, 88 Fed. Reg. 3482 (Jan. 19, 2023).

<sup>254</sup> *Id.*

FTC has limited jurisdiction,<sup>255</sup> analysts predict that the the FTC's ban on noncompetes could cause a dramatic collapse of investment in physician practices if investors could not prevent the core value of the investment (the physicians) from walking away.<sup>256</sup>

States that limit physician non-compete clauses via state statute or case law do so based on policy concerns about the physician-patient relationship and the availability of medical services.<sup>257</sup> With increased market consolidation, geographical restrictions may be so broad as to force a physician to either relocate to another region upon termination or to cease practice for a period of years.<sup>258</sup> Such onerous restrictions may chill physicians' willingness to voice professionalism concerns or exit a situation they consider ethically questionable.

Most states limit, rather than ban, physician non-competes through judicial application of general public policy considerations and a reasonableness standard.<sup>259</sup> Some states extend to physicians more explicit statutory protection.<sup>260</sup> Covenants not to compete are unenforceable in New Hampshire if they restrict the right of the physician to practice in any geographic region within the state.<sup>261</sup> In Connecticut, non-competes may not restrict a physician's ability to practice more than fifteen miles from the primary site where the physician practices.<sup>262</sup> Additionally, restrictive covenants in Connecticut are unenforceable if the physician's agreement is

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<sup>255</sup> Samantha Liss, *Nonprofit Hospitals May Evade Noncompete Ban Enforcement, Experts Say*, HEALTHCARE DIVE (Jan. 20, 2023), <https://www.healthcaredive.com/news/noncompete-ban-apply-nonprofit-hospitals/640769/>.

<sup>256</sup> See, e.g., Frank Diamond, *How FTC's Noncompete Agreements Rule Could Impact Healthcare*, FIERCE HEALTHCARE (Jan. 6, 2023) <https://www.fiercehealthcare.com/payers/how-ftcs-noncompete-agreements-rule-might-affect-healthcare-industry>; Samantha Liss, *Doctors No Longer Bound By Noncompetes Under FTC's Proposed Ban*, HEALTHCARE DIVE (Jan. 11, 2023), <https://www.healthcaredive.com/news/physicians-no-longer-bound-by-noncompetes-ftc-ban/639920/>; *Hospitality Newsletter*, BLAKE MADDEN (Workweek, Austin, Tex.), Jan. 10, 2023 (predicting that if FTC ban on noncompetes is finalized, "Physician practice M&A would fall apart. Would PE-backed groups crumble? . . . Why provide capital for a business whose core asset could leave the next day?").

<sup>257</sup> Loeser, *supra* note 249, at 287.

<sup>258</sup> *Id.*

<sup>259</sup> *Id.*

<sup>260</sup> *Id.*

<sup>261</sup> N.H. REV. STAT. ANN. § 329:31-a (2016).

<sup>262</sup> CONN. GEN. STAT. § 20-14p(b)(2)(A)(ii) (2016).

terminated by the employer without cause.<sup>263</sup> Others states concerned about preserving physician autonomy under PE investment could consider adopting similar laws or making physician non-competes presumptively unenforceable rather than relying on courts to scrutinize the reasonableness of non-compete restrictions for physicians more closely than for other commercial contractors.

Imposing non-disclosure or anti-disparagement clauses (gag clauses) is another restrictive employment practice that inhibits physicians from confronting troubling aspects of the PE investment.<sup>264</sup> These gag clauses might, for instance, prevent physicians from speaking out publicly or to patients, about utilization practices, up-coding, reductions in staffing levels or supervision, or other concerns about quality of patient care.<sup>265</sup>

Similar professionalism concerns about the use of gag clauses in physician contracts arose in the managed care era in the 1990s, where managed care plans contractually barred physicians from discussing with patients the availability of medically necessary treatment options not covered by the health plan.<sup>266</sup> Other gag provisions prevented physicians from making remarks that would undermine confidence in the health plan.<sup>267</sup> While the plans contended the gag clauses protected proprietary information and enhanced market competition, critics worried they undermined patient safety, the ability of patients to exercise informed consent, and physicians' clinical judgment.<sup>268</sup>

Under pressure from the American Medical Association (AMA) and the public, many states passed laws regulating or restricting the use of gag clauses in physician-managed care plan contracts.<sup>269</sup> Most prohibit clauses that prevented physicians from discussing treatment options, although some

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<sup>263</sup> *Id.* § 20-14p(b)(2)(B)(ii).

<sup>264</sup> Scheffler et al., *supra* note 74, at 34–35; Perlberg, *supra* note 251; Morgenson, *supra* note 17.

<sup>265</sup> Perlberg, *supra* note 251.

<sup>266</sup> See generally Julia A. Martin & Lisa K. Bjerknes, *The Legal and Ethical Implications of Gag Clauses in Physician Contracts*, 22 AM. J.L. & MED. 433, 433 (1996); Joan H. Krause, *The Brief Life of the Gag Clause: Why Anti-Gag Clause Legislation Isn't Enough*, 67 TENN. L. REV. 1, 2–6, 10–13 (1999); Bethany J. Spielman, *After the Gag Episode: Physician Communication in Managed Care Organizations*, 22 SETON HALL LEGIS. J. 437, 441 (1998).

<sup>267</sup> Martin & Bjerknes, *supra* note 266, at 444.

<sup>268</sup> Spielman, *supra* note 266, at 445, 448; Martin & Bjerknes, *supra* note 266, at 449.

<sup>269</sup> Krause, *supra* note 266, at 3–4.

statutes more broadly protect physicians who publicly express concerns about the plan—akin to an anti-disparagement ban.<sup>270</sup>

Despite the popularity of anti-gag clause laws in the managed care era, retrospective assessments cast doubt on their effectiveness.<sup>271</sup> One problem was the lack of precision about what constitutes a gag clause, so it is unclear whether anti-disparagement or confidentiality agreements are covered by the gag clause bans.<sup>272</sup> Another problem is that gag clause prohibitions were a “paper tiger,” because they did not change managed care plans’ ability to terminate physicians without cause, the ultimate weapon to elicit physician compliance.<sup>273</sup>

Thus, if states today want to protect physicians’ clinical autonomy from control by investors, it is not enough to prohibit gag clauses. Such protections should be paired with legal protections for whistleblowers as an exception to the at-will employment doctrine.<sup>274</sup> In a state with such exception, an employee may not be terminated for exposing employer conduct that is against the public policy of the state.<sup>275</sup> Policymakers could explicitly define the types of non-competes, non-disclosure, and anti-disparagement clauses that are against public policy when applied to physicians by corporate-employers.<sup>276</sup> Expanding whistleblower protections to physicians constrained by termination clauses in their employment agreements may enable some to voice their concerns.<sup>277</sup>

Restricting the use of these various provisions in physician employment agreements can help preserve the professional autonomy of physicians to leave or speak out about revenue-generating practices that may pose

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<sup>270</sup> *Id.* at 20–24; Spielman, *supra* note 266, at 457. Washington, for a brief time, expressly protected physicians who criticized health plans. *Id.* But the provision was repealed in 2000. 2000 Wash. Sess. Laws, ch. 5, § 29.

<sup>271</sup> Krause, *supra* note 266, at 2.

<sup>272</sup> *Id.* at 10. *See also*, U.S. GOV’T ACCOUNTABILITY OFF., GAO/HEHS-97-175, EXPLICIT GAG CLAUSES NOT FOUND IN HMO CONTRACTS, BUT PHYSICIAN CONCERN REMAINS 5 (1997) (finding that there was “little consensus” about what provisions constituted gag clauses).

<sup>273</sup> Krause, *supra* note 266, at 13–15.

<sup>274</sup> Jennifer L. D’Isidori, *Stop Gagging Physicians!*, 7 HEALTH MATRIX 187, 210–11 (1997).

<sup>275</sup> *Id.* at 212–13.

<sup>276</sup> *Id.* at 213.

<sup>277</sup> *Id.* at 212–13. Some state whistleblower laws, however, cover only criminal acts or apply only to state employees. *Id.* at 218.

dangers to patient care.<sup>278</sup> Additionally, courts' willingness to award punitive damages when whistleblowers are wrongfully terminated for raising these concerns may embolden physicians who would otherwise be chilled by the threat of termination.<sup>279</sup> As in eras past, professional associations have published ethical guidelines to reiterate the primacy of the patient's best interests over financial profit, driven by corporate consolidation, physician employment, PE-ownership, and the shift to value-based care.<sup>280</sup> Though responding to contemporary commercialization in medicine, these professional and ethical guidelines reference decades-old state laws as potential tools to protect physicians and their patients: the corporate practice of medicine, fee-splitting, and employment regulation.<sup>281</sup> Together with timeworn federal antitrust and fraud and abuse laws, the legal tools to regulate the contemporary surge of PE investment in health care have been around for decades.

### III. TOWARD BETTER REGULATION OF PRIVATE EQUITY IN HEALTH CARE

The profit-seeking genie is out of the bottle, and while we may lament the corporate financialization of health care, there is no going back. Moreover, rosy tales of health care's historically charitable and mission-driven nature are exaggerated.<sup>282</sup> As long as there has been money to be

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<sup>278</sup> Scheffler et al., *supra* note 74, at 34–35; Perlberg, *supra* note 251; Morgenson, *supra* note 17.

<sup>279</sup> *Brovont v. KS-I Med. Servs.*, 622 S.W.3d 671, 694, 703 (Mo. Ct. App. 2020) (affirming lower court's decision to submit Dr. Brovant's wrongful-discharge claim to a jury and reinstating the jury's punitive damages award of \$10 million against each defendant).

<sup>280</sup> See, Ryan Crowley, Omar Atiq & David Hilden, *Financial Profit in Medicine: A Position Paper from the American College of Physicians*, 174 ANN. INTERNAL MED. 1447, 1460 (2021); Matthew DeCamp & Lois Synder Sulmansy, *Ethical and Professionalism Implications of Physician Employment and Health Care Business Practices: A Policy Paper from the American College of Physicians*, 174 ANN. INTERNAL MED. 844, 845 (2021); AM. MED. ASS'N, ISSUE BRIEF: CORPORATE INVESTORS 1–2 (2019), <https://www.ama-assn.org/system/files/2019-12/issue-brief-corporate-investors.pdf>.

<sup>281</sup> See DeCamp & Snyder Sulmansy, *supra* note 280, at 844.

<sup>282</sup> See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 21–29 (1982) (describing the history of U.S. health system as one dominated by the professional sovereignty of physicians, how that authority translated into economic power, and how physicians' professional sovereignty clashed with corporate and institutional interests of hospitals and payers in the latter half of the 20<sup>th</sup> century).



made in health care, there have been corporate-like incentives for profit maximization.<sup>283</sup>

PE investment in health care is just the latest manifestation of the long trend of increasing commercialization of medicine.<sup>284</sup> And so long as the U.S. treats health care as a market commodity, profit-seeking will persist. One response would be to fundamentally rebuild the health care system around the principle that health care is a human right rather than a market commodity.<sup>285</sup> Nevertheless, reasonable minds differ whether and what role

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<sup>283</sup> See, e.g., Arnold S. Relman, *The New Medical-Industrial Complex*, 303 NEW ENG. J. MED. 963, 963 (1980) (lamenting in 1980 the rise of the “medical-industrial complex, . . . a large and growing network of private corporations engaged in the business of supplying health-care services to patients for a profit — services heretofore provided by nonprofit institutions or individual practitioners.”); Bruce Steinwald & Duncan Neuhauser, *The Role of the Proprietary Hospital*, 35 L. & CONTEMP. PROBS. 817, 818-20 (1970) (describing the history of “proprietary” for-profit hospitals in the U.S., dating back to the late 19<sup>th</sup> century).

<sup>284</sup> See, STARR, *supra* note 282, at 428. In 1982, Starr wrote the following: Medical care in America now appears to be in the early stages of a major transformation in its institutional structure, comparable to the rise of professional sovereignty at the opening of the twentieth century. Corporations have begun to integrate a hitherto decentralized hospital system, enter into a variety of other health care businesses, and consolidate ownership and control in what may eventually become an industry dominated by huge health care conglomerates. *Id.* at 428; See also, John E. McDonough, *Termites in the House of Health Care*, MILBANK Q. OP. (Nov. 14, 2022), <https://www.milbank.org/quarterly/opinions/termites-in-the-house-of-health-care/> (writing in 2022 that private equity has “achieved growing prominence as a force in the American economy and the United States health care system” and continues the 45-year trend toward the financialization of the economy).

<sup>285</sup> Although a full survey of this debate is beyond the scope of this paper, one of the authors has written elsewhere about what such foundational reforms might look like. See, Erin C. Fuse Brown, Matthew B. Lawrence, Elizabeth Y. McCuskey, & Lindsay F. Wiley, *Social Solidarity in Health Care: American-Style*, 48 J. L. MED. ETHICS 411, 423 (2020) (“For next-step health reforms to move us toward greater social solidarity in health care, reformers must contend with four legal fixtures — federalism, pluralism, privatization, and individualism — that have stymied the ACA and previous reform efforts.”); Lindsay F. Wiley, Elizabeth Y. McCuskey, Matthew B. Lawrence, & Erin C. Fuse Brown, *Health Reform Reconstruction*, 55 U.C. DAVIS L. REV. 657, 661 (2021) (“We must reconstruct health reform, and ultimately the health system, using new principles and a new method. Incremental reforms . . . must be designed to be *intentionally confrontational*, with an eye toward their place in the broader project of upending or transcending the legal structures that undermine public health and propagate subordination and inequity.”)

private ordering, and thus private profit, should play in delivering health care within a universal care system.<sup>286</sup>

Meanwhile, the health care system is threatened by the incursion of PE *now*, and policymakers and enforcers need tools readily at hand. Thus, setting aside as currently unattainable those reforms that would turn health care from commodity to social good, the policy goal we propose to address the problems of PE in health care is more instrumental, incremental, and immediate. Rather than uprooting or barring PE investment in health care providers altogether, we seek legal interventions aimed at curbing the aspects of that investment that pose the most significant risks to patients, professionalism, and health care spending: the assertion of control by corporate profit-maximizing interests over clinical decision-making.

The specific harms can take the form of increased prices, diminished patient access from consolidation, overutilization and overbilling, diminished quality from inadequately supervised care or understaffed care, and constraints on physicians' autonomy and clinical decision-making from onerous employment practices.<sup>287</sup> Policy tools to curb the harms of corporate control of health care are as old as the health care system itself, offering a small glimmer of hope. For the most part, we already have in some form the legal tools needed to address some of the most worrisome risks to PE in health care—they just need to be sharpened to apply to this particular problem.

These policy levers exist at the federal and state levels, including antitrust laws, federal health care fraud and abuse laws, state corporate

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<sup>286</sup> See, MARTHA MINOW, PARTNERS, NOT RIVALS: PRIVATIZATION AND THE PUBLIC GOOD 140 (2002); Lindsay F. Wiley, *Privatized Public Health Insurance and the Goals of Progressive Health Reform*, 54 U.C. DAVIS L. REV. 2149, 2150 (2021) (discussing the pros and cons of private health insurance plans administering public health care programs, such as Medicare and Medicaid, and concluding that private administration can be compatible with solidarity principles of public health care programs); Jon D. Michaels, *Privatization's Pretenses*, 77 U. CHI. L. REV. 717, 717-18 (2010); David J. Meyers, Andrew M. Ryan, Amal N. Trivedi, *How Much of an "Advantage" Is Medicare Advantage?*, 328 JAMA 2112, 2112 (2022) (summarizing research on Medicare Advantage—the private insurance plans for Medicare beneficiaries—to conclude that the findings are mixed at best, with studies finding modest quality of care advantages but significant overpayments to Medicare Advantage compared with traditional Medicare). See also, Megan Brenan, *Majority in U.S. Still Say Gov't Should Ensure Healthcare*, GALLUP (Jan. 23, 2023), <https://news.gallup.com/poll/468401/majority-say-gov-ensure-healthcare.aspx> (finding in public opinion poll that 57% of U.S. adults say the government should ensure health care coverage for all, but 53% say that the health system should be based on private insurance).

<sup>287</sup> See *supra* Part I.C.

practice of medicine prohibitions, state fee-splitting laws, and state employment laws.<sup>288</sup> Legislative or regulatory actions may be needed to better target these existing laws. In some instances, however, new policies may be needed to target PE investors to make their operations more transparent and close the payment loopholes that PE investors have exploited for profit.<sup>289</sup> The main theme, however, is that policymakers are not writing on a blank slate, but rather can build upon a foundation of federal and state laws that have been dealing with different forms of the same problem for decades—the distortions created by economic motivation in the delivery of health care.

#### A. *Better Use of the Laws We Have*

##### 1. Sharpening Antitrust Enforcement Tools

Enforcement of federal antitrust laws can target harmful effects of PE-driven consolidation, and federal fraud and abuse enforcement can recoup ill-gotten revenues from PE-backed health care entities that engage in upcoding, overbilling, or inadequate supervision as a revenue strategy.

At the federal level, the Hart-Scott-Rodino Act's reporting threshold could be greatly reduced for health care acquisitions, allowing for pre-merger review of physician acquisitions, particularly with a view to the cumulative effect of subsequent add-ons.<sup>290</sup> These reforms could be part of overall legislation to strengthen antitrust authority and increase resources for economic study and enforcement, as advocated by antitrust experts and enforcement officials.<sup>291</sup>

This reduction of the Hart-Scott-Rodino threshold for health care transactions would allow more visibility, review, and oversight of all

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<sup>288</sup> See *supra* Part II.

<sup>289</sup> Fuse Brown et al., *supra* note 13, at 17-18. The line between new versus revised laws is not necessarily a bright one but we draw it nonetheless as one possible way to group public policy responses. *Id.*

<sup>290</sup> Martin Gaynor, *What to Do about Health-Care Markets? Policies to Make Health-Care Markets Work*, BROOKINGS, THE HAMILTON PROJECT 23 (Mar. 2020), [https://www.hamiltonproject.org/assets/files/Gaynor\\_PP\\_FINAL.pdf](https://www.hamiltonproject.org/assets/files/Gaynor_PP_FINAL.pdf).

<sup>291</sup> Jonathan B. Baker & Fiona Scott Morton, *Confronting Rising Market Power*, ECON. FOR INCLUSIVE PROSPERITY 4 (May 2019), <https://econfp.org/wp-content/uploads/2019/05/Confronting-Rising-Market-Power.pdf>; Gaynor, *supra* note 290, at 22-24; FED. TRADE COMM'N, REMARKS OF COMMISSIONER REBECCA KELLY SLAUGHTER, ANTITRUST AND HEALTH CARE PROVIDERS: POLICIES TO PROMOTE COMPETITION AND PROTECT PATIENTS 5 (May 14, 2019), <https://www.ftc.gov/public-statements/2019/05/remarks-commissioner-rebecca-kelly-slaughter-antitrust-health-care>.

smaller health care transactions (including facilities like hospices or behavioral health treatment centers), not just those pursued by PE firms.<sup>292</sup> To bolster the case for this change, the FTC and DOJ should follow through with their proposal to assess the market impact of accretive, add-on acquisitions cumulatively, instead of individually.<sup>293</sup> Further, the FTC could, under Section 6(b) of the Federal Trade Commission Act, use its subpoena authority to investigate certain markets to study health care transactions that fall below the federal reporting threshold, including PE investments.<sup>294</sup>

Even if federal antitrust authorities were to take all these steps, their resources are too limited to oversee all health care transactions, in all places, all the time.<sup>295</sup> Thus, federal antitrust enforcement should be augmented by state enforcement and oversight. State attorneys general have parallel antitrust authority, allowing them to also take steps to review and challenge physician practice acquisitions that fall below the federal reporting thresholds.<sup>296</sup> To further this second line of antitrust oversight, states could adopt legislation requiring acquiring entities, including PE firms, to notify the state attorney general of proposed transactions with dollar values less than the federal threshold.<sup>297</sup> For example, Washington, Connecticut, and Massachusetts require notification of certain physician practice transactions

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<sup>292</sup> Gaynor, *supra* note 290, at 23.

<sup>293</sup> Scheffler et al., *supra* note 74, at 54-55.

<sup>294</sup> FED. TRADE COMM’N, STATEMENT OF COMM’R ROHIT CHOPRA, REGARDING PRIVATE EQUITY ROLL-UPS AND THE HART-SCOTT RODINO ANNUAL REPORT TO CONGRESS 2 (July 8, 2020), [https://www.ftc.gov/system/files/documents/public\\_statements/1577783/p110014hsra\\_nualreportchoprastatement.pdf](https://www.ftc.gov/system/files/documents/public_statements/1577783/p110014hsra_nualreportchoprastatement.pdf); FED. TRADE COMM’N, STATEMENT OF COMM’R CHRISTINE S. WILSON, JOINED BY COMM’R ROHIT CHOPRA CONCERNING NON-REPORTABLE HART-SCOTT RODINO ACT FILING 6(B) ORDERS (Feb. 11, 2020), [https://www.ftc.gov/system/files/documents/public\\_statements/1566385/statement\\_by\\_commissioners\\_wilson\\_and\\_chopra\\_re\\_hsr\\_6b.pdf](https://www.ftc.gov/system/files/documents/public_statements/1566385/statement_by_commissioners_wilson_and_chopra_re_hsr_6b.pdf).

<sup>295</sup> *See, e.g.*, FED. TRADE COMM’N, REMARKS OF FEDERAL TRADE COMM’N CHAIR LINA M. KHAN, REGARDING THE PROPOSED RESCISSION OF THE 1995 POLICY STATEMENT CONCERNING PRIOR APPROVAL AND PRIOR NOTICE PROVISIONS 1–3 (July 21, 2021), <https://www.ftc.gov/legal-library/browse/cases-proceedings/public-statements/remarks-chair-lina-m-khan-regarding-proposed-rescission-1995-policy-statement-concerning-prior> (noting the scarcity of agency resources for merger review as justification for reviving prior approval and notice requirements for future transactions by parties to consent agreements).

<sup>296</sup> Fuse Brown et al., *supra* note 13, at 20.

<sup>297</sup> Jaime S. King, Samuel M. Chang, Alexandra D. Montague, Katherine L. Gudiksen, Amy Y. Gu, Daniel Arnold & Thomas L. Greaney, *Preventing Anticompetitive Healthcare Consolidation: Lessons from Five States*, THE SOURCE ON HEALTHCARE PRICE & COMPETITION 9 (June 2020), [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=3627865](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3627865).

below the Hart-Scott-Rodino threshold, and Oregon requires prior notification, market impact analysis, and approval by the state.<sup>298</sup> A 2002 California law requires prior notice of all material transactions involving health care entities—including physician practices with 25 or more physicians—to the state’s Office of Health Care Affordability (OHCA), which is authorized to conduct a market-impact review.<sup>299</sup> Although the OHCA does not have the authority to stop a transaction or attach conditions of approval, it may refer any worrisome transaction to the state attorney general for further action under the AG’s antitrust authority.<sup>300</sup> More than the federal government, several states have signaled they are willing to provide antitrust and market-impact review of physician practice acquisitions by PE investors, and more states should follow suit.<sup>301</sup>

## 2. Sharpening the Corporate Practice of Medicine Prohibition

Although seemingly antiquated, the corporate practice of medicine doctrine remains a viable tool to regulate the recent incursion of PE into the health care marketplace. Every state maintains a medical practice act that controls, to varying degrees, the ability of corporate entities to participate in the health care system.<sup>302</sup> Some states have amended their laws in an attempt to modernize the health care economy and the delivery of care, while others remain vigilant in protecting the medical profession from corporate interests.<sup>303</sup> The task for legislatures, regulators, and private litigants is understanding the landscape of their state’s corporate prohibition and using the tools at their disposal in order to protect the health care

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<sup>298</sup> WASH. REV. CODE § 19.390.030 (2019); CONN. GEN. STAT. § 19a-486i (2018); MASS. GEN. LAWS ch. 6D, §13 (2013); H.B. 2362, 81st Leg. Assemb., Reg. Sess. (Or. 2021) (requiring pre-transaction notice, review, and approval by the Oregon Health Authority for all transactions involving health care entities including physicians, where one party had average revenue of \$25 million or more and the other party had average revenue of \$10 million or more in the preceding three fiscal years).

<sup>299</sup> S.B. 184, 2021-2022 Reg. Sess. (Cal. 2022) (codified at CAL. HEALTH & SAFETY CODE § 127507 (West 2022) (requiring prior notice of transactions by health care entities that sell, transfer, dispose of, or transfer control of a “material amount of its assets” on after April 1, 2024).

<sup>300</sup> Cal. S.B. 184.

<sup>301</sup> Alexandra D. Montague, Katherine L. Gudiksen & Jaime S. King, *State Action to Oversee Consolidation of Health Care Providers*, Milbank Mem’l Fund 10–11 (Aug. 5, 2021), [https://www.milbank.org/wp-content/uploads/2021/08/State-Action-to-Oversee-Consolidation\\_ib\\_V3.pdf](https://www.milbank.org/wp-content/uploads/2021/08/State-Action-to-Oversee-Consolidation_ib_V3.pdf).

<sup>302</sup> Hall, *supra* note 163, at 460.

<sup>303</sup> See Marous, *supra* note 167, at 160 (noting that, although Illinois provides no express exemption from the prohibition on the corporate practice of medicine, Virginia is “more permissive”).

profession from dangerous levels of corporate control without squelching desirable innovations or entrenching obstructive turf guarding.

Legislatures can amend their medical practice acts to narrow or close the loopholes currently exploited by PE to circumvent the corporate practice prohibition. Under SB-642, for example, the California legislature is attempting to prevent the continued abuse of the MSO model currently used by many PE health care ventures.<sup>304</sup> By requiring the medical practice to maintain the reality rather than just the appearance of control over the practice's business operations, the MSO model will be a less attractive private equity investment.<sup>305</sup>

However, legislatures might also have to strike a delicate balance between protecting the integrity of the health care industry and embracing innovation. The legislation proposed in California would permit health care providers to share a portion of their professional fees with management organizations, presumably to promote economic efficiencies and scale.<sup>306</sup> The proposal strikes this balance because licensed physicians would continue to control the business operations while still being permitted to contract with lay entities to increase operational efficiencies.<sup>307</sup> Furthermore, the bill achieves this balance while making the medical practice less attractive for PE, which would like the maximal amount of control in order to quickly sell the practice for a profit.

For many health care regulators, necessary measures may be as straightforward as enforcing the laws on the books. New York, for example, maintains a strong prohibition against professional fee-splitting.<sup>308</sup> Other states, such as California and Illinois, prohibit fee-splitting but have carved out statutory exceptions that allow for PE to maneuver.<sup>309</sup> Nevertheless, the nature of the PE investment and ownership possibly renders the corporate structure unlawful. Illinois' fee-splitting law, for instance, allows health care providers to share their professional fees so long as the medical practice controls the amount of fees charged or collected.<sup>310</sup> Due to the control PE exerts over a practice's business operations, it would not be surprising or uncommon for the firm to have control over the fees charged by the physicians. In many states, therefore, health care regulators need to look no

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<sup>304</sup> S.B. 642.

<sup>305</sup> *Id.*

<sup>306</sup> CAL. BUS. & PROF. CODE § 650(b).

<sup>307</sup> S.B. 642(2).

<sup>308</sup> N.Y. EDUC. LAW § 6530 (McKinney 2021).

<sup>309</sup> 225 ILL. COMP. STAT. 60/22.2(d); CAL. BUS. & PROF. CODE § 650(b).

<sup>310</sup> 225 ILL. COMP. STAT. 60/22.2(d).

further than the business arrangement between the medical practice and the PE investor to provide effective oversight.

Finally, private litigants promoting their own interests can use existing laws in ways that creatively challenge corporate control over the medical practice. In *AAEMPG v. Envision*, a management services organization is suing PE-backed physician staffing firm, Envision, under California's existing medical practice act.<sup>311</sup> Although the plaintiff is promoting its pecuniary interest, other organizations see this litigation as a way to combat PE directly in the courts.<sup>312</sup> Take Medicine Back, a nonprofit organization seeking to "reclaim the professional integrity of the field of emergency medicine," has stated that "[e]nforcing, strengthening, and litigating existing state prohibitions on the corporate practice of medicine should become a priority."<sup>313</sup> In July 2022, Take Medicine Back sent a letter to Joshua Stein, North Carolina Attorney General and president-elect of the National Association of Attorneys General, urging him to use his leadership position to help "launch a multi-state investigation into the widespread lack of enforcement of [corporate practice of medicine] laws in the United States."<sup>314</sup> During the course of litigation in the *Envision* case, parties will inevitably come up against complex corporate agreements that seek to disguise the level of control private equity exerts over medical practice. When de facto control is obscured on paper due to sophisticated contracting, litigants may turn to other sources of law, such as federal fraud and abuse laws, to demonstrate the level of knowledge and influence PE has regarding the medical practice.<sup>315</sup>

### B. Where We Need New Laws

Beyond simply sharpening the legal tools we have, in some cases, we need new laws, administrative rules, or significant statutory amendments to

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<sup>311</sup> Complaint at 4, *Am. Acad. of Emergency Med. Physician Grp., Inc. v. Envision Healthcare Corp.*, No. 3:22-CV-00421 (N.D. Cal. 2021).

<sup>312</sup> Mitchell Louis Judge Li, Robert McNamara & Meghan Galer, *The Reclamation of Emergency Medicine: "Take EM Back" White Paper*, TAKE MED. BACK 5, 7 (July 12, 2021), <https://site-kvrhx5vp.websitcdn.com/uploads/8E214CC5FF845307.pdf?v=221110022429>.

<sup>313</sup> *Id.* at 5.

<sup>314</sup> Letter from Mitchell Li, Founder, Take Med. Back, to Joshua Stein, Att'y Gen., N.C. Dep't of Just. (July 15, 2022), <https://site-kvrhx5vp.websitcdn.com/uploads/4aace09c76a44f3e9a51ef6e13b35b7e.pdf?v=223011124335>.

<sup>315</sup> See *supra* Part II.B.

address the harms of PE investment in health care. These new laws fall into three categories: closing Medicare payment loopholes being exploited by PE and others; increasing transparency of PE ownership; and altering the tax treatment of PE investors. The first category is specific to health care but not PE, while the latter two are the opposite—specific to PE but not to health care.

### 1. Closing Payment Loopholes

PE has targeted physician practices to take advantage of two revenue opportunities in Medicare payment policy: Medicare Part B payment for physician-administered drugs and Medicare Advantage risk-based payment policy.<sup>316</sup>

The Medicare Part B drug payment loophole is part of the investment strategy targeting procedural specialties, such as dermatology, ophthalmology, and gastroenterology, offering wraparound services that generate additional revenue beyond the office visit.<sup>317</sup> One such wraparound service is physician-administered drugs that are delivered in the office, which Medicare reimburses under Medicare Part B (for physician services) rather than Medicare Part D (the prescription drug benefit).<sup>318</sup> Physicians purchase Part B drugs and biologics and then bill the payer under a “buy and bill” system, which pays physicians more to administer more expensive drugs.<sup>319</sup> Medicare Part B’s drug payment rules pay physicians an add-on payment calculated as 6% of the drug’s average sales price, creating a perverse incentive to prescribe more expensive drugs, even if cheaper alternatives are available.<sup>320</sup> For example, Medicare Part B’s payment incentives are at work in ophthalmologists’ selection of drugs to treat wet macular degeneration, where physicians continue to administer a drug that is forty times more expensive, despite the availability of an equally

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<sup>316</sup> Fuse Brown et al., *supra* note 13, at 2.

<sup>317</sup> *Id.* at 13-14.

<sup>318</sup> Kavita K. Patel & Caitlin Brandt, *A Controversial New Demonstration in Medicare: Potential Implications for Physician-Administered Drugs*, HEALTH AFFS. FOREFRONT (May 3, 2016), <https://www.healthaffairs.org/doi/10.1377/forefront.20160503.054677/full/>.

<sup>319</sup> Paul B. Ginsburg & Steven M. Lieberman, *Medicare Payment for Physician-Administered (Part B) Drugs: The Interim Final Rule and a Better Way Forward*, USC-BROOKINGS SCHAEFFER ON HEALTH POL’Y (Feb. 10, 2021), <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/02/10/medicare-payment-for-physician-administered-part-b-drugs/>.

<sup>320</sup> See Patel & Brandt, *supra* note 318; Ginsburg & Lieberman, *supra* note 319 (describing how Medicare statutes pay physician practices 106% of the average sales price).



effective and cheaper alternative.<sup>321</sup> Investors have targeted certain physician specialties like oncology or ophthalmology that profit from the Part B payment incentive.<sup>322</sup>

One way to narrow the Medicare Part B drug payment loophole would be to alter the calculation for the add-on payment for Part B drugs, switching from 6% of the average sales price to a flat payment, grouped by therapeutic class and diagnosis.<sup>323</sup> A flat add-on payment change would flip the incentives for physicians to prescribe the cheaper alternative, but it would require a change in the Medicare statute.<sup>324</sup> Commentators and MedPAC recommend this and other adjustments to Medicare Part B payment policy to address lack of competition and price discipline for biosimilars and new, high-cost specialty drugs.<sup>325</sup> Though the intricacies of Medicare drug payment policy is beyond the scope of this article, the larger point is that because PE is adept at finding and exploiting payment loopholes for profit, an appropriate policy response is to close the payment loophole—but doing so is not always easy.

The second payment loophole stems from the way Medicare pays Medicare Advantage plans (private Medicare managed care plans) that creates incentives to inflate beneficiaries' risk scores through aggressive coding of diagnoses to draw higher payments.<sup>326</sup> Aggressive coding (or risk score gaming) can make Medicare Advantage enrollees appear sicker than

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<sup>321</sup> News Release, Nat'l Insts. of Health, Avastin as Effective as Eylea for Treating Central Retinal Vein Occlusion (May 9, 2017), <https://www.nih.gov/news-events/news-releases/avastin-effective-eylea-treating-central-retinal-vein-occlusion>; DEP'T OF HEALTH & HUM. SERVS., OFF. OF INSPECTOR GEN., MEDICARE PAYMENTS FOR DRUGS USED TO TREAT WET AGE-RELATED MACULAR DEGENERATION 1–4 13(Apr. 2012), <https://oig.hhs.gov/oei/reports/oei-03-10-00360.pdf>.

<sup>322</sup> Jeah Jung, Roger J. Feldman & Yamini Kalidindi, *The Impact of Integration Outpatient Chemotherapy Use and Spending in Medicare*, 28 Health Econ. 517, 517–19 (2019).

<sup>323</sup> BIPARTISAN POLICY CENTER, TRANSITIONING FROM VOLUME TO VALUE: ACCELERATING THE SHIFT TO ALTERNATIVE PAYMENT MODELS 19 (July 2015), <https://bipartisanpolicy.org/wp-content/uploads/2019/03/BPC-Health-Alternative-Payment-Models.pdf> (recommending flat add-on payments and better methods of calculating average sales prices for Medicare Part B drugs).

<sup>324</sup> Ginsburg & Lieberman, *supra* note 319.

<sup>325</sup> *Id.*; MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE AND THE HEALTH CARE DELIVERY SYSTEM 83–84 (June 2022), <https://www.medpac.gov/document/june-2022-report-to-the-congress-medicare-and-the-health-care-delivery-system/>.

<sup>326</sup> Fuse Brown et al., *supra* note 13, at 6.

comparable enrollees in traditional Medicare.<sup>327</sup> Primary care groups using this strategy can then share in the ensuing profits with Medicare Advantage health plans.<sup>328</sup> This payment loophole is drawing private equity and other corporate investors to purchase primary care practices that serve Medicare Advantage enrollees, even seeking to vertically integrate the primary care practices with Medicare Advantage plans to align incentives to intensively code, or even exaggerate, patients' diagnoses to draw higher payments.<sup>329</sup> MedPAC estimated that in 2019, Medicare Advantage plans' coding practices resulted in payments to MA plans that were 3% higher than Medicare FFS would have paid for the same beneficiaries, resulting in \$9 billion in overpayments to MA plans.<sup>330</sup>

Despite the "loophole" terminology, risk-code gaming is a massively lucrative (or costly) phenomenon.<sup>331</sup> Medicare Advantage accounts for nearly half of total Medicare spending.<sup>332</sup> Some estimate that the current payment policy and coding intensity will cause Medicare to overpay Medicare Advantage plans by \$600 billion over the 2023-2031 period.<sup>333</sup>

CMS could take certain actions under its existing regulatory and enforcement authority to curb risk-score gaming, including increasing the statutorily authorized "coding intensity adjuster"<sup>334</sup> to account for the risk-score gaming by Medicare Advantage plans that are driving historic profits for Medicare Advantage plans and the PE land-grab for primary care practices; increasing efforts to recoup overpayments from unsupported

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<sup>327</sup> JP Sharp, Leslie McKinney, Scott Heiser & Rahul Rajkumar, *Realizing the Vision of Advanced Primary Care: Confronting Financial Barriers to Expanding the Model Nationwide*, HEALTH AFFS. FOREFRONT (Mar. 30, 2020), <https://www.healthaffairs.org/doi/10.1377/forefront.20200325.524312/full/>.

<sup>328</sup> *Id.*

<sup>329</sup> Michael Geruso & Timothy Layton, *Upcoding: Evidence from Medicare on Squishy Risk Adjustment*, 128 J. POL. ECON. 984, 1021–24 (2020).

<sup>330</sup> MEDICARE PAYMENT ADVISORY COMM'N, MARCH 2021 REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 365, 381 (2021), <https://www.medpac.gov/document/march-2021-report-to-the-congress-medicare-payment-policy/>.

<sup>331</sup> Richard Kronick & F. Michael Chua, Industry-Wide and Sponsor-Specific Estimates of Medicare Advantage Coding Intensity, SSRN (Nov. 11, 2021), [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=3959446](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3959446) (click "Download This Paper").

<sup>332</sup> Jeannie Fuglesten Biniek & Tricia Neuman, *The Growth in Share of Medicare Advantage Spending*, KAISER FAM. FOUND. (Apr. 7, 2022), <https://www.kff.org/medicare/slide/the-growth-in-share-of-medicare-advantage-spending/>.

<sup>333</sup> Kronick & Chua, *supra* note 331.

<sup>334</sup> 42 U.S.C. § 1395w-23(a)(1)(C)(ii)(III).

coding practices through increased audit and enforcement of the Overpayment Rule. Using its regulatory authority, CMS could increase recoupment of overpayment by expanding the scope of its RADV audits, through greater enforcement of the Overpayment Rule, and by modifying the risk adjustment formula to reduce the impact of risk upcoding.<sup>335</sup>

Like with the recent legislation to address surprise billing, closing these payment loopholes could curb PE's appetite for physician practice acquisition by removing some of the low-hanging profit opportunities that provide minimal value to patients.

## 2. Transparency in Ownership

In a forthcoming article, political scientists Colleen Grogan and Miriam Laugesen make a powerful case that the lack of transparency in ownership and financial structures makes it much more difficult for policymakers, regulators, and payers and purchasers to understand the effects of PE investment in health services.<sup>336</sup> Unlike publicly traded firms, PE funds are not required to register or make disclosures to the Securities and Exchange Commission (SEC). Publicly available sources of ownership information for health care providers often fail to disclose the identity of the parent organization and obscure ownership hierarchies or interrelated entities.<sup>337</sup> Accordingly, short of directly regulating PE investment in physician practices, enhanced transparency could enable better monitoring of any effects on quality, price, utilization, and patient experience. Two existing online databases that CMS administers—Open Payments (for pharmaceutical and device manufacturers payments to physicians) and Medicare Care Compare (formerly “Physician Compare,” which reports physicians’ and clinics’ “star ratings”)—could be adapted to include practice ownership status.<sup>338</sup> Also, federal or state lawmakers could look to

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<sup>335</sup> Erin C. Fuse Brown, Andrew M. Ryan, Roslyn Murray & Travis Williams, Comment Letter on Ways to Strengthen Medicare Advantage (CMS-4203-NC) (Aug. 30, 2022), <https://www.regulations.gov/comment/CMS-2022-0123-2905>; Erin C. Fuse Brown, Travis Williams, Roslyn Murray, David Meyers, & Andrew M. Ryan, *Legislative and Regulatory Options to Improve Medicare Advantage*, at \*16-21 (draft on file with authors).

<sup>336</sup> Grogan and Laugesen, *supra* note 29, at \*7.

<sup>337</sup> MEDICARE PAYMENT ADVISORY COMM’N, JUNE 2021 REPORT TO THE CONGRESS: MEDICARE AND THE HEALTH CARE DELIVERY SYSTEM, 72, 81–82 (June 2021), [http://www.medpac.gov/docs/default-source/default-document-library/jun21\\_medpac\\_report\\_to\\_congress\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/default-document-library/jun21_medpac_report_to_congress_sec.pdf?sfvrsn=0).

<sup>338</sup> *Open Payments*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/openpayments> (last visited Dec. 6, 2022); *Find & Compare*

other aspects of corporate and business law that require advance disclosure of anticipated transactions in order to provide opportunity to vet their fairness or social impacts.<sup>339</sup>

Finally, going beyond the anti-gag clause legislation that gives physicians freedom to discuss their concerns, lawmakers could consider requiring active disclosure to patients of key aspects of practice ownership or management. Such a move would parallel the pattern that arose in response to controversy over managed care incentives. In that era, the prohibition of gag clauses was soon followed by state enactments that required providers or insurers to inform patients about physician incentives and payment arrangements.<sup>340</sup> These measures were meant to help patients understand possible motivations behind treatment (or non-treatment) recommendations in order for patients to make more informed decisions.<sup>341</sup> Similar enhancement of transparency regarding PE ownership or management could have similar advantages.

### 3. Tax Treatment of Private Equity

The profitability of PE investment is enhanced by the tax advantages it enjoys. As compensation for its management services, PE fund managers typically receive a management fee calculated as 2% of assets under management plus 20% of the profits generated by a fund.<sup>342</sup> The 2% fee is subject to ordinary income and self-employment taxes, while the 20% return on the investment profits (known as “carried interest”) taxed at preferential capital gains rates and is not subject to self-employment taxes for Social Security and Medicare.<sup>343</sup>

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*Providers Near You.*, CTRS. FOR MEDICARE & MEDICAID SERVS., (last visited Dec. 6, 2022); *see also*, Fuse Brown et al., *supra* note 13, at 25 (developing this recommendation).

<sup>339</sup> Possible analogues include advance notice of plant closings, 29 U.S.C. § 2100 et. seq., or disclosures in advance of takeover bids, 15 U.S.C. § 78n(d). Cf. Lucian A. Bebchuk & Roberto Tallarita, *The Illusory Promise of Stakeholder Governance*, 106 CORNELL L. REV. 91, 133–37 (2020) (expressing skepticism that corporate leaders will, even if prompted, seriously consider factors other than shareholder value).

<sup>340</sup> Krause, *supra* note 266, at 34–38.

<sup>341</sup> *Id.* at 37.

<sup>342</sup> *Briefing Book*, TAX POL’Y CTR. (May 2020), <https://www.taxpolicycenter.org/briefing-book/what-carried-interest-and-how-it-taxed>; Victor Fleisher, *Two and Twenty: Taxing Partnership Profits in Private Equity Funds*, 83 N.Y.U. L. Rev. 1, 3–4 (2008).

<sup>343</sup> The PE fund managers’ 20% share of profits are subject to the 20% long-term capital gains rate, rather than the ordinary income tax rate of 37% for top-earners. *See* Greg Iancurci, *What Carried Interest Is, and How It Benefits High-Income Taxpayers*,

Though the PE managers' 20% share of the fund's profits can be viewed as compensation for the management of the investment, the tax code does not tax these returns as ordinary income. Many argue this loophole gives an unfair tax advantage to wealthy private equity fund managers compared to other capital investors (such as investment bankers) or regular employees and other service providers that pay higher ordinary income tax rates on their compensation.<sup>344</sup>

Several bills and tax proposals have proposed to close or narrow the carried interest loophole.<sup>345</sup> An earlier version of the Inflation Reduction Act passed in 2022 would have required private equity fund managers to hold their assets for five years (instead of three) to qualify for the preferred 20% long-term capital gains rate, while holdings for less than five years would be taxed at a 37% rate.<sup>346</sup> Nevertheless, Senator Krysten Sinema (I-AZ) insisted on removing the tax reform for PE as a condition of her support

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CNBC (Aug. 8, 2022 3:09 PM), <https://www.cnn.com/2022/08/08/what-carried-interest-is-and-how-it-benefits-high-income-taxpayers.html> (describing how carried interest for private equity managing partners is taxed); Internal Revenue Service, *Self-Employment Tax (Social Security and Medicare Taxes)*, <https://www.irs.gov/businesses/small-businesses-self-employed/self-employment-tax-social-security-and-medicare-taxes> (last updated Aug. 25, 2022) (describing self-employment tax rates); Congressional Budget Office, *Tax Carried Interest as Ordinary Income* (Dec. 13, 2018), <https://www.cbo.gov/budget-options/54795> (describing how carried interest is currently taxed and estimating that taxing it as ordinary income would generate \$14 billion in additional revenues from 2019-2028).

<sup>344</sup> See Tax Pol'y Ctr., *supra* note 343; AMS. FOR FIN. REFORM, FACT SHEET: CLOSE THE CARRIED INTEREST LOOPHOLE THAT IS A TAX DODGE FOR SUPER-RICH PRIVATE EQUITY EXECUTIVES 1-4 (Oct. 2021), <https://ourfinancialsecurity.org/2021/10/close-the-carried-interest-loophole-that-is-a-tax-dodge-for-super-rich-private-equity-executives/>.

<sup>345</sup> See, e.g. Press Release, FACT SHEET: The American Families Plan (Apr. 28, 2021), <https://www.whitehouse.gov/briefing-room/statements-releases/2021/04/28/fact-sheet-the-american-families-plan/> (proposing "to close the carried interest loophole so that hedge fund partners will pay ordinary income rates on their income just like every other worker"); Carried Interest Fairness Act of 2021, H.R. 1068, 117th Cong. (2021) (proposing to tax carried interest compensation to private equity or hedge fund partners as ordinary income tax rates, not capital gains).

<sup>346</sup> Inflation Reduction Act of 2022, H.R. 5376, 117<sup>th</sup> Cong. (2022) (enacted without carried interest tax provision as Pub. L. No. 117-169, 136 Stat. 1818 (2022)); see also Alan Rappeport & Emily Flitter, *Carried Interest is Back in the Headlines. Why It's Not Going Away*, N.Y. TIMES (Aug. 5, 2022), <https://www.nytimes.com/2022/08/05/business/economy/carried-interest-krysten-sinema.html>; Erik Wasson, *Democrats Drop Carried Interest as Sinema Paves Way for Tax Vote*, BLOOMBERG NEWS (Aug. 5, 2022, 7:26 AM), <https://news.bloombergtax.com/daily-tax-report/sinema-backs-tax-climate-bill-as-carried-interest-dropped>.

for the Inflation Reduction Act, so this tax advantage for PE continues.<sup>347</sup> These tax reform proposals would apply to PE broadly, not just their health care investments, and they seek to level the tax treatment of PE's earnings with other types of capital investors, managers, or service providers.

Though it faces much stronger political headwinds than closing the carried interest loophole, an alternative tax reform to achieve similar ends would entail equalizing tax rates on capital gains and ordinary income.<sup>348</sup> Physician-owners can reap tax advantages when they sell their practice to a buyer for a high acquisition price in exchange for employment contracts for lower salaries for a period of years.<sup>349</sup> This deal structure permits physicians selling the practice to convert some of their employment income (taxed at ordinary income rates and subject to payroll taxes) into long-term capital gains (taxed at lower rates).<sup>350</sup> Equalizing ordinary income and capital gains tax rates would eliminate the loophole enabling this sort of tax arbitrage, whether pursued by PE or other sources of capital.

Tax reforms such as closing the carried interest loophole or equalizing ordinary income and capital gains rates would dampen the tax distortions favoring capital over labor and corporate profit over professional independence. These tax reforms might cool PE investors' voracious appetite for health care targets, but it would not eliminate it.

### *C. Past, Present, and Future of Corporatization and Financialization of Health Care*

In years past, we have questioned the continuing vitality and need for certain laws as the health care delivery system has changed—particularly the advent of managed care in the 1980s and 1990s.<sup>351</sup> For example, the corporate practice of medicine doctrine has been declared dormant, if not moribund, state fee-splitting and physician employment laws have largely gathered dust, and even federal fraud and abuse laws have been critiqued

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<sup>347</sup> Andrew Ross Sorkin, Vivian Giang, Stephen Gandel, Lauren Hirsch, Ephrat Livni & David F. Gallagher, *A Tax Loophole's Powerful Defender*, N.Y. TIMES: DEALBOOK (Aug. 5, 2022), <https://www.nytimes.com/2022/08/05/business/dealbook/sinema-tax-loophole-carried-interest.html>.

<sup>348</sup> See, e.g., Press Release, FACT SHEET: The American Families Plan, *supra* note 345 (proposing to equalize ordinary income and capital gains tax rates). Note that if the carried interest loophole persisted, the returns on investment would still be exempt from self-employment taxes. *Id.*

<sup>349</sup> FUSE BROWN ET AL., *supra* note 13, at 26.

<sup>350</sup> Barry F. Rosen, *Sale to Private Equity – Part 2*, GORDON FEINBLATT LLC (Dec. 14, 2020), <https://www.gfrlaw.com/what-we-do/insights/sale-private-equity-part-2>.

<sup>351</sup> Hall, *supra* note 163, at 449; Marous, *supra* note 167, at 168–69.

for their inflexibility and burden on the industry's shift to value-based payment.<sup>352</sup>

However, the admonition of our depression-era elders rings in our ears, “Don’t throw that out; you never know when you may need it.” So, faced with this contemporary problem of PE’s rapid entry into health care, we find ourselves raiding the dusty attic of policy tools past in search of ones well-suited to address the perennial concerns over the corporatization and financialization of health care. We are glad the tools were not thrown out, because they may prove useful against the genuine risks posed by PE investment in health care. Moreover, legal tools already codified are more quickly adaptable than designing all new policies to curb the risks posed by PE investment in health care. In some instances, broad new laws—like the No Surprises Act—are needed to close gaping loopholes. But these are hard to pass, so we should not rely solely on building new policies when existing ones can be sharpened and redeployed.<sup>353</sup>

A second observation highlights state law’s importance in addressing the risks of PE investment in health care.<sup>354</sup> Perhaps the centrality of states stems from states’ traditional roles as the regulators of medical practice.<sup>355</sup> However, it may be surprising in this era of increased federal oversight over a sprawling health care industry.<sup>356</sup> Sometimes, a state’s role is that of co-enforcer of federal laws or their state equivalents (such as antitrust or fraud

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<sup>352</sup> See, e.g., Huberfeld, *supra* note 161, at 244 (“The corporate practice of medicine doctrine is a relic; a physician-centric guild doctrine that is at best misplaced, and at worst obstructive, in the present incarnation of the American health care system.”); *Modernizing Stark Law to Ensure the Success Transition from Volume to Value in the Medicare Program: Hearing Before the Subcomm. on Health of the H. Comm. on Ways and Means*, 115<sup>th</sup> Cong. (2018), (statement of the American Hospital Association); Marilyn L. Uzdavines, *The Great American Health Care System and the Dire Need for Change: Stark Law Reform as a Path to a Vital Future of Value-Based Care*, 7 TEX. A&M L. REV. 573, 575 (2020) (“Health care fraud and abuse laws are one of the main barriers . . . limiting new payment options to support a value-based payment model”); Anne B. Claiborne, Julia R. Hesse, Daniel T. Roble, *Legal Impediments to Implementing Value-Based Purchasing in Healthcare*, 35 AM. J.L. & MED. 442, 455–57 (2009).

<sup>353</sup> See *supra* Part III.A.

<sup>354</sup> See *supra* Part II.C–E.

<sup>355</sup> See, e.g., Patricia J. Zettler, *Toward Coherent Federal Oversight of Medicine*, 52 SAN DIEGO L. REV. 427, 446–454 (2015); Nathan Cortez, *The Law of Licensure and Quality Regulation*, 387 NEW ENG. J. MED. 1053, 1053–56 (2022).

<sup>356</sup> Abbe R. Gluck & Nicole Huberfeld, *What Is Federalism in Health Care for?*, 70 STANFORD L. REV. 1689, 1720 (2018).

and abuse laws).<sup>357</sup> In other cases, the laws themselves are creatures of state law (such as state corporate practice of medicine prohibitions or physician employment laws) with no federal counterpart.<sup>358</sup> Interested parties should take note that these policy levers exist at every level and within every branch of government: state and federal, litigation in court, regulatory action by executive agencies, and legislation. Nor are the laws limited to government enforcement.<sup>359</sup> Rather, there are a variety of private actions that aggrieved parties can bring, whether physicians, patients, or would-be competitors, as well as qui tam whistleblowers.<sup>360</sup> The good news is that we have a variety of existing tools to address the commercialization of health care by PE.<sup>361</sup> But the bad news is that our industrial-age tools may not be up to this digital-age problem. PE is vastly resourced, shrouded in secrecy, and extremely nimble.<sup>362</sup> Against the march toward corporatization and financialization in health care, we have plenty of tools, but they may not be enough.

#### IV. CONCLUSION

Six decades ago, Nobel prize-winning economist Kenneth Arrow articulated the core reasons for shielding physician practice from conventional market dynamics of crass commodification and commercialization.<sup>363</sup> As medical cost inflation raged out of control, however, this position came under attack for supporting physicians' attempts to fend off any form of economizing influence.<sup>364</sup> It was rightly felt that Arrow's strong defense of professional values needed to yield, at least to some extent, to market-driven efforts to restrain and rationalize medical spending. It now appears that the market-professionalism pendulum has swung too far in the direction of unconstrained profiteering. Some balance must be maintained between core professional values in medical practice on the one hand and the market economy in which medical

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<sup>357</sup> See *supra* Part III.A.1.

<sup>358</sup> See *supra* Part II.C.2.

<sup>359</sup> See *supra* Part II.B.1–2.

<sup>360</sup> See *supra* Part II.B.1–2.

<sup>361</sup> See *supra* Part III.A.

<sup>362</sup> Katz Olson, *supra* note 29, at 8-10.

<sup>363</sup> Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 948–58 (1963).

<sup>364</sup> See generally UNCERTAIN TIMES: KENNETH ARROW AND THE CHANGING ECONOMICS OF HEALTH CARE (Peter. J. Hammonds et al. eds., 2003) (re-examining Kenneth Arrow's observations on how traditional market forces are often inapplicable to the market for health care).



care is practiced. Rampant PE investment in physician practices threatens to disrupt that balance.

Through past cycles of this never-ending tug of war, various bodies of law and regulation have been marshalled to guard the professional ground.<sup>365</sup> At times, these defenses have been excessive, but now they appear unable to withstand the assault. So what to do?

The influx of PE in health care, the ongoing consolidation of every aspect of the health care market, and rising costs show that the corporatization of health care has not delivered affordable, equitable, or accessible health care—quite the opposite. The legal tools we have are ultimately unable to solve the bigger issue—that we still have not found the right balance between treating health care as a social good or a market commodity.

PE investment in health care is just the latest manifestation of the commercialization of medicine. It will not be the last. Taking commercialization to new extremes, however, marks a critical juncture calling for reassessment of the role of professionalism in health care delivery. Without returning to a bygone era or complete capitulation to professional hegemony, a more robust set of public policy mechanisms is needed to prevent powerful providers and suppliers from dictating prices, gaming reimbursement, and treating health care as an extractive exercise more than a social good—regulated, accessible, and affordable to all.

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<sup>365</sup> See Hall, *supra* note 163, at 431 (reviewing the history of legal attempts to balance professionalism and profiteering in medicine).



TABLE: POLICIES TO ADDRESS PRIVATE EQUITY INVESTMENT IN HEALTH CARE

Policy	Risk Addressed	State, Federal, or Both	Policy Change
Antitrust review	Consolidation, higher prices	Both (parallel federal and state antitrust enforcement authority)	Reduce or eliminate Hart-Scott-Rodino Act reporting threshold for smaller health care transactions; State legislation to expand merger review below HSR reporting threshold, including serial add-on acquisitions
Fraud and abuse enforcement	Overbilling, up-coding, risk score gaming, overutilization, self-referrals	Both (federal and private enforcement of federal laws, state enforcement of state equivalents)	None - increase enforcement under existing laws
Corporate practice of medicine, fee-splitting laws	Financial conflicts of interest, loss of physician autonomy	State	Clarify laws to restrict inappropriate uses of MSO model
Employment laws	Anticompetitive restrictions on physicians, patient access to providers, quality concerns	Both	FTC proposed rule to ban noncompetes. State legislative changes to restrict noncompetes, nondisclosure/gag, and nondisparagement clauses.
Closing Medicare payment loopholes	Overbilling, risk-score gaming, overutilization	Federal	Federal statutory or regulatory action needed to change Medicare Part B prescription drug payment incentives, adjust for Medicare Advantage risk score gaming
Transparency	Opacity of private equity ownership obscures accountability, research	Both	Federal or state statutory or regulatory action to require transparency of health care provider ownership or advance disclosure of anticipated transactions
Tax-treatment of PE	Unequal tax incentives for private equity investors	Federal	Eliminate carried interest loophole

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