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# Private Equity in Health Care

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FROM THE EDITOR

# Is Pursuing Profit Commensurable With Providing Good Health Care?

Jad F. Zeitouni

The following ideas have guided me and will continue to guide me throughout my career: everyone should get health care when they need it, and a goal of care should be to help improve patients' health and lives. It has been clear to me that capitalist forces—in particular, markets and the systemic disparities they create—directly pose barriers to realizing this tenet. The clash between the ideal of health equity and the reality of profit-driven care models reflects a broader issue: health care in the United States is a true quagmire. Regulators, policy makers, special interest groups, advocates, and stakeholders (physicians, health care workers, and patients) all clash on how to best provide care in this country.

The conflict between providing access to equitable health care and making health care a profitable endeavor has been ongoing in modern America. There was a substantial growth of for-profit hospitals and nursing homes in the 1970s and a subsequent shift to a business-minded approach to health care, even among not-for-profit hospitals.[1] As this growth continued, literature began to question the ethical implications of the profit-driven approach to health care, such as whether for-profit health providers reduce access to care and treat health care as a commodity.[2] Meaningful progress has been made in advancing medicine in some areas and in providing equitable care, such as by reducing racial disparities in quality measures among patients hospitalized for common conditions such as pneumonia, heart failure, and myocardial infarction.[3] Yet inequities in access to care and life expectancy among the highest and lowest income earners have grown, along with the profits of nonclinical actors in health care—insurance, pharmaceutical, and administrative companies.[4,5,6,7]

Another player in US health care has emerged rapidly over the past 5 years: private equity (PE).[8] Growth in PE has been documented[9,10] and reflects the current political discourse, as some policy makers consider how to regulate it,[11] perhaps motivated by evidence that PE ownership is associated with an increase in hospital-acquired adverse events and higher costs for patients.[9,10]

PE might seem ambiguous to some. Simply put and to be clear, it's a pool of money (that can be from individuals, companies, retirement funds, or pensions, to name a few) in a private firm that is used for investment. PE's business model is unique in that it identifies companies that have room for profit growth, assets to leverage, or costs that can be cut. It purchases these companies, often utilizing a leveraged buyout.[12] A PE firm

then usually moves to cut costs, sell or leverage assets, and drive up profits, selling the acquired companies in a short horizon, usually within 7 years.[9] This model has proved massively lucrative to both PE firms and their investors. While some firms have been in the health care sector for years, the popularity of PE acquisitions of physician practices grew tremendously between 2012 and 2021.[8]

This topic is one that should concern not just clinicians and economists. Every person in this country has received or will receive health care, and a deleterious actor in health care can dramatically affect the delivery, quality, and equity of health care in the United States—*deleterious* being the key operating word. Given increasing inequity and costs of health care services and goods, PE is poised to be a disruptive actor in health care.[8]

PE acquisitions of nursing homes, clinics, and hospitals have become commonplace. The effect of these acquisitions is still being studied, but more and more studies have shown this effect to be negative.[9] PE can, at times, have a positive impact on health care. As we decipher the current impact of PE's entrance into health care, we must begin examining the future implications and direction of this growth. Doing so will help guide future advocacy, policy, and regulation to ensure that patients and other stakeholders are not hurt.

In this issue, contributors explore these implications, along with potential solutions, in depth. They examine specific case scenarios, policy implications, potential legal regulations, medical education impact, and potential benefits of PE in health care. They also delve into questions such as whether PE should own residency training positions and how practice-owning clinicians should navigate a PE-acquisition offer.

One of the core ethics values in health care is *beneficence*—advocating for and acting to promote what's good for patients. Beneficence is the lens through which PE and this theme issue should be viewed. Is the growth of PE in health care and its associated impact in the best interests of patients? Each reader will have their own takeaways from this issue, and I challenge them to be advocates based on these takeaways.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

# What Are Physicians' Duties to Patients When They Sell Their Practices?

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**Abstract**

Physicians have fiduciary duties to respond with care to patient's clinical needs and vulnerabilities, whereas private equity (PE) companies have no such ethical or legal duties to patients and strive to maximize financial returns for their investors. This commentary on a case considers ethical conflicts of interest that arise when physicians sell their practices to PE firms and describes what physicians should consider when selling to fundamentally profit-driven entities.

## Case

Dr W owns their community-based family practice, recently turned 65 years old, and will soon retire after 35 years of caring for patients. Dr W is approached with a lucrative buyout offer from a private equity (PE) company interested in primary care patient panel acquisition. Dr W is unfamiliar with the company and its practices and only has a few weeks to accept or decline the offer. Dr W wonders what they owe their many long-term patients as their career ends and how those patients will be affected by the change as they consider how to respond to the offer.

## Commentary

This case is increasingly common, as PE investment in health care has grown in recent decades.[1] In 2022, more than $85 billion of deal value was announced globally, with more than 50% of buyouts attributed to the provider sector (eg, hospitals, physician offices).[2] The number of PE-owned physician practices increased 6-fold between 2012 and 2021.[3,4] Increasing PE investment has been noted across multiple specialties, including otolaryngology,[5,6] dermatology,[7,8] ophthalmology,[9,10] and others.[11,12,13] Moreover, the Medicare Payment Advisory Commission and American Medical Association advise that the true extent of PE investment in health care cannot be determined exactly, as PE firms are not publicly traded, often utilize nondisclosure agreements, and lack consistent public reporting requirements.[14,15]

PE firms have a fiduciary responsibility to their investors and portfolio companies, which has a profound impact on the ownership structure and financial incentives of medical practices. In general, PE firms aim to realize profits from acquiring, managing, and reselling businesses over holding periods of 3 to 7 years.[13,16] PE firms develop targets, or financial goals, based on achieving a return on investment of the capital that they

have invested; they typically target returns (known as multiples on invested capital) of 2.5 times the initial investment, which yields a net internal rate of return of roughly 20% at 5 years.[17] These objectives and time horizons in turn necessitate the realization of rapid growth in earnings by increasing revenue or decreasing expenses. In certain scenarios, these incentives may yield benefits to physicians or their patients through decreased administrative overhead (eg, use of shared services), increased capital investment, or economies of scale (ie, the cost savings gained by increased level of production or extending shared services to more businesses invested in by the PE firm).[6,18,19,20] However, many physicians and policy makers fear that the core incentives of PE could risk eroding physician satisfaction and autonomy and impede physicians' ability to provide high-quality care. Within the United States, there is less satisfaction and autonomy among PE-employed physicians, and there is concern that PE-employed physicians are co-opted or unduly incentivized to prioritize profit over patient care.[21,22,23]

### Private Equity and Outpatient Care

Studies on the impact of PE investment in health care have increased in the last decade, with the preponderance of data suggesting that PE acquisitions are associated with reduced staffing levels and on-hand medical supplies.[24] A 2023 systematic review concluded that PE ownership was associated with increased costs to payers and patients,[25] largely driven by increases in payments per claim, amounts charged per claim, and amounts paid per visit.[26,27,28] Prices at PE-acquired practices have also been found to significantly outstrip those of matched controls across multiple specialties, especially in areas where a PE firm controls a significant share of the local market.[4] Indeed, reduction of market competition through consolidation may be the mechanism by which large PE firms increase service costs. Changes in procedure volume, use of ancillary testing, or use of higher-priced medications could also be contributing to the increased per-patient cost.[27,29,30]

Several studies have also noted increases in practice visits and patient volume following PE acquisition,[26,27] which could be a lever that PE firms use to increase revenue. Although this strategy likely increases access for patients requiring a doctor's care, it may decrease the quality of care provided. In a recent survey, nearly half of physicians at PE-owned practices reported that ownership changes worsened their relationships with patients, largely due to decreased time and communication with patients.[31] Appointment availability appears to vary by payer, with some secret shopper studies demonstrating decreased access for Medicaid patients and stable-to-increased access among Medicare and privately insured patients in PE-owned relative to non PE-owned clinics and practices.[32,33] Moreover, visits are more likely to be with non-physician clinicians at PE-owned practices, which could be due to increased physician turnover and increased employment of advanced practice practitioners.[32,34] In some specialties, such as dermatology, this workforce shift among PE-owned practices has raised concerns regarding the volume of procedures performed that are not clinically indicated or are performed by advanced practice practitioners without sufficient supervision.[35]

In addition to the cost and volume of care, quality of care could also be impacted by PE acquisitions in medicine. In a recent survey by the Physicians Advocacy Institute, many physicians in PE-owned practices reported that ownership changes had a negative impact on quality of patient care due to decreased autonomy and increased focus on financial incentives.[31]

Notably, potential benefits include access to capital for technology and facilities, as PE firms might be able to purchase new equipment or space; economies of scale through consolidation, as PE firms controlling several offices or groups may be able to negotiate better prices from suppliers; and relieving clinicians of the burden of administrative and financial aspects of practice. However, the objective impact of PE ownership on quality and outcomes of outpatient care remains unclear due to limited evidence.[25] More research will be needed to quantify the changes associated with PE investment in health care, but progress continues to be challenging due to a lack of comprehensive, publicly available data.[19]

### What to Think About Prior to Selling

As highlighted above, the incentives of PE firms—both in the abstract and in documented cases—can conflict with the priorities of physicians and patients. As the practice's current owner, Dr W has both the power and the obligation to determine the manner of its disposition, thereby influencing how it could deliver care to patients in the future. It is important to note that national trends in decreased physician ownership of independent practices suggest that Dr W could face difficulty in finding a noncorporate purchaser,[18,36] but if there are other alternatives like selling to a large physician-owned medical group or an academic medical center, these should also be considered alongside the current offer. In the absence of other willing buyers, Dr W could also consider closing the practice upon retirement. While doing so could allow Dr W to avoid a potential ethical quandary about the practice's future ownership, the loss of the practice could itself harm patients by reducing the availability of care. As a result, closure is also not without ethical consequence.

From a legal perspective, state corporate practice of medicine (CPOM) laws must also be considered in the sale of a medical practice to a non-physician. These laws were largely drafted in the early 19th century to limit the influence of corporate interests on physicians' clinical decisions and professional autonomy, such as through ownership and control of medical practices.[15,37] However, the scope and enforcement of CPOM laws vary widely by state, and critics have argued that they are outdated and easily circumvented by corporations through the use of intermediaries such as management services organizations, which can then assume de facto control over physician practices.[38] Federal- and state-level antitrust laws also need to be taken into consideration, depending on the transaction size, but it is estimated that over 90% of PE acquisitions in health care do not meet the current Hart-Scott-Rodino Antitrust Improvements Act threshold for reporting ($119.5 million in 2024) and thus largely operate outside the public and regulatory radar.[4,21,39,40]

### Obligations to Patients

If Dr W proceeds with the sale of their practice to the PE company after weighing these considerations, one of the most pressing risks to Dr W's patients is the maintenance of physician integrity and autonomy. Despite regulations to restrict nonphysician influence on clinical decision-making, violations have been reported and prosecuted in multiple specialties[41,42,43] and continue to remain a significant concern for clinicians in PE-owned practices.[24,44,45] During sale negotiations, there are opportunities for Dr W to codify protections for remaining physicians with regard to clinical decision-making and other critical areas of the practice.[46] Ways to codify protections could range from covenants in purchase and sale documents to brokering investment positions for physicians in the practice sufficient to secure some degree of direct operational control even after the PE

buyout. Dr W could also leverage the current offer to generate alternative offers from entities with potentially better-aligned incentives or deal terms.

After sale of the practice, Dr W has a legal and moral responsibility to notify their patients regarding the upcoming change in practice ownership, their retirement from the practice, and how patients can access or transfer their medical records. In addition to the federal Health Insurance Portability and Accountability Act, some states also require explicit patient consent for the transfer of their medical records to a new clinician.[47] Although not all states legally require patient notification of a change in practice ownership, Dr W should proactively disclose information regarding the new ownership, including the names of the individual or corporation assuming ownership, out of respect for patient autonomy. With this information, patients can be empowered to make informed choices when seeking care.

After the relinquishment of the practice is complete, Dr W will no longer have a duty to steward their prior patients' health interests. If there are other physicians remaining in the practice or joining it, their priority should continue to be putting their professional responsibility to care for patients above any self-interest or legally permissible contractual relationship.[15,48,49] Specifically, physicians should continue to make decisions for patients based on their individual needs, resisting pressures to over- or under-provide care to reach financial milestones or operational goals.

Regardless of practice ownership model, it is also important for practicing physicians to understand federal and state legislation regarding fraud, kickbacks, and non-physician influence on clinical decision-making.[50] Some have argued that methods commonly used by PE firms to achieve growth in profitability (such as dictating referral patterns for ancillary services, increasing procedure volume, or billing for higher levels of service) could carry increased risks of violating fraud and abuse laws such as the Physician Self-Referral (Stark) Law and Anti-Kickback Statute.[51,52,53] If such concerns were to arise, there are well-established mechanisms for reporting to the US Department of Health and Human Services (HHS),[54] as well as protections for whistleblowers.[55]

Finally, although Dr W would no longer be directly caring for patients after retirement, they could still advocate for patients to be safeguarded against potential exploitation by PE interests. This topic has been the focus of multiple physician advocacy groups[56,57,58] and has been gaining traction on a federal level in recent years. In 2023, a bill, HR 3262, was introduced to the US House of Representatives that would require certain health care entities (including PE-owned physician practices) to report mergers, acquisitions, and changes in ownership to HHS for public disclosure.[59] In March 2024, the US Federal Trade Commission, Department of Justice, and HHS held a public workshop to examine the role of PE investment in health care markets and published a request for public comment.[60] The following month, the US Senate Committee on Health, Education, Labor, and Pensions held a subcommittee field hearing titled "When Health Care Becomes Wealth Care: How Corporate Greed Puts Patient Care and Health Workers at Risk."[61] During the hearing, Senator Edward Markey of Massachusetts announced a draft bill titled the Health Over Wealth Act, which seeks to require greater transparency and accountability regarding for-profit investment in health care.[62]

## Prioritizing Health

PE investment in health care has grown dramatically in recent years, developing into an area of significant interest for patients, physicians, and legislators. Although PE purports

to offer benefits to health care practices—including capital, business expertise, and operational efficiency—evidence from outpatient physician practices has shown that PE acquisition decreases market competition and raises costs for payers and patients. Furthermore, although studies on outcomes and quality in this setting are still limited, available evidence suggests that practice patterns change for the worse with PE acquisition due to increased pressure for profit. Ultimately, the primary responsibility of PE is to investors rather than to patients, and while rigorous research and federal regulations are critical for addressing the impact of PE investment on health care, the core of medicine will always be the care of patients. As such, the moral and legal duty of physicians remains as it always has been: to prioritize the health and well-being of their patients, a responsibility that takes precedence above all else.[63]

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

# When and How Should Patients Be Informed About Clinicians' or Organizations' Sale of a Clinical Practice to a Private Equity Buyer?

Cheryl Erwin, PhD, JD and Sheryl Tatar Dacso, DrPH, JD, MPH

**Abstract**

Private equity (PE) firms' acquisition and management of health service delivery entities, such as specialty physicians' practices, have been associated with increased cost and diminished quality of care. This commentary on a case argues that clinician-sellers have obligations to disclose to their patients known and foreseeable changes—especially those affecting services' cost or quality or health outcomes—to which PE ownership could contribute.

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## Case

SB arrives for a regularly scheduled appointment with Dr W, their primary care physician for the past 25 years. While in the waiting room, SB overhears office staff members talking about Dr W's practice being acquired by a private equity (PE) firm and what that might mean for their jobs.

When SB is taken to an examination room and Dr W enters, SB asks, "Dr W, are you planning to retire and sell your practice? If so, what does that mean for me?"

Dr W considers how to respond.

## Commentary

In recent years, PE firms have made major investments in health care through the acquisition of hospitals and clinician practices. PE firms are private investment vehicles that can acquire assets of a hospital or practice and manage the business going forward. Whether the acquisition is of a hospital or clinician practice, the net result has been a shift in the health care landscape from independent practice toward direct physician employment. A 2022 report by the Physicians Advocacy Institute found that, at the end of 2021, 74% of physicians in the United States were employed by a hospital, health system, or other corporate entity.[1] In 2023, that number had risen to 78% of all physicians.[2]

One driver of physician employment that led to PE acquisitions was the adoption of managed care arrangements by state and federal health care programs. Payers established a range of managed Medicare and Medicaid products that led hospitals, beginning in the 1990s, to seek alignment with groups of practitioners using business models such as independent practice associations and physician hospital organizations.[3] As the Centers for Medicare and Medicaid Services introduced new programs to reduce costs and increase access after the passage of the Affordable Care Act in 2010,[4] hospitals found it necessary to establish their own employed or captive practice model in order to meet payer changes. For traditional independent practices, the costs of managing care under new payer models affected profitability and resulted in physicians taking early retirement or joining a health system. As fee-for-service programs diminished, access to funds and relief from high overhead became important to traditional practices, making them attractive targets for PE rather than traditional sources of funding.

In states that prohibit the corporate practice of medicine, such as Texas, California, and New York,[5] unlicensed entities cannot directly employ physicians or control or be paid for medical services.[6] There are statutory and structural exceptions to this prohibition that vary by state and that have been used by hospitals, and now PE firms, to exercise operational control over medical practices. Statutory exceptions allow nonprofit entities, such as critical access hospitals, federally qualified health centers, medical foundations, and similar nonprofit health corporations such as certified nonprofit health corporations in Texas, to function as a medical practice and employ physicians.[6] Structural exceptions use variations on a management services organization (MSO) that might contract with rather than own a practice or appoint a "friendly" MSO physician executive who has acquired an ownership stake in the practice to serve as its medical director.[6] Hospitals and other health care entities can de facto acquire a practice and employ its physicians using one or both of these models.

This commentary will address when and how patients should be informed of a potential acquisition of a clinical practice by a PE firm after briefly discussing ethical issues affecting patients and clinicians.

## PE and Ethics

For independent practices, there may be few options for accessing capital to relieve financial pressures, manage regulatory compliance requirements, and deal with the increasing cost of private practice operations. PE provides as an exit strategy that gives independent physicians a windfall from the sale while allowing the practice to continue under third-party management. The ethical implications of these transactions have been a secondary consideration and have not often been addressed in the context of the relationship of a physician to their patient. Yet there are often increased costs of and decreased quality of services following PE investment.[7,8,9] The research raises concerns about the relationship between PE funding and health care costs, as well as about how certain investment structures affect patients.[10] Because both patients and payers face higher costs under PE arrangements, both cost and quality of care are key ethical considerations of which Dr W should be aware.

## When Should Dr W Respond?

PE transactions involve a detailed due diligence review of the practice, which focuses on financial and compliance issues rather than any ethical considerations, by the PE company. These ethical issues are often overlooked or not even recognized, as the

practice and its practitioners often remain in place after the transaction and the practice has come under PE management. Unless the transaction involves a merger with another entity, considerations of new funding and management support may not be recognized by either party to the transaction, although they can affect cost and quality of care. Therefore, it should be the physician's responsibility to consider not only the financial and regulatory issues related to the transaction, but also the ethical implications and consequences of the proposed transaction for the patient. Many PE transactions do not result in a sale, and it should not be assumed that Dr W will sell her practice. The transaction process is always preceded by a mutual nondisclosure agreement among the parties. These transactions are long, tedious, and require extensive negotiation.

However, once the purchase agreement has been fully negotiated and closing is imminent, the physicians will inform their staff, but often not their patients. Yet the patient has an interest in the transaction outcome, which is arguably no different than when a physician relocates their practice or retires. Most state laws require patient notice if a physician leaves a practice. Some states require disclosure to the state of any transaction of a certain value involving the change of ownership or control of a health care business.[11] Since loss of staff and patients can significantly affect the value of the practice and negotiated purchase price, an ethical dilemma arises of when to disclose. Considering the sale's potential effects on quality and cost of services early in the process can not only guide the decision of when to disclose but also allow for inclusion of these ethical implications in the transaction.

Patients may have questions about the new management whether they are voiced or not. Once the agreement has been finalized, Dr W should inform her patient immediately and honestly, consistent with the terms of any agreement. Indeed, she should have considered this issue prior to facing such a question in the exam room. Dr W has an ethical obligation to consider the impacts of a sale of her practice on her patients, to try to address these in the negotiations, and to respond to patients' concerns.

### What Should Dr W Care About?

*Patients.* Trust is a part of the patient-clinician relationship and is acknowledged as essential because of the vulnerability of patients.[12] Trust between the patient and health care organization is necessary because it both is desirable in itself and allows for better health care to ensue.[13] Research suggests that hospital-acquired adverse events have increased by as much as 25% for Medicare beneficiaries admitted to hospitals in which PE holds a controlling ownership interest.[14] Keeping patients' interests in mind when considering a transaction, physicians should try to anticipate and address their patients' concerns about the transaction's potential effects on cost and quality of care to maintain their trust.

While patients may not be aware of the cost and quality impacts of PE investment, Dr W has an obligation to inform herself of the potential consequences before she discloses the transaction to her patients. How she responds to patients when she does disclose will depend on the stage and nature of the transaction—specifically, if she is to continue to personally provide services to her patients. She should provide information, either verbally or in writing, notifying patients of any administrative changes and be prepared to answer their questions. Best communication practices in this case would be to have an informational handout ready to be provided once the transaction has closed. If Dr W is leaving the practice, state law will specify the required steps for notification. If she is staying, a handout that explains the nature of the changes should suffice. Patients

always have the right to change their clinician. Even if patients do not need to be specifically informed about the potential impact of PE on costs or quality of care, the practitioner should be a patient advocate by addressing any concerns that might arise and presenting the requested information honestly.

Many patients are likely to have questions about their health records' storage, confidentiality, and usage by a PE entity. Generally, the practice will retain custody of patient records, and a notice to patients of that fact is appropriate. If a new practice takes over as part of an acquisition of assets, a change in ownership or clinician could require patient authorization for transfer of records to any new entity. Dr W should understand how the practice will handle its custody of the records, particularly if she plans to leave. Under that scenario, patients who desire to stay with the practice need to know whom they will see in the future to avoid abandonment and ensure continuity of care.

*Regulators.* PE transactions can also present issues of concern to regulators, which is another reason Dr W should consider the transaction's potential effects on quality of care. In addition to malpractice claims associated with poor outcomes, poor quality of care and medical errors can result in reduced reimbursement to practitioners and penalties to hospitals,[15] including loss of Medicare provider status.[16] Recent concerns about patient safety and outcomes associated with PE involvement in health care have been raised by Congress and several state legislatures.[17,18]

*Insurers.* Insurers are also concerned about the increased presence of PE but for reasons related to contract negotiation and compliance with government programs. Although beyond the scope of this article, insurance can be a consideration in a practice's decision to embrace PE management. Payers contracted with government programs, such as Medicare or Medicaid, are subject to compliance requirements that may become difficult to address in a PE-managed practice. Physicians who have delegated management to PE firms may find themselves responsible for the actions of management and unaware of the ethical, financial, and quality issues associated with a PE-managed practice. For these reasons, they should involve a qualified health lawyer to represent them early in the transaction and to advise on specific issues unique to their own situation.

## Content of Disclosure

The disclosure of a known or foreseeable PE sale should be regarded as clinically and ethically relevant to patients, as it has the potential to impact their care or continued access to professional services or clinicians at the practice. The disclosure should inform patients about any changes in practice policies or processes under the new arrangement. Changes to scheduling, fees, insurance coverage, and staffing should be provided. If new business arrangements could adversely affect patients requiring continuity of acute care, these should be disclosed and addressed immediately. Upon request, patients should be provided with referral options and assistance as available under their respective health plans.

## Balancing Patients' and Physicians' Interests

Patients rely on their doctors for candid information regarding all aspects of their care. While sale of a practice to a PE company might be financially appealing to physicians, it should not compromise the needs of patients for continuity and quality of care. Ethical considerations related to the potential sale of a practice should be addressed during

negotiations, with attention to how overhead costs are allocated to the practice and how billed charges are determined, as these processes affect patient co-pays and deductibles.

Physicians in solo or small practice settings might not have access to specially trained health care lawyers who are familiar with the considerations involved in these types of transactions. It is advisable for any physician who is in this position to consult with an attorney prior to entering negotiations and to consider other arrangements that could be more beneficial to patients and to the community where the practice is located.

Physicians also should consider the potential effects of PE investment in a hospital where they are employed or to which they refer. These should be disclosed to the patient, who should be given a choice, if available, to seek care at a different hospital. The content of that disclosure, the timing, and the method of providing information to patients should be considered prior to admission, as the hospital is unlikely to make such a disclosure at admission.

In summary, not all PE transactions are alike. Not all circumstances involving a physician or practice are the same. However, it is the physician's responsibility to take patients into consideration when contemplating a PE or other transaction involving a change in ownership or control of a practice.

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MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

# Should Private Equity Firms Own Residency Slots?

Mark Varvares, MD, Jad F. Zeitouni, and Stacey Gray, MD

**Abstract**

Private equity (PE) margin maximization and profit-making strategies focus on acquisition, short-term ownership, and sale of health care entities, including residency program opportunities. PE ownership durations generally have 3 purposes: reduce staff, sell assets, and refinance debt. The purpose of graduate medical education (GME), however, is to provide learning and training opportunities in a variety of clinical, academic, technical, and research domains. This article offers examples of PE involvement in residency training and argues that PE and GME purposes not only conflict but add instability to graduate medical education learning environments. This article also suggests reasons why PE investment in GME, including residency "slot" ownership, undermines academic health centers' ethical and educational obligations to trainees in their GME programs.

## "Slot" Ownership

For 135 years, postgraduate resident education has been a core component of a physician's extensive training, during which a recent graduate grows into a practicing physician.[1] All the while, this has been done under the close stewardship of academic health professions institutions, with education as their priority. The goals of residency include training future generations of physicians with a primary focus on clinical skills, ethics, academics, and research. Residents, through clinical exposure during training and mentorship from their teachers and colleagues, are expected to grow into independently practicing physicians. Residents are taught through patient-centered care that prioritizes patient outcomes and allows for learning opportunities. Moreover, residents are given protected time for education and scholarship.

Purchase by private equity (PE) and other profit-focused entities of residency "slots" directly conflicts with the above-stated goals. Exploiting residency slots as an investment detracts from the long-standing institution of residency training by undermining the stability of training programs. PE's goal is simple: to acquire a business, cut costs and make it more valuable, and then sell the business within a relatively short period of around 5 to 10 years.[2] PE firms also have tax advantages and lack certain regulatory oversight that publicly traded companies have.[2] Residency programs owned by PE firms

have the unnecessary burden of worrying about when, not if, their hospital and training program will be sold to another profit-focused entity.

Commodification of residency slots by PE frames these training slots as an asset that can be leveraged in financial transactions or used to generate profit rather than as a key component of medical education that represents an investment in the future of health care in the United States. Viewing residents as assets or employees rather than as trainees can have downstream effects, as residents are expected to boost profit by maximizing numbers of patients they see and numbers of procedures in which they participate rather than focusing on their education. Unsurprisingly, given residents' financial and work stress, institutions are seeing a growing trend toward trainee unionization, with the goal of affording some protection of the priorities of trainees.[3] Moreover, if PE firms own and operate hospitals in order to decrease costs and only care for patients with less complex and therefore less costly problems, trainees at those institutions will lose the exposure to and training in caring for more critically ill patients.[4] This loss could influence their skill development and ability to care for such patients in the post-training environment. In other ways as well, PE firms' cost-cutting orientation could create inequity between PE-owned and non-PE owned programs. Given the PE emphasis on decreasing costs, trainees at PE-owned institutions could have fewer resources for and less guidance in providing quality services. Each of these factors can affect the quality of a resident's education and career development. They can also affect the quality of and access to care provided by trainees at PE-owned hospitals.

This paper examines the history of residency programs, their current structure and funding, the growth of PE in health care, and why PE firms should not own residency positions.

## History of Residency Programs and Funding

The basis of the current residency training structure in the United States was introduced 135 years ago.[1] Accrediting bodies, specialization, and subspecialization took root in the first half of the 20th century.[5] Residency slots grew exponentially following World War II, and, by 1975, residency programs were the ubiquitous standard for medical students following graduation from medical school.[5] While residency training has undergone changes, the standard of creating a cohesive training environment that emphasizes learning by participating in patient care has remained the same.

The majority of resident training positions are funded by the federal government.[6] This federal funding has been provided since 1965, following the establishment of the Centers for Medicare and Medicaid Services (CMS).[7] In 2015, the federal government allocated approximately $15 billion to graduate medical education (GME), with Medicare providing the majority (71%) of this funding.[8] Medicaid contributed 16%, while the Veterans Health Administration accounted for 10%.[8] The remaining support comes from various other federal sources.[8]

Medicare imposes caps on direct and indirect payments to teaching hospitals.[6] According to the US Government Accountability Office, 70% of teaching hospitals were over at least one cap and half of hospitals in counties with clinician shortages were over both caps in 2018.[6] These health systems and hospitals utilized other funding sources, including state and private, to fund training positions beyond their cap.[6] Direct payment is based on a hospital's number of resident physicians and Medicare patient volume, while indirect payment is based on the ratio of resident physicians to inpatient beds.[7] In

2018, roughly 70% of teaching hospitals and hospital systems funded more residency slots than their allotment from CMS, while only 20% of hospitals funded under their allotment.[6] This trend could, in part, be due to the lack of growth of CMS-funded residency slots, which was capped in 1997 by Congress at 1996 levels.[7] Congress granted federal funding for 1000 new residency slots in 2020, which was the first time CMS-funded residency slots were increased since 1997.[7]

This slow growth of government residency funding leads us to question how profit-oriented, short-horizon entities like PE firms would approach residency funding in an acquired hospital or hospital system. As mentioned, PE works by acquiring a business to grow the revenue of the company, reducing costs, refinancing debt, and then exiting through a sale.[9] There is genuine concern that a PE-owned hospital could cut certain funding to residency slots, such as funding for educational enrichment and scholarly activity, in the name of cutting costs. PE-owned entities can also seek to capitalize on GME training funding sources by maximizing patient volumes to increase revenue. It should be questioned whether PE-owned entities should be able to take advantage of government-funded residency slots intended for educating future physicians by regarding residents as affordable labor to increase profits.

## Growth of Private Equity in Health Care

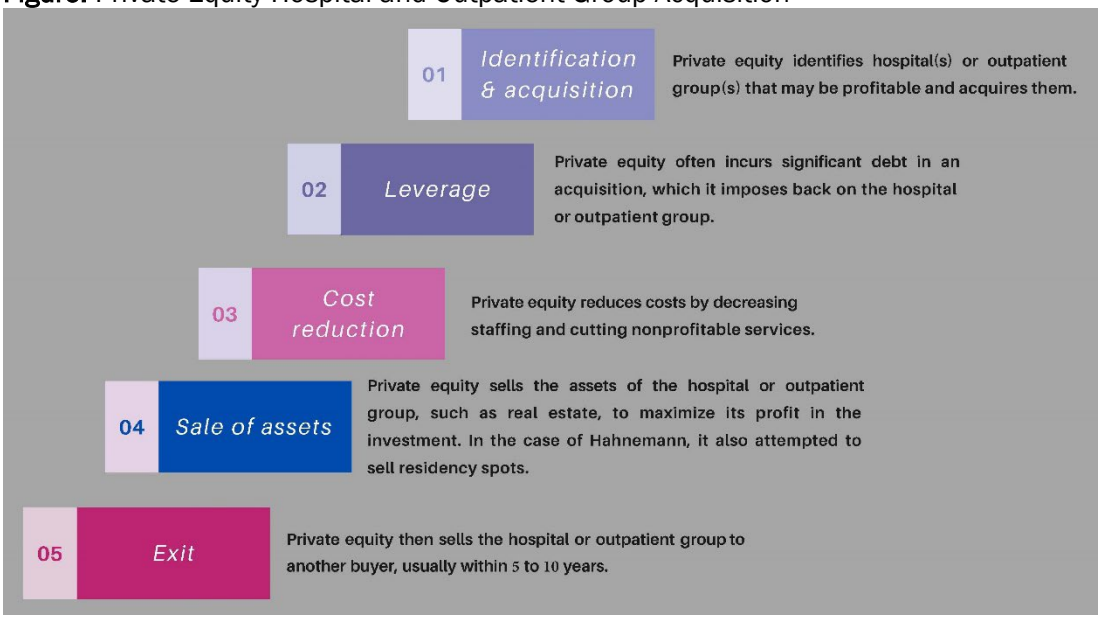
Before we examine our core question of whether PE firms should own residency slots, we must look at the broader growth of PE in health care. Total PE investment in health care has increased tremendously over the past quarter century. PE investment in health care totaled $5 billion in 2000, climbed to $100 billion in 2018, and reached $200 billion in 2021.[10,11] These firms invest in multiple areas of health care, including hospitals, nursing homes, and clinics.[9] The number of acquisitions of physician practices has risen sharply (600% between 2012 and 2021), with PE firms tending to focus on lucrative practices such as dermatology, gastroenterology, and ophthalmology.[10,11]

PE's ownership of hospitals has been even more substantial. PE firms now own around 30% of for-profit hospitals in the United States (460 hospitals).[12] Patient care often suffers in hospitals owned by PE. A recent study in *JAMA* found that PE acquisitions were associated with a 25% increase in hospital-acquired adverse events, such as falls and certain infections, relative to control hospitals.[13] Moreover, these hospitals tended to admit lower-risk and younger patients while increasing transfers of more complex patients to other hospitals.[13]

## Hahnemann as a Case Study

In order to purchase hospitals and outpatient groups, PE firms assume significant debt, which, in turn, is placed on the hospitals or outpatient groups[2] (see Figure). Companies that are acquired via such a leveraged buyout have a 10-fold increased risk of going bankrupt.[2] There have been several poignant examples of hospitals saddled with debt experiencing supply and staffing shortages, closures, and a systematic bleeding of assets.[14,15] Staffing shortages can further burden residents in these hospitals and affect the quality of care provided.[16] Additionally, hospital closures not only devastate their surrounding communities but also disrupt medical residency training, leaving physicians-in-training facing uncertainties about their educational future. This is exactly what happened at Hahnemann Hospital in Philadelphia, Pennsylvania, which mostly serves underserved patients whose care is covered by Medicare and Medicaid.

**Figure.** Private Equity Hospital and Outpatient Group Acquisition




Hahnemann Hospital had financial hardships for decades and was bought by a for-profit health care company, Tenet Heath, in 1998.[17] The hospital, along with its 570 residency spots, was sold in 2018 to an affiliate of Paladin Healthcare Capital—a PE firm focused on smaller hospitals—in partnership with a real estate-focused PE firm.[17] This acquisition led to suspicion that the hospital was purchased for redevelopment purposes rather than for sustaining a teaching hospital vital to its community. The hospital filed for bankruptcy and was closed in 2019, although the real estate was not included in the bankruptcy.[17] At the same time, the PE company attempted to sell the 570 federally funded residency slots, circumventing regulations set by CMS.[17] This sale was initially approved by a bankruptcy judge but was halted following an appeal by CMS.[17]

This case provides an example of the negative effects of PE on both the community and trainees. To our knowledge, it is the only example in the literature of a PE firm completely owning residency slots. However, as PE grows its market share in hospitals and outpatient groups, its interactions with residents are likely to grow. These interactions can range from PE firms directly owning and administrating residency slots, which is what happened at Hahnemann, to residents completing a short rotation (1-2 months) at PE-owned hospitals or clinics. The Hahnemann example highlights the ethical conflict between PE and residency training. Rather than seeing its residency slots as a responsibility to protect and ensure the continuation of trainees' vital education, the PE firm attempted to financially leverage its residency slots in its bankruptcy case while ensuring that it retained the real estate of Hahnemann. Trainees should be assured of the stability of their residency program and be protected from events that can impact the progression of their training. The PE firm violated that trust.

Following the Hahnemann closure, the American Medical Association called for added protections for trainees, greater oversight of hospital closures, and policies for clinical site closures.[18] The American Academy of Family Physicians echoed calls for close oversight and regulation of PE-funded residencies.[19] Additionally, the president of the Accreditation Council for Graduate Medical Education (ACGME) and coauthors addressed the Hahnemann incident in a commentary in *Academic Medicine*.[20] This

commentary laid out the ACGME's plan to deal with future closures. This plan includes soliciting resident input on how to support well-being in situations like Hahnemann and developing tools and protocols to address future interference in GME.[20] The commentary stopped short of directly addressing PE.

The ACGME should, however, directly address PE. Among the ACGME's vision elements are advancing graduate medical education in health care delivery systems that equitably meet local and regional community needs and developing residents and fellows who prioritize the needs of patients and their communities.[21] The Hahnemann closure starkly illustrates the conflict between PE and the ACGME's vision. The PE firm strategically closed a safety net hospital serving an underserved community—choosing profit over community health needs and thereby directly contravening the principle of equitable health care delivery.

### Graduate Medical Training and Private Equity

To our knowledge, there is scant literature examining or discussing the impact of PE on managing teaching hospitals and their residents. Hahnemann was a large hospital with a considerable number of training positions, and these GME slots were up for sale less than 2 years after PE acquisition of the hospital. There are numerous large hospital systems and universities that operate under one GME umbrella. These systems have hundreds and sometimes thousands of residency slots. It is doubtful that PE leadership would be properly equipped or competent to handle a hospital system with a large share of Medicare-funded residencies. Unlike traditional hospital leadership with backgrounds in academic medicine, PE executives approach health care primarily from a financial perspective. This disconnect leaves them unprepared to navigate the complex requirements of residency programs, including accreditation standards, medical education delivery, and the balance between service and education—all essential components of running a teaching hospital system.

There are a few examples of trainees working in PE-owned clinical practices, particularly in dermatology. A large share of the clinical sites for the dermatology residency at the Kansas City University of Medicine and Biosciences Graduate Medical Education Consortium are PE-owned dermatology practices. The company that owns these clinical sites provided residents with a stipend of $10 000 and the option of a yearly $30 000 loan, which was paid back following completion of training or was forgiven if trainees signed a contract with the PE-backed dermatology practice,[22] but this program has since ended. PE can provide financial incentives to academic institutions as well. In 2019, Rush University Medical Center agreed to a clinical and academic affiliation with a PE-backed large dermatology group for an ownership share in the group.[23]

Both of these examples show how PE provides financial incentives to academic institutions and residents to be involved in PE-backed residency training. If trainees work in PE-owned hospitals and outpatient groups, it is imperative that residency training be solely managed by academic institutions with close, quality oversight. Government should regulate the financial relationship that academic institutions can have with PE, as well as strictly oversee what a PE firm can provide trainees in the form of salary and incentives.

### Discussion and Conclusion

The negative impact of PE on health care and GME is clear. PE firms have shown a willingness to use residency slots as commodities to sell for profit without regard for

residents' training progression and the communities these residents serve. They have financially incentivized residents to rotate in their practices as a means for recruiting. PE ownership threatens resident training through multiple mechanisms: chronic staffing shortages that compromise supervision, reduced exposure to complex patients, diminished educational and scholarly opportunities due to budget cuts, and a focus on revenue generation that undermines the educational mission.

There is a need for added regulation and legislation to monitor PE's encroachment in health care, including residency training. The goals of residency training and PE do not align. Residency training should be in a stable environment where the focus is on learning, professional growth, and providing patient-centered care. PE does not provide this stability, given its short timeline for exits and propensity to close or indebt hospitals. PE provides an environment focused not on learning but rather on increasing revenue and cutting costs. PE-owned hospitals also can struggle to teach trainees patient-centered care given their higher incidence of adverse events,[13] overextended staff, and focus on more lucrative specialties.[10,11]

PE has, in large part, been shown to have had a negative impact on health care. The case of Hahnemann Hospital made clear that the PE firm was disingenuous in its commitment to the community, physicians, and trainees. Residencies were seen as commodities, and they were nearly auctioned in bankruptcy court. Residency slots should never be seen as an asset that generates revenue but rather as an obligation to train the medical workforce of the future. If the goal of the training program is to provide dollars to the bottom line, then physician training will be shortchanged.

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**HEALTH LAW: PEER-REVIEWED ARTICLE**

## Can Current Legal Tools Respond Adequately to Risks of Private Equity Investment in Health Care?


Robert I. Field, PhD, JD, MPH



### Abstract

As private equity (PE) funds acquire a growing share of America's health care system, their focus has expanded to include not only hospitals and nursing homes but also physician practices. Some PE acquisitions have infused much-needed capital into resource-starved entities, but others have led to higher prices, diminished quality of services, and billing fraud. Some PE acquisitions have also forced viable entities into bankruptcy by stripping their real estate and other assets. This article explains how legal and regulatory responses to these outcomes can be impeded by corporate structures that PE funds commonly use to obscure responsibility. It also suggests reforms that could strengthen enforcement capacity.



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### Private Equity's Growth in Health Care

Private equity (PE) funds have been acquiring a growing share of America's health care system, with the value of investments increasing from $41.5 billion to $119.9 billion in the decade between 2010 and 2019.[1] The bulk of these investments were initially in hospitals, nursing homes, and other institutional providers, of which they acquired a considerable number. As of 2024, PE funds owned more than 386 hospitals, representing 30% of for-profit facilities in the country.[2] As of 2022, they owned about 5% of nursing homes enrolled in Medicare,[3] and, as of 2023, they also owned more than 20% of mental health facilities in some states.[4]

Following this start, the scope of interest of PE funds has broadened to include physician practices. Acquisitions of these entities increased from 75 to 484 a year between 2012 and 2021.[5] In 2021, a single PE fund had a market share of at least 30% in 108 metropolitan area practice markets and at least 50% in 50 of those markets.[6]

Supporters of PE investment point to what some see as much-needed capital infusions, streamlining of previously inefficient operations, and paperwork burden reduction for clinicians.[7] PE firms also have a more streamlined governance structure than traditional

investment companies that allows them to be more nimble in making major decisions.[8] However, critics point to evidence of serious deleterious effects, including higher prices, reductions in quality, increases in instances of billing fraud, and financial stress that has forced some viable entities into bankruptcy.[9] Enforcement of laws to mitigate these effects has increased in response, but government regulators often face a number of formidable obstacles.[10]

## PE Business Model

The PE investment model uses a fund comprising a small group of investors to acquire an ongoing enterprise that is not publicly traded.[11] The funds are typically structured as partnerships with a general partner managing acquired entities and affiliated corporations providing ancillary services.[12] While private individuals have invested in health care for decades, they have predominantly been health care professionals and individuals with knowledge of the field.[13] PE funds, on the other hand, invest on behalf of wealthy individuals and institutions, who often have no prior knowledge of health care business or specific interest in the ongoing success of acquired entities or in their capacity to offer services.[13] In many cases, the primary goal is to generate short-term profit rather than continued operation.[13]

PE health care acquisitions commonly include 4 elements that tend not to be found in traditional for-profit investments:[14] (1) embedding acquired entities in complex and opaque corporate structures; (2) refinancing and loading the debt onto acquired entities; (3) transferring acquired entities' assets, especially real estate, to a related owned business; and (4) developing business relationships between an acquired entity and providers of ancillary services that they also own.[9] These elements offer several benefits to PE firms. Complex corporate structures can shield individual investors from lawsuits, claims of creditors, and enforcement penalties for substandard care.[9] They can also make it difficult for regulators to determine responsibility for abusive behaviors.[9] Regulatory oversight is further impeded by the private ownership structure of PE firms, which allows them to avoid regulatory filings that would be required of publicly traded businesses.[9] By loading debt from an acquisition onto an acquired entity, they can shield the fund itself and its investors from liability for repaying it.[9] Selling an entity's real estate to a related business generates further revenue from rent that the entity is required to pay for use of its own facility.[15] Intertwined corporate relationships also generate revenue by requiring an entity to make payments to providers of ancillary services, such as billing and purchasing, that the PE fund also owns.[9] The entity may even be required to pay management fees to the fund's general partner for its oversight.[14]

## Consequences

On the one hand, the business literature documents many instances of acquired entities benefiting from PE investment.[16] Such benefits are most notable when needed capital has been infused into failing or underperforming companies or service delivery streams.[17] PE funding has also helped financially stable providers expand their range of services. For example, one partnership was developed to create 67 primary care clinics focused on elderly patients with an investment of $800 million.[18] Some smaller independent physician practices stand to realize benefits from PE investment by gaining resources to compete in an increasingly expensive and competitive marketplace.[19]

However, instances of significant negative consequences also abound, including financial ruin for some acquired entities. An analysis of health care bankruptcies in

2023 found that they had been rising for several years and that at least 21% of health care companies filing for bankruptcy that year were owned by PE firms.[20] A study of 484 PE leveraged buyouts found that the probability of bankruptcy for the target firm was about 18% higher than for nonacquired firms.[21] This consequence may be of little concern to many PE funds, as they commonly use bankruptcy as a deliberate exit strategy for the entities they acquire.[21] A recent example is illustrative. A few years after one PE firm became the owner of a network of 31 hospitals in 8 states, the network found itself $400 million in debt.[22] In response, the PE firm arranged for the hospitals' landlord to contribute financial support over the next 4 years.[22,23] It then sold a majority stake in the organization to the chief executive officer and realized an $800 million profit. Soon thereafter, the network filed for bankruptcy.[22]

For those entities that remain ongoing enterprises, PE ownership is often associated with higher prices paid by patients and insurers.[13] A systematic review of 55 studies of PE ownership of health care entities found cost increases to be the most consistently reported outcome.[24] A study using data from the Healthcare Cost Institute Commercial Claims Research Dataset, which includes about 55 million covered lives, found per-patient expenditure increases in 6 of 10 physician specialties, ranging from 4% to 16% after PE acquisition.[5] The price increases in 3 specialties were greater when a PE-owned practice controlled more than 30% of a market.[5] A survey published in 2020 identified the kinds of practices most likely to be acquired as anesthesiology, multispecialty, emergency medicine, family medicine, and dermatology.[25] A study of the effects of PE acquisition on practices in one of those specialties, dermatology, found that the volume of patients seen by each dermatologist was 4.7% to 17% higher than in nonacquired practices 3 years after acquisition and that prices paid for routine visits were 3% to 5% higher 1.5 years after acquisition.[26]

Despite charging more, PE-owned providers do not necessarily produce better quality of care and have been found in numerous instances to produce the opposite.[26,27] For example, a study of 4500 PE-owned dialysis centers found that those in concentrated markets have higher risk-adjusted rates of patient hospitalization and lower survival rates.[28] A study of PE-owned hospitals found that they have fewer full-time equivalent employees, lower patient satisfaction scores, and lower performance on quality metrics.[29] A study that analyzed 662 095 Medicare Part A claims found that acquired entities have a 25.4% higher rate of adverse events—including falls, central line-associated blood stream infections, and surgical site infections—than matched control hospitals.[30] Another analysis of 5.3 million Medicare claims over a 12-year period found significant increases in short-term mortality in PE-owned facilities that might be associated with operational changes, such as shifts in resources away from staffing.[31]

PE-owned health care entities have also been involved in numerous instances of billing fraud.[9] One study of PE-owned physician practices found higher costs, overutilization of many services, upcoding in billing, and constraints on physician autonomy, along with compromised patient care.[32] The cost of such practices to government programs such as Medicare and Medicaid can be substantial.[27]

### Legal Responses

The negative consequences of PE health care acquisitions have led to increasing attention from government regulators and legislators. In terms of regulatory enforcement, attention has focused on 3 main areas.[9] The first is violations of antitrust laws related to the effects of PE acquisitions in reducing competition and raising prices.

The second is violations of safety standards by hospitals and nursing homes, which have followed investigations by state regulators. The third is fraudulent billing practices under Medicare and Medicaid, resulting in prosecutions for fraud by federal and state enforcement agencies. Rising concern over PE acquisitions has also led 3 federal agencies—the Federal Trade Commission (FTC), the Department of Justice's Antitrust Division, and the Department of Health and Human Services—to jointly request information about health care dealmaking more broadly.[33] In terms of attention from legislators, some members of Congress have expressed concern that PE health care acquisitions violate antitrust laws, leading to support for legislation that would increase oversight.[34] In addition, several states have enacted laws to curtail PE health care acquisitions, and more are likely to follow.[35]

Actions such as these may be having an effect. Over the past 3 years, total PE health care acquisitions have begun to slow, from a high of 1204 in 2021 to 866 in 2023.[36] At the same time, continued enforcement against abusive practices has encountered significant obstacles.[37] Most notably, regulators face the task of disentangling the complex and opaque structure of PE corporate arrangements to determine responsibility for specific abuses.[38] PE funds are also often able to avoid reporting requirements of transactions to the FTC and other agencies because of the private structure of the acquisitions.[38] Moreover, while there is growing enforcement activity focused on economic issues, such as increased market concentration and higher prices, less has centered on patient care concerns.[29] Yet lapses in quality of care are arguably the most consequential negative outcome that PE acquisitions can produce.

## Reform

To address these enforcement challenges, 3 kinds of reforms would be especially helpful. The first would mandate greater transparency by PE firms in ownership arrangements and corporate structure.[2] This requirement would include more extensive reporting to the FTC and state regulatory authorities before transactions are finalized and lowering of financial thresholds for required reporting.[5] The FTC could use this authority to scrutinize transactions more carefully for potential anticompetitive effects, which is a particular concern in acquisitions of physician practices.[13] However, state agencies may have more leeway than the FTC in this regard as a result of the Supreme Court's 2024 ruling in *Loper Bright Enterprises v Raimondo*, which denied federal agencies the decades-old deference that courts had applied in considering challenges to their regulatory initiatives.[39]

A second reform would tie Medicaid reimbursement, the mainstay of financing for most long-term care facilities and many hospitals, more closely to spending on direct care.[40] Allowing reimbursement for ancillary expenses, such as rent and management, to be provided by affiliated entities incentivizes PE-acquired entities to divert spending to such nonclinical functions. The third would enhance the powers of state regulators, who have primary responsibility for patient safety, to monitor quality of care more closely in acquired providers.[36] This is a special concern for nursing homes, in which cost-cutting measures such as reduced staffing levels can have catastrophic consequences.[40] Such enhanced powers could include authority to conduct more frequent inspections, to impose larger fines for substandard care, to issue guidelines on the use of midlevel and unlicensed clinicians, and to implement more comprehensive recordkeeping, along with more resources to implement these measures.

## Conclusion

PE ownership of health care entities relies on a model that seeks to maximize short-term profits at the expense of long-term business sustainability. Among its main elements is the vesting of control of acquired providers in investors with little knowledge of or interest in health care. This arrangement produces a corporate structure that may be ill-suited to maintaining a high level of quality in an industry responsible for the lives and health of almost everyone at one time or another. Those charged with protecting the public's health and safety should have the strongest possible arsenal of legal tools to respond.

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# Physician Engagement With Private Equity Firms

Amber R. Comer, PhD, JD and Jake Young, PhD, MFA, MPH

**Abstract**

Private equity investments in health care raise several clinical and ethical questions about private equity's influence on clinicians' practices. This article canvasses how these questions are navigated in AMA *Code of Ethics* opinions.

## Private Equity in Health Care

Private equity firms follow an investment model that seeks high-yield, short-term profits.[1] Although the premise of this investment model seemingly runs counter to ethical tenets of medicine, in recent years it has become increasingly common to apply this investment model to the provision of health care. Private equity firms purchase health care entities by leveraging the physician practice or hospital as security for a loan with the goal of yielding a 20% to 30% return within 3 to 7 years.[2,3,4] Proponents of private equity assert that this model reduces inefficiencies while also providing the much-needed capital infusions these firms bring to often struggling health care practices.[5] Critics assert that private equity firms' prioritization of profits turns health care into a commodity, jeopardizes patient care, overburdens health care entities with debt, and limits physician control over clinical decision-making.[3,5,6] Regardless of whether one supports or opposes incorporation of a private equity model in health care, the untenable misalignment of the competing values of profit and patient care invariably creates ethical dilemmas that impact clinical practice.

Private equity investments in health care raise several important questions related to clinical practice, including whether it is ethical to sell a medical practice to a private equity firm, whether physician employment in a private equity-owned medical practice can be in alignment with medical ethics, and what options physicians have if their hospital or practice has been acquired by a private equity firm and they believe it has negatively impacted patient care.

## The AMA *Code of Medical Ethics* on Private Equity

When faced with conflicts of interest between financial incentives and the delivery of care, such as those raised when private equity invests in health care entities, the American Medical Association (AMA) *Code of Medical Ethics* calls on physicians to prioritize patient welfare. Specifically, the AMA *Code* states that the "primary objective of the medical profession is to render service to humanity; reward or financial gain is a

subordinate consideration" and "where the economic interests of the hospital, health care organization, or other entity are in conflict with patient welfare, patient welfare takes priority."[7] Additionally, the AMA *Code* specifies that "under no circumstances may physicians place their own financial interests above the welfare of their patients."[7] Given that the primary objective of a private equity firm is profit, physicians considering either selling their practice to a private equity firm or contracting with a private equity-owned hospital for employment should carefully reflect on their professional and ethical obligation to prioritize patient care and well-being and whether entering into a partnership or employment agreement with a private equity firm might jeopardize these commitments.[8]

## Applying the AMA *Code of Medical Ethics*

*Private equity-owned practices' obligations to uphold medical ethics.* Morally, all entities with direct involvement in the provision of health care have an obligation to uphold the ethics of the medical profession. However, as outside investors, private equity firms are bound to uphold medical ethics standards only with respect to the law and the contractual obligations of the physicians they are in partnership with or employ. Therefore, the onus to ensure compliance with medical ethics standards is placed on the medical administrators and physicians who partner with or are employed by private equity-backed practices. Given the inherent ethical conflict in the private equity model between maximizing profit and ensuring the well-being of patients, physicians who partner with or are employed by a private equity-backed practice must ensure that they enter into agreements that allow them to uphold the ethical standards of the medical profession, including prioritizing the well-being of patients over profit.

*The ethics of selling a medical practice to a private equity firm.* While the private equity model is not in and of itself inherently unethical, applying this business structure to health care presents potential conflicts of interest arising from the business obligation to increase profit and medical ethical principles, which prohibit physicians from placing profit above patient welfare. While the incursion of private equity into health care does warrant concern, it is possible for private equity firms to align their financial interests with patient care, such as by shifting health care payment and delivery to value-based models. However, due to the possibility or even likelihood that private equity investment in health care entities will lead to a misalignment of values, physicians considering selling their practices to or seeking employment from private equity-owned health care entities should carefully assess whether they can do so while still upholding their professional and ethical obligations. Physicians who decide to enter into partnership with private equity firms should engage in contract negotiations to modify or remove any terms that unduly compromise their ability to uphold their ethical or professional obligations.

*Physician employment by a private equity-owned health care entity.* Because the private equity business model in health care creates the risk of conflicts of interest by prioritizing profit over patient welfare, physicians employed by private equity-backed practices may find themselves in an untenable position of dual loyalty. Their fundamental ethical obligation to promote patient welfare requires physicians to ensure that any employment contract they enter into does not create untenable conflicts of interest. Therefore, physicians should negotiate or remove any contractual terms that unduly compromise their ability to uphold their ethical obligations.[8] However, as acknowledged by the AMA Council on Ethical and Judicial Affairs, "physicians have little

leverage in changing entire payment structures or reimbursement mechanisms when negotiating employment contracts."[9]

*Physician professionalism and private equity*. Despite physicians' best intentions to promote and prioritize patient care, the discordance between the private equity business model of maximizing profit and physicians' foremost ethical obligation to ensure patient well-being inherently creates ethical dilemmas. In the event that a physician in partnership with or employed by a private equity-backed practice fails to uphold the legal or ethical obligations of the profession of medicine, their physician colleagues must report behavior that is not in alignment with ethics guidance to the appropriate governing or oversight body.[10,11] For example, physicians who become aware that a colleague is regularly upcoding should report it to their practice compliance officer or internal compliance department, or, if there is no internal mechanism, they should report it to the relevant regulatory body, such as the Centers for Medicare and Medicaid Services (CMS) Office of Inspector General or the Department of Justice (DOJ), depending on the severity and circumstances. It is imperative that physicians hold one another accountable to ensure the safety of patients and the public's confidence in the medical profession.[11,12] In the event that a physician in partnership with or employed by a private equity-backed practice feels that administrative decisions driven by private equity's focus on profit have created systemic problems that negatively impact patient care, the physician has an ethical obligation to report these issues as well. Physicians seeking to address administrative or systemic problems should contact the applicable clinical authorities, including the peer review body, human resources department, or ethics committee of a hospital if employed by one, the local or state medical society, or the state medical license board, as well as the Federal Trade Commission (FTC) or the DOJ in instances of suspected fraud or abuse.

## Recommendations

All physicians should oppose the corporate practice of medicine to protect the patient-physician relationship and prevent corporate interference in medical decision-making. Due to the current incursion by private equity firms into the medical profession, the following recommendations are offered to physicians employed by or contracting with private equity-backed practices to uphold the ethical principles of medicine.

- Physicians should be aware of the ethical conflicts associated with private equity involvement in health care,[13] which often prioritizes profit over the medical profession's core ethical duty to provide quality patient care above all other concerns. Physicians who partner with or are employed by a private equity-backed practice must ensure that they enter into agreements that allow them to uphold the ethical standards of the medical profession.
- Physicians should view partnership agreements and employment contracts with private equity-backed practices in light of their ethical obligations to ensure that the arrangement is transparent and minimizes ethical conflicts of interest, does not compromise physicians' well-being or their ability to provide quality care, and does not reduce physician autonomy and oversight. Ideally, formal agreements would be entered into with the assistance of legal and ethics counsel.
- When entering into an employment contract with a private equity-backed practice, physicians should be aware of the ways that this business model may jeopardize their professional and ethical obligations. Physicians should negotiate their contracts to ensure that the terms align with ethical and professional obligations.

- Physicians should only enter into contracts that do not require them "to practice beyond their professional capacity and provide contractual avenues for addressing concerns related to good practice, including burnout"[9] or quality care delivery.
- Physicians have an ethical duty to report any conduct, practice, or policy they become aware of that violates, or that they strongly suspect of violating, ethical or legal standards or that poses a threat to patient welfare.[12] Physicians should report known or suspected ethics violations to the applicable clinical authorities, including, if relevant, the peer review body of the hospital or the local or state medical society. The state medical licensing board should be notified if there is an immediate threat to patient health or safety.[12] Entities responsible for enforcing fraud and abuse laws, such as the DOJ, the FTC, the Department of Health and Human Services Office of Inspector General, and CMS, as well as offices of state attorneys general, should also be contacted whenever applicable.

## Conclusion

Because private equity business models focus on maximizing profit, they create ethical conflict when applied to health care due to physicians' duty to prioritize the well-being of patients over profit. Private equity investments in health care raise several important ethical questions related to clinical practice, including whether private equity-owned practices are bound by medical ethics, if selling a medical practice to a private equity firm is ethical, and how to respond when a private equity practice is negatively impacting patient care. This article responds to these questions and stresses the importance of physicians' ethical and professional obligations to prioritize the welfare of their patients over the pursuit of profit.

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POLICY FORUM: PEER-REVIEWED ARTICLE

# How Should We Stop Private Equity Firms From Exploiting Public Health Insurance?

Yashaswini Singh, PhD, MPA

**Abstract**

Private equity (PE) investments in health care have grown to over $750 billion in the past decade and include every segment of the US health sector. Although PE investments can provide capital and improve efficiency of health service delivery, PE's emphasis on short-term profitability could raise costs, diminish quality of care, and negatively influence clinician autonomy and career satisfaction. This article first canvasses what is currently known about how PE investments in physician practices influence clinician practice patterns and then proposes regulatory and legislative strategies for restricting harms of PE ownership of clinician practices and for fostering affordable and high-value health services.

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## Practice Environment Changes

The environments in which health professionals practice and patients receive care continue to change. Over 3 quarters of physicians in the United States are now salaried employees of hospitals, health systems, or other corporate entities, including private equity (PE) firms, health insurers, and retail firms.[1] A long-standing literature has illustrated how variation in ownership structures of clinicians' practices—including chain ownership, hospital-affiliation, and PE ownership, among others—can affect service delivery.[2,3,4,5,6]

Despite rapid changes in the organization and ownership of physician practices, the role of physicians has largely remained the same: to maintain the patient-physician relationship, which has historically been based on the basic principle of trust. This trust demands that physicians act as agents on behalf of patients with a primary obligation to act in the patient's best interest. As major changes in physician ownership reverberate throughout the US health care system, there is growing concern that corporations employing physicians are not simply providing ancillary operational support but also exerting control over clinical decisions with the potential to challenge the trust that patients have historically placed in clinicians. A key symptom of this broader trend is the

remarkable increase in PE investments in health care focused on generating short-term returns for financial investors.[7] PE investment in health care has increased significantly over the past 2 decades, growing from $5 billion in 2000 to $100 billion by 2018.[7] While physician employment by large organizations is not problematic per se, targeted policy interventions and enhanced transparency can act as guardrails to mitigate the undesirable effects of PE investment on health care quality, access, and patient outcomes.

## PE Investments in Physician Practices

Typically, PE firms purchase a majority ownership interest in health care providers, invest resources to drive operational efficiencies, expand market share, increase revenue (eg, by adding more profitable services),[8,9] decrease costs (eg, by changing staffing composition),[10] and then sell the practice within a few years to generate returns for the firm's investors. In recent years, PE investment has focused on physician practices, starting with hospital-based specialties, including anesthesia, emergency medicine, and radiology, and extending to office-based specialties such as dermatology, gastroenterology, ophthalmology, and, more recently, primary care, behavioral health, and cardiology.[11,12,13,14,15] After PE acquisition, physicians generally become salaried employees and might retain some minority ownership stake in the acquired practice, as PE firms want physicians to share in their growth objectives. PE firms grow acquired practices in part through "platform and add-on" consolidation that involves, first, acquiring "platform practices" that could be large, well-managed physician practices and, second, expanding market share through add-on acquisitions of smaller practices that are then merged with the larger platform practice.[16,17] Finally, to realize desired returns on investment, PE firms aim to exit investments by selling practices within 3 to 8 years.[18] PE firms might sell practices to another PE firm, the public via an initial public offering, health systems, or an insurance company, although most PE sales to date have been to other PE firms.[18]

PE firms' exit incentives and need to resell the acquired practice at a profit soon after acquisition can create incentives to change physician practices to make them more profitable. Studies of physician practices have shown that PE-owned practices can drive potential inappropriate use of medical and surgical procedures, ranging from laboratory tests to diagnostic imaging, and retinal drugs[8,9]; increase referrals to other physicians employed by the same multispecialty practice[5,19]; engage in surprise out-of-network and other billing practices[20,21,22] that can erode patient trust; and change the workforce composition of their practices to increase reliance on advanced practice clinicians.[10] Furthermore, PE firms might also limit populations served, such as Medicaid or Medicare patients, due to lower rates of reimbursement or higher complexity procedures.[23]

In theory, PE firms may improve the quality of care by facilitating operational efficiencies, facilitating investments in the use of technology, and providing administrative support for value-based care contracts.[16,24] However, empirical evidence of the effects of PE investment on quality of care, based on studies examining settings other than physician practices (eg, hospitals and nursing homes), is mixed.[25,26,27,28] A recent study of chain ownership of fertility clinics found that such chains can facilitate resource and knowledge transfers needed to enhance quality under certain regulatory conditions.[3] Taken together, these mixed results highlight the need for more targeted research on the effects of PE on quality of care, particularly in physician practices, for which evidence remains sparse. Importantly, the lack of systematic reporting and

disclosure requirements for PE acquisitions prevents our understanding of the exact nature of physician employment arrangements under PE firms, making it difficult to assess PE's true impact on patient outcomes.[29]

## Policy Solutions

PE investments in physician practices can offer advantages such as financial stability, practice management assistance, and practice innovation.[3,16] However, studies increasingly show that this organizational setting can also bear powerfully on practice patterns. PE investments in physician practices echo concerns related to the double agent problem, wherein physicians try to be accountable to both their patients and their employers. In particular, PE's short-term financial incentives raise specific concerns about whether physicians' obligations to a firm might conflict with their obligations to patients in ways that undermine quality, access, and outcomes. While physician employment by large organizations is not problematic per se, targeted policy interventions to protect physician autonomy and enhance transparency of ownership can act as guardrails to safeguard patient interests.

*Strengthen laws to protect professional autonomy*. The "corporate practice of medicine" (CPOM) doctrine refers to state-specific regulations that prevent corporate entities from owning or exerting control over medical practices. Some state laws make exceptions for all or certain types of nonprofits, and others make no exceptions for nonprofits to own medical practices and employ physicians.[30] Nevertheless, CPOM restrictions have been largely unsuccessful at preventing corporate ownership of physician practices, as some of the states with the most stringent CPOM protections have seen a flurry of PE investments in recent years.[31] This growth is in part due to PE firms relying on a workaround, known as the "professional corporation-MSO," or "friendly professional corporation" model, which relies on management services organizations (MSOs) to exercise functional control over a physician practice.[32] States can strengthen CPOM laws by closing loopholes and directly regulating MSOs to allow medical professionals to maintain ultimate control over key clinical decisions.[31]

*Enhance ownership transparency*. Policy makers, researchers, and the public currently lack comprehensive data on who owns or controls physician practices, which are often acquired or controlled through complex corporate and contractual structures that obscure the identity of PE or corporate investors.[29] Providing a centralized national database to enhance transparency on practice ownership and control can allow patients, policy makers, researchers, and other stakeholders to understand the extent and effects of corporate ownership, including by PE firms. While steps have been taken to improve ownership transparency in certain settings like nursing homes,[33,34] significant gaps in comprehensive data on ownership structures hinder effective oversight and accountability measures. Greater transparency can beget greater trust.

*Strengthen existing fraud and abuse laws*. As Brown et al argue, PE firms' incentives "to rapidly increase the profitability of acquired practices raises risks of overutilization, overbilling or upcoding … and self-referrals for ancillary services."[11] Federal and state statutes, such as the 1972 Anti-Kickback Statute and the 1995 Physician Self-Referral (Stark) Law, "restrict compensation of physicians based on their referral behavior," including by banning explicit compensation arrangements that account for the volume or value of physician referrals.[19] Despite these legal and contractual restrictions, in practice violations could be difficult to detect if referral incentives are hidden within newly formed employment relationships or performance incentives. Increasing

enforcement under existing laws (including the False Claims Act, Anti-Kickback Statute, Stark Law, and state law counterparts) and tightening rules for self-referrals for ancillary services could mitigate incentives for potential overutilization and billing fraud.

*Enforce antitrust laws*. In addition to federal antitrust statutes, many states, including Connecticut, New York, and Oregon, have passed laws to increase scrutiny of health care transactions that fall below reporting thresholds and to improve antitrust monitoring.[35] As my colleagues and I have written elsewhere, "until recently, physician practice consolidation, in general and by PE firms in particular, had faced limited regulatory scrutiny by federal antitrust agencies."[18] Given the Federal Trade Commission and the Department of Justice newly revised Merger Guidelines,[36] examining the cumulative effects of platform and add-on consolidation by PE firms will be key areas for research and policy focus. However, these efforts should be accompanied by enhanced funding and resources for antitrust agencies' oversight of acquisitions most likely to reduce competition.

*Reexamine restrictive contract clauses, including non-compete agreements*. Non-compete agreements aim to balance the interests of the employer, who has invested in the physician's training, and the interests of the physician, who might leave the practice and seek alternate employment. In practice, non-compete agreements restrict physicians from practicing within a particular geographic region after leaving the practice, for a specific period of time. While data on non-compete agreements is limited due to non-disclosure agreements, anecdotal evidence suggests wide variation in the nature of physician non-compete agreements across ownership types, ranging from a 1-year, 35-mile noncompete agreement to a 2-year, 100-mile noncompete agreement.[37,38] These restrictions can disrupt patient-physician relationships, restrict access to care, and prevent physicians from notifying patients or transferring medical records if a physician leaves a practice. The Federal Trade Commission and several states have proposed or passed laws to restrict non-compete clauses in employment contracts.[39,40] Together, these protections would allow physicians to speak out or leave over ethical or professional concerns they encounter in practice.

## Conclusion

Rapid growth of PE investments in physician practices highlights the long-standing tension between medicine as a profession and health care as a business, raising specific concerns about whether PE's short-term financial incentives affect clinical decision-making and the patient- physician relationship by eroding patient trust. By clinicians prioritizing patient interests and regulators enhancing transparency and accountability, in addition to implementing targeted regulatory interventions, clinicians and regulators can foster a high-value and equitable health system.

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POLICY FORUM: PEER-REVIEWED ARTICLE

# Private Equity Strategies in Nonprofit Health Care

Zachary J. Gallin and Emily L. Xu, MD

## Abstract

Private equity firms exacerbate health inequity by driving hospital closures in historically underserved communities. Now nonprofit health systems seem to be adopting private equity practices to do the same. Drawing on a case study of one nonprofit hospital system that has adopted private equity business practices to acquire and close community hospitals, this article argues that nonprofit hospitals' adoption of private equity acquisition and closure practices sacrifices their missions, prioritizes profit, and works to the detriment of local communities. This article construes this set of practices as a breach of organizational ethics that must be addressed via policy changes, specifically by placing guardrails on closures and promoting responsible health care investments.

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## Overview of the Problem

Private equity firms invest in operating companies that are not listed on public stock exchanges. Investors acquire such a company using borrowed money and restructure the acquired company to increase its value before reselling.[1] Private equity firms have become increasingly involved in the health care sector and now own about 460 hospitals nationwide.[2]

Supporters of private equity in health care argue that private equity ownership of clinics and hospitals can increase health care quality and efficiency by prioritizing investments in rapidly growing sectors.[3] However, a growing body of research shows that private equity in health care has increased costs for patients and worsened health outcomes.[4] Furthermore, private equity ownership of health systems has exacerbated health inequities by decreasing access to care through hospital closures in historically underserved communities.[5] Academic discourse on private equity's negative impacts has not yet fully addressed how the business practices of nonprofit hospital systems—which engineer health system mergers and hospital closures to reap profits—parallel those of private equity.

Health system mergers and the growth of private equity in health care share causes and effects. First, both are driven by rising pressure on health systems to increase profit. Second, both are characterized by a power imbalance in which community hospitals and their patients are left at the mercy of wealthy investors. Finally, both often result in critical primary care shortages in historically underserved communities.

Here, we describe a case example of how a nonprofit health system adopted behaviors of private equity companies by acquiring a community hospital and then forcing its closure. We discuss how underregulated free-market economics drive acquisition and closure of community hospitals by incentivizing resource allocation based on profit over community needs. On the basis of our analysis, we call for increased government regulation that promotes responsible health care investments by mandating that nonprofit hospital systems gather feedback from local communities during hospital acquisitions and closures.

## Private Equity Strategies Used by Heath Care Systems

America's first hospitals shared a mission to serve the destitute,[6] but in the 1920s, hospitals were forced to begin generating income due to increasing demand for services and professionalization that raised the cost of care.[7] Between 1980 and 2009, 18% of hospitals closed as expenditures rose and demand fell,[8] while others adapted by shifting services to a wealthier patient population.[9] At the same time, community hospitals merged with larger health systems to survive, resulting in major consolidations. For instance, about 85% of New York State's hospitals were consolidated into larger hospital networks between 2006 and 2019.[10]

Health system consolidation increases health care costs while decreasing care accessibility and quality.[11] As hospitals close, nearby communities suffer from loss of long-time doctors at the hospitals, increased travel distance to care, limitations in accessing emergency services, and fewer health care job opportunities. Furthermore, health care workers may find themselves pushed out of their workplaces and forced to adapt to a volatile health care system.[12] Hospital closures also overburden nearby community hospitals. For example, when a major public hospital temporarily closed after Hurricane Sandy, patients needing emergency care were redistributed to the nearby public hospital at rates unexplained by proximity alone.[13] Increased volume at nearby, already strained hospitals may lead to "spillover effects" that negatively impact the quality of patient care.[14]

Private equity firms have driven community hospital closures by buying health systems, restructuring them to generate short-term profits, and then leaving them with untenable debt.[15] For instance, a private equity company bought a hospital system (Hospital System A) in 2010, then made over $800 million by selling Hospital System A's buildings and land. The private equity company resold Hospital System A to its physicians 10 years later, leaving it bankrupt and forcing the planned closure of 2 of Hospital System A's hospitals.[16] A community coalition has responded to the hospital closures with a series of public rallies.[17] Likewise, community members have called for the state government to impose stricter regulations on the acquisition and closure of local hospitals.[18] The fate of the 2 hospitals is pending.[19]

Some hospital networks have adopted the rhetoric of private equity companies, endorsing the diversion of essential services from the indigent to the wealthy under the guise of "innovation" and "entrepreneurship." For instance, in one city where there are

no private equity-owned hospitals,[2] nonprofit health systems have undergone lucrative mergers in which community hospitals are viewed as assets that can be bought and restructured or closed to increase profits. Nonprofit health systems are fraught with ethical conflict in their mimicry of private equity, as they often present themselves as community benefactors to retain their tax-exempt status despite simultaneously prioritizing profits.[20]

### One Case

These dynamics are exemplified in another case that included a nonprofit hospital system (Hospital System B) and a community hospital it acquired. In 2013, Hospital System B acquired several community hospitals through a merger with a smaller hospital system, thus growing its profit margins through increased negotiating power with insurers and access to new patients.[21] In 2023, Hospital System B announced its plan to close one of the community hospitals it had acquired.[22] It paired these closure plans with a diversion of resources toward more profitable medical services, establishing a concierge clinic in 2018 and a new cancer center in 2021.[23,24]

After announcing its plans to close one of its community hospitals, Hospital System B faced protests from the local community. Community activists formed a community coalition, which demonstrated through a health equity impact assessment that the community hospital's closure would have a devastating impact on many residents, limiting their access to care.[25] Additionally, community members challenged Hospital System B's claims that the hospital's planned closure was due to financial strain, arguing that Hospital System B had deliberately closed the community hospital's most profitable services to create a picture of financial struggle.[26] The local community filed multiple lawsuits against Hospital System B, accusing it of scheming to profit off the sale of the community hospital's real estate. The hospital closure was recently approved by the State Department of Health, but the community hospital remains open while the most recent lawsuit wends its way through the court system.[27]

Although Hospital System B's acquisition of a community hospital and ensuing attempts to close the hospital mirrors the private equity firm's behavior toward Hospital System A, there are key differences. The private equity firm resold Hospital System A's assets, leading to its bankruptcy, which in turn drove 2 planned local hospital closures, whereas Hospital System B is directly attempting to close the community hospital. Furthermore, at the time of merger, Hospital System A was a for-profit company in debt, while the community hospital was part of a financially stable nonprofit. For-profit and nonprofit health systems in the United States are regulated and taxed differently and thus have different obligations to serve the public interest.[28]

Despite these differences, there are uncanny parallels between the business practices of the private equity firm and Hospital System B. Both profited from purchasing a health system and then defunding it and closing services. Additionally, both cases involved pushback from local community members, with calls for increased government regulation of health system mergers and hospital closures.

Overall, the parallels between Hospital System B's management of the community hospital and the private equity company's behavior toward Hospital System A demonstrate how nonprofit health systems may emulate private equity as they undergo mergers and hospital closures.

## Call to Action

Nonprofit health systems' imitation of private equity firms is unethical, as it prioritizes profits over patients and local communities. Envisioning the health care system of our near future, we call on nonprofit health systems to reject replacing their social mission with the values of private equity. To hold health systems accountable, we propose several policy actions at the institutional and government level.

*Institutional implementation of community-based health care model*. Policy reform can create a more equitable distribution of health care resources that improves health outcomes.[29] However, policy solutions must be envisioned in partnership between nonprofit health systems and the communities most impacted by the encroachment of private equity culture in health care. Working with communities requires building long-term relationships, breaking down hierarchies, and rejecting profit as the gold standard. To drive this shift from a private equity model to a community-based health care model, nonprofit health systems must be held accountable. A socially accountable health system is led by community members rather than outsiders with a vested interest in profits. Moreover, in this model, hospitals' success is measured not by the upper limits of their "excess revenue" but by the health of their surrounding communities.

*Government regulation of hospital closures*. While nonprofit health systems strive to implement a community-based health care model, policy makers must address impending hospital closures. For instance, New York State passed a law in 2021 that requires hospitals to submit a health equity impact assessment and certificate of need before closing services.[30] Additionally, New York State enacted Article 45-A in 2023, which requires health systems to notify the public before major mergers or acquisitions, thereby improving transparency.[31] Each of these pieces of legislation limit the power of nonprofit health systems and private equity alike to engage in the unethical business practices that resulted in the rapid planned closure of 2 of Hospital System A's hospitals and the planned closure of a community hospital (vis-a-vis Hospital System B) without substantial community input. Such strong moratoriums on hospital closures are needed to minimize retaliation by health systems and help build community power.

The perverse incentives that led to Hospital System A's planned hospital closures and Hospital System B's planned closure of the community hospital are present across the nation. Therefore, policy makers nationwide must set guardrails on profit-driven financial behavior by nonprofit hospital systems and increase transparency requirements regarding hospital closures in surrounding communities. For example, policy makers should require nonprofit hospital systems to conduct health equity impact assessments and gather community input before closing hospitals or services. Additionally, they should financially incentivize health systems to notify and solicit feedback from local communities during major mergers and acquisitions.

Health care workers can join the discussion of hospital closures by advocating for safety-net hospitals. Specialty-specific advocacy groups can help health care workers amplify their collective voices in conversations with policy makers.[32] As private equity practices pull nonprofit health systems from their social mission, policy change is needed within nonprofit hospital systems and state governments for community benefit. Furthermore, consideration of federal policy reform is warranted, as our case study delineates the consequences of adverse incentives that impact nonprofit hospital systems nationwide.

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MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

# Health Inequity Profiteering by Private Equity Firms

Thomas Statchen and Colleen M. Grogan, PhD

**Abstract**

This article explains how some investment practices of private equity (PE) firms generate profit by taking advantage of inequitably underserved patients in the US health care system. In particular, patients with general medical or mental health needs who seek care at safety-net hospitals or in carceral facilities and patients seeking mental health services are vulnerable to the following PE strategies: purchasing low-quality practices where patients lack opportunities to get care elsewhere, maximizing consolidation of deeply fragmented health service delivery systems, and avoiding accountability for poor-quality service that results from regulatory opacity. For each problem area, the article offers a policy response to mitigate harm to patients.

## Extracting Increased Profit Margin From Vulnerability

Private equity (PE) firms utilize capital from private sources like institutions and individuals to acquire assets, usually with the goal of significantly increasing the value of the asset over a short time period.[1] PE investment in health care has grown substantially over the past 20 years. The number of buyouts of physician practices increased 6-fold between 2012 and 2021.[2] In 2022 alone, over 850 health-care related PE deals occurred.[3] Traditionally, many of these deals occurred in high-reimbursement specialties.[2] However, PE's investments have increasingly extended to practices that care for patients who are particularly vulnerable due to the nature of their illness or structural inequity in the health care system. Through these investments, PE firms are identifying specific methods by which to profit from this vulnerability—with little evidence of improved care.[4,5,6] Here, we will focus on why PE investments in health care are ethically troubling when PE firms target specific groups of vulnerable patients. To illuminate this argument, we focus on the following cases—safety-net hospitals, prison health care, and behavioral health—although the argument can be extended to other health care settings or sectors serving vulnerable populations.

## Ethics Trouble

While for-profit companies have long invested in health care, 3 main features of PE—moral hazard, short-term horizon, and lack of disclosure—make investments in entities that care for vulnerable patients concerning because they allow profit to be reaped from bad behavior rather than fair competition, with no accountability mechanisms in place. First, PE firms acquiring companies through leveraged buyouts results in a classic

problem of moral hazard, wherein the general partner entity is protected from negative consequences of its management decisions but stands to gain from high rates of return because leveraged buyouts are largely funded by debt, with the general partner entity putting up as little as 1% to 2% of equity but receiving as much as 20% of the returns.[7] Second, because PE firms promise investors a high return in a short time period, most PE-backed firms are expected to sell companies within 5 to 7 years of acquisition, which creates an incentive to boost profits quickly rather than focus on long-term, sustainable investments.[7] Third, because there are no consistent regulatory requirements for PE firms to disclose details of their acquisitions,[8] the management practices of PE-acquired health care companies and the practices of PE firms remain opaque, with the result that it is extremely difficult for policy makers or patients to hold PE firms accountable. Rarely do patients know if they are receiving care from a PE-backed provider. As such, if problems do occur, the patient blames the hospital, for example, but not the PE firm that acquired it. As described below, the combining of these features with the structural features of vulnerability highlights PE's bad behavior in pursuit of profit without—or with delayed—accountability.

### Exploitation of Lack of Choice

A core principle on which markets rest is choice of provider of a good or service.[9] However, vulnerable populations, particularly individuals who are incarcerated or mandated to receive rehabilitative services, frequently do not have choice or even the ability to advocate concerns about where they receive health care services. Because these patients lack political power, there are few powerful countervailing voices when PE causes harm.

PE firms have invested heavily in prison health care and the "troubled teen industry" that provides behavioral health care to adolescents with significant needs.[10,11,12] Two of the largest companies that provide prison health care across many states are both PE owned. In 2017, these 2 companies were projected to make $2.5 billion in profit.[13] These profits came largely through capitated payments from local governments to provide health care within prisons. As is often the case for stigmatized populations with little political power, most states failed to oversee or monitor the publicly funded care provided to these groups.[14,15] This fact, alongside patients' lack of choice in the care received, allowed PE companies to cut costs significantly, boosting profits. A *CNN* investigation in 2019 found that the focus on "cost containment" of one company that provides prison health care led to the deaths of patients within its care.[16] An analysis by *The Nation* revealed that lowering clinician-to-patient ratios within prisons was a major cost-cutting practice. For example, another prison health care provider only employed 15 physicians for a contract covering 25 000 prisoners in Alabama.[17] In the troubled teen industry, one large provider was controlled by different private equity firms from 1998 to 2015. During this time, state regulatory agencies in Oregon and California shut down or reprimanded the provider's facilities over concerns about safety and quality, including incidents that led to the deaths of children in their custody.[12]

While prison health and the troubled teen industry are extreme examples, PE firms take advantage of similar dynamics in nursing home and hospice care. PE-backed nursing homes have reduced clinician-to-patient ratios, which contributes to the higher-than-average mortality rates among these vulnerable institutionalized patients with restricted autonomy in choosing or changing clinicians.[5] After findings demonstrated lower nurse staffing, declining compliance with quality measures, and higher mortality rates in PE-backed nursing homes came to light,[5,18] President Biden passed an executive order

directing the Centers for Medicare and Medicaid Services to write new staffing rules to increase quality of care and protect safety.[19] One new rule, passed in April 2024, is a 24/7 onsite registered nurse requirement for nursing homes.[20] Although staffing regulations are an important way to hold nursing homes accountable, it is noteworthy that the regulations come after many years of abuse and do not target PE behavior or extend to other sectors with significant PE investments. As such, policy makers should proactively consider care quality and labor regulations that target PE behavior in clinical settings where patients have limited or no options instead of waiting many years for abuse to surface. On PE's role in prison health, it might be helpful to follow New York City's lead in eliminating contracts with PE-owned health care providers for correctional health services and instead providing care through a public benefit corporation to reduce the profit motive and lack of accountability.[21]

### Exploitation of Fragmentation for Monopoly Power

A common PE investment strategy is to target vulnerable health care sectors characterized as fragmented and undercapitalized. The substance use disorder (SUD) treatment system was historically operated primarily by small treatment provider organizations that received funding through government block grants.[22] When the Affordable Care Act of 2010 required Medicaid programs to cover SUD benefits, these small treatment centers needed capital to invest in the electronic records and billing systems necessary to submit claims to state Medicaid programs and Medicaid managed care organizations.[22] This need for capital created an opportunity for PE firms to acquire small SUD provider organizations through a process referred to as a "roll-up," which provides economies of scale by consolidating administrative and infrastructure costs. Such roll-ups are a win for PE firms because they are assured consistent Medicaid reimbursement while keeping costs down. PE investment also seems like a win for SUD treatment providers because they receive needed capital with the promise of improved patient care.[23] Although an apparent win-win, especially for a sector that has long suffered from lack of investment, the roll-up process over time has contributed to massive consolidation in the behavioral health care sector (and more broadly in the US health care system).[24] Numerous studies concur that higher health care prices is one of the main effects of consolidation.[25] In health sectors serving vulnerable patients, such as behavioral health, monopoly power is also associated with troubling patient care practices. PE acquisitions of opioid treatment programs (OTPs), largely stand-alone clinics known as methadone clinics, provide a telling example. Methadone is one of the most effective medications for opioid use disorder. It is tightly regulated and can only be dispensed through OTPs.[26] A 2020 study found that for-profit methadone clinics were more likely to underdose patients compared to nonprofit providers.[27] Today, 65% of methadone clinics are for profit, a dramatic rise in the last 20 years that is tied to increasing investment by PE firms.[4,24] These firms own 30% of methadone clinics nationally, and every clinic in certain states—providing one firm with a statewide monopoly.[4]

PE-backed OTPs fight to maintain required onsite dosing of the medication, which pays 5 times more on a weekly basis for opioid use treatment than the cost of the medication itself.[4] The funding for onsite dosing is intended to be spent on drug testing and counseling, which, in conjunction with methadone, have mixed evidence of effectiveness.[4] These additional services are not required for dispensing of methadone in other countries, such as the United Kingdom, Australia, and Canada, where general practitioners and pharmacists can prescribe and dispense the drug.[28] The high costs associated with this approach have led addiction treatment providers to call for a

reexamination of these policies to make treatment more affordable and accessible.[28] However, PE firms have collaborated to retain or form lobbying groups aimed at maintaining the status quo, opposing legislation aimed at allowing take-home prescriptions.[4] This example demonstrates how PE's monopoly power translates into political power, which can be used to advocate for the continuation of flawed clinical practices.

Policy solutions to address roll-ups and private equity-generated monopolies may already exist through antitrust regulations; federal investigations now target roll-ups for possible anti-competitive behavior. In 2023, the Federal Trade Commission (FTC) began a lawsuit against a an anesthesia group and the private equity firm that created it, alleging that they engaged in rolling-up a significant portion of anesthesia practices in a particular state to "drive up the price of anesthesia services provided … and boost their own profits."[29] For this approach to be effective, however, the FTC needs more capacity to take on very large firms with deep pockets that can lawyer up and stall FTC legal procedures, often for many years.

### Exploitation of Regulatory Opacity

Through opaque, purely financial dealings, PE firms can profit from vulnerability. Until recently, PE firms have largely been able to shroud their ownership influence,[30] which allows them to avoid blame when problems emerge. Moreover, due to vulnerable patients' lack of political power, PE firms' opaque financial dealings can go unexamined until it is too late. For example, one academic center serving a primarily low-income community was purchased by a PE firm that ran the hospital in partnership with another PE firm that owned the real estate. The hospital subsequently went bankrupt, but the investors were able to sell the real estate.[31] While it is unclear whether or how much profit was made due to the lack of disclosure, it is clear from reporting after the closure that, while patients were transferred to new hospitals—often with severely fragmented care—the financial actors involved in the deal have recouped their losses.[32] This set of occurrences is not unique: similar events have played out at other vulnerable hospitals, such as a multi-hospital system from which investors garnered nearly $700 million in profits through dividend recapitalization, among other financial mechanisms.[33] In this instance, the diversion of profits did not attract major attention from state regulators until a decade after purchase, at which point the already poor financial state of the system resulted in reductions in services, laying off of workers, and sale of hospital real estate around the country.[33] This lack of oversight was likely worsened by the limited political power of the uninsured patients with low income that the system's hospitals primarily served.

The harm caused by the opaque financial dealings of private equity can hopefully be prevented or mitigated through increased requirements for transparency. California is currently considering a bill to require health care transactions by PE firms to be disclosed in advance, which would be an important first step.[34] However, transparency must also be tied to clear processes for oversight that identify when regulators should step in. Furthermore, to protect vulnerable patients' access to health care, government should consider ways to invest capital in needed community resources like safety-net hospitals, which may not be able to otherwise access it. While PE did not create inequities in the US health care system, allowing unregulated private investments to target distressed safety-net systems has accelerated these trends. There is no evidence of true, positive disruption caused by PE investment. Instead, PE investment seems to focus on devising ways to derive profit from safety-net hospitals' struggle and failure.

## Next Steps

Throughout this article, we have called for increased oversight and regulation of PE firms. Oversight can be effective: in the case of one hospital system, Rhode Island regulators made approval of the PE firm's sale of its stake contingent on the firm's putting $80 million in an escrow account to ensure that the firm's 2 Rhode Island hospitals remained open.[33] However, without improved transparency, it is difficult to systematically implement guardrails. At a federal level, there have been bills introduced that would reform the industry by improving transparency and requiring PE firms to take more responsibility for the financial health of their investments.[35] Improved transparency would also allow for more systematic study of the impact of PE, which could shed more light on the concerns we have raised.

It is important to recognize that PE is acting as an accelerant of existing failures baked into the structure of our fragmented, segregated, and inequitable health care system by more efficiently exploiting these failures for profit.[36] Because vulnerable populations face structural barriers to accessing care, clinicians and health care organizations should also consider advocating for the creation of a universal system of care, thus reducing the vulnerability of specific patient populations.

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MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

# How Private Equity Undermines Rural Health Equity

Jake Young, PhD, MFA, MPH

**Abstract**

Capital and staff shortages have forced many rural hospitals to close. Private equity investment in rural hospitals has been one solution to these problems. This article argues, however, that private equity firms' business practices, especially shortening acquisition-to-sale time and maximizing profit margin, generate overall health care market instability. This consequence can be particularly devastating for people living in rural areas of the United States, who report worse health outcomes, more chronic disease, and more restricted access to health services than people in urban or suburban regions.

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## Rural Hospitals and Private Equity

Rural hospitals face fiscal challenges due to high levels of poverty and often a lack of state Medicaid expansion,[1] which are contributing factors in the increased rates of closure and staffing shortages that plague rural hospitals.[2] In comparison to urban populations, rural communities also generally experience worse health outcomes, including higher rates of chronic disease, serious mental illness, and all-cause mortality.[2] Rural residents also often have difficulty accessing care due to the distance to and the availability of treatment.[2]

The dire financial situation of many rural hospitals makes them an attractive investment for private equity firms seeking to make a quick return. Yet these potential profits gamble with the lives of patients and the livelihoods of their practitioners. The private equity business model aims to maximize earnings before interest, taxes, depreciation, and amortization, commonly used as a proxy for cash flow. Toward this end, private equity firms seek high returns on their investments, including hospitals, by selling them again for a profit of at least 20%, usually within 3 to 7 years of the acquisition.[1,3] This primary focus on return on investment is inherently at odds with health care's primary ethical commitment to the health and well-being of patients. Hospitals, regardless of their financial model, have responsibilities to use health care resources to provide quality care to the communities they serve and are ethically obligated to prioritize patient care above all other considerations.[4]

## Investment Strategies

PE investment in health care increased over 20-fold from 2000 to 2018.[2,5] Overall, private equity firms are more likely to target hospitals located in metropolitan areas with populations of at least 1 million people compared to rural areas.[6] However, the private equity business model has not left rural hospitals untouched, with many recent acquisitions centered on for-profit hospitals in the southern region of the United States.[6] These hospitals are attractive to private equity firms because they are often financially vulnerable, with over 30% of rural hospitals estimated as being at risk of closing or losing services.[7] Private equity firms view these hospitals as cheap investments, but the risk that these firms take on is not simply financial risk—in a very real sense the risk of these investments is borne by physicians and the patients they serve who may lose their jobs and their access to care, respectively, if the hospital reduces services or ends up closing.

Private equity firms typically purchase hospitals through a leveraged buyout, whereby the hospital itself serves as the security and the purchase is financed through loans.[3] Private equity firms then aim to increase their profits dramatically or liquidate the most valuable assets of the hospital.[3] Other strategies include sale-leaseback transactions or dividend recapitalizations.[7] A sale-leaseback transaction is when a company sells its land and then leases it back to generate revenue.[8] The sale-leaseback strategy can be especially problematic for hospitals that are already struggling financially prior to takeover because it decreases the assets the hospital has while at the same time increasing monthly operating costs.[8] As a result, it can be difficult for hospitals to continue to pay their staff competitive wages and provide the necessary resources to render services to patients. Sale-leaseback was the strategy used by Lateral Investment Management, which acquired Santa Cruz Valley Regional Hospital in Green Valley, Arizona, out of bankruptcy in 2018 for $26 million.[8] After receiving millions of dollars in pandemic relief funds and selling the hospital's real estate for $60 million in 2021, Lateral Investment Management closed the hospital in 2022, leaving the rural community without its only hospital.[8] Dividend recapitalization is a type of leveraged recapitalization in which a company raises debt—and typically lowers equity—to fund increases in cash dividends to shareholders.[8] Dividend recapitalization can also lead to negative outcomes for hospitals because it often leaves them with increased debt.[8] Many rural hospitals already struggle financially, and leaving them riddled with debt after a private equity acquisition can be disastrous.

These investment strategies can lead to a reduction of funds for staffing and treatments, lower quality of care, and, ultimately, the closure of hospitals. Closures of rural hospitals have been increasing in recent years and are more likely to be of for-profit hospitals.[2,9,10,11] When rural hospitals close, many patients often lose access to care because they live in health care deserts where people lack access to adequate health care services. As underscored by this consequence, the business practices of private equity firms are fundamentally at odds with the values of health care. The risk they take on is not simply financial risk but risk that entire patient populations must bear, as private equity acquisition upsets the ethical norms and commitments of hospitals and potentially leads to greater instability within the health care system, which can have a direct impact on the health and well-being of patients.[12]

## Undermined Health Service Marketplaces

Despite the concerns many physicians have regarding private equity acquisition, there are some potential benefits that may arise when private equity obtains ownership of a

hospital. Private equity firms can provide hospitals with access to needed capital and can shift the administrative burden of managing a practice away from physicians so they can focus more on clinical care.[3]

By entering into the health care market, private equity firms assume an ethical responsibility to adhere to the values of the medical field. Just as a business owner who becomes a judge is expected to adhere to the ethics and morals of the courtroom rather than to those of business when in their capacity as an arbitrator of the law, so private equity firms are ethically obligated to follow the ethical norms of the medical profession when they choose to enter the health care market. This means placing an emphasis on utilizing health care resources to prioritize quality patient care over quick returns on investments, which is in stark contrast to private equity firms' current practices.

Strategies employed by private equity often negatively impact rural as well as urban hospitals. Leveraged buyouts can lead to financial instability, which can be deleterious for hospitals that are already facing financial difficulty, as is the case with many rural hospitals.[13] Private equity firms' focus on investment returns can also lead to many negative quality and cost outcomes for hospitals and for patients,[14] and it can create conflicts of interest for physician employees who may feel that the financial goals of private equity firms are at odds with their own professional and ethical duties to provide quality care to patients.[2]

There are also legal concerns that private equity firms' involvement in health care violates the Anti-Kickback Statute (AKS; formally, the Medicare and Medicaid Fraud and Abuse Statute) and the False Claims Act (FCA), which were enacted to protect patients and federal programs from fraud and abuse.[15,16] The AKS is intended to prevent exchanges of money or other valuable goods or services that influence referrals for services or items covered by federal health care programs, while the FCA is intended to penalize false claims related to billing for services reimbursed by the federal government.

Common strategies that private equity firms rely on to increase revenue include cutting staff to minimize costs and increasing the prices for services (especially high-volume services).[5,8] Increases in prices may make health care services unaffordable for some patients. This is especially problematic in rural health care settings, where patients are more likely to have low income.[17] Additionally, by reducing staff, there might not be enough personnel to provide quality patient care, which can also lead to moral distress and physician burnout.

A primary means by which private equity firms increase prices and reduce access to care is through health care consolidations. To expand market share and increase value, private equity firms often employ an add-on approach in which they acquire smaller add-ons after the initial purchase of a large, established health care entity. This practice by private equity has dramatically increased acquisitions and mergers and industry consolidation within health care over the past decade.[5]Although consolidation can lead to facility closures, it may also lead to the formation of multiple-hospital affiliations that create economic stability and prevent closures, which could be beneficial for rural hospitals already at financial risk.[18] Health care market consolidation has rapidly increased over the past 2 decades, and advocates tout the benefits of these mergers, such as increased coordination and reduced administrative costs. However, the evidence suggests that market consolidation actually leads to increased prices, reduced

quality of care, and negative impacts on innovation and competition.[19] Not only do cross-market mergers within health care lead to price increases, but there are concerns that large health systems that acquire smaller, rural hospitals may be less responsive to community needs by eliminating services, reducing spending on community benefits, and ultimately reducing access to care.[20]

Analyzing the impact of private equity acquisitions can be difficult, however, since acquisitions generally go unreported and unreviewed, as they typically do not exceed the financial threshold for mandatory reporting.[8] Furthermore, private equity firms' widespread use of nondisclosure agreements adds to the opacity of their transactions and the effects they have on the health care industry.[21] The secrecy with which private equity firms are able to operate obscures the fact that the risks that they take on through their acquisitions are directly felt by patients. Stronger oversight and new regulations to ensure greater transparency of these acquisitions and mergers are needed to better protect the populations that these hospitals serve.

## Protecting Access

To protect rural hospitals from the deleterious effects of private equity investment, federal and state governments need to leverage the current tools at their disposal to increase oversight of private equity health care acquisitions to better hold the investing firms accountable. They can do so by utilizing federal antitrust laws to prevent health care acquisitions and mergers from creating monopolies and by further leveraging the FCA and AKS to deter private equity firms from engaging in illegal and unethical practices. The federal government already incentivizes whistleblowers to file FCA lawsuits by offering to award them up to 30% of the government's recovery,[22] but hospitals should also consider including formal mechanisms for medical employees to bring forward FCA claims as part of official reporting mechanisms to help establish a culture of compliance.

Aside from relying more on existing laws and regulations, federal and state governments should also consider amending current policies and creating new laws to increase regulation of private equity firms. For example, Congress could amend the FCA to target specific business practices not currently prohibited or broaden liability for corporate investors under certain circumstances. This type of policy change could also limit the use of sale-leaseback strategies and dividend recapitalization, while simultaneously offering greater protections for hospital staff. Congress could also "update federal health care laws, such as the Social Security Act, that require certain hospitals and other providers to disclose information regarding their ownership."[23]

Notably, in June 2024, Massachusetts senators Ed Markey and Elizabeth Warren introduced the Corporate Crimes Against Health Care Act, aimed specifically at private equity investors in health care. The bill includes requirements that health care providers that receive federal funding publicly report changes in ownership and financial data, provides mechanisms to financially penalize executives for "serious, avoidable, financial difficulties," and creates criminal penalties when private equity "looting" of a health care entity results in a patient's death.[16] Some state legislatures have also made recent moves to regulate private equity investment in health care, including New York, California, and Massachusetts.[16]

One of the greatest dangers of private equity investment in health care services is the lack of transparency that allows these firms to take on financial risk that is felt by

patients and practitioners as risk to their health and livelihoods, respectively—a situation that pits a commitment to shareholders against a commitment to health and well-being. It is therefore imperative that the government increase oversight of private equity acquisitions of hospitals, particularly rural hospitals. However, increased oversight alone is not enough. It is also essential that federal and state governments increase funding for rural health care institutions to ensure that private equity does not exacerbate the closure of rural hospitals and to ensure that rural populations can obtain appropriate and timely, quality health care.

As mentioned, rural hospitals tend to attract private equity interest when they are struggling financially. If these hospitals were better funded, there could be less incentive for rural hospitals to sell to private equity. More government investment could help improve rural health outcomes and help ensure that rural hospitals are able to pay their staff members fair and competitive wages while delivering quality health care.

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MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

# When Does Private Equity Ownership of Physician Practices Violate "First, Do No Harm"?

Preethi Subbiah and Richard M. Scheffler, PhD

**Abstract**

One driver of the corporatization of medicine has been private equity (PE) firms' acquisition of physician practices. This article describes when PE firms' investments in or ownership of physicians' practices undermine health service delivery operations and patients' outcomes to the point of violating *primum non nocere*, a key ethical requirement for physicians to prioritize harm avoidance in practice. This article then suggests how to balance the interests of health care as a commercial enterprise with health care as a critical human right.

## Avoiding Harm

A foundational ethical value in modern medicine—"first, do no harm"—is attributed to the modern Hippocratic Oath, a variant of which is sworn by most American medical school graduates.[1] But this guiding principle is being violated in ways never imagined, as private equity (PE) firms buy up physician practices and put profits ahead of patients.[2] Research by Kannan et al and Borsa et al has shown that, as PE acquisitions grow, prices increase and patients suffer from lower-quality care.[3,4] To understand this ethical dilemma, we begin by explaining the evolution of corporate practice of medicine (CPOM) laws and their role in the regulation of medical practice. We then discuss what PE is, how it operates and changes the practice of medicine, and new laws that are being proposed to strengthen the CPOM. We end by discussing how laws need to protect physicians' autonomy to ensure provision of the best services for patients.

## Legal Evolution

During the early 1900s, courts and physicians began to place restrictions on who controlled the operation of hospitals.[5] Physicians determined treatment plans, diagnoses, and relationships with patients. However, if the practice was owned by a corporation, these factors could be decided or heavily influenced by the corporate owners. Over time, the CPOM doctrine was introduced to prevent business interests from superseding patient interests. To ensure that corporations' financial interests align with their ethical obligations to patients and doctors, the CPOM doctrine holds that corporations cannot practice medicine or employ physicians to provide professional medical services.[6] This doctrine protects physicians' autonomy in exercising their clinical judgment. Most states have a CPOM law that prohibits nonphysician entities from

practicing medicine or employing physicians.[6] However, CPOM laws differ by state. Seventeen states have no CPOM laws, twelve have laws with exceptions for all nonprofit corporations, eleven have laws with exceptions for specific types of nonprofits, and eleven have laws with no exceptions.[7] This variation allows state governments to address the individual needs of the state and apply policies that align with their political priorities. For example, in California, nonprofit corporations can hire clinicians as long as they do not charge patients for their services,[8,9] and in Arizona, nonprofit organizations can provide medical services only through physicians who have been licensed to practice in the state.[10] In Nevada, nonprofits that are organized as medical groups can employ physicians,[11] and in North Carolina, charitable organizations are exempt from the CPOM.[12] With the increasing number of PE acquisitions in health care, these laws play an even greater role in protecting patients and physicians.

### Private Equity Growth

PE firms operate as partnerships, wherein fund managers raise money from institutional and wealthy investors to purchase hospitals, physician practices, and nursing homes and contribute only a small portion of the fund's total assets themselves.[13] The majority of the funds used for acquisitions come from large investment banks in the form of debt with the acquired entities' assets being placed as collateral.[14] PE funds typically follow a "2-and-20" fee model, charging an annual management fee of 2% of the invested money and taking 20% of the profits.[15] These funds usually have a lifespan of 10 years from soliciting to returning results on investment, during which they acquire, manage, and sell companies, usually within 3 to 5 years, to enhance their value through restructuring, capital investment, and management expertise.[15]

The PE business model in health care changes how entities operate, which can lead to several kinds of harm. To boost profitability, acquired entities typically undertake cost-cutting measures that can adversely affect the quality of care, such as replacing highly qualified workers with lower-paid staff and reducing operational costs.[16] By cutting costs and billing for more care, the firm seeks to increase the profits that it makes for its shareholders. PE managers might place intense pressure on physicians "to perform more profitable procedures or to shift the business focus from a less profitable practice to a more profitable practice."[15] As employees, physicians have limited say in these decisions. Market conditions in health care that incentivize PE firms to enter include continued growth in health care spending and the need for practices to have capital in order to expand and stay competitive in a rapidly consolidating market. PE firms also produce financial harm by engaging in consolidation strategies to dominate markets, thereby increasing their pricing power and leveraging acquired companies for further growth.[3,15] These practices can lead to increased market concentration, higher prices, and potentially lower quality of care.[3] Despite their potential for harmful impacts, many PE acquisitions escape antitrust scrutiny due to existing reporting thresholds and regulatory gaps,[17] making effective oversight challenging.

PE's influence on health care has notably surged over the past decade, with firms acquiring 5779 physician practices in 307 metropolitan areas between 2012 and 2021.[18] In about one-third of US metropolitan areas in 2021, PE firms held over 30% market share in at least 1 specialty.[15,18] Physicians selling their practices reap monetary rewards. Typically, the payout is in the millions, depending on the specialty. Physician sellers can retain a share in profits of PE firms, although they lose influence over time.[19] This option is attractive to senior physicians, especially those looking to retire.

## Strengthening Regulation

With increasing PE acquisitions in health care, the US government, at both the federal and the state level, is attempting to increase scrutiny of these transactions. On the federal level, Senators Sheldon Whitehouse and Chuck Grassley launched an inquiry into PE in health care,[20] and Senator Edward Markey introduced the Health Over Wealth Act to regulate investor-owned health care activities.[21] The Federal Trade Commission (FTC) has also taken action by suing United States Anesthesia Partners for alleged antitrust violations,[22] thereby highlighting the risks of financialization in the health sector. Meanwhile, a joint inquiry into PE control of health care involving the FTC, Department of Justice, and Department of Health and Human Services further underscores this growing scrutiny.[23]

Additionally, recent state legislative efforts emphasize the growing need to regulate the consolidation of health care systems and the influence of PE and corporate entities on medical practices. Oregon's HB 4130,[24] to be reintroduced in the 2025 cycle, prohibits individuals from holding positions in both a medical corporation and a management services organization with which it has a contract. Oregon is 1 of 2 states so far that has proposed new CPOM legislation targeting the "friendly professional" corporation model. Importantly, it is the only bill that would allow the blocking of a PE transaction by a state agency.[25] Massachusetts also focuses on the friendly physician model but does so through transaction oversight and limiting real estate agreements between PE firms and health care entities.[26] In New York State, Article 45-A has been in effect since August 1, 2023.[27] It requires health care entities to notify the Department of Health about significant transactions, thereby enhancing transparency and public oversight.

These legislative measures collectively highlight the range of concerns regarding the CPOM doctrine and the push for profits over patient care that can result when PE purchases a physician practice.

## Corporate Clinicians?

PE ownership, with its prioritization of profit, challenges physicians' dual goals of doing what is best for the patient and for the profitability of the practice. In PE-owned practices, the PE firm has control of finances, billing, management, and operations, which can conflict with the principle of "do no harm." For example, the push for profits might include incentives for doctors to overtreat patients, suggest more profitable treatments, or perhaps shorten the visit times with patients to increase volume. CPOM laws are intended to give physicians more control of the practice, especially treatment decisions and patient care plans.

What does that mean for health care as a commercial enterprise? To consistently ensure patient protection, laws need to protect the autonomy of physicians over the push of PE firms to maximize profits. Since most stakeholders are focused on their own interests, there is a need for government regulation to strengthen the autonomy of physicians while also allowing the practice to make profits. We conclude that PE firms present a great challenge to the practice of medicine and the ethical responsibility of physicians to do no harm. We suggest that physicians use clinical guidelines and their best judgment regardless of who owns the practice. However, they should be especially mindful when the practice is owned by a PE firm. Physicians can mitigate the influence of PE ownership through professional organizations such as the American Medical Association or their county medical societies. Moreover, when physicians consider selling their practice, PE is not the only option; physicians might consider alternative

business arrangements, such as selling their practice to a nonprofit hospital, health system, or other physician-owned organization that is generally more concerned with the health and well-being of patients.

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ART OF MEDICINE

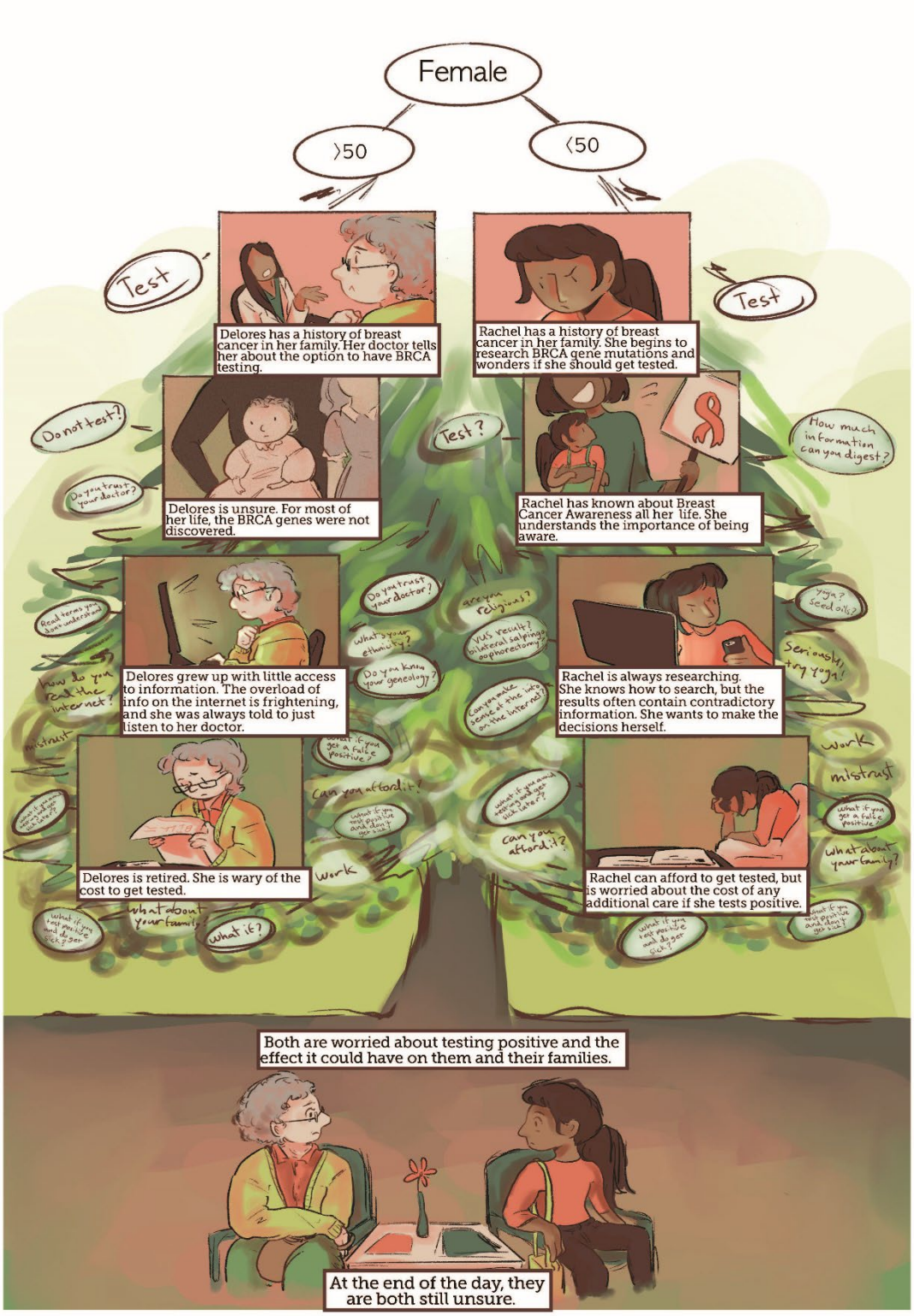
# Wavering on Branches of a Decision Tree

Lio Barnhardt

**Abstract**

Risk-benefit analyses are part of most health decisions and are investigated visually and narratively in this comic, which follows a story of 2 women assessing merits and drawbacks of breast cancer testing.

**Figure.** *Decision Tree Comic*




Abbreviation: BRCA, breast cancer.

## Media

Procreate digital illustration.

## Caption

Risk assessment decisions about whether to test for breast cancer (BRCA) gene mutations can be confusing and are certainly multifactorial. Decision trees are common visual tools for mapping choices and their possible consequences. This tree follows the story of 2 women—differing in age, internet and health literacy, and risk tolerance—struggling with decisions about whether and when to undergo BRCA testing. As their decision paths travel figuratively down the tree, their option sets become more complex and overwhelming. Although we live with a persistent influx of information, information does not make knowledge without individual investments in thinking and carefully applying that information to oneself and other stakeholders. Overall, as Delores and Rachel learn, choices might only rarely, if ever, be "correct," but they should be made with care, not only for our own selves, but for the relationships in which our selves are held.

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VIEWPOINT: PEER-REVIEWED ARTICLE

# How Should We Assess Quality of Health Care Services in Organizations Owned by Private Equity Firms?

Ambar La Forgia, PhD and Ryan C. McDevitt, PhD

**Abstract**

This article assesses research on private equity ownership's influence on health care quality. A review of several prominent studies supports the conclusion that private equity ownership does not have a universally positive or negative effect. Past research has found that providers backed by private equity generally have mixed quality outcomes post acquisition, depending on the sector and measures evaluated. This article outlines ways in which research findings are misconstrued and cautions against drawing conclusions from a narrow sample of literature about private equity based on studies in one sector.

*The American Medical Association designates this journal-based CME activity for a maximum of 1* AMA PRA Category 1 Credit™ *available through the* AMA Ed Hub™. *Physicians should claim only the credit commensurate with the extent of their participation in the activity.*

## Private Equity in Health Care

Over the past decade, private equity (PE) firms have invested hundreds of billions of dollars across the US health care system.[1] The rise of PE in health care has coincided with heightened scrutiny of its influence by academics, policy makers, and politicians. Critics view PE's emphasis on maximizing returns through cutting costs and negotiating higher payments as inevitably leading to unaffordable and lower-quality care.[2] Workshops like the Federal Trade Commission's March 2024 event often take a highly critical view of PE,[3] admonishing the entire investment class for a perceived decline in quality following buyouts of hospitals, nursing homes, and various other providers. Empirical evidence offers some nuance for making these assessments, with studies showing equivalent or improved outcomes after PE firms obtain an ownership stake, depending on the sector.[4] Specifically, proponents of PE's growing role point to its success at providing access to capital, streamlining operations, and turning around underperforming entities through financial discipline and better management practices.

This article assesses research on private equity ownership's influence on health care quality and cautions against drawing conclusions from a narrow sample of literature about private equity based on studies in one sector.

## Looking Closer at Outcomes

A recent meta-analysis of PE in health care shows why reductively labeling these investments as "good" or "bad" would be misguided. In Borsa et al's exhaustive review, nearly one-third of the studies focused on nursing homes, with hospitals and dermatology together composing another third.[5] That nursing homes make up a disproportionate share of the research on PE should immediately caution against reaching any broad conclusions. Although nursing homes play an essential role in the health care system, they may not reflect what would happen in sectors like surgery or anesthesiology. Borsa et al found that, of 8 studies evaluating health outcomes, only the 3 studies on nursing homes found any harmful effect of PE.[5] In other health care settings, PE was associated with no or moderate improvements in health outcomes,[5] a finding somewhat at odds with the prevailing narrative that PE is always and everywhere bad for patients.

Borsa et al also distinguish "quality" from other outcomes, defining quality "as any measure included on an established, specialty specific evaluation instrument, or more general measures such as staffing per patient day or appointment availability" or readmissions.[5] Under this definition, 27 studies included in the review evaluated quality, with 21 finding at least some harm and 12 finding at least some benefit. By a nearly two-to-one margin, then, a cursory review of the literature would once again suggest that PE is decidedly bad for patients. A closer look, however, reveals that benchmarks like facility staffing could be better viewed as imperfect proxies for more direct measures of health outcomes like mortality. Although one might argue that a better staffed facility is likely to be a higher quality one, relying solely on this measure to assess the impact of a PE investment would be akin to judging the quality of a basketball team solely by the number of players on its roster; basketball teams are ultimately judged by the number of games they win, just as health outcomes serve as the final say on a health care provider's effectiveness. With only one article in the review finding "harmful" quality that ultimately translated into "harmful" outcomes,[6] the practical relevance of these quality measures—at least beyond nursing homes—remains unclear.

Because patients may find it difficult to assess, or even observe, their quality of care, PE firms may instead invest in improving more salient measures of quality, such as recommendation, satisfaction, or experience scores. By these measures, 4 studies in Borsa et al's review found negative effects on patient experience in nursing homes and hospitals following PE acquisition,[7,8,9,10] whereas Gandhi et al provide evidence that only after the Centers for Medicare and Medicaid Services introduced a 5-star rating system did PE-backed nursing homes divert resources toward the measures being evaluated.[11] A patient's experience and quality of care can also be influenced by physician burnout. While PE firms may decrease burnout by reducing financial uncertainty and providing managerial support, they could also exacerbate it by restricting physician autonomy and increasing patient caseloads.[12] For these alternative measures, more data-driven analysis is needed before making any definitive conclusions about the impact of PE on quality.

## Critiques

An ostensibly clear case of care deteriorating at PE-backed providers comes from a recent, award-winning[13] study of hospital-acquired conditions.[14] The article attracted considerable media interest, with profiles in the *New York Times*[15] and commentary in the *Washington Post*.[16] Regulators and politicians took notice as well: Congresswoman Katie Porter, for instance, posted on X that, "Shocking no one—when private equity firms

take over hospitals, the quality of care decreases. Every Californian should receive the health care they need and deserve, regardless of who owns their hospital."[17] This outsize media attention stands in contrast to the nuanced findings in the article, however, and illustrates the need to remain circumspect about the broader conclusions one can draw from such research.

First, the article's main finding, and the one mentioned most prominently in headlines and politicians' social media posts, is a 25.4% increase in hospital-acquired conditions following a PE acquisition.[14] At baseline, such hospital-acquired conditions, like a patient fall or bloodline infection, are exceedingly rare, making up 0.2% of all hospitalizations.[14] Placed in this context, the reported increase in such conditions relative to the number of hospitalizations at PE-acquired hospitals of 4.6/10 000 would lead to 2.3 more adverse events each year at a typical hospital with 5000 annual hospitalizations. Although the headlines report an alarming surge in hospital-acquired conditions, the risk of contracting one at a PE-owned hospital was 0.01% higher than at similar facilities in the control group.[14]

Second, the article uses different econometric methods for the main results and those in the supplement. When using the Callaway and Sant'Anna method for estimating difference-in-differences with multiple time periods in supplement eTable 13, the overall increase in hospital-acquired conditions in PE hospitals falls by a third, to 3.0/10 000, and 2 of the 12 hospital-acquired conditions flip to a statistically insignificant reduction.[14] More fundamentally, PE-acquired hospitals had a lower rate of adverse events to begin with and therefore had less room for improvement, but the article's statistical model assumes that PE-backed hospitals would have experienced the same drop in hospital-acquired conditions as the comparison group had it not been for the change in ownership. For example, falls and trauma at PE hospitals remained constant at 6.8/10 000 post acquisition but fell from 8.7/10 000 to 6.9/10 000 at the control hospitals.[14] Through the lens of the article's difference-in-differences research design, the relative lack of improvement at PE hospitals is interpreted as a 27.3% decline in quality even though their rate stayed constant at 6.8/10 000—in fact, it remained slightly better than the comparison group's post-acquisition rate of 6.9/10 000. Taken to an extreme, even a PE-backed hospital with no hospital-acquired conditions whatsoever would be viewed as having caused quality to decline when, in reality, the differential trends at PE and non-PE hospitals are due to non-PE hospitals approaching the superior performance of PE-acquired hospitals, rather than to PE-acquired hospitals suddenly providing worse care themselves.

Third, economic incentives that would motivate PE owners to allow hospital-acquired conditions to increase are not readily apparent. The article states that "the diagnoses underlying hospital-acquired conditions are not used in the assignment of a diagnosis related group and cannot be used to increase diagnosis related group severity (payment); worse performance on these conditions results in Medicare payment reductions."[14] Such penalties would seem to suggest that PE owners have a strong incentive to reduce hospital-acquired conditions, while competing incentives that could hypothetically lead to lower quality of care, such as cutting costs through mass layoffs and lax safety protocols, are alluded to in the discussion rather than tested directly in the analysis.

Fourth, the study found that more consequential outcomes, like mortality and readmission, either improved or remained the same at PE-acquired hospitals. The 0.2

percentage point reduction in inpatient mortality at PE hospitals, for instance, is described as "small" even though its magnitude is 4 times larger than the 0.05 percentage point increase (4.6/10 000) in hospital-acquired conditions at PE hospitals highlighted as the article's key point, more than offsetting all the negative effects. And, as with the meta-analysis discussed above, the increase in adverse events did not translate into worse downstream outcomes. If anything, a causal interpretation of the article's estimates would imply that PE owners get 5 fewer deaths in exchange for every additional hospital-acquired condition, a seemingly desirable trade-off any policy maker would be happy to accept.

Finally, only 17 hospitals contributed data for the full 3 years before and after a PE acquisition. Even taken at face value, results driven primarily by 17 hospitals can provide only so much insight into the broader impact of PE, calling into question the article's more general conclusion that "[t]hese findings heighten concerns about the implications of private equity on health care delivery."[14]

## Next Research Steps

Despite a steady stream of research over the past decade on PE's impact on health care, many questions remain unanswered. The first relates to the underlying market characteristics that explain how a PE owner might influence a provider's quality of care. For instance, why is PE seemingly bad for nursing homes on some measures of quality[5] but good for their COVID response?[11] More broadly, why is PE typically bad for nursing homes but neutral for hospitals and good for fertility clinics?[6,18,19] Moreover, do the objectives and business practices of PE firms differ from other ownership arrangements, such as large retailers like CVS Health or Amazon? With research suggesting that even nonprofit providers may behave similarly to those backed by PE firms,[20,21] policy makers concerned about the quality of care provided by PE-owned facilities may be better served by directly targeting specific aspects associated with worse health outcomes through regulations and standards and then applying them universally to all types of owners. Such a strategy has already been successfully used to promote ownership transparency[22] and end noncompete agreements[23] throughout large swaths of the health care system—business practices commonly used by, but not unique to, PE firms.

Finally, how do PE investments connect to the overarching objectives of the US health care system? Policy makers have sought to restrain spending for years, but, in our experience, PE investors tend to be criticized for cutting costs, even when cuts do not lead to worse outcomes. Similarly, some routinely call for expanding access to care but then become dismayed when PE-backed providers increase their volume, often portraying this increase as wasteful and unnecessary or requiring a shift to nonphysician clinicians. In this case, large institutional investors are generally responding to policies and regulations that favor efficiency and consolidation, with PE's widespread investment in health care being a symptom of these broader trends rather than their cause. In addition, it remains unclear how PE-backed health care systems perform in terms of equity (eg, by race, ethnicity, gender, geography) or how the incentives for PE might promote or hinder advancing these objectives.[1]

Research on PE in health care has so far shown that its impact depends on the setting (eg, specialty, facility) and outcomes measured. Due to PE firms' wide range of investment styles and strategies, as well as the unique challenges and needs of providers as varied as nursing homes, dental practices, and surgical centers, studies focused narrowly on one specific sector cannot serve as a sound basis for policy

makers, journalists, and some fellow academics to make sweeping statements about PE influence in US health care.

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