

# **Private Equity Investment in Physician Practices: Legal and Policy Responses**

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Thank you to FTC Chair Khan and Commissioners Slaughter and Bedoya for hosting this workshop and inviting me to present. My name is Erin Fuse Brown, and I am the Catherine C. Henson Professor of Law and Director of the Center for Law, Health & Society at Georgia State University College of Law. My research examines a range of topics of health law and policy, including private equity investment in health care.

My remarks today will open with a brief summary of the trends in private equity investment in health care, particularly focusing on physician practices.

Second, I will identify the key public policy concerns raised by private equity’s entry into physician markets to patients, physicians, and the health care market overall.

Third, to figure out how to address these risks, we must ask what revenue strategy is driving investment into a particular market segment. Identifying the payment loopholes or revenue “playbooks” that are being pursued tells us where to target enforcement or policy change.<sup>1</sup>

Finally, I will highlight potential legal and policy levers to address these risks.

## **Trends in Private Equity Investment in Physician Practices**

Private equity investment in health care has increased significantly over the past two decades, accelerating in recent years, although slowing this past year largely due to high interest rates. Private equity capital investment in the health care industry-wide grew 2000% in the roughly 20 years from 2000 to 2018, from \$5 billion to \$100 billion.<sup>2</sup> Over the past decade, the estimated total deal value in current dollars, 2010-2020 = \$750 billion.<sup>3</sup>

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<sup>1</sup> Erin C. Fuse Brown, Loren Adler, Erin Duffy, Paul B. Ginsburg, Mark Hall & Samuel Valdez, USC-Brookings Schaeffer Initiative for Health Pol’y, *Private Equity Investment as a Divining Rod for Market Failure: Policy Responses to Harmful Physician Practice Acquisitions* 12-14 (2021), <https://www.brookings.edu/essay/private-equity-investment-as-a-divining-rod-for-market-failure-policy-responses-to-harmful-physician-practice-acquisitions/>.

<sup>2</sup> Eileen Appelbaum & Rosemary Batt, *Private Equity Buyouts in Healthcare: Who Wins, Who Loses?* 5 (Ctr. for Econ. & Pol’y Rsch., Working Paper No. 118, 2020), <https://cepr.net/report/private-equity-buyouts-in-healthcare-who-wins-who-loses/>

<sup>3</sup> Richard M. Scheffler, Laura M. Alexander & James R. Godwin, *Soaring Private Equity Investment in the Healthcare Sector: Consolidation Accelerated, Competition Undermined, and Patients at Risk* 39-42 (2021), <https://publichealth.berkeley.edu/wp-content/uploads/2021/05/Private-Equity-I-Healthcare-Report-FINAL.pdf>.

More recently, the trend has shifted from focusing on hospitals and nursing facilities to physician practices. Over the last decade, private equity entered the physician market aggressively, targeting particular specialties, which can be grouped into 3 main categories:

1. Hospital-based physicians: Emergency, Anesthesiology, Radiology
2. Office-based specialties: Dermatology, Ophthalmology, Gastroenterology, Orthopedics
3. Primary Care and other specialties paid under capitated or value-based models

Other reports and researchers have identified emerging areas for private equity investment, such as behavioral health, telehealth, and hospice providers.<sup>4</sup>

Private equity investors have identified a particular revenue strategy for each of these specialty categories. But there is one thing that all these revenue playbooks have in common – consolidation through serial acquisitions via the “roll-up model.”

### **Private Equity Roll-up Model**

In the case of physician practices, private equity investors have used a “platform and roll-up” model where multiple small companies in the same market are acquired and merged.

The private equity firm targets a platform practice, which is a high-performing (high revenue) practice with a desirable market position. Then it grows that practice by adding on multiple small practices to expand the footprint of the practice and increase revenues. A bigger company generally means more market share, revenues, and profits. The valuation of the smaller roll-up entities suddenly take on the valuation of the larger platform practice, increasing overall sales potential and exit value.<sup>5</sup>

The private equity sponsor forms a management company to manage the operations of its portfolio companies. Note, due to state laws restricting the corporate practice of medicine the private equity-backed management services organization may not outright own the practices, but they exert *de facto* control over the practices via contract.<sup>6</sup>

The platform and roll-up model explains how private equity investment into physician specialty markets leads to greater horizontal consolidation of those markets, illustrated by the FTC’s antitrust complaint against U.S. Anesthesia Partners and Welsh Carson, its private-equity funder.<sup>7</sup> Greater consolidation increases market leverage to command higher prices.

### **How is Private Equity different than traditional corporate investment?**

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<sup>4</sup> Benjamin Brown, Eloise O’Donnell & Lawrence P. Casalino, *Private Equity Investment in Behavioral Health Treatment Centers*, 77 JAMA PSYCHIATRY 229, 229 (2020) (providing data on, and identifying the rationale behind, PE’s increasing presence in the behavioral health sector); Joan M. Teno, *Hospice Acquisitions by Profit-Driven Private Equity Firms*, JAMA HEALTH F., Sept. 30, 2021, at 1-2 (highlighting and discerning the potential repercussion of the recent influx of PE into hospice);

<sup>5</sup> Lawrence P. Casalino, Rayhan Saiani, Sami Bhidya, Dhruv Khullar & Eloise O’Donnell, *Private Equity Acquisition of Physician Practices*, 171 ANNALS INTERNAL MED. 114 (2019)

<sup>6</sup> Jane M. Zhu, Hayden Rooke-Ley & Erin Fuse Brown, *A Doctrine in Name Only—Strengthening Prohibitions Against the Corporate Practice of Medicine*, 389 NEW ENGL. J. MED. 965 (2023).

<sup>7</sup> Complaint at \*1-2, FTC v. U.S. Anesthesia Partners, Inc., No. 4:2023cv03560 (S.D. Tex. Sept. 21, 2023), <https://www.ftc.gov/legal-library/browse/cases-proceedings/2010031-us-anesthesia-partners-inc-ftc-v>.

In some ways, private equity is just the most recent form of corporate, for-profit health care. However, there are three features that distinguish private equity from traditional corporate investment, which heighten the public policy concerns.<sup>8</sup>

First, private equity investment is highly leveraged. Compared to traditional corporate investment, it adds significant debt burdens to the target companies.

Second, private equity operates on a very short time horizon of 3-7 years where exit is needed as the hurdle to earn the big returns. Traditional corporations seek to operate as a going concern with exit not necessary to generate returns.

Together, this creates moral hazard.<sup>9</sup> Private equity reaps all the upside of rapidly increased revenues, but it does not bear the risk because the debt is on the target company, losses are limited to its small capital investment, and because it's not a repeat-player in the industry it has less reputational capital at stake.

### **Harms of PE investment in physician practices**

There are 3 main risks that policymakers are concerned about related to private equity investment in health care:

1. ***Consolidation and cost increases*** from market power, up-coding, and aggressive risk-adjustment. Private equity revenue increases from exploitation of payment loopholes and financial engineering translate to higher health care costs for everyone else.
2. ***Harms to patient care***, driven by staffing reductions, cost-cutting, closure of less profitable services and facilities.
3. ***Harms to the clinical workforce***, including physician moral injury and burnout, exit, staffing shortages, and loss of professional autonomy.

### **Identifying the Private Equity “Revenue Playbooks”**

My colleagues and I have posited that we can use private equity investment as a divining rod to identify market dysfunctions and payment loopholes.<sup>10</sup> Robbers rob banks, so the saying goes, because that is where the money is. The same premise applies here: private equity investors target certain market segments because they have found a revenue opportunity to exploit. So, we can follow the money to identify the revenue playbooks that are drawing the investors. If we can find the loopholes, then we can fashion a policy response to close them.

Payment loopholes tend to be very specific to the particular sector or specialty being targeted. However, some strategies are common across specialty types. First, consolidation via the roll-up model is a common strategy across specialty types to increase market power of the physicians. Another tactic common across the board is for investors to control the captive physicians. The MSO takes control over the practices, including control over hiring, firing, scheduling, contracting, billing, coding, which can threaten professional autonomy and cause

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<sup>8</sup> BRENDAN BALLOU, PLUNDER: PRIVATE EQUITY’S PLAN TO PILLAGE AMERICA 30-32 (2023)

<sup>9</sup> See Christopher Cai & Zirui Song, *A Policy Framework for the Growing Influence of Private Equity in Health Care Delivery*, 329 JAMA 1545, 1545-46 (2023).

<sup>10</sup> See, Fuse Brown et al., *Private Equity Investment as a Divining Rod for Market Failure*, *supra* note 1.

burnout and moral injury, while using non-competes and gag clauses to prevent physicians from leaving or speaking out if they have concerns about these practices or quality of care.<sup>11</sup>

Here are the revenue playbooks that private equity has pursued across various physician specialty categories.<sup>12</sup>

***Hospital-based physicians.*** The revenue playbook motivating private equity investment in hospital-based physicians, such as emergency physicians and anesthesiology, was an out-of-network surprise billing strategy.

About a decade ago, private equity investors like KKR and Blackstone moved heavily into hospital-based specialties. What makes hospital-based specialties unique is that patients do not choose these physicians, so their patient volume does not depend on being in-network with health insurance plans. They can stay out of network, charge higher rates, and balance-bill patients for what health plans do not cover.

***Office-based specialties.*** There is a different revenue strategy at play for office-based specialties like dermatology, ophthalmology, and gastroenterology. These are specialties that engage in a lot of outpatient procedures that are typically reimbursed on a fee-for-service basis by Medicare and commercial payers. In particular, these practices can self-refer a number of lucrative “ancillary services” (e.g., physician-administered drugs, pathology labs, imaging, or physical therapy) for which they can bill intensively.

The strategy is to capture and consolidate the market, increase the volume of patients and self-referrals for ancillary procedures, increase intensity of procedures, reduce staffing levels to increase revenue. This can lead to higher prices, unnecessary services, and potentially understaffed or inadequately supervised care.

***Primary Care.*** For primary care, investors have figured out a way to exploit the ability to game coding practices to increase risk-adjusted payments from Medicare Advantage and other value-based payment models.

One strategy is to invest in and expand practices predominantly serving patients enrolled in Medicare Advantage plans or to combine the private equity-owned primary care practice and a Medicare Advantage plan into a vertically integrated pay-vider. The revenue strategy is to extensively code—or even exaggerate—Medicare patients’ diagnoses and comorbidities, which increases federal payments to the plans and translates to more revenue for the investors.

Value-based payment models may also create financial incentives to stint on care through prior authorization, increasing the risk that patients will be denied needed care. There is also an incentive to reduce costs by substituting less expensive providers for physicians, further threatening patient care, access, and quality.

*{End of prepared remarks. The following may be referenced during discussion.}*

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<sup>11</sup> Heather Perlberg, *How Private Equity is Ruining American Healthcare*, BLOOMBERG (May 20, 2020, 5:09 PM), <https://www.bloomberg.com/news/features/2020-05-20/private-equity-is-ruining-health-care-covid-is-making-it-worse>.

<sup>12</sup> Erin C. Fuse Brown, Loren Adler, Erin Duffy, Paul B. Ginsburg, Mark Hall & Samuel Valdez, USC-Brookings Schaeffer Initiative for Health Pol’y, *Private Equity Investment as a Divining Rod for Market Failure: Policy Responses to Harmful Physician Practice Acquisitions* 21 (2021), <https://www.brookings.edu/essay/private-equity-investment-as-a-divining-rod-for-market-failure-policy-responses-to-harmful-physician-practice-acquisitions/>.

## Legal and Policy Responses to Private Equity Investment in Health Care

Legal enforcement and policy responses to private equity in health care address the revenue strategies and risks of societal harms to health care patients, clinicians, and costs. These include:

1. *Ownership transparency* – to improve the availability of data on ownership and control structures of health care providers.
2. *Antitrust enforcement and competition policy* – applied to private equity investors and the roll-up strategy.
3. *Fraud and abuse enforcement* - over captive referrals, upcoding, or other revenue-generating tactics that may violate federal fraud and abuse laws.
4. *Policies to protect physicians' clinical autonomy from corporate control*, including strengthening the corporate practice of medicine doctrine, state and federal restrictions on physician non-competes.
5. *Close payment loopholes* exploited by private equity to increase revenues without adding value.

### ***Policy Response: Ownership Transparency***

All of the policies and enforcement action under existing laws would be enhanced by increased ownership transparency.<sup>13</sup> Policymakers, researchers, and the public currently lack comprehensive data on who owns or controls health care providers. We cannot study these phenomena or craft appropriate regulatory responses without understanding the extent of private equity penetration in health care. This is particularly true of physicians. We need a publicly available, searchable database for anyone to be able to look up who controls their doctor's office.

### ***Policy Response: Antitrust Enforcement***

Private equity's roll-up model contributes to market consolidation of these physician specialties. In some localities, PE penetration has reached 40-50% of the market share of some specialties.<sup>14</sup> But because the value of these transactions typically falls below the mandatory reporting threshold under the Hart-Scott-Rodino Act, these acquisitions tend to go unreported and therefore unreviewed by antitrust authorities, leading to further consolidation.<sup>15</sup>

Recently, the FTC and DOJ have stepped up antitrust scrutiny of private equity roll-ups, including in the case against U.S. Anesthesia Partners and Welsh Carson, the 2023 Merger

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<sup>13</sup> Yashaswini Singh & Erin C. Fuse Brown, The Missing Piece In Health Care Transparency: Ownership Transparency, Health Affs. Forefront (Sept. 22, 2023), <https://www.healthaffairs.org/content/forefront/missing-piece-health-care-transparency-ownership-transparency>.

<sup>14</sup> Yashaswini Singh, Jane M. Zhu, Daniel Polsky, Zirui Song, *Geographic Variation in Private Equity Penetration Across Select Office-Based Physician Specialties in the US*, 3 JAMA HEALTH F., Apr. 29, 2022, at 1 fig. 1, doi:10.1001/jamahealthforum.2022.0825; Richard M. Scheffler, Laura Alexander, Brent D. Fulton, Daniel R. Arnold & Ola A. Abdelhadi, *Monetizing Medicine: Private Equity and Competition in Physician Practice Markets* 9, 30, (2023), [https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG\\_Private-Equity-I-Physician-Practice-Report\\_FINAL.pdf](https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf);

<sup>15</sup> Cory Capps, David Dranove & Christopher Ody, *Physician Practice Consolidation Driven by Small Acquisitions, So Antitrust Agencies Have Few Tools to Intervene*, 36 Health Affs. 1556, 1560-61 (2017); Thomas G. Wollman, *How to Get Away with Merger: Stealth Consolidation and its Real Effects on US Healthcare* 2-5 (Nat'l Bureau of Econ. Rsch., Working Paper No. 27274, 2020), [https://www.nber.org/system/files/working\\_papers/w27274/w27274.pdf](https://www.nber.org/system/files/working_papers/w27274/w27274.pdf).

Guidelines,<sup>16</sup> and the proposed Hart-Scott-Rodino rules,<sup>17</sup> which would increase transparency of prior roll-up acquisitions by an entity subject to reporting.

Congress could take further steps to reduce the Hart-Scott-Rodino Act reporting threshold for health care acquisitions or explicitly allow the threshold to be triggered by the cumulative effect of serial roll-ups.

In addition, more states could follow the lead of Oregon, California, Massachusetts, to pass laws to require that a broad range of health care transactions (large and small, vertical or horizontal, for-profit and nonprofit) are subject to prior notice, review, and approval for market and public welfare implications.<sup>18</sup>

### ***Policy Response: Fraud and Abuse Enforcement***

Private equity firms' emphasis on increasing the profits of acquired practices may increase risks of overutilization, overbilling or upcoding, and self-referrals for ancillary services. The same pressure to maximize profits may also lead to stinting on less profitable services (or patients) or increased use of nonphysicians without adequate supervision.

These threats to patient care and health care spending from providers' financial incentives are generally addressed by federal fraud and abuse laws; namely, the False Claims Act, Anti-Kickback Statute, and Stark Law. When private equity firms assume active management control to increase the profitability of acquired practices, the easier it will be for the government to assert that the private equity firm knowingly participated in the improper conduct by its portfolio practices and hold the private equity firm liable.

Stepped-up enforcement under these laws by government and private whistleblowers alike could address some of the fraud and abuse risks posed by private equity investment in physician practices, such as unlawful billing and referral practices.<sup>19</sup> Others have written about how to apply fraud and abuse laws to address patient care harms and financial relationships in the nursing home context.<sup>20</sup>

### ***Policy Response: Policies to protect physicians' clinical autonomy from corporate control***

State and federal policymakers can strengthen prohibitions on the corporate practice of medicine and physician non-compete clauses to address the workforce harms posed by private equity investment in physician practices.

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<sup>16</sup> U.S. Dep't of Justice & Federal Trade Comm'n, Merger Guidelines, Dec. 18, 2023, <https://www.ftc.gov/reports/merger-guidelines-2023>.

<sup>17</sup> Federal Trade Comm'n, Premerger Notification; Reporting and Waiting Period Requirements, 88 Fed. Reg. 42178, 42178 (June 29, 2023).

<sup>18</sup> Erin C. Fuse Brown & Katherine L. Gudiksen, Models for Enhanced Health Care Market Oversight — State Attorneys General, Health Departments, and Independent Oversight Entities, Milbank Memorial Fund (Jan. 25, 2024), <https://www.milbank.org/publications/models-for-enhanced-health-care-market-oversight-state-attorneys-general-health-departments-and-independent-oversight-entities/>.

<sup>19</sup> Erin C. Fuse Brown & Mark Hall, Private Equity and the Corporatization of Health Care, 76 Stan. L. Rev. at \*26-36 (forthcoming 2024), pre-print available at: [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=4373557](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4373557).

<sup>20</sup> Robert I. Field, Barry Furrow, David R. Hoffman, Kevin Lownds & Hilary Pearsall, *Private Equity in Health Care: Barbarians at the Gate?*, 15 Drexel L. Rev. 101 (2023).

The “corporate practice of medicine” prohibition is a long-standing doctrine that bars nonprofessionals like corporate investors from owning or controlling medical practices.<sup>21</sup> However, private equity investors have figured out how to contractually circumvent the corporate practice prohibition through the use of management services organizations and so-called “friendly-PC” arrangements to control the physician practice, even without formal ownership. States are considering legislation to strengthen the corporate practice of medicine to allow professional practices to maintain ultimate control over key business as well as clinical decisions<sup>22</sup>.

Further, policymakers could prohibit noncompete terms for employed physicians that preclude group members from practicing in the areas where the firm operates for a prescribed length of time. These noncompetes are not unique to private equity, but because these firms often cover a much larger geographic area than conventional physician practices, the anticompetitive effects and burdens on physicians can be larger. Regulation of non-competes is typically the realm of state law, but the FTC has recently stepped in with a proposed rule to bar non-compete clauses in employment contracts across all sectors, including for physicians.<sup>23</sup> The proposed rule would classify the use of employee non-compete agreements as an unfair method of competition.

Restricting the use of noncompetes and gag-clauses in physician employment would allow medical professionals to speak out or leave about ethical or professional concerns they encounter in practice, including those driven by revenue-maximization strategies of private equity investors.

### **Policy Response: Close Payment Loopholes**

One policy response is to close payment loopholes that PE exploits for profit. The primary example is the No Surprises Act, which closed the loophole allowing hospital-based physicians to use staying out-of-network and balance-billing as a revenue strategy.<sup>24</sup>

Another loophole is changing Medicare Part B payment system for physician-administered drugs (exploited in ophthalmology to raise revenues by selecting higher-cost but clinically equivalent drugs).<sup>25</sup>

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<sup>21</sup> Jane M. Zhu, Hayden Rooke-Ley & Erin Fuse Brown, *A Doctrine in Name Only—Strengthening Prohibitions Against the Corporate Practice of Medicine*, 389 NEW ENGL. J. MED. 965 (2023).

<sup>22</sup> H.B. 4130, 2024 Reg. Sess (Or. 2024), <https://olis.oregonlegislature.gov/liz/2024R1/Measures/Overview/HB4130>; Amelia Templeton, Oregon lawmakers could limit corporate ownership of medical practices, Oregon Public Broadcasting, Feb. 22, 2024, <https://www.opb.org/article/2024/02/22/oregon-lawmakers-could-limit-corporate-ownership-of-medical-practices/>.

<sup>23</sup> FTC, Non-Compete Clause Rule, 88 Fed. Reg. 3482 (proposed Jan. 19, 2023) (to be codified at 16 C.F.R. pt. 910).

<sup>24</sup> Consolidated Appropriations Act, Pub. L. No. 116-260, 134 Stat. 1182 (2020) (containing the No Surprises Act); Sarah Kliff & Margot Sanger-Katz, *Surprise Medical Bills Cost Americans Millions. Congress Finally Banned Most of Them*, N.Y. TIMES: THE UPSHOT (updated Sept. 30, 2021), <https://www.nytimes.com/2020/12/20/upshot/surprise-medical-bills-congress-ban.html>.

<sup>25</sup> Paul B. Ginsburg & Steven M. Lieberman, *Medicare Payment for Physician-Administered (Part B) Drugs: The Interim Final Rule and a Better Way Forward*, BROOKINGS INST.: USC-BROOKINGS SCHAEFFER INITIATIVE ON HEALTH POL’Y (Feb. 10, 2021), ; Medicare Payment Advisory Comm’n, Report to the Congress: Medicare and the Health Care Delivery System 83-84 (2022), <https://www.medpac.gov/document/june-2022-report-to-the-congress-medicare-and-the-health-care-delivery-system/>.

For primary care practices, the loophole is the ability to increase federal payments to Medicare Advantage plans by aggressively coding patient diagnoses.<sup>26</sup> To close this loophole, Medicare Advantage payment policy could be tightened to better account for this risk code gaming, increase recoupment of overpayments, and make the quality bonus payments for MA more meaningful and difficult to achieve.<sup>27</sup>

## Conclusion

In sum, private equity investors have flooded the market, increasing the financialization of health care. Even though corporate or profit-in-medicine is not a new phenomenon, private equity poses sufficient heightened risks to warrant an immediate policy response.

The good news is that we already have many tools to address the risks of corporate investments in physician practices, but they may need sharpening. The legal and policy levers exist at the federal and state levels, span every branch of government, and even include private enforcement actions.

Private equity moves quickly and its strategies may be followed by other investors and players in the health care industry. Thus, policies should target the policy concerns, payment loopholes, consolidation broadly, rather than targeting private equity specifically.

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<sup>26</sup> Soleil Shah, Hayden Rooke-Ley & Erin C. Fuse Brown, *Corporate Investors in Primary Care—Profits, Progress, and Pitfalls*, 388 New Eng. J. Med. 99, 100 (2023); Reed Abelson, *Corporate Giants Buy Up Primary Care Practices at Rapid Pace*, N.Y. Times, (updated May 12, 2023) <https://www.nytimes.com/2023/05/08/health/primary-care-doctors-consolidation.html> (describing how investors are targeting primary care practices to capture and profit from Medicare Advantage patients by gaming the risk-adjusted and value-based payment formulas under these private Medicare plans)

<sup>27</sup> Erin C. Fuse Brown, Travis C. Williams, Roslyn Murray, David J. Meyers & Andrew M. Ryan, *Legislative and Regulatory Options to Improve Medicare Advantage*, 48 J. OF HEALTH POLITICS, POL'Y & LAW 919, 935 (2023) (available at <https://read.dukeupress.edu/jhpl/article/doi/10.1215/03616878-10852628/379609/Legislative-and-Regulatory-Options-to-Improve>).