Private Equity Investments in Physician Practices in Maryland

As Required by Chapter 378 of the 2024 Laws of Maryland (SB 1182/HB 1388)

AUTHORS

Yashaswini Singh, PhD, MPA

Roslyn Murray, PhD, MPP

Megha Reddy, MSPH

Jared Perkins, MPA

Neil Mehta, BA

Christopher Whaley, PhD

Erin Fuse Brown, JD, MPH

Under Contract to the Maryland Health Care Commission

January 22, 2025

CAHPR CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH

School of Public Health BROWN UNIVERSITY

Table of Contents

Executive Summary

Background

The Maryland General Assembly passed legislation in 2024, Ch. 378 (SB 1182/HB 1388), directing the Maryland Health Care Commission to study, in consultation with relevant stakeholders, the evolving role of private equity in the Maryland health care economy. Private equity (PE) firms generally acquire a physician practice to enhance its value and resell (exit) within three to seven years. While PE acquisitions may bring technological and operational efficiencies into a practice, PE's short-term profit incentives may result in undesirable effects on the cost and quality of care. Concerns over PE in health care have prompted federal inquiries by the Department of Justice (DOJ), Federal Trade Commission (FTC), and Department of Health and Human Services (HHS). At present, state-specific studies of PE-investment are sparse, reinforcing a need for state-specific evidence to inform policymakers about the extent of PE penetration within the market, the distribution of investment across geographic areas, and the types of specialty markets affected. This report provides regulators, policymakers, and key stakeholders in Maryland with evidence on trends in PE investments in physician practices in Maryland, summarizes the empirical literature on the effects of PE investment in health care, and sets forth potential state policy options to address concerns regarding consolidation and physician autonomy, and to enable ongoing oversight.

Study objective

The objective of this report is to provide evidence on trends in PE investments in physician practices in the state of Maryland. We conducted economic analyses of public and proprietary data sources to determine PE penetration, participation of PE-affiliated physicians in payer networks and value-based programs—such as the Maryland Primary Care Program (MDPCP)—and characteristics of Maryland communities affected by PE acquisitions. Based on our analysis, we provide potential policy options for agencies such as the Maryland Department of Health and the Office of the Attorney General that could shape oversight of physician practice acquisitions in the Maryland health care market.

Key findings

Private equity investments in physician practices have increased in Maryland. PE penetration in Maryland increased from 1.8% in 2014 to 15.5% by 2021. Specialties with the highest PE penetration as of 2021 were gastroenterology (16.7%), ophthalmology (25.2%), primary care (27.3%), dermatology (36.2%), and urology (63.3%). PE expansion is geographically uneven. As of 2021, PE penetration was highest in Prince George's County (53.2%), suggesting that half of all physicians seen by residents of Prince George's County were PE affiliated. Seven rural counties had no PE penetration across the evaluated physician specialties: Garrett County, Kent County, Cecil County, Caroline County, Calvert County, Dorchester County, and Somerset County.

PE-affiliated physicians showed higher rates of in-network participation in both commercial and Medicare Advantage plans compared to non-PE physicians. Previous research has shown that PE acquisitions of physician practices increase commercial prices negotiated by private insurers.[18,29] Thus, PE-affiliated practices may increase the cost of healthcare to patients and payers[18] even while network-participation remains high. Other studies have shown PE firms can also increase the cost of care by deploying out-of-network billing - a strategy where providers do not enter into an in-network contract with insurers but instead charge the full cost of the service to the patient – in select specialties, such as emergency medicine and anesthesiology. [4,5,6]

PE-affiliated physicians had higher participation rates in Maryland value-based programs, such as MDPCP. The growth of value-based payment has created a demand for capital by primary care and other practitioners who require sufficient size, information technology infrastructure, and management capacity to succeed under capitation and risk-based payment models.[7] While it is plausible that practices that participate in value-based payment programs are also more likely to obtain investment from PE to support the scale and technological capacity necessary for these programs, to the best of our knowledge, there are no peer reviewed studies on this phenomenon to date.

Policy Options

Using the model legislation developed by the National Academy for State Health Policy as a foundation, there are three policy options for Maryland to address health care consolidation, corporatization, and health care closures: (A) Enhanced oversight of certain

health care transactions; (B) Strengthening protections for physicians and the clinical workforce; and (C) Transparency of ownership and control relationships. While these three policies are mutually reinforcing, they also can be pursued on an *a la carte* basis. Notably, these policy options are intentionally designed to apply to a wide range of health care entities, transactions, and ownership and control entities, regardless of the transacting parties, including health systems, payers, private equity, publicly traded companies, retail companies, or others.

Conclusion

Private equity firms have invested in a growing share of physician practices in Maryland with notable variation across different regions and specialties. Overall, private equity penetration in physician practices in Maryland is greater than national estimates across evaluated specialties. Early evidence suggests greater participation of PE-affiliated practices in value-based programs. At the same time, previous research on PE investments in physician practices has highlighted potential adverse effects on health care competition, costs, and the clinical workforce. Policy efforts can aim to create a competitive market environment that balances the need for capital investment by medical practices with appropriate guardrails to protect patients and the clinical workforce against the pitfalls of consolidation and corporatization in health care.

I. Introduction

Private equity (PE) refers to firms that invest in companies not listed on public exchanges, with the goal of restructuring, improving profitability, and then selling the businesses for a profit. In general, PE firms commonly use the leveraged buyout (LBO) model to acquire majority ownership stakes in their investment targets. The goal of PE investments is to generate above market returns for investors upon selling the entity (i.e., "the exit"), typically within three to seven years.[8] While PE acquisitions may bring capital infusions to facilitate technological improvements and improve the efficiency of care, PE's short-term, for-profit incentives may result in undesirable effects on the cost and quality of care for patients, payers, and health care workers. Concerns over PE in health care have prompted a federal inquiry by the Department of Justice (DOJ), Federal Trade Commission (FTC), and Department of Health and Human Services (HHS) (see Appendix Table 1 for public comments from Maryland stakeholders). In addition, many states have passed laws to increase scrutiny of health care transactions that fall below reporting thresholds and improve antitrust monitoring.[9]

The Maryland General Assembly passed legislation in 2024 to require greater state oversight of nursing home acquisitions. Chapters 816 and 817 (Senate Bill 1000/House Bill1122) requires a purchaser of a nursing home to submit a "Notice of Acquisition/Transfer of Ownership interest" to the Maryland Health Care Commission (MHCC) and provide specified notice to the residents, resident representatives, and employees of the nursing home. The executive director of MHCC must review a completed Notice of Acquisition/Transfer of Ownership interest within 45 days and, in consultation with the Secretary of Health (or their designee), may approve the acquisition, approve the acquisition with conditions, deny the acquisition, or refer the request for acquisition to MHCC's commissioners for a final decision. Other related legislation, Ch. 378 (SB 1182/HB 1388) directed the MHCC to study the evolving role of PE in the Maryland health care economy beyond long-term care, where the State is already taking a more active role. This legislation arose in response to the growing concerns on the impact of PE firms on patient care and the alignment of their objectives with Maryland's health care priorities.

Maryland's health care market and policy landscape have unique features driven by its innovative payment models and regulatory frameworks. Maryland is unique in having an All-Payer Model for hospital payments, overseen by the Health Services Cost Review Commission (HSCRC). This means all payers, including Medicare, Medicaid, and private

insurers, pay the same rate for services at each hospital.[1] In addition, since 2019, Maryland has operated under a Total Cost of Care (TCOC) Model,[10] an expanded model to manage health care costs for Medicare beneficiaries. Another component of the TCOC model is the Maryland Primary Care Program (MDPCP), a voluntary program for primary care practices that receive care management fees and performance-based incentives to improve outcomes for Medicare patients. In addition, the Episode Quality Improvement Program (EQIP), aimed at specialists and non-hospital providers, focuses on bundled payments for episodes of care, incentivizing specialists to manage the cost and quality of specific clinical episodes, like hip and knee replacements or certain types of cancer treatment. The participation of PE-affiliated entities in these programs remains unknown.

In this context, the objective of this study is to provide evidence on trends in and policy implications of PE investments in physician practices in the state of Maryland. To undertake this analysis, we conduct economic analysis of public and proprietary data sources to determine the extent and geographic prevalence of PE in the Maryland health care market, participation of PE-affiliated physicians in payer networks, participation of PE-affiliated physicians in value-based payment programs such as MDPCP and EQIP and examine the characteristics of Maryland communities that are affected by PE acquisitions of physician practices. Based on our analysis, we propose policy options to guide Maryland's oversight of PE acquisitions in the Maryland health care market, including by the Maryland Department of Health and the Office of the Attorney General.

II. An Overview of Private Equity Investments in Health Care

Between 2010 and 2020, PE firms have invested approximately $750 billion nationally in health care in several settings, including nursing homes [11–14], hospitals [15–17], and physician practices.[1,2,18,19] On the one hand, PE acquisitions in health care may bring technological and operational efficiencies into a practice. On the other hand, PE's short-term financial incentives and ownership model may have negative effects for health care access, quality, or spending as described below.[12–14,16] This concern has been the basis of multiple federal and state investigations into the impact of PE on health care. This includes a cross-

1 At the time of this report, there are no identified acute care hospitals in Maryland that are owned or affiliated with PE firms. See, https://pestakeholder.org/private-equity-hospital-tracker/

government inquiry by the DOJ, FTC, and HHS on whether growing PE threatens "patients' health, workers' safety, quality of care and affordable health care for patients and taxpayers." [20]

Trends in PE Investments in Physician Practices

PE investments in physician practices are part of a broader trend toward corporate ownership practices. Based on a recent report, it is estimated that 80% of physicians are employed by corporate owners including health systems, PE firms, and other corporate entities.[21] Nationally, PE investments in physician practices emerged in the mid-2010s and span various specialties, including procedural specialties such as dermatology, gastroenterology, ophthalmology, and more recently, specialties under value-based care models such as primary care, oncology, and cardiology.[18,19]

Proponents of PE investment state that they facilitate capital infusions in physician practices to support administrative operations, revenue cycle management, and technological investments to improve the efficiency of care.[22] In addition, with the growth of value-based care models, many physician practices need financial backing to take on downside risks that many of these value-based models require.[23] Beyond providing financial support, PE firms might present opportunities for operational expertise that can reduce administrative burden.[24] However, these potential benefits must be weighed against concerns regarding the quality of patient care and overall health care costs, as the impact of PE on health care varies significantly depending on the type of health care setting.[25] As such, it is essential to consider the broader effects on patient care and health care system sustainability when evaluating PE's role in health care.

Effects of PE Investments

One approach that PE firms follow is a "platform and roll-up" strategy to grow physician practices. First, PE firms may acquire a large, well-established practice (the platform) and then gradually increase market share through subsequent acquisitions of smaller practices (add-ons) (see below for examples of platform growth in Maryland).[15,16] Empirical evidence has found that PE acquisitions of physician practices are associated with increases in commercial prices by 11% for certain procedural specialties, including dermatology, ophthalmology, and gastroenterology,[18] and by 70% for neonatology.[11,26] In addition, PE-

affiliated practices have been found to change prescribing patterns by favoring the use of higher-priced drugs, leading to increased Medicare spending.[27]

The effects of PE acquisitions of physician practices on the quality of care are mixed. Most of the quality evidence regarding PE ownership in health care stems from sectors outside of physician practices, making it difficult to generalize its impact across settings. For instance, PE-owned nursing homes experienced an 11% increase in patient mortality following acquisition.[12] Other research has shown PE-acquired hospitals experienced a 25% rise in hospital-acquired adverse events, including a 38% increase in central-line bloodstream infections, despite fewer central lines being used.[16] In contrast, Cerullo et al. (2021)[17] found that PE-owned acute care hospitals experienced improved in-hospital and 30-day mortality rates for acute myocardial infarction compared to non-PE-owned hospitals, although no significant improvements were seen for other areas such as 30-day readmissions or stroke and pneumonia mortality. PE ownership has also been shown to generate positive effects in the fertility sector, particularly in in-vitro fertilization (IVF) clinics where after PE acquisition, the number of IVF cycles and transfers (clinic volume) increased, and IVF success rates improved.[28] These mixed results highlight the need for more targeted research into PE's impact on the quality of care, particularly in physician practices, where the evidence remains sparse.

PE acquisitions of physician practices also affect the health care workforce. Empirical evidence has shown that PE acquisitions change the workforce composition by increasing the hiring of advanced practice providers (APPs) like nurse practitioners and physician assistants while increasing the rate at which physicians enter and exit practices.[17] At present, it is unknown if the increase in APPs expand patient access or reflect substitution away from physicians. Anecdotally, PE acquisitions can also affect physician employment through the use of non-compete terms in employment agreements that limit the ability of physicians to work for, or establish, a competing practice within a certain geographic radius after leaving a practice. The Maryland General Assembly recognized this linkage when they directed MHCC to conduct a study on PE and market concentration in legislation that limited use of non-compete clauses in contract.

A recent survey of 525 physicians suggests that many physicians hold negative perceptions about PE.[29] At the same time, some physicians consider PE employment to be a favorable alternative to health system employment, with perceptions of improved clinical autonomy, independence, and reduced administrative burdens. Generally, physician

perspectives vary based on factors such as physician age, partner vs. non-partner status, and employment type—with younger physicians and those in non-partner roles tending to have more mixed views on PE, often due to job instability, clinical workload, and changes in the clinical workforce after PE acquisition.[30,31]

The empirical literature on the effects of PE investments in physician practices raises concerns about adverse effects on competition, costs, and the clinical workforce. However, much of the existing research is based on average estimates of PE penetration and its effects on a national level. State-specific studies of PE-investment are sparse, reinforcing a need for more state-specific evidence to inform policymakers about the extent of PE penetration within the market, the distribution of investment across geographic areas, and the types of specialty markets affected to inform policy on this issue. This report aims to characterize the trends in PE involvement in Maryland physician practices, summarize the empirical literature on what is known about the effects of PE investment, and set forth state policy options to address the concerns regarding consolidation, physician autonomy and workforce effects, and enable ongoing oversight.

III. Data & Methodology

To conduct our analyses, we built a longitudinal dataset from 2014-2021 combining several proprietary data sources to identify PE-affiliated physician practices in Maryland. We constructed our dataset in multiple steps. To summarize the process, we 1) identified PE acquisitions of physician practices using data from Pitchbook and internet searches, 2) identified physicians in acquired practices and their National Provider Identifiers (NPIs) by linking acquisition data to the Medicare Data on Provider Practice and Specialty (MD-PPAS), and 3) linked data on physician affiliation to data provided by MHCC on participation in payer networks, participation in value-based programs, and other publicly available data sources.

Identifying PE acquisitions

Our primary source of data on PE transactions is a proprietary list of LBOs by PE firms in the "Clinics/Outpatient services" sector compiled by Pitchbook, a financial database that tracks mergers and acquisitions across industries and has been used by other studies examining PE in health care. Given that there is no single data source that tracks the complete

universe of PE acquisitions of physician practices, a limitation of this data is that it might under-report some PE acquisitions. To account for this, we supplemented Pitchbook data with manual searches.

Identifying physicians at PE-affiliated practices

To identify physicians at acquired practices, we linked acquisitions to data from MD-PPAS available from 2014-2021 following methodology in previous research.[2] The MD-PPAS contains all registered providers in the United States who billed Medicare at least once and are registered in the Provider, Enrollment, Chain and Ownership System (PECOS). By linking acquisition data to MD-PPAS data, we identified all physicians affiliated with PE and non-PE practices from 2014-2021. Using physician specialty information, we classified physicians into the following 8 specialties: primary care, cardiology, dermatology, gastroenterology, ophthalmology, oncology, urology, and orthopedics.

We estimated PE penetration as the share of physicians in the evaluated specialties that were affiliated with PE firms. We assigned physicians a ZIP code based on the ZIP code where a physician derived the plurality of Medicare fee-for-service claims in 2021. We then calculated PE penetration at the ZIP code level, as the share of physicians that are affiliated with PE. Importantly, the ZIP code assigned to a physician reflects the ZIP code from where the physician draws the majority of billed claims rather than the ZIP code where the physician practices. As a result, estimates of PE penetration may not reflect the true number of physicians practicing in a given ZIP code or geographic region.

Identifying characteristics of Maryland communities affected by PE

We categorized ZIP codes into three categories: 1) regions with no PE activity, 2) regions with low PE penetration (defined as regions with below-median PE penetration, approximately <15% in Maryland), and 3) regions with high PE penetration (defined as regions with above-median PE penetration, approximately >15% in Maryland). Next, we linked our data on PE penetration at the ZIP code level with the Area Deprivation Index (ADI) from the University of Wisconsin, the American Community Survey (ACS), and Census. The ADI is a composite measure that assesses the socioeconomic disadvantage of communities based on various factors such as income, education, and employment. While

ADI is generally measured at the level of the census tract, given data limitations we aggregated census-tract ADI measures to the zip-code level. Additionally, we integrated other ZIP code-level data from the ACS and Census, which detail social and economic characteristics of the population. These linkages allowed us to examine the characteristics of communities that are most exposed to PE-affiliated physicians.

Identifying participation in payer networks

We linked data on PE affiliation with data from the Maryland Medical Care Data Base (MCDB) using physician NPIs for providers holding MD or DO credentials. MHCC used MCDB claims to identify in-network arrangements at the NPI, payer ID, and plan type (e.g., health maintenance organization) level, indicating that there was a contract when the majority of claims in the year were paid on an in-network basis. A provider was considered to be "in-network" if it participated in at least one plan as an in-network provider. This allowed us to identify physician-insurer contracts, categorized by plan type for two market segments: commercial and Medicare Advantage (MA). Using this data, we calculated the share of PE-affiliated physicians participating in payer networks across different market segments and plan types.

Identifying participation in value-based programs

We linked data on PE-affiliated physicians, collected at the NPI level, with data provided by MHCC on clinician participation in MDPCP and EQIP programs. The linked dataset allows us to identify the share of PE-affiliated physicians participating in value-based programs, separately by affiliation type (PE-affiliated or not).

Limitations

We define PE affiliation based on our analysis of proprietary data sources. This definition includes LBOs that involve a PE firm. This definition does not include related for-profit entities that are primarily financed by venture capital, affiliated with payers, acquired by health systems, or purchased by other for-profit entities in health care.[2]

[2] For example, our analysis does not include venture-capital backed entities such as Aledade, an accountable care organization with a focus on primary care practices operating in Maryland and 44 other states.

In addition, there is no systematic data available to identify the nature of PE exits. Thus, we are unable to determine when PE-affiliated firms undergo a change in ownership resulting from PE exit (to become formerly PE-affiliated). As a result, we consider an entity to be PE-affiliated if it was ever PE-affiliated. In cases where PE-affiliated practices have undergone an exit (where PE firms sell their stake to another investor or an Initial Public Offering (IPO)), these practices would continue to be considered as PE-affiliated. This approach is consistent with existing research that shows changes to practice patterns after PE acquisition persists after PE exit.[32] Relatedly, given the lack of systematic disclosure requirements for PE, we do not have data to differentiate between majority vs minority investment stake, board composition, use of management services organizations (MSOs) or other factors that might potentially differentiate practices with PE investments. In addition, we estimate PE penetration at the ZIP code level by assigning ZIP codes to physicians based on the ZIP code from where the physician draws the majority of billed claims. As a result, estimates of PE penetration may not reflect the true number of physicians practicing in a given geographic region.

Further, our analysis is limited to physicians (MDs and DOs) in office-based specialties that have shared mechanisms of revenue generation.[3] Important data limitations include lack of data on certain categories of health care services that have witnessed increased private equity penetration in recent years such as emergency medicine, anesthesiology, dental practices, women's health and obstetrics care, to name a few.[5,33,34] Thus, our estimates of PE penetration are likely to be underestimated.

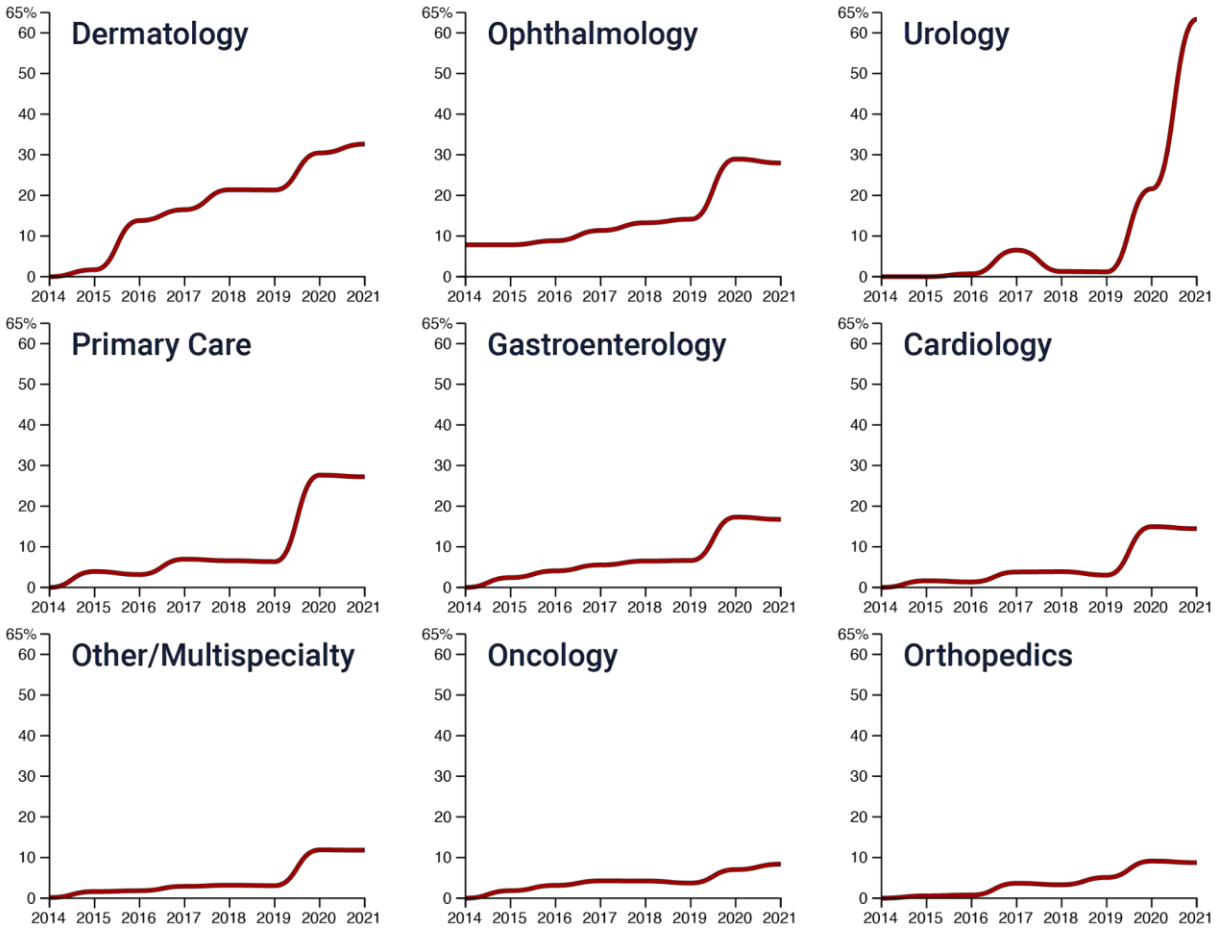
Finally, we rely on data provided by MHCC to examine the participation of PE-affiliated practices in payer networks and value-based programs, including data from the MCDB which might not represent all medical claims. These data were provided as of November 2024 and may include measurement error. For example, data network participation was inferred from medical claims billed; thus, we may underestimate the true network participation of providers if they did not submit claims in a given year. In addition, data on provider participation in Medicaid managed care organizations was not available. As a result, we were unable to examine the participation of PE-affiliated providers in managed Medicaid plans. In addition, MHCC data is cross-sectional thus our analysis is descriptive and does not identify causal relationships between PE affiliation and participation in payer networks and participation in value-based programs.

IV. Key findings

A. Trends in PE Investments in Physician Practices

Figure 1 shows that the average PE penetration rate increased between 2014 and 2021 for all evaluated specialties. Between 2019, before the beginning of the COVID-19 pandemic, and 2021, after the peak of the pandemic, penetration rate increased for Urology (from 1.2% to 63.3%), primary care (from 6.3% to 27.2%), cardiology (from 3.0% to 14.4%), oncology (from 3.7% to 8.3%), ophthalmology (from 14.1 to 27.9%), and orthopedics (from 5.1% to 8.8%). In contrast to specialties that witnessed an increase in PE penetration during the pandemic, dermatology was an early target of PE investment with investments beginning around 2016.

Figure 1: Share of Physicians in PE-Affiliated Practices in Maryland, by Physician Specialty, 2014 - 2021



***Source**: Author's analysis of data from the Pitchbook, press releases, and internet searches linked to Medicare Data on Provider Practice and Specialty.*
***Notes**: The vertical axis represents PE penetration or the share of physicians in the evaluated specialty that is in a PE-affiliated practice. PE = private equity. PE affiliation is estimated as of 2021, as a result analysis may underestimate practice affiliation changes since 2021.*

Overall, across all physician specialties, the average PE penetration was approximately 15.5% in 2021 with variation across specialties (**Table 1**). In 2021, the specialties with the highest PE penetration were gastroenterology (16.75%), ophthalmology (25.12%), primary care (27.25%), dermatology (32.91%), and urology (63.32%). Across all evaluated specialties, PE penetration in Maryland was greater than estimates of PE penetration nationally (Appendix Table 2).

Table 1: Share of Physicians in PE-Affiliated Practices, by Physician Specialty, 2021

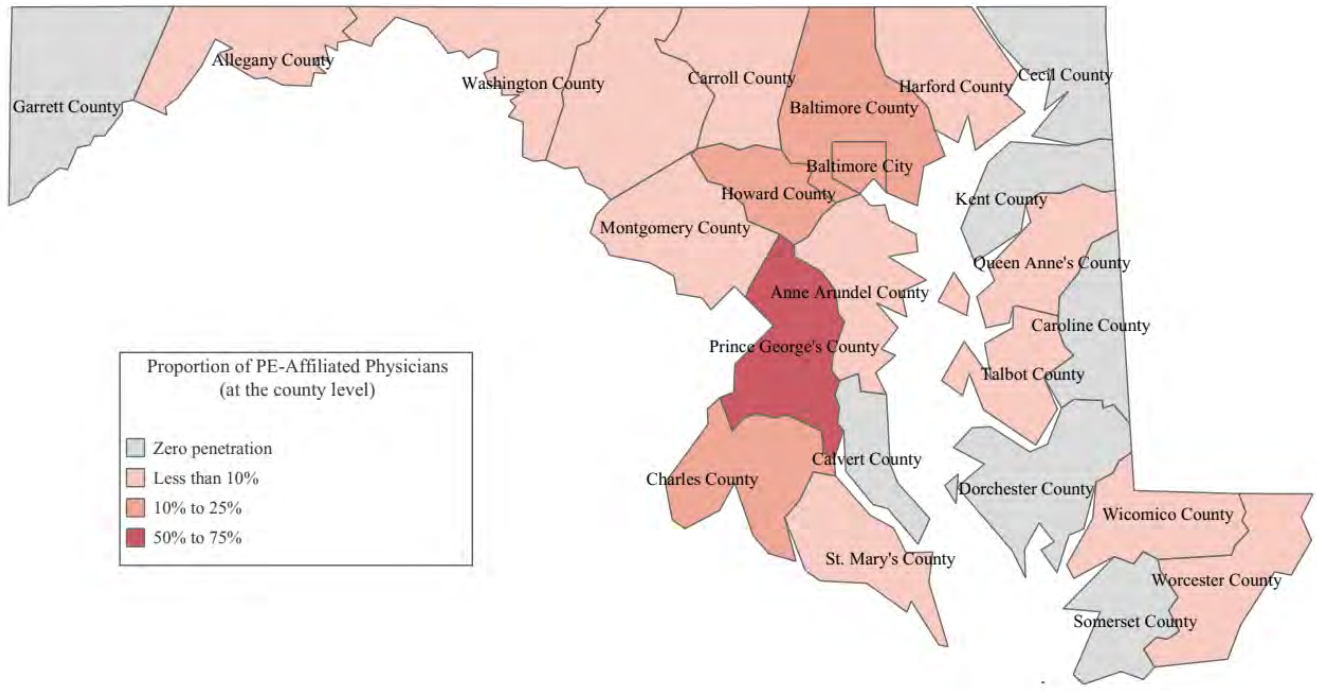
Specialty	**PE penetration in Maryland**
Oncology	8.4%
Orthopedics	8.8%
Cardiology	14.5%
Gastroenterology	16.7%
Ophthalmology	25.2%
Primary care	27.3%
Dermatology	36.2%
Urology	63.3%
Average across all specialties	**15.5%**

***Source**: Author's analysis of data from the Pitchbook, press releases, and internet searches linked to Medicare Data on Provider Practice and Specialty.*
***Notes**: PE = private equity. A limitation is that this PE affiliation is as of 2021. As a result, analysis may not represent ownership changes since 2021. PE penetration represents the share of physicians that are in PE-affiliated practices as of 2021.*

Figure 2 highlights the geographic variation in PE penetration across all evaluated specialties in Maryland counties (see Appendix Table 3 for additional detail). Prince George's County had the highest share of PE-affiliated physicians with an average PE penetration of 53.2% as of 2021. Appendix Figures 1-8 highlight additional variation in PE penetration across Maryland counties for each physician specialty.

In 2021, seven counties had no PE penetration across the evaluated physician specialties: Garrett County, Kent County, Cecil County, Caroline County, Calvert County, Dorchester County, and Somerset County.

Figure 2: Geographic variation in PE penetration in Maryland, 2021



***Source**: Author's analysis of data from the Pitchbook, press releases, and internet searches linked to Medicare Data on Provider Practice and Specialty.*
***Notes**: PE = private equity. The ZIP code assigned to a physician reflects the ZIP code from where the physician draws the majority of billed claims rather than the ZIP code where the physician practices. As a result, estimates of PE penetration may not reflect the true number of physicians practicing within a given county. PE penetration is estimated as of 2021 and may not represent changes to affiliation since 2021. Proportion categories not shown in the legend indicate that no value in the dataset falls within that range. Specialties include dermatology, gastroenterology, ophthalmology, cardiology, orthopedics, oncology, primary care, urology and other multispecialty practices.*

Case Descriptions of Notable PE Transactions in Maryland

This section highlights illustrative examples of select PE-affiliated practices in Maryland. The information is based on analysis of data reported in Pitchbook and publicly available sources such as press releases, industry reports, and practice and/or parent company websites. These examples highlight variation in how PE firms can achieve practice growth and expansion as well as variation in PE exit strategies across clinical specialties. Notably, there is no systematic data to identify potential sources of heterogeneity across transactions. As a result, examples below may differ based on the nature of PE firms involved, deal structure, involvement of Management Services Organizations (MSOs), nature of debt financing, nature of operational control, and other key factors.

Urology: Chesapeake Urology

(also known as United Urology Group)

Initial PE Investment

In July 2016, Audax Group acquired Chesapeake Urology, marking one of the first PE-backed consolidations in urology and establishing United Urology Group (UUG) as a national platform for urology practice management.

Platform Growth and Expansion

Following Audax's investment, Chesapeake Urology expanded significantly within Maryland and other states including Colorado, Arizona, Delaware, and Tennessee. In 2017, Chesapeake Urology acquired Central Maryland Urology Associates (two Maryland offices) and Urological Consultants, PA (five Maryland offices and a surgery center). Chesapeake Urology acquired two additional offices in June 2018 with its acquisition of Peninsula Urology Associates. Most notably, UUG entered a joint venture in June 2022 with United Surgical Partners International (USPI), a subsidiary of Tenet Healthcare to manage 22 ambulatory surgery centers across Maryland, Colorado, and Arizona, further diversifying its services and geographic reach.

PE Exit and Current Affiliation

In October 2024, OneOncology (backed by PE firm TPG), acquired United Urology Group, marking the exit of previous PE investors Audax. Under TPG, OneOncology currently operates 39 locations in Maryland.

Dermatology: Anne Arundel Dermatology

Initial PE Investment

In September 2015, New MainStream Capital (NMS) acquired Anne Arundel Dermatology. In 2018, the platform company received additional capital from PE firms Pantheon Ventures and NMS.

Platform Growth and Expansion

Following NMS's initial investment, Anne Arundel Dermatology expanded its network from 16 locations to 74, by acquiring physician practices across Maryland, Virginia, and Tennessee. Currently Anne Arundel Dermatology spans 27 locations in Maryland, including in Chevy Chase, Hunt Valley, Silver Spring, Havre de Grace, Bethesda, Eldersburg, and Rockville.

PE Exit and Current Affiliation

In October 2020, Ridgemont Equity Partners acquired Anne Arundel Dermatology. This acquisition marked the exit of NMS and Pantheon. Since this acquisition, Anne Arundel Dermatology has not experienced additional growth in Maryland; however, it has expanded its presence in Pennsylvania, North Carolina, and Florida.

Primary Care: Privia Health

Initial PE Investment

Privia Health operates as a Physician Management Services Organization (MSO), to support physicians transition to value-based care models. Privia Health received growth funding from a consortium of investors in 2014, including PE firms, Pamplona Capital Management, Brighton Health Partners, Annox Capital, Morgan Noble Healthcare Partners; VC firm, Cardinal Partners; and investment firm, The Goldman Sachs Group.

Platform Growth and Expansion

Privia Health's growth in primary care in Maryland began in 2020 with locations in Rockville, MD and additional growth in Ellicott City, Bethesda, Silver Spring, and Annapolis.

PE Exit and Current Affiliation

On April 29, 2021, Privia Health completed its initial public offering (IPO). Pamplona Capital Management partially exited its stake in Privia Health through a secondary transaction with

Elevance Health (formerly Anthem) in 2021. The firm fully exited its investment in May 2023, through a sale to PE firm, Rubicon Partners.

Orthopedics: Pivot Health Solutions

(now Athletico Physical Therapy)

Initial PE Investment

Pivot Health Solutions received PE financing in November 2013 from PE firms CI Capital Partners and InTandem Capital Partners.

Platform Growth and Expansion

Pivot Health Solutions expanded its operations across several states including Washington, D.C., Virginia, Maryland, Delaware, North Carolina, Pennsylvania, and West Virginia. In Maryland, Pivot Health established a substantial presence with 59 locations across 48 cities. Notably, 58 of these Maryland locations were acquired in 2015.

PE Exit and Current Affiliation

In July 2019, initial PE investors exited the investment. In February 2022, Pivot Health Solutions was acquired by Athletico Physical Therapy, supported by PE firm, BDT & Company.

Ophthalmology: Vision Innovation Partners

(Formerly Known as Chesapeake Eye Care)

Initial PE Investment

In July 2017, the PE firm Centre Partners acquired Chesapeake Eye Care Company in a LBO deal. This transaction combined Maryland-based Chesapeake Eye Care and Whitten Laser Eye under a new entity. The firm then acquired several additional locations, including Maryland Eye Associates and Select Eye Care, before rebranding as Vision Innovation Partners in 2019.

Platform Growth and Expansion

Vision Innovation Partners expanded into Pennsylvania by acquiring a practice group with nine locations in the state. It continued expansion in Maryland (in cities like Annapolis,

Towson, Prince Frederick, Hagerstown, Baltimore, and Frederick) and acquired locations in Washington D.C. and Virginia, eventually acquiring 63 locations until Centre Partners' exit in 2022. The group currently operates 28 practices in Maryland.

PE Exit and Current Affiliation

Centre Partners sold Vision Innovation Partners to the San Francisco-based PE firm Gryphon Investors in 2022.

Gastroenterology: PE GI Solutions

(Formerly Known as Physicians Endoscopy)

Initial PE Investment

In 2013, Pamlico Capital invested in Physicians Endoscopy through an LBO.

Platform Growth and Expansion

In 2015, the company expanded to new locations in Pennsylvania, Ohio, New Jersey, and Georgia. In August 2019, Physicians Endoscopy expanded by acquiring 12 gastroenterology physician locations in Maryland, previously affiliated with Capital Digestive Care. In March 2021, the firm rebranded as PE GI Solutions and soon after expanded to eight new locations in Southeast Virginia. Currently, PE GI Solutions manages 103 locations, including 21 in Maryland in the cities of Chevy Chase, Germantown, Ijamsville, Columbia, Laurel, National Harbor, North Bethesda, Olney, Rockville, and Silver Spring.

PE Exit and Current Affiliation

Pamlico Capital, exited on August 22, 2016, selling the company to PE firm, Kelso & Company. PE GI solutions was acquired by SCA Health, a subsidiary of Optum, in June 2022 through a strategic sale. At that time, PE GI solutions oversaw over 90 locations.

Emergency Medicine: US Acute Care Solutions (USACS)

Initial PE Investment

USACS received initial PE investments in June 2015 from PE firm, Welsh, Carson, Anderson & Stowe (WCAS) and EMP Holdings (Corp.).

Platform Growth and Expansion

In Maryland, USACS notable acquisition occurred in 2015 through the acquisition of MEP Health, a Maryland-based provider specializing in emergency care, urgent care, and observation services. These investments have allowed USACS to expand its operations in Maryland, where the company now operates 27 locations. Aside from clinic-based acquisitions, USACS also acquired Maryland based Alteon Health, a practice management company based in Germantown.

PE Exit and Current Affiliation

USACS's initial PE investor, WCAS, exited through a sale to PE firms, TowerBrook Capital Partners and Apollo Global Management. USACS currently has a broad national presence, with 320 locations across 26 US states with a significant footprint in Texas (65 locations), Ohio (39 locations), Colorado (32 locations), Virginia (29 locations), Maryland (27 locations), California (24 locations), Florida, and Pennsylvania (18 locations each).

B. Characteristics of Maryland communities with high PE penetration

Table 2 tabulates demographic characteristics of Maryland communities by PE penetration as of 2021. Of the 309 ZIP codes in Maryland with practicing physicians, the majority (213) have no practicing PE-affiliated providers, while 71 ZIP codes have low PE penetration—where 0-15% of practicing physicians are PE-affiliated—and 25 have high PE penetration—where more than 15% of practicing physicians are PE-affiliated. The total population in these areas with no PE penetration (approximately 2.7 million) and low PE penetration (around 2.4 million) is considerably larger than in high PE penetration areas, which account for about 759,967 residents.

Across all three categories, median age and the share of female residents are relatively similar. The communities with no PE penetration have the highest area deprivation index (ADI) score, indicating they are more disadvantaged than areas with any PE penetration. These communities tend to have lower median incomes, higher rates of individuals living below the Federal Poverty Level (FPL), and higher unemployment rates. These areas are also more rural, with lower rates of internet access and fewer vehicles per household.

Relative to areas with low PE penetration, areas with high PE penetration have a lower share of white residents and a higher proportion of the population that is urban, suggesting that

PE-affiliated providers are more concentrated in urban, diverse communities. In these areas, the median rent is higher, reflecting greater demand for housing, and internet access is more common, with a higher percentage of households having subscriptions.

Table 2. Demographic Characteristics by Zip Code based on PE Presence, 2020

	No PE (0% penetration)	**Low PE** (<15% penetration)	**High PE** (>=15% penetration)
Unique zip codes, n	213	71	25
Total population, n	2,712,333	2,444,402	759,967
Area deprivation index, mean (sd)	5.5 (2.4)	5.3 (2.2)	4.7 (1.9)
Median age, mean (sd)	39.1 (4.9)	39.4 (4.2)	39.5 (4.0)
Percent female, mean (sd)	51.3 (2.7)	51.9 (2.1)	52.0 (2.3)
Percent white, mean (sd)	56.7 (28.4)	54.0 (25.3)	44.4 (26.1)
Percent with high school degree, mean (sd)	90.1 (7.3)	91.1 (4.9)	90.2 (5.0)
Median income in $, mean (sd)	47,759.00 (12,656.5)	50,466.20 (15,555.6)	47,705.90 (10,537.0)
Percent unemployed, mean (sd)	3.6 (1.6)	3.4 (1.1)	3.5 (1.2)
Percent with incomes below the FPL, mean (sd)	6.3 (5.1)	6.2 (4.5)	6.1 (5.7)
Percent with no household vehicles, mean (sd)	7.8 (8.4)	9.3 (7.4)	8.6 (9.9)
Median rent in $, mean (sd)	1,429.40 (396.7)	1,516.00 (400.2)	1,629.30 (216.2)
Percent with internet subscriptions, mean (sd)	88.2 (7.5)	89.4 (6.5)	90.2 (4.0)
Percent uninsured, mean (sd)	6.0 (5.2)	5.8 (3.3)	6.6 (3.9)
Percent with Medicaid coverage, mean (sd)	14.5 (3.2)	14.8 (2.5)	15.9 (2.3)
Percent urban, mean (sd)	78.5 (33.7)	93.7 (12.3)	96.0 (14.2)

***Source**: Author's analysis of data from the American Community Survey, the University of Wisconsin School of Medicine and Public Health, and Pitchbook, press releases, and internet searches linked to Medicare Data on Provider Practice and Specialty. Analysis does not include zip codes with no identified physicians.*

***Notes**: FPL = Federal Poverty Level; PE = Private-equity. The area deprivation index (ADI) is on a scale of 1 to 10. Lower percentiles of the ADI are considered less disadvantaged communities, while higher percentiles are considered more disadvantaged communities. Means are weighted by population size in each zip code.*

Table 3 examines the relationship between PE penetration and various community characteristics using a linear regression with PE penetration as the dependent variable and community characteristics as independent variables. We found that a one percentage point increase in the share of the population that is white is associated with a 0.09 percentage point decrease in PE penetration, holding all the other community characteristics constant. This suggests that zip codes with higher PE penetration tend to be located in more diverse areas.

Table 3. Factors Associated with PE Penetration, 2020

Variables	Coefficient (Standard Error)
Area Deprivation Index, 1-10	-1.002
	(0.657)
Median Age	0.287
	(0.254)
Female, %	0.307
	(0.430)
White, %	-0.090*
	(0.047)
No Household Vehicles, %	-0.030
	(0.185)
Households with Internet, %	0.050
	(0.273)
Uninsured rate, %	0.329
	(0.266)
Medicaid Coverage, %	0.507
	(0.342)
Urban population, %	0.056
	(0.044)
Constant	-28.453
	(38.362)
Observations	307
R-squared	0.086

***Source**: Author's analysis of data from the American Community Survey, the University of Wisconsin School of Medicine and Public Health, and Pitchbook, press releases, and internet searches linked to Medicare Data on Provider Practice and Specialty.*
***Notes**: Standard errors in parentheses. *** p<0.01, ** p<0.05, * p<0.1 . FPL = Federal Poverty Level; PE = Private-equity. The area deprivation index (ADI) is on a scale of 1 to 10. Lower percentiles of the ADI are considered less disadvantaged communities, while higher percentiles are considered more disadvantaged communities. Means are weighted by population size in each zip code.*

C. Participation of PE-affiliated physicians in payer networks

Table 4 presents the numbers of physicians participating in commercial and MA payer networks, by in-network status and PE affiliation. Based on the MCDB data, the total number of physicians participating in commercial plans (in-network and out-of-network) is 15,937 of which 15,374 physicians (96.5%) are in-network. In MA plans, the total number of physicians (in-network and out-of-network) is 11,523, while 8,974 physicians (77.9%) are in-network.

Among PE-affiliated physicians, the total number of PE-affiliated physicians participating in commercial plans (in-network and out-of-network) is 1,650 of which 1,647 physicians (99.8%) are in-network. In MA plans, the total number of PE-affiliated physicians (in-network and out-of-network) is 1,605 while 1,496 physicians (93.2%) have in-network claims.

Among non-PE-affiliated physicians, the total number of physicians participating in commercial plans (in-network and out-of-network) is 14,287 of which 13,727 physicians (96.1%) are in-network. In MA plans, the total number of non-PE-affiliated physicians (in-network and out-of-network) is 9,918 while 8,378 physicians (84.5%) are in-network.

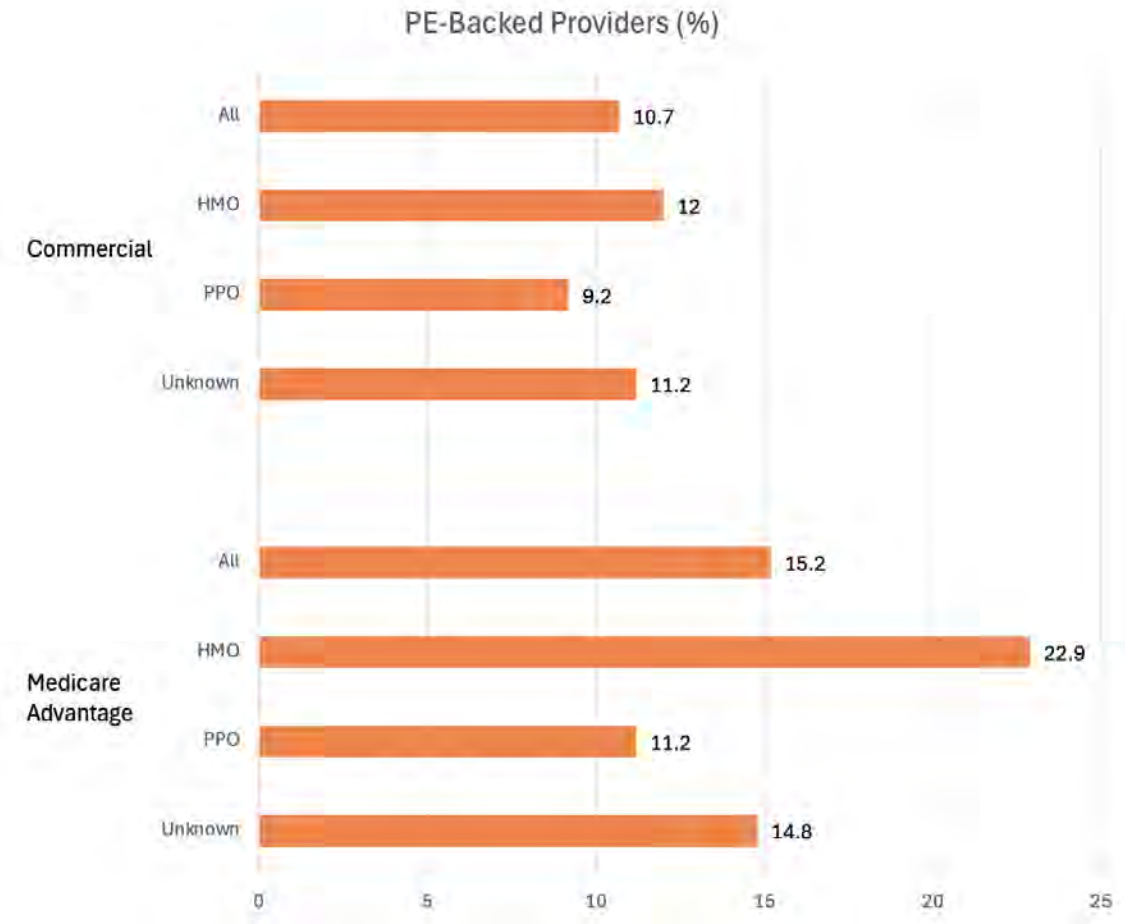
Table 4: Counts of Providers and PE-Affiliated Physicians in Payer Networks, 2021

	Commercial	Medicare Advantage
All physicians, n	15,937	11,523
In-Network Physicians, n	15,374	9,874
In-Network Physicians, %	96.5	77.9
PE-affiliated physicians, n	1,650	1,605
PE-affiliated In-Network Physicians, n	1,647	1,496
PE-affiliated In-Network Physicians, %	99.8	93.2
Non-PE-affiliated physicians, n	14,287	9,918
Non-PE-affiliated In-Network Physicians, n	13,727	8,378
Non-PE-affiliated In-Network Physicians, %	96.1	84.5

***Source**: Author's analysis of data from the Pitchbook, press releases, and internet searches linked to Medicare Data on Provider Practice and Specialty and provider network data from the Maryland Medical Care Data Base (MCDB).*
***Notes**: PE = private equity. A limitation is that this table includes only contracts with claims submitted in the calendar year 2021. As a result, some contracts active during that year may not be represented.*

Figure 3 summarizes the share of in-network providers that are PE-affiliated across plan types. In commercial networks, 10.7% of in-network providers are PE-affiliated, with variation across plan types. Specifically, 12.0% of in-network providers in commercial health maintenance organizations (HMO) are PE-affiliated, compared to 9.2% in preferred provider organizations (PPO). For commercial plans where the plan type is unknown, the share of PE-affiliated providers is similar to the overall rate at 11.2%.

Figure 3: Share of In-Network Physicians that are PE-Affiliated, by Payer Networks, 2021



***Source**: Author's analysis of data from the Pitchbook, press releases, and internet searches linked to Medicare Data on Provider Practice and Specialty and provider network data from the Maryland Medical Care Data Base (MCDB).*
***Notes**: HMO = health maintenance organization. PE = private equity. PPO = preferred provider organization. A limitation is that this table includes only contracts with claims submitted in the calendar year 2021. As a result, some contracts active during that year may not be represented.*

In contrast to commercial plans, MA networks have a greater proportion of PE-affiliated physicians across plan types. Overall, 15.2% of in-network providers in MA plans are PE-affiliated. In MA HMO plans, 22.9% of in-network providers are PE-affiliated, compared to 11.2% in MA PPO plans. The share of PE-affiliated providers in plans where the plan type is unknown (14.8%) aligns closely with the overall MA share.

D. Participation of PE-affiliated physicians in value-based care programs

1) Maryland Primary Care Program (MDPCP)

As of 2022 Maryland had 5,754 practicing primary care physicians and 1,524 primary care physicians participating in MDPCP (**Table 5**). Among PE-affiliated physicians, 37.7% (69 of 183) participated in MDPCP relative to 24.6% (1,368 of 5,571) of non-PE physicians.

Table 5. Number of primary care physicians participating in MDPCP, by affiliation type, 2022

	Participating in MDPCP (N = 1508)	**Not participating in MDPCP** (N=4,654)	**Total** (N = 5,754)
PE-affiliated	69	114	183
Non-PE	1,368	4,203	5,571
Total	1,437	4,317	5,754

***Source**: Author's analysis of data from the Pitchbook, press releases, and internet searches linked to Medicare Data on Provider Practice and Specialty and MDPCP participation data shared by MHCC.*
***Notes**: PE = private equity. A limitation is that this PE affiliation is as of 2021. As a result, analysis may not represent ownership changes since 2021.*

2) Episode Quality Improvement Program

As of 2022 Maryland had 2,825 physicians participating in EQIP. Among physicians participating in EQIP, 8% of physicians (226 of 2,825) were in PE-affiliated practices. PE-affiliated practices participating in EQIP include Anne Arundel Urology, Capital Digestive Care, Charles Emergency Physicians, Chesapeake Urology Associates, and Privia Medical Group Specialists.

Among PE-affiliated physician practices participating in EQIP, the only practice that generated savings in 2023 was Capital Digestive Care for episodes related to colonoscopy and upper gastrointestinal endoscopy. Capital Digestive Care generated $1,361,984 in savings for 12,275 episodes or $111 in savings per episode. In comparison, non-PE affiliated

physician practices generated an average of $58.60 in savings per episode for the same two clinical episodes (colonoscopy and upper gastrointestinal endoscopy)

V. Discussion

PE firms have rapidly invested in physician practices in Maryland. Initially, PE investments focused on high-margin, office-based procedural specialties such as dermatology, gastroenterology, urology, and ophthalmology, which are typically reimbursed using fee-for-service models from commercial insurers and Medicare. Over time, the scope of PE investments has broadened to include value-based specialties, such as primary care and cardiology, which generally involve many patients enrolled in Medicare Advantage and other risk-based payment models. Trends in PE investment in Maryland are similar to national trends although PE penetration in Maryland is notably higher, surpassing national averages across all physician specialties as of 2021 (see Appendix Table 2). At the same time, PE expansion is geographically uneven, with certain counties, like Prince George's County, experiencing high levels of PE penetration, while others, such as rural Garrett and outer suburban Cecil, had none.

PE-affiliated physicians showed higher rates of in-network participation in both commercial and Medicare Advantage plans compared to non-PE physicians. Previous research has shown that PE acquisitions of physician practices increase commercial prices negotiated by private insurers.[18,30] Thus, PE-affiliated practices may increase the cost of healthcare to patients and payers[18] even while network-participation remains high. Other studies have shown PE-affiliated providers can also increase the cost of care by deploying out-of-network billing - a strategy where providers do not enter into an in-network contract with insurers but instead charge the full cost of the service to the patient – in select specialties, such as emergency medicine and anesthesiology. [4,5,6 G] Given the cross-sectional nature of our analysis, we are unable to determine if PE investments facilitated greater participation of physicians in payer networks as in-network providers or if PE firms selected in-network physicians as investment targets.

Finally, PE-affiliated physicians had higher participation rates in Maryland value-based programs, such as MDPCP. The growth of value-based payment has created a demand for capital by primary care and other practitioners that require sufficient size, information technology infrastructure, and management capacity to succeed under capitation and risk-

based payment models.[23] Thus, it may be plausible for practices that participate in value-based payment programs to be more likely to obtain investment to support the scale and technological capacity necessary for these programs.

Overall, private equity investment in physician practices has accelerated in Maryland, with notable variations in its reach across different regions and specialties. Importantly, private equity investments in physician practices reflect a broader trend in corporate consolidation of physician practices nationwide. In recent years, the physician practice ecosystem has witnessed rapid changes to organization and ownership, with an increase in corporate consolidation by health systems, health insurers, retail companies, and private equity firms. This growth in consolidation has lessened competition, which in turn has affected health care affordability and access.[35]

VI. Policy Options

Many states have been seeking policy options to address consolidation and corporatization of health care entities. In response to requests from states, one of the contributors to this Report (Erin C. Fuse Brown) worked with the National Academy for State Health Policy (NASHP) developed model legislation titled, "Comprehensive Consolidation Model Addressing Transaction Oversight, Corporate Practice of Medicine and Transparency."[36] The model specifies three state policies to address health care consolidation, corporatization, and health care closures: **(A) Enhanced oversight of material health care transactions**; **(B) Strengthening protections for physicians and the clinical workforce**; and **(C) Transparency of ownership and control relationships**.

Notably, these policy options are intentionally designed to apply to a wide range of health care entities, transactions, and ownership and control entities. The effects of consolidation or corporate control of medical practices are not unique to private equity.[35] Thus, the policies are designed to apply to all material change transactions involving health care entities and medical practices, regardless of the identity of the transacting parties, including health systems, payers, private equity, publicly traded companies, retailers, or others.

While these three policies are mutually reinforcing, they also can be pursued on an *a la carte* basis and tailored to the specific characteristics of the state. States can determine

which agencies to vest authority, including sharing authority between different entities. Below, we offer possible authorities to regulate and oversee these additional powers, including the State Attorney General, the Department of Health, the Maryland Health Care Commission, and the Board of Physicians. Regardless of which agency or officials the additional authority is vested in, the additional authority for implementation, oversight and enforcement will also require additional resources, staff, data capacity, and the ability to contract with consultants and experts to assist with review and analysis. In some states, some of the transaction-specific costs of review and oversight may be charged to the transacting parties, but appropriations for additional full-time staff and analytic capacity will be necessary for ongoing operations.

A. Increasing state oversight over material health transactions, including PE transactions.

This policy addresses the concern that many states lack insight and oversight authority to prevent and monitor health care transactions that contribute to consolidation, increase costs, and lead to closures of key facilities or services.[37] Further, traditional federal and state antitrust enforcement tools may miss many transactions currently driving health care consolidation—vertical acquisitions or contractual affiliations of medical practices, for-profit investors including PE or health insurance companies, or serial transactions. Many of these transactions are too small to be reportable under the federal Hart-Scott-Rodino Act ($119.5 million in 2024), and states' authority may only extend to a limited range of transactions, such as those involving nonprofit hospitals.

As a result, several states have created enhanced oversight authority to review certain health care transactions by:[38]

- Requiring prior notice of material health care transactions, including transactions involving health care entities and PE investors, payers, management service organizations, real estate investment trusts, hospitals or health systems, staffing companies
- Expanding review authority of the Attorney General's office in conjunction with a state health agency

- Expanding the review criteria beyond traditional antitrust factors to a broader public interest standard including the effects on market competition, prices, workforce, access, availability of key services, quality, and equity
- Granting authority to block or impose conditions upon the transaction without a court order and provide continued oversight of the transacting parties and market overall

Currently, Maryland does not require prior notice or review of health care transactions that involve physician organizations. However, the state's existing statute on nursing home acquisitions (Md. Code Ann., Health-General § 19-120.2),[39] which gives the MHCC review and prior approval authority, offers a promising start. Further, acquisitions of nonprofit hospitals and nonprofit health plans or HMOs must be reviewed and approved by the Attorney General or the Maryland Insurance Administration, respectively (Md. Code Ann., State Gov't §§ 6.5-101 to 6.5-3.07).

Future legislation could expand this oversight to transactions of physician organizations by any entity, including health systems, PE funds, health insurers, staffing companies, retailers, or other acquirers. The trigger for review could include a transaction size (e.g., Indiana and Oregon review transactions valued at $10 million or more), including the cumulative value of serial acquisitions over time, which would permit review of transactions which fall below the Hart-Scott-Rodino Act threshold for federal review.[40] Covered transactions could include acquisitions, contractual control, and management services agreements. Explicitly including health care cost, quality, access, equity, workforce/labor considerations, long-term sustainability, and other "public interest" criteria in review may protect against increasing costs and/or decreasing quality following an acquisition.

Several potential organizations could serve as an oversight agency for these regulations. The State Attorney General could have joint oversight with a state health care agency, such as the State Department of Health, the MHCC, or the medical board, if the transaction involves provider organizations. In many states, the antitrust division of the Attorney General's office handles review of transactions, and states vary in the health agency vested with authority to review–ranging from independent market oversight offices to the offices within the health department. Legislation on transaction oversight should expand the

reviewing authority's ability to approve, disapprove or conditionally approve transactions without requiring the attorney general to seek a court order, and it should require ongoing oversight over approved transactions, including compliance with conditions imposed before the transaction.

In recent years, states have expanded their authority to review, and, in some cases block or condition, health care transactions without having to seek a court order.[37] Most states' requirements only apply to transactions involving hospitals (either nonprofit only or both nonprofit and for-profit), although five states require notice of nearly all health care transactions, including those involving provider organizations. Three of these states, Massachusetts, California, and Oregon, have pioneered a version of expanded health care transaction oversight that informed the development of the NASHP Model. In Massachusetts and California, material change transactions involving health care entities and provider organizations above a certain size threshold (measured in annual revenue or size of transaction), must submit an advance notice to a state agency (the Massachusetts Health Policy Commission and the California Office of Health Care Affordability, respectively). In all three states, the reviewing agency assesses potential effects of the transaction on cost, access, and other market and public interest factors. Neither agency can itself block a transaction, but both can refer transactions to their state Attorneys General for further action, including legal challenges to the transaction. [41] California advanced legislation in 2024 that would have authorized the Attorney General to block or impose conditions on health care transactions involving private equity groups and hedge funds and provider organizations, but the bill was vetoed by the Governor.[42] To date, Oregon is the only state with the authority (vested in the Oregon Health Authority) to review as well as block or impose conditions on material change transactions involving provider organizations, without having to seek a court order.[43]

B. Strengthening protections for physicians and other licensed health care workers

The second policy option that states are exploring is to increase protections for physicians and others in the health care workforce from growing corporate control through stronger regulation of the corporate practice of medicine (CPOM), non-compete clauses, and non-disparagement clauses.[43] These laws can be strengthened to protect physician and clinician

decision-making from control by unlicensed corporate entities with potentially misaligned pecuniary interests.

In 2024, Maryland passed HB 1388, which restricts non-compete clauses for licensed health care workers.[45] It bans new non-compete agreements effective July 1, 2025 for all such workers who earn less than $350,000 annually, and limits non-compete clauses for workers who earn more than $350,000 annually to one-year and a 10-mile radius from the principal place of employment. Although the breadth of HB 1388 obviates the need to implement new restrictions on non-compete clauses, other forms of restrictive covenants, including non-disparagement or nondisclosure agreements, could be similarly restricted for licensed health care workers.[46] Note, HB 1388 applies to nonprofit employers of licensed health care workers, including nonprofit hospitals, which the currently-enjoined FTC rule restricting non-competes would not. [47]

Additional protections for physicians in the form of stronger CPOM regulations could further protect their autonomy in both clinical and professional contexts.[48] The CPOM prohibition is a longstanding state legal doctrine that generally prohibits unlicensed lay entities from owning, employing, or controlling medical practices.[49] It stems from the legal prohibition on the unlicensed practice of medicine.

Like many states, Maryland has a historical CPOM doctrine based in common law and administrative opinions, with statutory exemptions for physician employment by hospitals and HMOs.[3] Maryland established a statutory CPOM prohibition for dentistry (Md. Code Ann., Health Occ., § 4-603). Professional corporations (PCs) must be exclusively owned by licensed professionals.[4] While Maryland's CPOM doctrine, in theory, prohibits PE firms, insurance companies, retailers, and other unlicensed lay-entities from owning medical practices or employing physicians, the CPOM doctrine has been circumvented by corporate management service organizations (MSOs) exercising contractual control over

[3] See, Dvorine v. Castleberg Jewelry Corp., 185 A. 562 (Md. 1936) (allowing lay-corporations to employ optometrists but suggesting a stricter CPOM standard for licensed physicians); Backus v. Cty Bd. of Appeals for Montgomery Cty., 166 A.2d 241, 242-43 (Md. 1960) (prohibiting dentists from practicing through corporations or other entities). See also, Md. Code Ann., Health-Gen., §§ 19-351(a)-(d); (exempting hospitals); 19-704 (exempting HMOs).

[4] Md. Code Ann., Corps & Ass'ns §§ 5-101, et seq,, 4A-203(10).

physician practices. Privia Health is an example of an investor-backed MSO that has been used to engage physician practices in Maryland.

The enforcement of the CPOM doctrine has eroded over time, coinciding with the rise of managed care and the carving out of exceptions for hospital or HMO employment of physicians. Most importantly, however, corporate entities have figured out contractual workarounds to circumvent the CPOM. PE funds, for example, typically create a MSO that does not outright own the PC but controls the practice through contractual mechanisms and/or by installing a "friendly physician" who works for the investor as the nominal head of the practice.

The CPOM doctrine can be strengthened legislatively to regulate the PC-MSO and friendly physician structure used to control medical practices.[36] Legislation to strengthen the CPOM could include the following provisions:

- **Clarify the CPOM prohibition in statute.** Legislation could explicitly prohibit unlicensed lay entities from owning or controlling medical practices, employing physicians, or interfering with clinical decisions. This includes a requirement that medical practices retain ultimate control over administrative, business, and clinical operations of the practice that may affect clinical decision-making, or the medical care delivered.

- **Regulate the PC-MSO and "Friendly Physician" structure.**
    - **Restrict dual ownership/financial interests in the MSO and PC.** To prevent financial conflicts of interest, the law could require individuals from serving as fiduciaries, directors, employees, or holding dual ownership interests in both a lay-owned MSO and a practice that is managed by the MSO. Exceptions could be made for MSOs that are fully or majority-owned by licensed clinical professionals.
    - **Ban restrictive covenants.** Further, legislation could prohibit non-disclosure, stock transfer restriction agreements, and non-disparagement clauses in provider contracts. These clauses are often deployed to obscure "friendly physician" arrangements and may restrict physicians from criticizing management or raising concerns about patient care.

    - **Ban "straw ownership" by friendly physicians.** Legislation could ban "straw ownership" by friendly physicians, requiring that PC owners be licensed in the state and meaningfully engaged in delivering medical care for patients of the practice.

- **For services that PCs continue to delegate to an MSO, the PC would retain the ultimate authority over and right to object to actions taken by the MSO that implicate patient care**.

    - **Staffing and patient time.** Decisions concerning hiring, firing, terms of employment, or staffing levels of licensed medical providers, as well as decisions that implicate the amount of time providers spend with patients;
    - **Clinical standards and coding.** Clinical standards and policies, and diagnostic coding practices and billing practices; and
    - **Prices and payers.** Prices and rates charged for services at the practice, decisions to contract with third-party payers, and the structure of such contracts.

- **Protections for employed physicians.** Finally, states are considering different approaches for hospital-employment of physicians and hospital-run MSOs. Some states, such as California, apply their CPOM requirements to hospitals. Other states, such as Oregon, would continue to permit hospitals to employ physicians, and apply a more limited set of protections against restrictive covenants and interference with clinical decisions by employed physicians.[48] The NASHP model, Part II, Section 4, enumerates protections for employed physicians.[36]

- **Enforcement.** These restrictions could be enforced by the state attorney general and board of physicians, with an additional private right of action for affected individuals, such as practice employees.

C. Increasing transparency of ownership and control of health care entities

Legislation to improve transparency of ownership and control of health care entities could address the opacity of ownership and control relationships that inhibit oversight. First, legislation could require all health care entities, including group practices, hospitals, health

systems, clinics, nursing facilities, and others to report information on ownership and control relationships to the Department of Health or other designated state health agency. Reportable information could include: owners, controlling entities, business structure, the ultimate owners or controlling parent, subsidiaries, entities under common control, significant equity investors, and MSOs. These reports could be compiled to produce a public registry of providers in the state, which would be updated periodically and upon any material change transaction, as defined by Section A. Massachusetts maintains a provider registry,[50] which formed the basis of the ownership transparency provisions in Part III of the NASHP Model. [36]

Conclusion

State policymakers are actively seeking ways to identify and address emerging forces that are shaping health care markets, including acquisitions of physician practices by private equity firms, payers, retail companies, and health systems. In addition, states seek to fill the gaps in federal and state antitrust authority over emerging forms of health care consolidation that might be too small to be reported or reviewed, but nonetheless contribute to ongoing health care consolidation and threaten the affordability, access, and sustainability of the clinical workforce. States are also working to understand the opaque and increasingly complex ownership and control relationships within the health care market and to strengthen protections for the professional autonomy of the clinical workforce. Policy efforts can aim to create a competitive market environment that balances the need for capital investment by medical practices with appropriate guardrails to protect patients and the clinical workforce against the pitfalls of consolidation and corporatization in health care.

References

1. Abdelhadi O, Fulton BD, Alexander L, Scheffler RM. Private Equity–Acquired Physician Practices And Market Penetration Increased Substantially, 2012–21. Health Affairs. 2024;43(3):354-362. doi:https://doi.org/10.1377/hlthaff.2023.00152

2. Braun RT, Bond AM, Qian Y, Zhang M, Casalino LP. Private Equity In Dermatology: Effect On Price, Utilization, And Spending. Health Affairs. 2021;40(5):727-735. doi:https://doi.org/10.1377/hlthaff.2020.02062

3. Brown EF, Adler L, Duffy E, Ginsberg PB, Hall M, Valdez S. Private Equity Investment as a Divining Rod for Market Failure: Policy Responses to Harmful Physician Practice Acquisitions. USC-Brookings Schaeffer Initiative for Health Policy; 2021.https://www.brookings.edu/wp-content/uploads/2021/10/Private-Equity-Investment-As-A-Divining-Rod-For-Market-Failure-14.pdf

4. Cooper Z, Scott Morton F, Shekita N. Surprise! Out-of-Network Billing for Emergency Care in the United States. *Journal of Political Economy*. 2020;128(9):3626-3677. doi:https://doi.org/10.1086/708819

5. Adler L, Milhaupt C, Valdez S. Measuring private equity penetration and consolidation in emergency medicine and anesthesiology. *Health Affairs Scholar*. 2023;1(1). doi:https://doi.org/10.1093/haschl/qxad008

6. Duffy EL, Garmon C, Adler L, Biener A, Trish E. No Surprises Act independent dispute resolution outcomes for emergency services. *Health Affairs Scholar*. 2024;2(11). doi:https://doi.org/10.1093/haschl/qxae132

7. Shah S, Rooke-Ley H, Fuse EC. Corporate Investors in Primary Care — Profits, Progress, and Pitfalls. The New England Journal of Medicine. 2023;388(2):99-101. doi:https://doi.org/10.1056/nejmp2212841

8. Braun RT, Jung HY, Casalino LP, Myslinski Z, Unruh MA. Association of Private Equity Investment in US Nursing Homes With the Quality and Cost of Care for Long-Stay Residents. *JAMA Health Forum*. 2021;2(11):e213817. Published 2021 Nov 19. doi:10.1001/jamahealthforum.2021.3817

9. Lee SS, Ke J, Shahinian V, Dupree JM. Private Equity In Health Care: A State-Based Policy Perspective. Health Affairs Forefront. Published online November 8, 2024. doi:https://doi.org/10.1377/forefront.20241106.200283

10. Centers for Medicare & Medicaid Services (CMS). Maryland Total Cost of Care Model | CMS. www.cms.gov. https://www.cms.gov/priorities/innovation/innovation-models/md-tccm

11. Scheffler RM, Alexander L, Fulton BD, Arnold DR, Abdelhadi OA. MONETIZING MEDICINE: PRIVATE EQUITY AND COMPETITION IN PHYSICIAN PRACTICE MARKETS. American Antitrust

Institute, the Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, University of California, Berkeley, and the Washington Center for Equitable Growth; 2023. https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf

12. Gupta A, Howell S, Yannelis C, Gupta A. Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes. SSRN Electronic Journal. 2020; Available at SSRN: https://ssrn.com/abstract=3537612 or http://dx.doi.org/10.2139/ssrn.3537612

13. Braun RT, Jung HY, Casalino LP, Myslinski Z, Unruh MA. Association of Private Equity Investment in US Nursing Homes With the Quality and Cost of Care for Long-Stay Residents. *JAMA Health Forum*. 2021;2(11):e213817. Published 2021 Nov 19. doi:10.1001/jamahealthforum.2021.3817

14. Gondi S,Song Z.Potential Implications of Private Equity Investments in Health Care Delivery. *JAMA*. 2019;321(11):1047–1048. doi:10.1001/jama.2019.1077

15. Offodile II AC, Cerullo M, Bindal M, Rauh-Hain JA, Ho V. Private Equity Investments In Health Care: An Overview Of Hospital And Health System Leveraged Buyouts, 2003–17. *Health Affairs*. 2021;40(5):719-726. doi:https://doi.org/10.1377/hlthaff.2020.01535

16. Kannan S, Bruch JD, Song Z. Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition. *JAMA*. 2023;330(24):2365–2375. doi:10.1001/jama.2023.23147

17. Cerullo M, Yang K, Joynt Maddox KE, McDevitt RC, Roberts JW, Offodile AC 2nd. Association Between Hospital Private Equity Acquisition and Outcomes of Acute Medical Conditions Among Medicare Beneficiaries. *JAMA Netw Open*. 2022;5(4):e229581. Published 2022 Apr 1. doi:10.1001/jamanetworkopen.2022.9581

18. Singh Y, Song Z, Polsky D, Bruch JD, Zhu JM. Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization. *JAMA Health Forum*. 2022;3(9):e222886.https://doi.org/10.1001/jamahealthforum.2022.2886

19. Singh Y, Reddy M, Whaley C. Trends in Private Equity Consolidation in Cardiovascular Care. *JAMA Health Forum*. 2024;5(6):e241478. doi:10.1001/jamahealthforum.2024.1478

20. Office of Public Affairs. Justice Department, Federal Trade Commission and Department of Health and Human Services Issue Request for Public Input as Part of Inquiry into Impacts of Corporate Ownership Trend in Health Care. Justice.gov. Published March 5, 2024. Accessed January 6, 2025. https://www.justice.gov/opa/pr/justice-department-federal-trade-commission-and-department-health-and-human-services-issue

21. Physicians Advocacy Institute. PAI-Avalere Report on Physician Employment Trends and Acquisitions of Medical Practices: 2019-2023. Physicians Advocacy Institute. Published April

2024. https://www.physiciansadvocacyinstitute.org/PAI-Research/PAI-Avalere-Study-on-Physician-Employment-Practice-Ownership-Trends-2019-2023

22. Zhu JM, Polsky D. Private Equity and Physician Medical Practices — Navigating a Changing Ecosystem. *New England Journal of Medicine*. 2021;384(11):981-983. doi:https://doi.org/10.1056/nejmp2032115

23. Rooke-Ley H, Song Z, Zhu JM. Value-Based Payment and Vanishing Small Independent Practices. *JAMA*. 2024;332(11):871-872. doi:https://doi.org/10.1001/jama.2024.12900

24. Nolte TN, Miedaner F, Sülz S. Physicians' Perspectives Regarding Private Equity Transactions in Outpatient Health Care-A Scoping Review and Qualitative Analysis. Int J Environ Res Public Health. 2022;19(23):15480. Published 2022 Nov 22. doi:10.3390/ijerph192315480

25. Borsa A, Bejarano G, Ellen M, Bruch JD. Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: systematic review. BMJ. 2023;382(1). doi:https://doi.org/10.1136/bmj-2023-075244

26. Yu J, Tyler Braun R, Bond AS, et al. Physician Management Companies and Neonatology Prices, Utilization, and Clinical Outcomes. Pediatrics. 2023;151(4):e2022057931. doi:10.1542/peds.2022-057931

27. Singh Y, Aderman CM, Song Z, Polsky D, Zhu JM. Increases in Medicare Spending and Use after Private Equity Acquisition of Retina Practices. Ophthalmology. 2024;131(2):150-158. https://doi.org/10.1016/j.ophtha.2023.07.031

28. Ambar La Forgia, Bodner J. Corporate Ownership and Firm Performance: Evidence from Fertility Clinics. Academy of Management Proceedings. 2023;2023(1). doi:https://doi.org/10.5465/amproc.2023.11712abstract

29. Zhu JM, Zeveney A, Read S, Crowley R. Physician Perspectives on Private Equity Investment in Health Care. JAMA Intern Med. 2024 May 1;184(5):579-580. doi: 10.1001/jamainternmed.2024.0062. PMID: 38466275; PMCID: PMC10928537.

30. Bruch, J. D., Foot, C., Singh, Y., Song, Z., Polsky, D., & Zhu, J. M. (2023). Workforce Composition In Private Equity–Acquired Versus Non– Private Equity–Acquired Physician Practices. Health Affairs, 42(1). https://doi.org/10.1377/hlthaff.2022.00308

31. Zhu JM, Song Z. The Growth of Private Equity in US Health Care: Impact and Outlook. NIHCM Foundation. https://nihcm.org/publications/the-growth-of-private-equity-in-us-health-care-impact-and-outlook

32. Richards MR, Whaley CM. Hospital behavior over the private equity life cycle. J Health Econ. 2024 Sep;97:102902. doi: 10.1016/j.jhealeco.2024.102902. Epub 2024 May 29. PMID: 38861907; PMCID: PMC11392649.

33. Kamyar Nasseh, LoSasso AT, Marko Vujicic. Percentage Of Dentists And Dental Practices Affiliated With Private Equity Nearly Doubled, 2015–21. *Health Affairs*. 2024;43(8):1082-1089. doi:https://doi.org/10.1377/hlthaff.2023.00574

34. Bruch JD, Borsa A, Song Z, Richardson SS. Expansion of Private Equity Involvement in Women's Health Care. *JAMA Intern Med.* 2020;180(11):1542–1545. doi:10.1001/jamainternmed.2020.3567

35. Fuse Brown EC, Singh Y, Whaley CM, Perkins J. The Rise Of Health Care Consolidation And What To Do About It | Health Affairs Forefront. Health Affairs Forefront. Published September 2024. https://www.healthaffairs.org/content/forefront/rise-health-care-consolidation-and-do

36. National Academy for State Health Policy (NASHP). Comprehensive Consolidation Model Addressing Transaction Oversight, Corporate Practice of Medicine and Transparency. NASHP. Published November 12, 2021. https://nashp.org/a-model-act-for-state-oversight-of-proposed-health-care-mergers/

37. Fuse Brown EC, Gudiksen KL. Models for Enhanced Health Care Market Oversight — State Attorneys General, Health Departments, and Independent Oversight Entities. Milbank Memorial Fund. Published January 25, 2024. https://www.milbank.org/publications/models-for-enhanced-health-care-market-oversight-state-attorneys-general-health-departments-and-independent-oversight-entities/

38. UC College of the Law San Francisco. Conditional Approval. The Source on HealthCare Price and Competition. https://sourceonhealthcare.org/market-consolidation/conditional-approval/

39. Md. Code, Health-Gen. § 19-120.2. Vol Section 19-120.2 - Changes of ownership.; 2024. https://casetext.com/statute/code-of-maryland/article-health-general/title-19-health-care-facilities/subtitle-1-health-care-planning-and-systems-regulation/part-ii-health-planning-and-development/section-19-1202-changes-of-ownership

40. Federal Trade Commission (FTC). New HSR thresholds and filing fees for 2024. Federal Trade Commission. Published February 1, 2024. https://www.ftc.gov/enforcement/competition-matters/2024/02/new-hsr-thresholds-filing-fees-2024

41. Mass. Gen. Laws ch. 6D § 13; Cal. Health & Safety Code § 127501.

42. Rooke-Ley H, Fuse Brown EC, Mehta N, Singh Y, Whaley CM. California's Failed Bid To Regulate Private Equity Investment In Health Care. *Health Affairs Forefront*. Published online December 6, 2024. doi:https://doi.org/10.1377/forefront.20241204.884303

43. Or. Rev. Stat. §415.500 et seq

44. "See Part II of NASHP's Model Legislation on 'Comprehensive Consolidation Model Addressing Transaction Oversight, Corporate Practice of Medicine and Transparency," available at https://nashp.org/a-model-act-for-state-oversight-of-proposed-health-care-mergers/"

45. Codified at Md. Code Ann., Lab. & Empl. § 3-716.

46. Fuse Brown EC, Reddy M, Whaley CM. The FTC's Noncompete Rule: Legal Challenges And Potential Solutions For Physician Markets. Health Affairs Forefront. Published online August 30, 2024. doi:https://doi.org/10.1377/forefront.20240828.827737

47. Fuse Brown EC, Reddy M, Whaley CM. The FTC's Noncompete Rule: Legal Challenges And Potential Solutions For Physician Markets. Health Affairs Forefront. Published online August 30, 2024. https://www.healthaffairs.org/content/forefront/ftc-s-noncompete-rule-legal-challenges-and-potential-solutions-physician-markets

48. Rooke-Ley H, Fuse Brown EC. Lessons From Oregon's Attempt To Strengthen The "Corporate Practice Of Medicine" Ban. Health Affairs Forefront. Published online May 2024. doi:https://doi.org/10.1377/forefront.20240501.954346

49. Zhu JM, Rooke-Ley H, Erin Fuse Brown. A Doctrine in Name Only — Strengthening Prohibitions against the Corporate Practice of Medicine. The New England Journal of Medicine. 2023;389(11):965-968. doi:https://doi.org/10.1056/nejmp2306904

50. Massachusetts Health Policy Commission. Registration of Provider Organizations. Published 2024. Accessed November 21, 2024. https://masshpc.gov/moat/rpo

Appendix

Additional Background on Data and Methods

To conduct our analyses, we built a panel dataset from 2014-2021 that identified acquisitions of physician practices by PE firms between 2014-2021. We constructed our dataset in multiple steps. To summarize the process, we 1) identified PE acquisitions of physician practices using Pitchbook data, 2) identified Tax Identification Numbers (TINs) associated with each acquisition by linking acquisition data to the Medicare Data on Provider Practice and Specialty (MD-PPAS). 3) identified all physicians (MDs and DOs) affiliated with each TIN.

Identify Private Equity Acquisitions

Our primary source of data on private equity transactions is a proprietary list of leveraged buyouts by PE firms in the "Clinics and outpatient services" sector compiled by Pitchbook Inc., a financial database that tracks mergers and acquisitions across industries and has been used by other studies examining PE in health care. Given that there is no single data source that tracks the complete universe of PE acquisitions of physician practices, a limitation of this data is that it might under report some PE acquisitions. To account for this, we supplemented Pitchbook data with manual searches.

Identifying TINs and physician NPIs affiliated with acquired practices

After identifying acquired practices, we used web searches to identify the physician owner or owners of the practices and their National Provider Identifiers (NPIs), similar to previous studies.[1–3] This was done by **first** identifying the organizational NPI for each acquired practice using the CMS National Plan and Provider Enumeration System (NPPES), which also lists the "Authorized Official" for the practice who is often a physician (MD/DO) that meets the following description: "a general partner, chairman of the board, chief financial officer, chief executive officer, direct owner of 5 percent or more of the provider being enumerated, or must hold a position of similar status and authority within the provider organization," and **second**, finding the individual NPI for the authorized official for the acquired practice. To validate this approach, we also used archived versions of physician practice websites and NPPES to identify the authorized official in the year of acquisition.

We then linked acquisitions to their Tax Identification Number (TIN) by matching the authorized official's or practice owner's NPI obtained from the NPPES data to the Medicare Data on Provider Practice and Specialty (MD-PPAS) in the year of acquisition. The MD-PPAS contains all registered providers in the United States who billed Medicare at least once and are registered in the Provider, Enrollment, Chain and Ownership System (PECOS); the database provides the legal business name, geographic location, TIN and provider's NPI. Acquisitions and owner NPIs were matched to MD-PPAS by matching the year of acquisition to the same year in the MD-PPAS data for each year 2014-2021. Using the MD-PPAS data, we then identified all NPIs associated with the acquired TIN at the time of acquisition. While there might be some measurement error in identifying which physicians are practice owners vs partners vs associates,

the precise identity of the physician owner is not relevant for our approach as we ultimately identify all physician NPIs affiliated with an acquired practice. We then followed all clinicians and practices across multiple years.

Estimate private equity penetration using MD-PPAS data

Using physician specialty information, we classified physicians into the following 8 specialties: primary care, cardiology, dermatology, gastroenterology, ophthalmology, oncology, urology, and orthopedics. We estimated PE penetration as the share of physicians in the evaluated specialties that were affiliated with PE firms. The denominator represents all physicians with at least one Medicare Part B claim in the 20% sample of Medicare fee-for-service claims data for 2021. First, we estimated PE penetration in physician practices in Maryland overall (all specialties combined), for the most recent year of data available (2021). Second, we estimated PE penetration within each specialty as of 2021.

Finally, we estimated PE penetration at a more granular level by estimating PE penetration for each county in Maryland. One challenge associated with doing so is that the MD-PPAS files available to us do not include granular geographic information, for example, 5-digit ZIP codes. To get around this, following previous research, we assigned physicians a ZIP code based on the ZIP code where a physician derived the plurality of Medicare fee-for-service Part B claims in 2021.[4] We then calculated PE penetration at the ZIP code level, as the share of physicians that are affiliated with PE.

This approach has limitations. First, the ZIP code assigned to a physician reflects the ZIP code from where the physician draws the majority of billed Medicare Part B claims rather than the ZIP code where the physician practice is located or where the physician resides.[4,5] As a result, estimates of PE penetration may not reflect the true number of physicians practicing in a given ZIP code or geographic region. Second, we rely on Medicare Part B data to attribute ZIP codes to physicians, thus, our estimates of PE penetration may vary using other sources of data (e.g., commercial claims data). Other researchers have proposed using various techniques including spatial analytics, text mining, and visual examination to identify physician practice locations; however, each approach has its limitations.[6] The absence of complete and systematic data on physician practice organizations has been widely acknowledged as a data challenge in the broader health economics and health policy literature. Nevertheless, claims-based measures that identify physician locations are considered to be more accurate than other data sources, including the American Medical Association (AMA) Masterfile data.[7]

References

1. Braun RT, Bond AM, Qian Y, Zhang M, Casalino LP. Private Equity In Dermatology: Effect On Price, Utilization, And Spending. *Health Aff Proj Hope*. 2021;40(5):727-735. doi:10.1377/hlthaff.2020.02062 [doi]
2. Braun RT, Lelli GJ, Pandey A, Zhang M, Winebrake JP, Casalino LP. Association of Private Equity Firm Acquisition of Ophthalmology Practices with Medicare Spending and Use of Ophthalmology Services. *Ophthalmology*. 2024;131(3):360-369. doi:10.1016/j.ophtha.2023.09.029
3. Singh Y, Bejarano G, Torabzadeh H, Borkar D, Whaley C. Increase in Physician Turnover in Private Equity-Owned Physician Practices. *Health Aff (Millwood)*. Published online March 2025.
4. Timbie JW, Kranz AM, DeYoreo M, et al. Racial and ethnic disparities in care for health system-affiliated physician organizations and non-affiliated physician organizations. *Health Serv Res*. 2020;55(S3):1107-1117. doi:10.1111/1475-6773.13581
5. Badinski I, Finkelstein A, Gentzkow M, Hull P. Geographic Variation in Healthcare Utilization: The Role of Physicians. Published online October 2023. doi:10.3386/w31749
6. Shi X, Xue B, Xierali IM. Identifying the Uncertainty in Physician Practice Location through Spatial Analytics and Text Mining. *Int J Environ Res Public Health*. 2016;13(9):930. doi:10.3390/ijerph13090930
7. Baldwin LM, Adamache W, Klabunde CN, Kenward K, Dahlman C, L Warren J. Linking physician characteristics and medicare claims data: issues in data availability, quality, and measurement. *Med Care*. 2002;40(8 Suppl):IV-82-95. doi:10.1097/00005650-200208001-00012

Appendix Table 1. Responses to DOJ-FTC-HHS Request For Information from Maryland stakeholders

Comments
Tracking Number: ltn-6e8g-vwy6 I've been enrolled in a UnitedHealthcare Advantage (UHC) plan since January 2023 that is available only to IBM retirees. This was advertised as a very high quality Advantage plan, supposedly far better than Advantage plans available to the public. 1. It took about 40 phone calls and 15 emails over a period of 3 months to get a piece of durable medical equipment approved. UHC pays about $40 per month and I have a copayment of $30 per month. Good think this piece of DME didn't rent for a lot more! 2. The dental coverage included with my UHC Advantage plan is very hard to access. Little more than the most basic services are covered. The plan pays dentists so little that few dentists even accept it. (The list of participating dentists on the UHC web does not reflect reality.) 3. The list of participating physicians on the UHC web site does not reflect reality. Many of the listed physicians have terminated their participation with UnitedHealthcare. There should be an accuracy requirement for the list of participating physicians and there should be penalties to UHC for listing providers that are not really in-network. 4. Many of the UHC phone reps lack even the most basic knowledge about the plan. In researching their backgrounds (via social networking), most of the phone reps have no credentials whatsoever in healthcare and most have not attended college at all. However, these reps are effectively making medical decisions that should be left to licensed healthcare providers. 5. The appeals process for UHC frequently results in boilerplate responses that have little to do with the grievance or appeal. The appeals reps often provide a phone number but they rarely answer their phones or respond to voicemail messages. Also, many of the appeals reps are in foreign countries. The phone connection quality is poor and they are very difficult to understand because of their accents. 6. UHC is in violation of multiple provisions of the HIPAA Privacy Rule. I submitted a formal complaint to the agency responsible for enforcement, HHS Office of Civil Rights, and even they cannot get UHC to comply with the Privacy Rule (although OCR seems to have a lot of problems internally). Senator Cardin has even tried to intervene but has been unsuccessful. In summary, everything about the UnitedHealthcare Advantage plan is designed to fail.

Tracking Number: ltp-gw01-rc5l

Healthcare consolidation and vertical integration have become increasingly prevalent in the modern healthcare landscape. When a single entity owns multiple stages of the healthcare delivery process, it gains an unprecedented ability to dictate terms and prices across the board. Independent pharmacies are almost non-existent, at times having to fill Rx's at a loss. Patients are directed to fill their Rx's at CVS or pay significantly more, because their pharmacy benefit manager, Caremark (CVS owned) doesn't reimburse an adequate amount to the pharmacy. Aetna (CVS owned) determined that Caremark was the best option for insurance.

Vertical integration had led to very little competition in the marketplace with only a few big players remaining and slowly destroying independent pharmacies and physician practices. Please regulate these healthcare monopolies. Break them up. Stop allowing a few companies to control and ruin all of our healthcare.

The central issue with this form of integration is the potential for monopolistic control. When a single entity owns multiple stages of the healthcare delivery process, it gains an unprecedented ability to dictate terms and prices across the board. Independent pharmacies are almost non-existent.

Tracking Number: lty-tlbf-fxma

The central theme of the sacred relationship between doctor and patient is best summarized by the statement "the patient's best interest is the only interest to be considered". When a private equity firm or other for-profit entity becomes an owner of a healthcare service there is, by definition, another party with its own interests and concerns standing between the doctor and the patient and that party has as at least one of its goals, profit which may cause it to pressure the healthcare provider to act in ways that are contrary to the patient's best interests.

Tracking Number: lu3-65yl-d5uf

Having been in the ER recently and having the nurse tell me later that they were working for some investors and that care was being badly affected, it is intolerable that private equity firms control about 25% of these facilities. The United States is, or at least was, a wealthy developed nation and has the worst damn healthcare system in the world. That healthcare here is treated as a for profit business is the reason why we spend more than any other country and get such bad outcomes.
Take this money out of our healthcare system. If nothing is done, people will die.

Tracking Number: lu6-y3wm-dc5i

Maryland has one of the longest wait times in emergency rooms of any state in the US. The increasing consolidation of the health care industry and its increasing control by private equity capital will surely accelerate this trend, prioritizing profits over patient wellbeing and worker safety and reducing the quality of care.

Please consider implementing policies to limit the ability of private equity firms to acquire and operate emergency rooms, such as stricter regulations on mergers and acquisitions in the healthcare industry, and greater transparency and accountability requirements for these firms. Thank you

Tracking Number: lu3-7gms-4j6w

Remove private equity firms from ERs.

Tracking Number: lu3-bzsi-l576

I am glad to see the government recognize the problems presented by consolidation in health care industries, particularly emergency rooms. Private equity firms often prioritize profits over patient care and worker safety, leading to higher costs, reduced quality of service, and increased risks for both patients and healthcare workers. This is a bad idea. There are many things that should NEVER be privatized. THIS, medical care, is one of them. It's a grave mistake and will cost MORE lives.

I demand you consider implementing policies that would limit or restrict the ability of private equity firms to acquire and operate emergency rooms. This could include stricter regulations on mergers and acquisitions in the healthcare industry, as well as greater transparency and accountability requirements for these firms. BANNING private equity firms from buying and operating emergency rooms all together, is the BEST solution Thank you.

Tracking Number: lu3-ujxs-icyk

Our healthcare system is already one of the most expensive of all of the developed countries

The last thing we need is further involvement of private equity. We had the first doctors union formed because private equity was interfering with their ability to provide patient care This happened recently in Pennsylvania.Keep the profit out of the healthcare business.They have no interest in patient care.They have no interest in universal support people from a healthcare perspective.They are only interested in profit and they do the best they can to reduce care for the patient, burden the provider with bureaucratic reports, and maximize their profit and margins

Tracking Number: lu4-0hv5-edib

Private Equity Firms have already destroyed the newspaper business, on which we depend for vital information. Private Equity Firms are gobbling up houses and apartment firms, putting affordable housing out of reach for millions of Americans. And they are looking at emergency rooms for the profit that can be obtained, rather than the essential provider of services for communities. Private Equity Firms must face limits. We depend on the national government to set those limits. The time for real change in the regulations on these firms is now.

Tracking Number: lu7-rzxd-qehs

Private equity firms shouldn't be in healthcare. Their interest is in profits, not patients. Please do what you can to stop that trend.

Tracking Number: lud-6zp7-qhr2

It's awesome to see the government acknowledging the issues with consolidation in healthcare, especially in emergency rooms. Private equity firms often prioritize profits over patient care and worker safety, which leads to higher costs, lower quality, and more risks. I think it's important for the government to put policies in place to limit or restrict these firms from acquiring and running emergency rooms. This could mean stricter regulations on mergers and acquisitions in healthcare and more transparency and accountability for these firms. Thanks!

Tracking Number: lv0-1kyf-8jjz

I am Emergency Medicine resident from a rural area. I strongly believe that for profit non physician owned or operated healthcare groups provide bad medical care. I have witnessed first hand how corporate groups create unsafe working conditions that cause harm to patients. In these conditions even well trained and well intentioned doctors can not help but provide poor quality medical care when corporate groups operate a health system.

Tracking Number: lvu-xi3r-vy3l

Private equity is a malignancy of our current healthcare model. PE firms perform hostile takeovers of established, well run, companies and make changes that maximize profits. Unfortunately those changes are at the detriment of patients safety and quality of healthcare delivery. After a PE firm discovers that the healthcare company is not as profitable as hoped they shutter business, often leaving derelict buildings in population centers. PE should not be allowed to own healthcare companies.

Tracking Number: lvu-9cas-av0f

It is excellent that the United States government will be looking at restricting private equity firms from receiving federal health acute and long term care monies. Taxpayer funds should be utilized as the federal government intended, to provide services for people and not to enrich investors who are working deliberately to destroy these services. Thank you!

Tracking Number: lvy-58oz-plwt

I graduated from EM residency with the desire to work for a nonprofit organization that I believed would always prioritize the best care for patients and wellness of physicians. Our nonprofit group lost the contract with University of Maryland Medical System, because the System believed our group to have an unsustainable business model. They canceled the contract and have hired US Acute Care Solutions. This "physician owned group" promised to operate with zero subsidy dollars due to their increased efficiency in billing and ability to negotiate with insurers. This now consolidates nearly 20-25% of all ED visits in the state of Maryland under a single for-profit company. I am concerned about how this will change the landscape of EM and affect physicians' ability to choose an employer. Although Non-compete clauses are now illegal, they seemed to have only been renamed "Non-interference" clauses.

Tracking Number: lvz-w0sm-ygus

I retired fully about 5 years ago after more than 40 years in practice as a board certified oncologist and hematologist serving a very racially mixed county, Prince George's, in suburban Maryland. Thirty years I saw the writing on the wall and warned my colleagues to be ware, that big business had discovered medicine. And, unfortunately, I was very prescient. Practices have been bought out, senior physicians and support staff have been fired and dollars meant for medical care are instead diverted to passive investors, all to the detriment of medical care and the emotional integrity of the caregivers. The trend is inevitable and terribly destructive to the country. No private entity not directly involved in patient care should be allowed to profit off medical care. The patients suffer, doctors and support staff suffer, financially and mentally. And furthermore, there should be no for profit insurance carriers either. Big business is gaming the system and we all suffer. David J Haidak, MD FACP

Tracking Number: lw5-9jpe-bu3u

I am a practicing cardiologist who applauds the DOJ, HHS, and FTC's decision to take a closer look at the privatization of health care practices and nursing homes in this country, which has grown exponentially over the last decade. As a practicing physician, I am convinced that guardrails need to be in place to protect patient access and choice to care.

Proponents of private equity acquisition of health practices would argue they provide practice owners with a graceful and profitable way out and is certainly better than simply closing up shop. In many ways, the interests of the private equity firm and the practice are aligned - the firm wants the practice to run efficiently, smoothly, and profitably. Maybe patient retention goes up, outdated systems are replaced, resources are allocated more efficiently. Any business-savvy practice owner would want the same thing.If I were a private practice owner, that's exactly how I would want my practice to run.

But the quality of patient care, the health of the surrounding community, and the wellbeing of the practice employees (doctors, APPs, nurses, receptionists, etc.) by definition become a lower priority than profit. The employees of the practice (which may include doctors, APPs, nurses, receptionists, etc.) usually get nothing out of this deal, and their livelihoods are put at risk because their salaries are a liability to the private equity firm whose sole mission is to maximize the profitability of the practice so they can eventually sell to another buyer at a higher price. That means doctors may need to see patients in 10-minute appointment slots instead of 20, a medical assistant will be doing intake on double the number of patients a day, and their wages will almost certainly go down if they're not outright let go. As the private equity firms increases their market share in local markets, competition decreases, prices for patients go up, and health care providers can't negotiate more sustainable working conditions or wages. We have seen this already with specialties such as ophthalmology, OB/GYN and gastroenterology in local markets when private equity market share exceeds 30%.

In the best case scenario, a private equity firm recognizes the value of employee wellness in improving recruitment/retention, invests in the employees, and everyone initially benefits from the initial infusion in capital. The old practice owners might even negotiate for some employees to have partial ownership in the practice so that when the practice is later sold for a profit, the employees share in some of the upside. But even if that happens, when the private equity firm eventually sells the practice to a new investor or corporation, those benefits/ownership end with the exit of the private equity firm, and the employees have no say over who their new owners will be.

I believe that private equity consolidation is a horrifying threat to healthcare providers and public health as it likely worsens the quality/access to/cost of care for patients as their their market share in local practice markets increases. The DOJ/HHS/FTC are right to be concerned and should take appropriate action to put guardrails on these transactions. I have attached a report by the American Antitrust Institute, University of California Berkeley, and the Washington Center for Equitable Growth that highlights many of these concerns.

Tracking Number: lwa-kuof-2dxc

Health care is now considered sick care. I work in Health care as a nurse. My company offers us a HDHP. For family coverage for me and my husband I pay close to 500.00 a month to have my health insurance and the deductible is over 5000.00 a year before they pay anything. This is sad and very unaffordable for most. Including me. These self funded insurances which only benefit the employer is sad at best. Prior to 2008. I paid 60.00 a pay period for insurance my deductible was 250.00 and if I got prescriptions at the pharmacy it was a 5.00 copay. What happened in this time frame. Federal regulations gave big businesses who are already making millions more freedoms to pass the cost to employees. You work all your life in Healthcare taking care of others and have no benefit from the companies you work for. I have to pay for Std disability and LTD which is expensive but needed. There was a time when you worked for a company for many years even after you retire they covered the cost and offered continued health benefits as retiree. Those days are long gone. Healthcare is a very broken system. I am not sure how to fix but it needs to be fixed. Start with the employers of these big companies. They make millions and should have to provide low deductible high quality Healthcare to their employees.

Tracking Number: lwa-uesi-jmmp

I am writing so provide my feedback as an emergency physician regarding the negative effect of consolidation and private equity influence in healthcare. The attached letter was also previously submitted to Senators Markey, Peters and Warren in regards to this topic.

Best,
Joshua Feblowitz

Tracking Number: lwf-5mub-6lit

I am an intensive care physician working in a large community hospital in the DMV area. While my hospital has so far remained free of this, I have been alarmed by the increasing role of private equity firms in the ownership and management of healthcare entities and I think this will require government regulation to control. These entities have no interest besides increasing profits for themselves and what will suffer is the quality of patient care and outcomes.

Tracking Number: lwr-mabj-ofcu

I own an outpatient physical therapy practice in Rockville Maryland. I have been in business since 2015. I am contracted/in network with CareFirst and since this time (2015) I have received no reimbursement increase. NONE! I have attempted to renegotiate with the payor and been declined. Inflation is up more than 30%. The premiums that I pay for my employees' health insurance is also up 30%. Patient co-pays and coinsurance are increasing yearly. My reimbursement rate, however, is relatively plummeting. Since the pandemic, healthcare providers salaries have increased considerably. Providers who want to continue to provide quality care are opting out of their insurance contracts as they can no longer afford to provide a service while accepting insurance reimbursement. Concierge medicine is contributing to disparities in healthcare. This is driven by plummeting insurance reimbursement all the while corporate profits continue to soar. Private equity is focused on one thing and that is making money. It has no business in patient care.

Tracking Number: lwx-z1n1-c9cm

I wanted to share my story about my experiences with Care First.
Specifically, how I paid a hefty time tax to ensure I wouldn't have medical debt.
In March of 2022, I re-broke my left leg.
Luckily, I had health insurance at the time with Care First that covered the ambulance ride, hospital stay, surgery and post-care.
I was mistaken in thinking that everything would work itself out when it came to resolving the billing.
I received my first bill a month after I got out of the hospital in April.
These were nothing big, they were standard co-pays of $30 or $60.
That didn't last long.
By September, I was receiving bills that were $30,000 or more.
The same thing happened in October.
That began the extremely long process of having to call Care First on a weekly or bi-weekly basis so I wouldn't continue to receive these large medical bills.
The sticker shock from seeing a medical bill for $30,000 took a toll on me.
The stress from having to spend hours on the phone with Care First affected my mental and physical state.
The anxiety of not knowing if receiving medical bills for $30,000 was messing up my credit didn't sit well with me.
This ordeal affected my work performance too.
I had to take time off from work and work longer hours because the Care First was only available during regular business hours.
Care First's offices aren't open during the evenings or on the weekends.
Their business practices aren't friendly for middle and working class people.
It took numerous months until I was able to get both Care First and the hospital on the phone at the same time to resolve the issues with my billing.
That's not my job and it's something they should have done on their own.
The hospital was sending their claims to Care First, but because Care First was taking so long to process the claims, the hospital was putting me on the hook for the medical bills.
Ultimately, it took over a year to resolve the billing with Care First.
I broke my leg in March 2022 and everything wasn't paid off until April 2023.
My message to Care First: Don't delay claims. Don't deny claims. Put the people first.
People have numerous responsibilities and obligations to deal with during their everyday lives.
Most people can't afford to spend hours on the phone with Care First over issues they should've handled themselves.

Tracking Number: lwz-18av-hhjl

I am writing to express my deep concerns regarding the antitrust practices associated with the acquisition of local small dental practices by dental support organizations (DSOs), e.g. Aspen Dental, Heartland Dental, Pacific Dental Services, etc. As a practicing dentist, I have witnessed firsthand the adverse effects of these acquisitions on competition, patient care, and the dental profession as a whole.

One particular issue that exacerbates the anticompetitive nature of DSO acquisitions is the exploitation of loopholes in state regulations. Many states mandate that a practicing dentist must be the owner of a dental practice. However, DSOs have been known to circumvent these regulations by registering practices under the name of a single dentist, thereby maintaining the appearance of compliance while exerting control over multiple practices.

This practice not only undermines the integrity of state regulations but also facilitates the unchecked expansion of DSOs at the expense of independent dental practitioners. By leveraging these loopholes, DSOs can amass significant market power and engage in anticompetitive behavior with impunity.
The consolidation of dental practices by DSOs has led to a significant reduction in competition within the industry, resulting in limited choices for patients and diminished quality of care. Furthermore, DSOs often prioritize profit over patient well-being, leading to pressure on dentists to meet production quotas at the expense of thorough and comprehensive treatment.
In addition to harming patient care, these practices also pose a threat to the livelihoods of independent dental practitioners. By acquiring numerous practices and exerting significant market power, DSOs can effectively drive out competition, leaving independent dentists with few options for practice ownership or employment.
This consolidation not only stifles innovation and diversity within the dental profession but also creates an environment ripe for anticompetitive behavior. DSOs, with their considerable resources and market influence, may engage in tactics that further solidify their dominance, such as steering referrals, setting reimbursement rates, and limiting access to essential services.
It is imperative that the Federal Trade Commission (FTC) takes decisive action to address these antitrust concerns and protect both patients and independent dental practitioners. Greater oversight and regulation of DSO acquisitions are necessary to ensure a competitive and diverse dental marketplace that prioritizes patient care above all else.

I urge the FTC to thoroughly investigate the practices of DSOs in acquiring and consolidating local dental practices and to take appropriate enforcement actions against any violations of antitrust laws.

Tracking Number: lx1-3zka-iprb

Monopolies are bad. I have had the same insurance for years, but I've had to switch pharmacies at least 3 times in the past 5 years because I can't get my medicines through a CVS/Caremark pharmacy and they've bought out EVERYONE. It's completely ridiculous. It's hard enough just getting insurance to cover my medications, but now I have to worry about monopolies freezing me out of places to get my medicine.

Tracking Number: lx2-hbev-fxyd

I urge the Department of Justice, DHHS and FTC to limit the consolidation of health care delivery and the encroachment of private equity in the health care sphere. I have received services from several providers that were bought out by private equity firms and subsequently experienced marked decreases in service quality and responsiveness to patient needs. Similarly, as private equity firms have bought out nursing facilities, a relative of mine who has worked in a number of nursing homes as a Certified Nursing Assistant has reported increased resident-to-staff ratios, stagnant staff pay and poorer care for residents. Profit is the primary purpose of private equity but should not be the main focus of health care services. Thank you.

Tracking Number: lx2-meke-p2g5

Reclaiming our healthcare market for the sake of patients

Tracking Number: lx2-mwp4-e51t

I'm writing on behalf of Progressive Maryland and our grassroots community members to urge that you use your authority and the regulatory tools at your disposal to address the corporate consolidation across our healthcare system. We talk to everyday Marylanders week in and week out who are feeling the pain that profiteering insurance companies and drug companies are inflicting with their high prices and in the case of insurers, denials of care. Hospitals have also gotten further away from their mission of providing good care, full staffing, and emergency room services. Insurance giants are paying CEOs record compensation packages and making it harder and harder for people to use their health plans to get the care they need when they need it. It's time to crack down, break up the consolidation and put protections and safeguards in place for patients and providers.

***Source**: The data compiled reflect a subset of comments submitted in response to a cross-government public inquiry by the Justice Department's Antitrust Division, Federal Trade Commission and Department of Health and Human Services into private-equity and other corporations' increasing control over health care. Comments were downloaded from regulations.gov using the docket ID for the RFI (FTC-2024-0022) and restricted to comments where the state of the respondee was Maryland.*

Appendix Table 2. PE penetration in physician specialties relative to national estimates

Specialty	PE penetration in Maryland	Estimates of national PE penetration
Oncology	8.4%	4%
Orthopedics	8.8%	4%
Cardiology	14.5%	2%
Gastroenterology	16.7%	14%
Ophthalmology	25.2%	6%
Primary care	27.3%	2%
Dermatology	36.2%	11%
Urology	63.3%	8%
Average across all specialties	15.5%	N/A

***Source**: Author's analysis of data from the Pitchbook, press releases, and internet searches linked to Medicare Data on Provider Practice and Specialty. Estimates of national PE penetration are adapted from Abdelhadi, et al. (2024) "Private Equity–Acquired Physician Practices And Market Penetration Increased Substantially, 2012–21." Health Affairs, 43(3), 354-362.*
***Notes**: PE = private equity. A limitation is that this PE affiliation is as of 2021. As a result, analysis may not represent ownership changes since 2021. PE penetration represents the share of physicians that are in PE-affiliated practices as of 2021.*

Appendix Table 3. PE penetration in all specialties by Maryland County, 2021

County	No. of Zip Codes	Total No. of PE-affiliated Physicians (2021)	Total No. of Physicians (2021)	Private Equity Penetration (%)
Allegany	22	11	275	4.0%
Anne Arundel	45	134	1711	7.8%
Baltimore City	47	444	3724	11.9%
Baltimore	49	312	2678	11.7%
Calvert	14	0	194	0.0%
Caroline	20	0	13	0.0%
Carroll	10	1	334	0.3%
Cecil	16	0	160	0.0%
Charles	25	47	326	14.4%
Dorchester	16	0	62	0.0%
Frederick	31	61	724	8.4%
Garrett	9	0	64	0.0%
Howard	19	182	1370	13.3%
Harford	24	2	569	0.4%
Kent	9	0	40	0.0%
Montgomery	76	238	2875	8.3%
Prince George	61	1539	2895	53.2%
Queen Anne	12	3	67	4.5%
Somerset	11	0	29	0.0%
St. Mary	28	1	209	0.5%
Talbot	16	2	227	0.9%
Washington	24	21	376	5.6%
Wicomico	19	1	328	0.3%
Worcester	11	14	154	9.1%

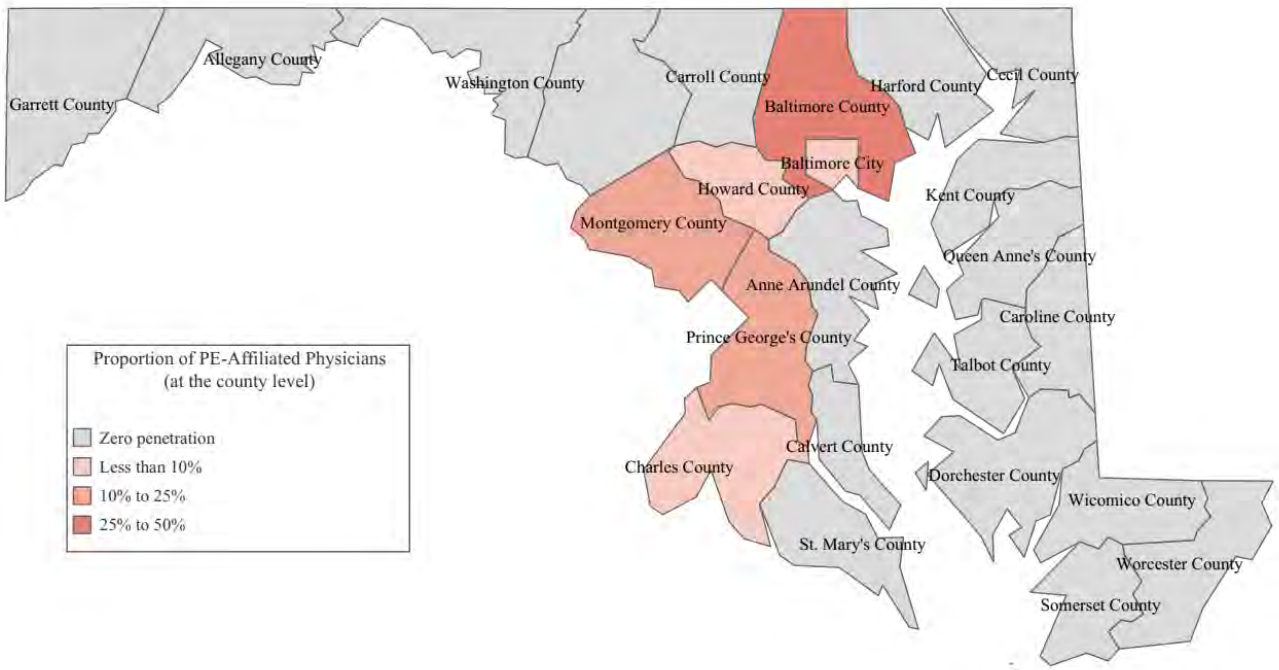
***Source**: Author's analysis of data from the Pitchbook, press releases, and internet searches linked to Medicare Data on Provider Practice and Specialty and 20% sample of Medicare Fee For Service claims data.*
***Notes**: PE = private equity. A limitation is that this PE affiliation is as of 2021. As a result, analysis may not represent ownership changes since 2021. PE penetration represents the share of physicians that are in PE-affiliated practices as of 2021.*

Appendix Table 4. PE penetration in all specialties by Maryland County, 2021

County	% PE Penetration							
	Oncology	Orthopedics	Cardiology	Gastroenterology	Ophthalmology	Primary Care	Dermatology	Urology
Allegany	0.0%	28.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Anne Arundel	0.0%	5.1%	4.6%	6.8%	43.6%	1.0%	76.2%	100.0%
Baltimore City	1.2%	1.3%	13.2%	12.2%	36.5%	29.4%	9.1%	0.0%
Baltimore	26.0%	8.2%	0.0%	26.4%	11.5%	15.2%	6.3%	96.5%
Calvert	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Caroline	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Carroll	0.0%	0.0%	0.0%	0.0%	0.0%	1.1%	0.0%	0.0%
Cecil	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Charles	9.1%	4.9%	0.0%	0.0%	28.6%	31.4%	0.0%	0.0%
Dorchester	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Frederick	0.0%	5.9%	0.0%	6.3%	25.0%	36.4%	0.0%	0.0%
Garrett	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Howard	2.2%	7.7%	16.7%	10.0%	36.4%	32.9%	5.0%	60.0%
Harford County	0.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Kent County	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Montgomery	13.8%	7.5%	5.8%	18.9%	12.4%	4.9%	41.1%	89.3%
Prince George	22.2%	27.6%	54.1%	58.0%	61.9%	71.6%	77.4%	63.6%
Queen Anne	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	76.2%	0.0%
Somerset	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
St. Mary	0.0%	4.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Talbot	0.0%	5.3%	0.0%	0.0%	0.0%	0.0%	0.0%	20.0%
Washington	0.0%	3.4%	0.0%	0.0%	0.0%	2.4%	72.7%	0.0%
Wicomico	0.0%	2.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Worcester	0.0%	5.3%	0.0%	0.0%	0.0%	0.0%	0.0%	66.7%

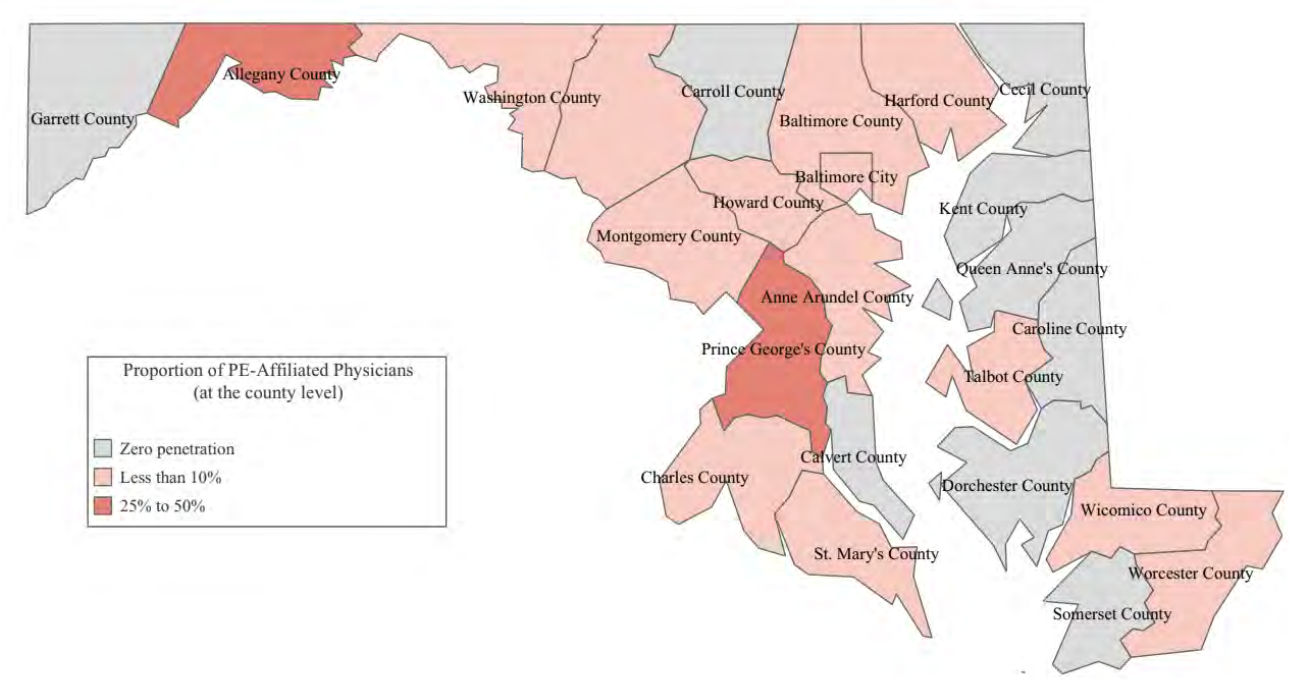
***Notes/Source**: Author's analysis of data from the Pitchbook, press releases, and internet searches linked to Medicare Data on Provider Practice and Specialty and 20% sample of Medicare Fee For Service claims data. PE = private equity. PE penetration represents the share of physicians that are in PE-affiliated practices as of 2021.*

Appendix Figure 1: Geographic Variation in PE Penetration in Oncology, 2021



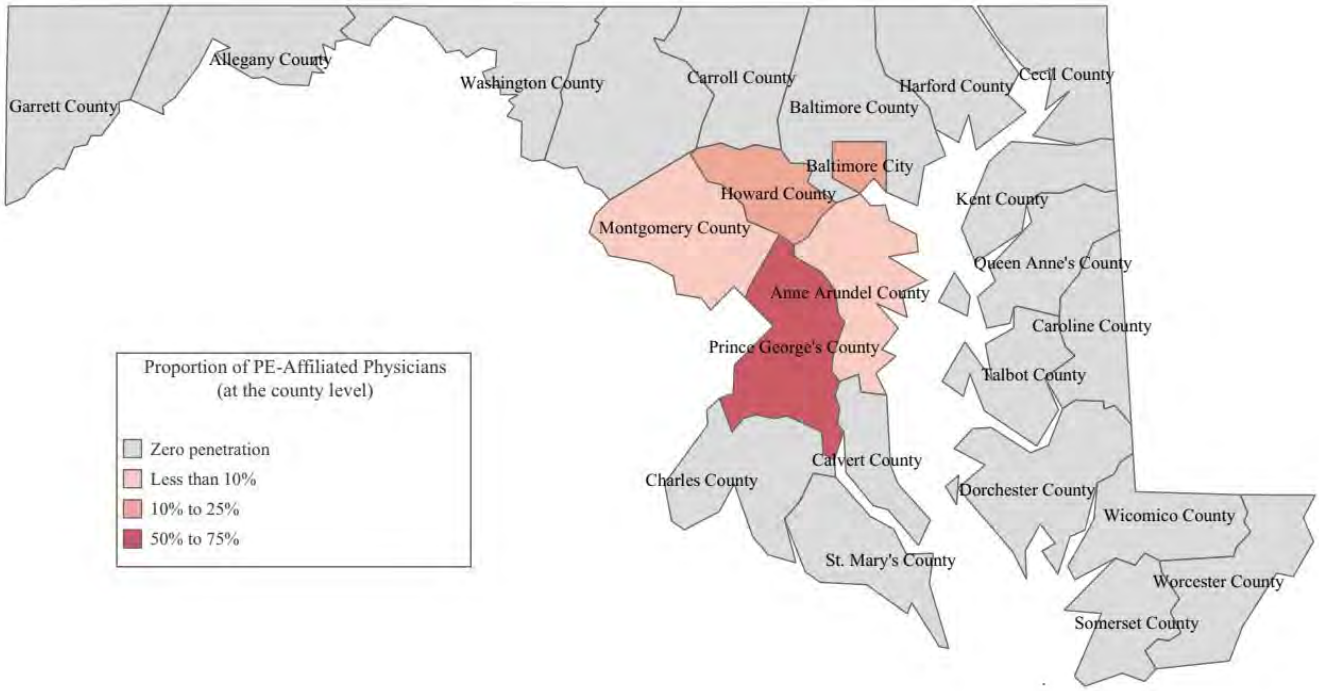
***Source**: Author's analysis of data from the Pitchbook, press releases, and internet searches linked to Medicare Data on Provider Practice and Specialty.*
***Notes**: PE = private equity. A limitation is that this PE affiliation is as of 2021. As a result, analysis may not represent ownership changes since 2021. Proportion categories not shown in the legend indicate that no value in the dataset falls within that range.*

Appendix Figure 2: Geographic Variation in PE Penetration in Orthopedics, 2021



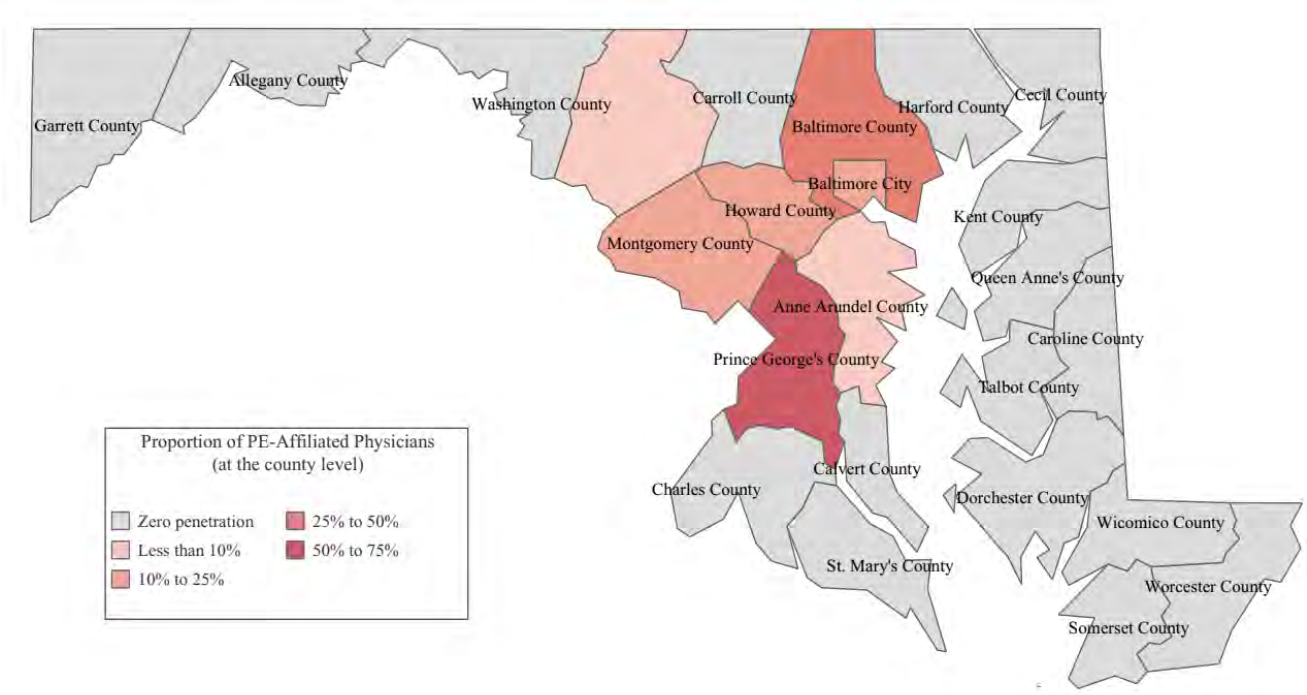
***Source**: Author's analysis of data from the Pitchbook, press releases, and internet searches linked to Medicare Data on Provider Practice and Specialty.*
***Notes**: PE = private equity. A limitation is that this PE affiliation is as of 2021. As a result, analysis may not represent ownership changes since 2021. Proportion categories not shown in the legend indicate that no value in the dataset falls within that range.*

Appendix Figure 3: Geographic Variation in PE Penetration in Cardiology, 2021



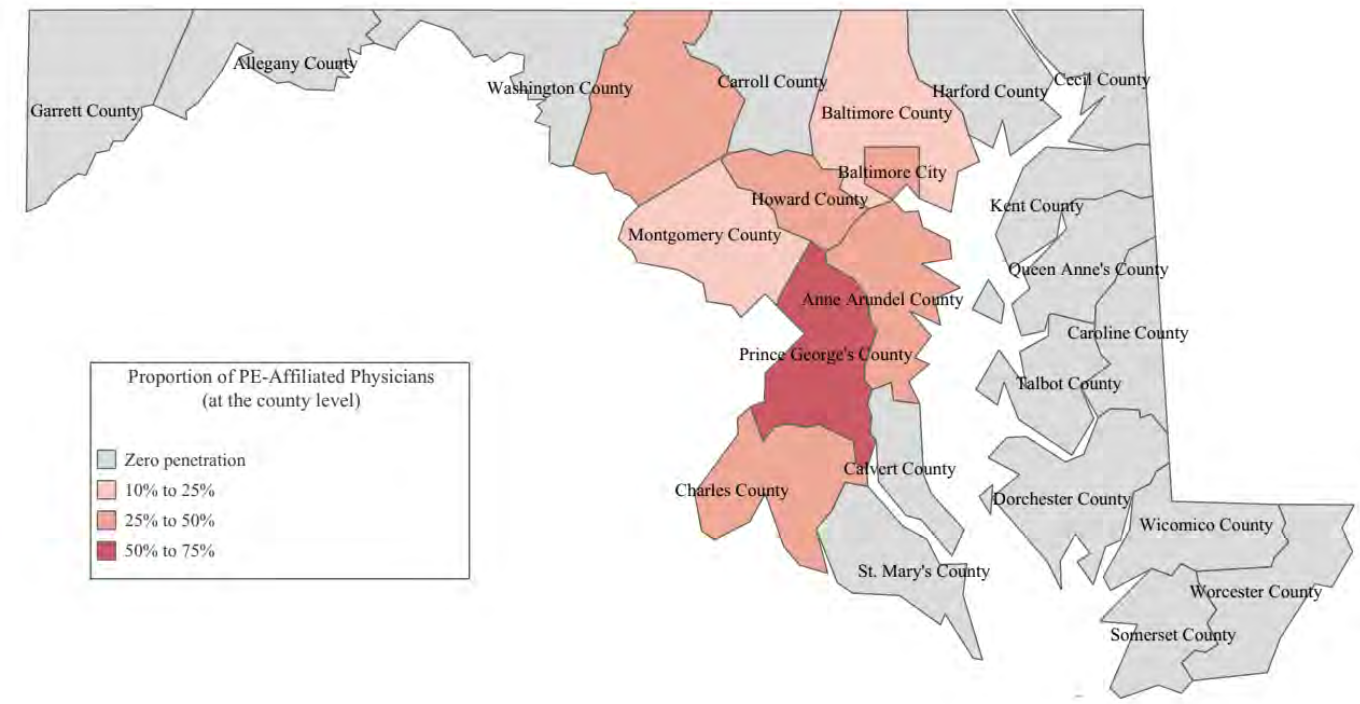
***Source**: Author's analysis of data from the Pitchbook, press releases, and internet searches linked to Medicare Data on Provider Practice and Specialty.*
***Notes**: PE = private equity. A limitation is that this PE affiliation is as of 2021. As a result, analysis may not represent ownership changes since 2021. Proportion categories not shown in the legend indicate that no value in the dataset falls within that range.*

Appendix Figure 4: Geographic Variation in PE Penetration in Gastroenterology, 2021



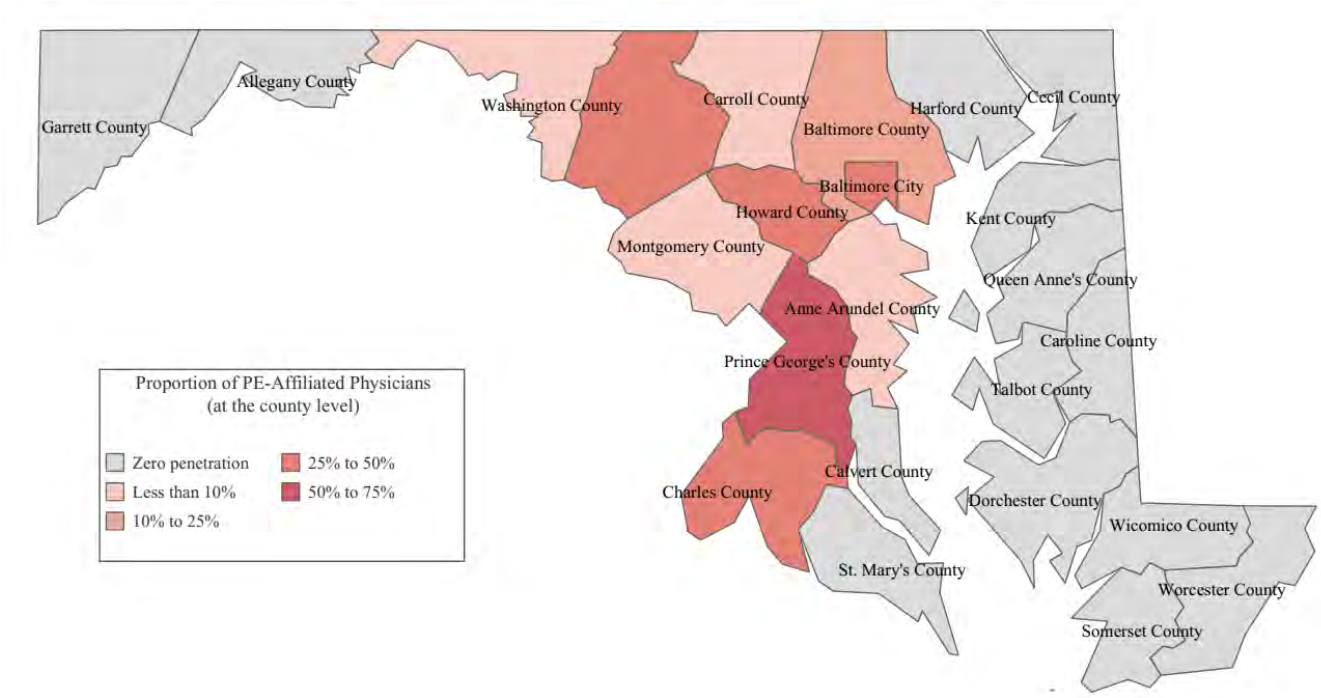
***Source**: Author's analysis of data from the Pitchbook, press releases, and internet searches linked to Medicare Data on Provider Practice and Specialty.*
***Notes**: PE = private equity. A limitation is that this PE affiliation is as of 2021. As a result, analysis may not represent ownership changes since 2021. Proportion categories not shown in the legend indicate that no value in the dataset falls within that range.*

Appendix Figure 5: Geographic Variation in PE Penetration in Ophthalmology, 2021



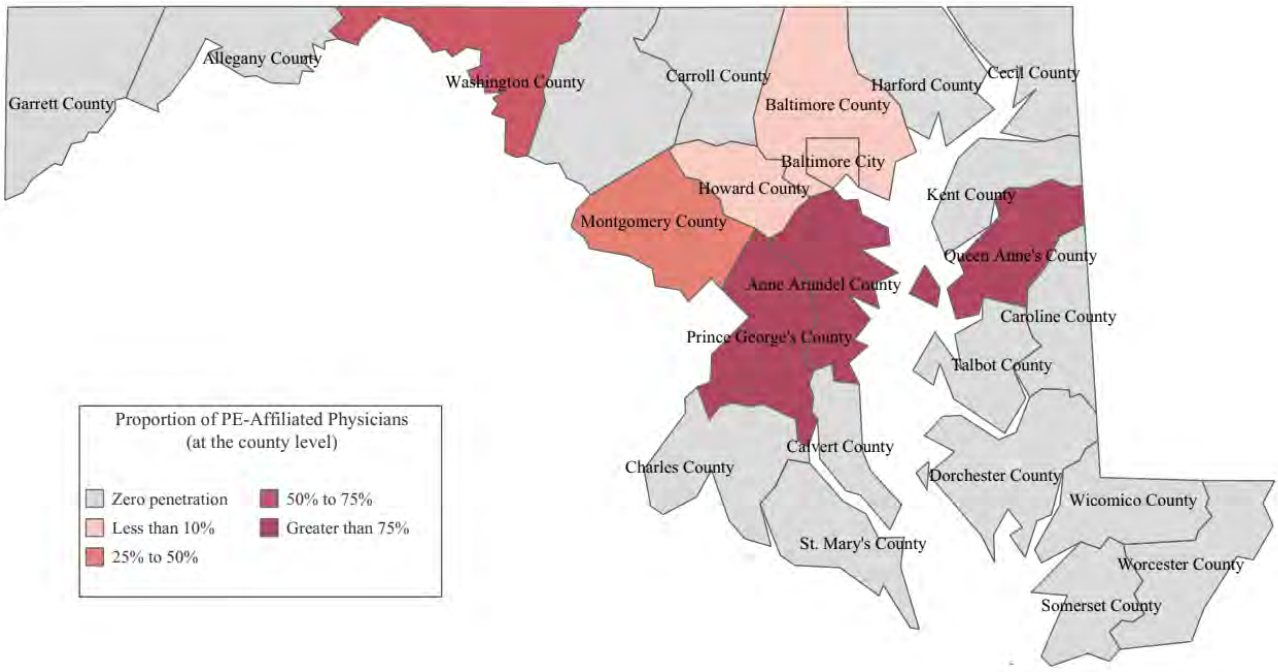
***Source**: Author's analysis of data from the Pitchbook, press releases, and internet searches linked to Medicare Data on Provider Practice and Specialty.*
***Notes**: PE = private equity. A limitation is that this PE affiliation is as of 2021. As a result, analysis may not represent ownership changes since 2021. Proportion categories not shown in the legend indicate that no value in the dataset falls within that range.*

Appendix Figure 6: Geographic Variation in PE Penetration in Primary Care, 2021



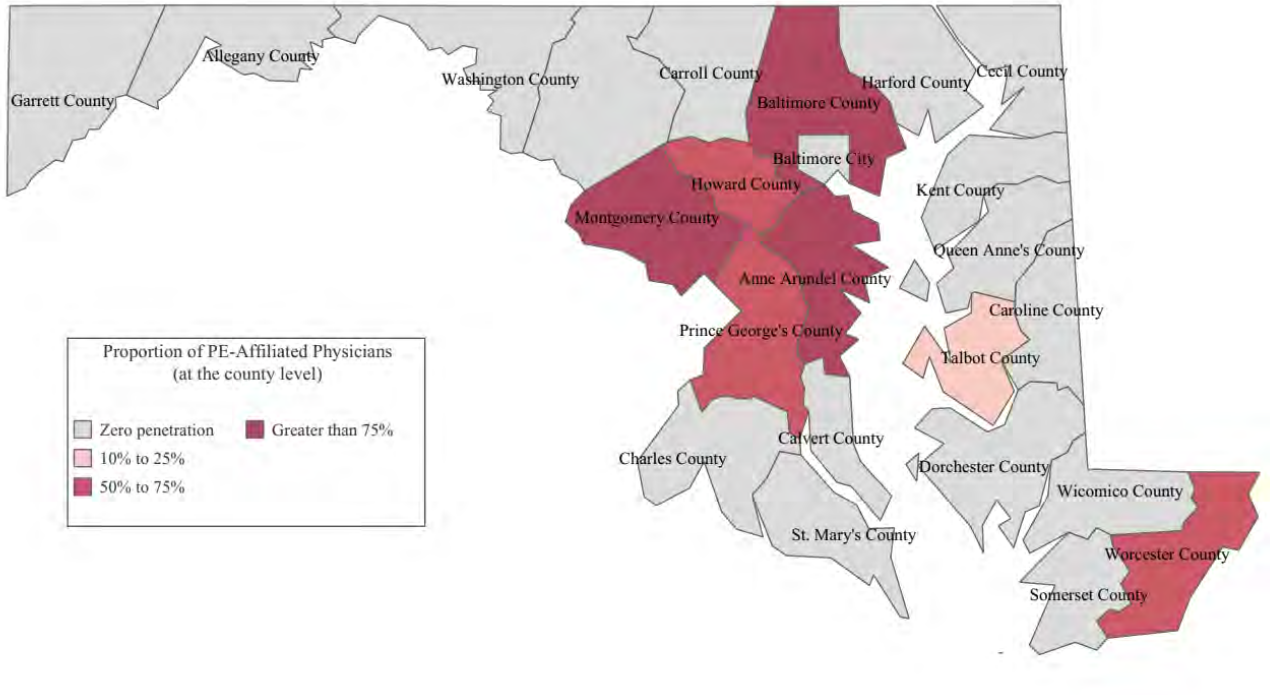
***Source**: Author's analysis of data from the Pitchbook, press releases, and internet searches linked to Medicare Data on Provider Practice and Specialty.*
***Notes**: PE = private equity. A limitation is that this PE affiliation is as of 2021. As a result, analysis may not represent ownership changes since 2021. Proportion categories not shown in the legend indicate that no value in the dataset falls within that range.*

Appendix Figure 7: Geographic Variation in PE Penetration in Dermatology, 2021



***Source**: Author's analysis of data from the Pitchbook, press releases, and internet searches linked to Medicare Data on Provider Practice and Specialty.*
***Notes**: PE = private equity. A limitation is that this PE affiliation is as of 2021. As a result, analysis may not represent ownership changes since 2021. Proportion categories not shown in the legend indicate that no value in the dataset falls within that range.*

Appendix Figure 8: Geographic Variation in PE Penetration in Urology, 2021



***Source**: Author's analysis of data from the Pitchbook, press releases, and internet searches linked to Medicare Data on Provider Practice and Specialty.*
***Notes**: PE = private equity. A limitation is that this PE affiliation is as of 2021. As a result, analysis may not represent ownership changes since 2021. Proportion categories not shown in the legend indicate that no value in the dataset falls within that range.*

Private Sector Ownership of Health Care Practices and Health Care Facilities: Request for Comment

Chapter 378 (House Bill 1388) an ACT concerning Labor and Employment-Noncompete and Conflict of Interest Clauses-Clauses for Veterinary and Health Care Professionals and Study of Health Care Markets directs the Maryland Health Care Commission (MHCC) to study how acquisitions of physician practices and health care facilities by private equity (P.E) firms, health systems and health care payers impact Maryland's health care system. MHCC is contracting with the Brown University School of Public Health to study the impact of private equity and separately contracting with The Hilltop Institute of the University of Maryland Baltimore County (UMBC) to study the dynamics and consequences of insurer market concentration as well as the impact of health systems' and health care plans' ownership of physician practices and health care facilities.

All stakeholders — including patients, consumer advocates, doctors, nurses, health care providers, health plan and health system administrators, and employers are invited to share their comments in this Request For Comment (RFC). The questions are broad and cover different types of purchasers including private equity firms, health plans, and health systems. MHCC seeks comments on acquisitions in particular of physician practices and ambulatory surgery centers. We also seek comment on a broader range of health care organization acquisitions including nursing homes, hospice providers, home health agencies, home- and community-based services providers, behavioral health providers, pharmacy benefit managers, and health information technology firms involved in clinical and administrative functions.

Comment: respondents have two options to provide comments: respond to questions below in a text document and email to mhcc.rfc_acquisitions@maryland.gov or complete this Google Form. In either case, a commenter is invited to respond to all or some of the questions. If a respondent emails comments in an attachment, MHCC prefers that the attachment be a Word or PDF document.

The MHCC is accepting comments through November 26, 2024. If you have any questions, please contact dee.stephens1@maryland.gov .

Introductory Question

1. Provide information on your role, the company you work for, and/or what you do (e.g., consumer, patient, physician, physician practice owners, employed physician, medical staff, health system, payer-affiliated practice, etc.)

General Questions on External Investment in the Maryland Health Care Market

2. MHCC is examining trends in private sector investment in the Maryland health care market. How do you define or understand the following ownership arrangements:
    a. Private equity
    b. Venture capital
    c. Practice management services organizations
    d. Health insurers

    e. Hospitals and health systems
    f. Other retail investors
3. How has access to health care services in vulnerable communities been impacted by external investment?
4. In your experience, what factors attract investors (including PE firms, private investors, health plans, and health systems) to the Maryland health care market?
5. Are specific health care sectors (long-term care facilities, hospitals, physician practices) particularly attractive to certain types of investors?
    a. If yes, which sectors are particularly attractive to which types of investors?
    b. If no, please elaborate.
6. What do you think are the key challenges associated with external investment (including private equity, private individuals, health plans, and health systems) in health care in Maryland?
    a. Key challenges for physicians?
    b. Key challenges for patients?
7. What do you think are the key benefits associated with external investment (including private equity, private individuals, health plans, and health systems) in health care in Maryland?
    a. Key benefits for physicians?
    b. Key benefits for patients?

Questions Specific to Private Equity

8. What is your experience with participation in PE-affiliated practices across payer networks? (e.g., commercial, Medicare Advantage, Medicaid, Medicare)
9. What is your understanding of and/or experience with participation of PE-affiliated practices in value-based payment programs? (e.g., Maryland Primary Care Program, Episode Quality Improvement Program, commercial insurer alternative payment models)
10. How do private equity investments in health care affect the following stakeholders:
    a. Consumers and patients
    b. Physician workforce (practice owners and employed physicians)
    c. Advanced practice providers
    d. Hospitals and health systems
    e. Payers and payer-affiliated organizations
    f. State agencies

MedStar Health

9 State Circle, Suite 303
Annapolis, MD 21401
C 843-319-1665
charles.r.conner@medstar.net

Charles R. Conner III, Esq.
Vice President, Government Affairs

November 26, 2024

Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215

Dear Mr. Steffen:

MedStar Health is one of the largest non-profit health systems in Maryland, with 32,000 employees, 10 hospitals, and over 700 access points for care, covering 225 zip codes in 17 counties. MedStar Health's mission is to provide care to patients across our communities, and to do that we have made and are making substantial investments in recruiting and retaining top quality physicians and deploying them across the region. The proliferation of private equity into the healthcare space threatens the high-quality care health systems can provide for Marylanders.

One of the challenges with private equity is that in order to drive revenues for their investments, it is advantageous to cherry pick specialists with higher reimbursements for procedures, such as GI specialists, and set them up in non-regulated spaces that they can easily flip when the time comes to get their return on investment. To turn greater profits, practices focus on two things – increasing patient volume and revenue growth along with expense control. These layered goals can compromise quality and the financial model.

Why that hurts nonprofit hospitals is three-fold:

1. We work in regulated spaces where we have to provide a full range of services to all patients, and manage the total cost of care. All Maryland hospitals offer necessary services that lose money (either because they are expensive to offer or because reimbursement for those services is low or both) by balancing those losses against the revenue generated by more lucrative specialty services. That is the delicate balance struck by the total cost of care model. If private equity lures specialty physicians away from nonprofit hospitals, that revenue leaves the total cost of care model and negatively impacts the ability of hospitals to provide other critically needed services.

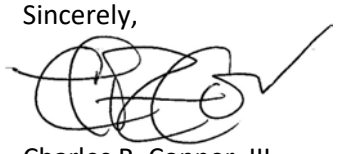
2. Private equity drives up the cost of health care by driving up the compensation of physicians. To compete and recruit/retain top talent, nonprofit hospitals must increase the amount it devotes to physician compensation and benefits, increasing costs and restricting revenue available to invest in building infrastructure, new technology and non-physician personnel. These external pressures undermine the long-term sustainability of nonprofit hospitals in Maryland.

3. Private equity by definition is focused on generating equity for its investors. They do not invest in the communities or act as anchor institutions. Once they have maximized their return on investment, they sell out(or shut down) the business. The impact is to undermine the stability of the healthcare system in Maryland. For the community, their hospitals have less ability to invest in needed services, and the new ambulatory surgery or procedural suite that private equity created and sold off can no longer sustain itself, so it leaves the community altogether. Private equity disrupts the industry for short term gain, and a net loss to the community.

-more-

Restrictive covenants cannot cure all these ills, but it gives nonprofit hospitals some assurance that when it invests in high-end services (paying top talent, buying new technology, and capital investments in infrastructure), it will create value and be able to retain it and reinvest it in serving the community. At a minimum, if a physician leaves, he or she won't be immediately competing with the hospital, and thus, the hospital has a chance to recruit and replace the physician and maintain the services.

Sincerely,



Charles R. Conner, III
Vice President, Government Affairs

MPCAC

MARYLAND PATIENT CARE AND ACCESS COALITION

November 25, 2024

VIA ELECTRONIC DELIVERY

Ben Steffen
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215

RE: Private Sector Ownership of Health Care Practices and Health Care Facilities

On behalf of the Maryland Patient Care and Access Coalition ("MPCAC"), we appreciate the opportunity to respond to the Maryland Health Care Commission's ("MHCC") Request for Comment on Private Sector Ownership of Health Care Practices and Health Care Facilities ("RFC"). MPCAC supports MHCC's vision of "ensur[ing] that informed consumers hold the health care system accountable and have access to affordable and appropriate health care services through programs that serve as models for the nation."[1] In examining acquisitions of, and affiliations with, physician practices and health care facilities by third-parties—whether they be health systems, health care payors or financial investors—and the impact of such acquisitions on Maryland's health care system, we believe it critically important that MHCC consider all facets of health care consolidation. Moreover, because Maryland stands alone amongst the States in how it pays for health care delivery, we believe it is important that MHCC's study of these acquisitions be tailored uniquely to Maryland rather than an extrapolation of studies across other states or at the national level.

MHCC's focus on physician practices and ambulatory surgery centers is of particular relevance to MPCAC, given the leading role MPCAC has played as the voice of independent medicine in the State over the last 20 years. For two decades, MPCAC's mission has been to promote and protect the high-quality, cost-efficient care furnished to patients in Maryland in the independent medical practice setting. Formed in 2004, MPCAC is made up of independent physician practice members and is led by its physician Board of Directors. The physicians in MPCAC's member practices care for hundreds of thousands of patients each year in the fields of gastroenterology, medical oncology, orthopedic surgery, radiation oncology, urology, and other specialties. We believe that independent practices serve as a competitive counterbalance to highly-consolidated health systems and vertically-integrated health care payers, offering a critical access point for patients to receive high quality care in communities across the State. MPCAC's member practices recognize that to remain independent, we must continue to grow our practices and capabilities. We recognize that there are various strategic approaches available to independent practices to maintain their independence and

[1] Maryland Health Care Commission, https://mhcc.maryland.gov/ (last accessed November 20, 2024).

believe that health policy in the State needs to be shaped in such a way that ensures a robust community of independent medical practices delivering care alongside health systems, academic medical centers, and vertically-integrated payor/provider models ("pay-viders").

Our comments are organized to respond to the questions in the RFC in two parts, focusing on the implications that market consolidation has on patients obtaining care in the independent practice setting:

- In Part I, we address the unique circumstances faced by independent practices in Maryland's health care market and explain various ownership structures for physician practices that seek to remain independent (RFC Question 2).

- In Part II, we discuss our experience and observations on the impact of external investment on physician practices (RFC Questions 3 and 6 – 10).

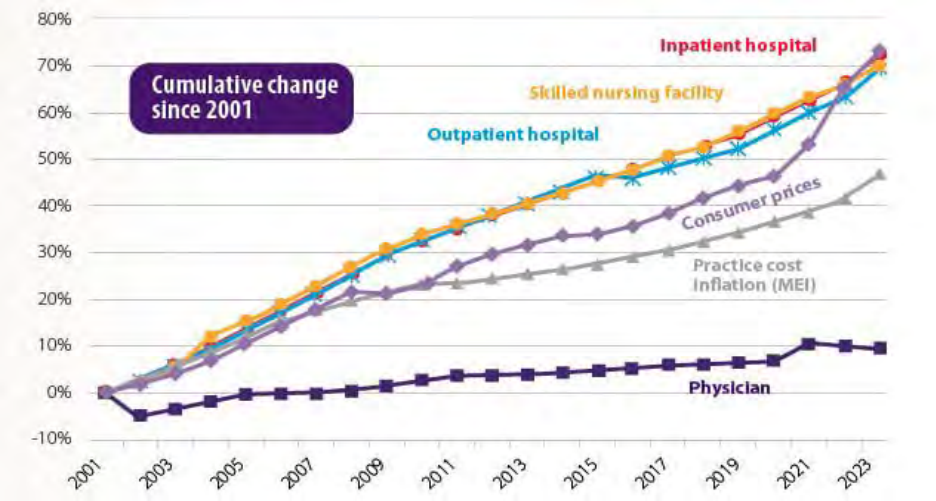
Part I – Independent Practices in Maryland Face an Uphill Competitive Battle

By nature of their community orientation, independent physician practices provide convenient, high-quality care to patients, often at a lower cost than the same services provided by competing hospital-based providers. Independent practice is also on the decline. Many physicians are either leaving the practice of medicine altogether or are turning to acquisition or partnership with external investors or larger health care provider entities, resulting in further consolidation of the health care market. The consolidation of physician practices across the country is pervasive and well-documented and should rightly be studied as it relates to health care delivery in Maryland. However, the issue of physician practice consolidation is largely misunderstood. Not enough attention has been paid to "why" physician practices have chosen to engage in transactions with larger health care provider entities or external investors. Understanding this "why" is critical to understanding the impact of such transactions on health care delivery and should be the foundation upon which any future policy recommendations are based.

a. Flaws in Reimbursement

Over the last 23 years, Medicare reimbursement rates in the physician office setting, when adjusted for inflation, have declined by approximately 30 percent. At the same time, reimbursement in the hospital setting, including for provider-based clinics, has increased substantially to take account of the rising costs of health care delivery, as illustrated in the graph below:[2]

[2] Sources: Federal Register, Medicare Trustees' Reports, Bureau of Labor Statistics, Congressional Budget Office. See also American Medical Association, Economic and Health Policy Research, September 2022 (noting that for 2001-2022, when adjusted for inflation in practice costs, Medicare physician payment declined 22 percent), available at https://www.ama-assn.org/sites/ama-assn.org/files/2022-09/medicare-updates-inflation-chart.jpg (last accessed November 16, 2024).



The dramatic differential in reimbursement between the physician practice setting and hospital setting has eroded the ability of independent physician practices to keep their doors open – let alone compete. This has destabilized the business model for physicians who practice in the independent setting and has fueled the accumulation of capital and consolidation of physician practices by health systems and vertically-integrated health care payers that deliver care.

b. Structural Advantages of Health Systems and Vertically-Integrated Health Care Payers

Health systems and vertically-integrated health care payers have a considerable competitive advantage by virtue of their ability to capitalize on their economies of scale, high-volume purchasing power, concentration of business expertise, and financial resources to invest in recruiting physicians, building or modernizing facilities, and adopting expensive technology platforms. As compared to independent physician practices, these structural, competitive advantages compound when taking into account the difference in reimbursement. As a result, many independent practices have had to choose between selling their practice to a hospital or vertically-integrated payer or finding a better way to compete. For most, maintaining the status quo is simply not a viable option.

c. Independent Practice Ownership & Partnership Models

Some independent practices, including several MPCAC members, have maintained their independence without a change in ownership or financial partner, borrowing from traditional lenders or risking their own financial resources to grow and expand their practices. Others have chosen to access capital and administrative support through partnerships with management services organizations ("MSOs") or through affiliations with other corporate entities. An MSO is a company that specializes in providing practices with non-clinical business support and access to capital that enables practices to compete for the best and brightest physicians and other clinicians, to expand their footprint into communities with less access to care, and to bring innovative care delivery models into the lower-cost independent practice setting.

Some MSOs have outside investors such as private equity firms, while others are started and owned by independent practices themselves to better concentrate resources and create management services offerings for other independent practices. Consistent with corporate practice of medicine ("CPOM") laws, the MSOs do not purchase or otherwise own the medical practices; rather, these MSOs stand alongside the medical practices offering them the business support that physicians in hospitals and health systems have long taken for granted. The MSO partnerships allow physicians to delegate management of the business side of their practice while preserving their independence, clinical decision-making autonomy, and presence in the community.

d. Physician Practices Pursue Partnerships to Remain Viable

As an alternative to being acquired by health systems or vertically-integrated payers, some independent physician practices have engaged in these strategic partnerships as a mechanism for responding to the financial and structural disadvantages that they face as compared to their colleagues practicing medicine in large corporate settings. These practices engage in these transactions to preserve their autonomy and access resources they need to open new clinics in underserved communities, build ambulatory surgical centers to perform procedures that cost a fraction of the same procedures done in the hospital setting, and develop the infrastructure and analytics to bring state-of-the-art technologies to the treatment of injuries, illnesses, and disease that their competitors have had access to as a result of their inherent scale.

An added benefit to these transactions is that they tend to result in a lower cost-of-care. A recently published study by health care consulting firm Avalere examining trends across physician practice affiliation models in five specialties (cardiology, gastroenterology, medical oncology, orthopedics and urology) found that per-beneficiary Medicare expenditures were on average $963 lower for beneficiaries whose physicians moved from an unaffiliated private practice model to a private equity-affiliated private practice in the 12 months following the transition. As compared to hospital-affiliated practices, Medicare expenditures were on average 9.8% lower than for similar patients in hospital-affiliated practices in 2022.[3]

Recent studies show that partnerships between independent practices and private equity-backed MSOs only represent a small fraction of care delivery models in the country. A recent report from PitchBook found that only 3.3% of healthcare providers in the country are private equity backed.[4] A similar analysis done in the Avalere study referenced above found that, in 2022, only 6% of

[3] *Medicare Service Use and Expenditures Across Physician Practice Affiliation Models*, AVALERE (Sept. 18, 2024), https://avalere.com/insights/medicare-cost-and-utilization-across-physician-affiliation-models (last accessed November 20, 2024).

[4] *PitchBook Analyst Note: Quantifying PE Investment in Healthcare Providers,* PITCHBOOK (July 8, 2024), https://pitchbook.com/news/reports/q3-2024-pitchbook-analyst-note-quantifying-pe-investment-in-healthcare-providers (last accessed November 11, 2024).

Medicare-enrolled physicians in the five specialties studied furnished care in private equity-affiliated private practices.

An additional consideration to account for as MHCC examines health care market consolidation in our State is the unique way in which Maryland reimburses hospitals under its All-Payer Model. It is critical that MHCC's study evaluate the effect of physician transactions on cost-of-care in a way that accounts for Maryland's All-Payer Model.

Part II – The Impact of External Investment on Independent Practices

Strategic partnerships through these different affiliation models have been a valuable tool for independent practices to preserve their independence and for patients to ensure the continued existence of a robust care delivery model outside the hospital and health system setting. As it relates to external investment, the experience and observations of MPCAC's member practices have been that the various types of external investments that have allowed independent physician practices to remain independent (individual investments, private equity support of MSOs, and corporate investors) have been to the significant benefit of patients and physicians in Maryland.

a. The Benefits of External Investment on Physicians and Patients

Several MPCAC members have seen the benefits of external investment in the form of improved access to care, greater ability to participate in value-based care, and strengthening the continuity of care. By way of example:

- The MPCAC member practices affiliated with MSOs, including those owned by individual physicians and those supported by private equity, have been able to leverage the I-T and administrative infrastructure of their MSO platforms to successfully participate in the Episode Quality Improvement Program to deliver high quality care, at a lower cost to patients in Maryland. Each practice saw no significant change in their participation in payer networks regardless of their financial partner.

- In service of their mission to serve their entire community, the MPCAC independent practices affiliated with private equity-backed MSOs have maintained their participation in Medicaid. Due to the financial and administrative support provided, one such practices built a new office, recruited new providers, and developed capabilities to fulfill the previously unmet need for care in vulnerable communities in Baltimore and Prince George's County. This new clinic and its providers now deliver higher complexity care to patients than they previously would have been capable of without the capital investment from their MSO partner.

- A urology practice with a PE-backed MSO partner has been able to introduce into the community setting new technology for kidney stone and enlarged prostate procedures, enhanced outpatient interventional radiology, and clinical research. These initiatives have

created access to cutting-edge care for patients in their own community as a convenient alternative to the same care delivered in an academic medical center.

- An orthopedic practice that has partnered with an MSO created through the individual investment of its physicians was able to use this organization to develop tools for patients to communicate with their providers and schedule same-day and urgent care appointments. The MSO has also used this investment to develop tools for physicians to monitor and improve the quality of care they deliver and to assist in knowledge sharing of best practices between physicians. Furthermore, the MSO-independent practice partnership has enabled physicians to develop sophisticated compliance programs to reinforce their commitment to the ethical practice of medicine.

- A urology practice partnered with a PE-backed MSO was able to weather a recall of scopes used in common urologic procedures and maintain access to care for a community of patients at high risk of recurrent malignancy because the practice's MSO partner facilitated affordable access to alternative, disposable equipment during the recall.

These are but some of many examples of how MPCAC's member practices have benefited from investment by MSOs. In these cases, the capital and administrative support provided through this investment has served as a critical accelerant driving these practices to expand access in underserved communities, develop new clinical capabilities, improve the quality of care they deliver, and ensure continuity of care for patients in Maryland. Furthermore, physicians in these practices are now more than ever able to practice at the top of their licenses in coordination with their clinical staff.

b. The Challenges Associated with External Investment

External investment in physician practices does not come without issues and challenges—whether that be in the form of hospitals and health systems acquiring practices, commercial payors venturing into the world of care delivery, or independent practices affiliating with MSOs. Paramount of these issues—regardless of the site of service—is the threat of non-licensed individuals and entities inappropriately influencing the physician-patient relationship. Such influence can come in the form of interfering with decisions related to patient care, including directing referrals or setting physician schedules or coding procedures, or it can come in the form of exerting undue influence on a physician practice by controlling the hiring or firing of physicians or other clinical staff based on their clinical proficiency, owning or controlling the content of patient medical records, and setting the parameters with which physicians contract with payers or other physicians.

It is critical to recognize that this problem can occur regardless of whether the external investor is a private individual, health system, health plan, or private equity firm. Fortunately, case law in Maryland has established a prohibition against the corporate practice of medicine that prohibits

such infringements in the physician practice setting.[5] However, this protection has not historically extended to hospitals or health maintenance organizations.[6] MPCAC firmly believes that no investment, regardless of source, should undermine the sanctity of the physician-patient relationship and the clinical autonomy of physicians and other licensed clinicians.

It is important to recognize that for physicians seeking external investment through acquisition by a health system partner, they also face the challenge of preserving their clinical autonomy and ability to determine where they refer patients for health care services. Physicians in independent practices seek other types of external investors precisely to avoid this loss in autonomy when practices are acquired by larger institutional health care providers. In fact, the ability to direct patient care based on the patient's best interests rather than by directive from health system ownership is often a selling point for recruiting new physicians to independent practices that are affiliated with a sophisticated MSO partner.

Physician burnout and satisfaction has become a national crisis – resulting in physicians reducing their hours or leaving the practice of medicine altogether. Physicians experience burnout in all care settings, but to a greater degree in hospital-owned practices.[7] Not only does this run the risk of exacerbating the nationwide shortage of physicians, it also threatens to bleed into patients' experience in receiving care.[8] According to a recent survey done by Bain & Co., "physicians at practices owned by or serving hospitals and health care systems are almost three times more likely to be dissatisfied than those at practices owned by physicians."[9] Their dissatisfaction with management-led health system and health care payer-owned practices is driven by a combination of factors, including a lack of leadership alignment with clinician needs, intentional or unintentional exclusion of physicians in strategic decision-making, uncoordinated adoption and integration of technology, and failure to respond to physician feedback. As a result, physicians are increasingly looking to move to physician-led, rather than management-led, practices. It is no surprise that the pain points for physicians in management-led practices are much of what we have seen independent practices improve upon or build as new capabilities through partnerships with external investors that have preserved their independence and autonomy. While physician burnout

---

[5] *See, e.g.*, *Harris v. State*, 2019 WL 4928640 n.8 ("[t]he conduct of the licensed healthcare providers would of course, also violate Maryland law as they took directions from a layperson while practicing medicine").

[6] Md. Code Ann., Health-Gen. § 19-351(a) (West) ("Except as provided [for podiatrists, dentists, and psychologists] … this subtitle does not affect the right of a hospital or related institution to employ or appoint staff"); Md. Code Ann., Health-Gen. § 19-704 (West) ("A health maintenance organization may operate as authorized by this subtitle notwithstanding any prohibition against the corporate practice of medicine").

[7] *See* Jessica Creager et al., *Associations Between Burnout and Practice Organization in Family Physicians*, 17 ANNALS FAM. MED., no. 6, 2019, at 504; Bryan Robinson, *2 In 5 Hospital Employees Considering Private Practice For Better Work-Life Balance*, FORBES (July 14, 2023), https://www.forbes.com/sites/bryanrobinson/2023/07/14/2-in-5-hospital-employees-considering-private-practice-for--better-work-life-balance/ (last accessed Nov. 19, 2024).

[8] *See Front Line of Healthcare Study: Key Insights*, Bain & Co., at 3 (Spring 2024) ("~90% of clinicians agree their employee experience impacts customer experience, but at management-led organizations, <60% report their organizations have employee experience mechanisms in place.")

[9] Erin Ney, MD & Monica Pinto Basto, *Satisfaction: Lessons from Physician-Owned Practices*, Bain & Co. (Oct. 4, 2024), https://www.bain.com/insights/boosting-physician-satisfaction-lessons-from-physician-owned-practices/ (last accessed Nov. 20, 2024).

is an issue that needs to be addressed across the spectrum, the support of these external investors has helped to preserve options for physicians and other clinicians to choose how they want to practice medicine.

These issues are important to consider as part of obtaining a broader understanding of the impact of transactions with external investors and confirms the need for MHCC to differentiate between challenges that are universal to physician practices and the unique challenges that physicians might confront in specific care delivery settings.

****

The unique health care landscape in our State demands that MHCC's study perform a localized examination of acquisitions and investments in health care entities, and we encourage MHCC to consider the importance of preserving the viability of independent medicine when evaluating recommendations at the conclusion of the study. MPCAC appreciates the opportunity to respond to the RFC and would be more than happy to engage in further discussion with MHCC on how independent medical practices improve patient access and outcomes through the expansion of high-quality, lower-cost care in the community setting.

Sincerely,

Nicholas P. Grosso, M.D.
MPCAC President & Chairman of the Board

Michael Weinstein, M.D.
MPCAC, Health Policy Chair

cc: Joseph C. Bryce, Esq., Manis Canning & Associates
Nicholas G. Manis, Manis Canning & Associates

Timestamp	2024/11/25 4:02:12 PM EST
Questions	Responses: amar.duggirala@gmail.com
the company you work for, and/or what you do (e.g., consumer, patient, physician, physician practice owners, employed	Physician practice owner
private sector investment in the Maryland health care market. For questions 2a-2f, explain how you define or understand the following	Non-publicly traded private held companies that invest in organizations to produce profits
2b. Venture capital	Organizations that raise money from private investors then invest or buy companies to manage and produce profits
organizations	Organizations that assist medical practices in administrative and billing management
2d. Health insurers	Companies that provide healthcare/medical insurance for consumers
2e. Hospitals and health systems	Hospitals are in-patient healthcare facilities. Health systems are large healthcare organizations that provide medical care to consumers/patients.
2f. Other retail investors	Small scale investors that invest in public companies
services in vulnerable communities been impacted by external investment?	External investors typically do not understand the healthcare needs of vulnerable communities and their focus is not to improve health or medical care but in generating profits.
attract investors (including PE firms, private investors, health plans, and health systems) to the	High incomes of consumers/patients and a well developed healthcare system
health care sectors (long term care facilities, hospitals, physician practices) particularly attractive to certain types of investors? 5a. Yes, which sectors are	Physician practices are attractive to private equity
5b. No, please elaborate.	
challenges for physicians associated with external investment (including private equity, private individuals, health plan, and health systems) in health care in Maryland?	Private equity is interested in generating short term profits, not improved long term health outcomes. Once there is no more profit to gain, they will leave the healthcare space or the state of MD. There is health plan consolidation in Md, leading to low reimbursement rates for physicians and low competition. Large health systems are buying out physician practices because they cannot compete with private equity and they get lower reimbursement rates than larger systems for the same work.
challenges for patients associated with external investment (including private equity, private individuals, health plan, and health systems) in	Private equity has led to profits being the motivator for practices rather than good service and health outcomes. Practices owned by private equity and health systems are much harder to navigate for patients and more difficult to see actual physicians (rather than mid-levels)
benefits for physicians associated with external investment (including private equity, private individuals,	Improved reimbursements
benefits for patients associated with external investment (including private equity, private individuals,	Easier to navigate the administrative issues between their private equity practice, health insurer and health systems.

participation of PE-affiliated practices across payer networks? (e.g., commercial, Medicare	I am not in a PE-affiliated practice. I am in a small physician owned practice. I know many of the PE-affiliated practices participate with commercial, MA, Medicare, but often not medicaid
and/or experience with participation of PE-affiliated practices in value-based payment programs? (e.g., Maryland Primary	I know some of the PE-affiliated practices do participate in value-based programs.
believe private equity investments in health care affect the following stakeholders:	Poorly. I believe they get worse service from less trained healthcare workers (ie, mid-level providers), with worse long term outcomes
(practice owners and employed physicians)	Worsens the physician workforce by placing profits over patient care, it increases burnout and moral injury.
10c. Advanced practice providers	Mid level providers will see increased job opportunities as they are cheaper to employ, but they will cost the system more over the longterm.
10d. Hospitals and health systems	Can provide short term increased profits
organizations	Will increase costs to payers over time
10f. State agencies	Will create consolidation of healthcare and make health care outcomes worse in underserved areas