REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (A-25)
Regulation of Corporate Investment in the Health Care Sector

EXECUTIVE SUMMARY

Policy D-215.982, "The Corporate Practice of Medicine, Revisited" and Policy D-160.904, "The Regulation of Private Equity in the Health Care Sector" were adopted at the 2024 Annual Meeting. The former asks our American Medical Association (AMA) to revisit the concept of restrictions on the corporate practice of medicine including, but not limited to, private equities, hedge funds, and similar entities, review existing state laws and study needed revisions and qualifications of such restrictions and/or allowances, in a new report that will study and report back by the 2025 Annual Meeting with recommendations on how to increase competition, increase transparency, support physicians and physician autonomy, protect patients, and control costs in already consolidated health care markets; and to inform advocacy to protect the autonomy of physician-directed care, patient protections, medical staff employment and contract conflicts, and access of the public to quality health care, while containing health care costs. The latter asks our AMA to propose appropriate guidelines for the use of private equity in health care, ensuring that physician autonomy and operational authority in clinical care is preserved and protected.

The corporate practice of medicine (CPOM) can take many forms. For example, private or public for-profit companies can purchase ownership stake in health care businesses, investment firms can partner with or acquire physician practices or hospitals, or health insurance companies can directly employ physicians.

There are risks and benefits associated with corporate investment and partnership. Corporate investment can offer a way for a practice to avoid selling to a hospital or health system, manage human resources, information technology, and other administrative tasks on behalf of the practice, offer lucrative deals for physician-owners wanting to retire or sell their practice, and help with medical liability costs. Risks include a loss of control of business decisions and/or clinical autonomy, drastic cost cutting measures, replacing physicians with non-physician practitioners, restrictive non-compete agreements, loss of liability tail coverage and retirement benefits, loss of employment, and the possibility of debt or bankruptcy for the physician-owner after the corporate investor has extracted profits and exited the partnership.

CPOM doctrine provides a legal basis for protecting the integrity of patient care in a health care environment complicated by corporate influence. Broadly, CPOM prohibitions forbid lay (i.e., non-physician) corporations from practicing medicine, owning physician practices, or otherwise employing physicians to provide medical services. While most states have CPOM restrictions in place, there is no single definition of what constitutes a valid CPOM exemption. Each state's CPOM doctrine has been shaped uniquely over the years by a combination of statutes, regulations, court decisions, attorney general opinions and actions by medical licensing boards. CPOM restrictions generally aim to avoid the commercialization of medical practice that might result when corporations own practices, to address misalignment between a corporation's obligation to its shareholders and a physician's obligation to their patients, and to ensure that a physician's exercise of independent medical judgment is not threatened because they are employed by a corporate entity.

The Council offers a series of recommendations to strengthen guidelines for physicians considering corporate partnerships, support capital reserve and leverage standards for firms looking to acquire health care facilities, and support the enforcement of regulations and legislation pertaining to the corporate control of practices in the health care sector. These recommendations aim to ensure physician clinical autonomy and operational authority are preserved and protected.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-A-25

Subject: Regulation of Corporate Investment in the Health Care Sector

Presented by: Stephen Epstein, MD, MPP, Chair

Referred to: Reference Committee G

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Of note, the Council on Ethical and Judicial Affairs (CEJA) has prepared a related report, CEJA Report 5-A-25, "Protecting Physicians Who Engage in Contracts to Deliver Health Care Services" which offers specific ethics analysis and guidance for physicians impacted by private equity's involvement in medicine.

BACKGROUND

The corporate practice of medicine (CPOM) can take many forms. For example, private or public for-profit or non-profit companies can purchase ownership stakes in health care businesses, investment firms can partner with or acquire physician practices or hospitals, or health insurance companies can directly employ physicians. Private equity firms apply several types of investment strategies. Traditional private equity firms utilize funds from leveraged buyouts to take a controlling stake in mature companies, venture capital firms invest in fledgling businesses, and growth equity firms partner with promising later-stage businesses to help them expand.

As stated in Board of Trustees Report 9-I-24, it is important for AMA policy to distinguish between corporate investment, corporate ownership, and corporate control in physician practices:

> The Board of Trustees believes that decisions made by a corporate investor on matters often characterized as operational or administrative may in some cases intrude on clinical decision-making and physician autonomy, as well as affect quality of care and patient outcomes. This is not simply in cases where the difference may be blurred, even matters that may be typically characterized as operations (coding, billing and collections, administrative, and non-clinical

> management, risk management, etc.) may themselves be implemented in ways that interfere with clinical decision-making and physician autonomy and/or expose physicians to liability.

Private equity acquisitions of health care entities increased six-fold in a decade, growing from 75 deals in 2012 to 484 deals in 2021.[1] Since 2012, private equity firms have spent approximately $1 trillion on health care transactions and between 2018 and 2023, private equity firms spent $505 billion on health care acquisitions.[2,3] The shift toward private equity investment may have been exacerbated by the COVID-19 pandemic as a solution for practices struggling financially. According to the Private Equity Stakeholder Project, it is estimated that eight percent of all private hospitals in the United States and 22 percent of for-profit hospitals are owned by private equity firms.[4]

Private equity deals range from tens to hundreds of millions of dollars and are expected to deliver 20 to 30 percent returns to investors. Key tactics include increasing prices and volume.[5] Another common investment tactic for private equity firms following acquisition includes sale-leaseback arrangements, which sell acquired facilities' land and buildings to repay investors and then charge the facility rent on assets they once owned. On average, after a private equity firm acquires a hospital, the hospital's assets decrease by 24 percent relative to hospitals not purchased by private equity.[6] Private equity firms typically purchase an established practice and acquire smaller practices to create regional brands that can exercise greater bargaining power with insurers and medical supply companies. With these acquisitions, emphasis shifts to increasing profits, often by extracting higher contracted payment rates, lowering overhead, and increasing volume and ancillary revenue streams (i.e., imaging, procedures, over the counter products).[7]

The CPOM doctrine provides a legal basis for protecting the integrity of patient care in a health care environment complicated by corporate influence. Broadly, CPOM prohibitions forbid lay (i.e., non-physician) corporations from practicing medicine, owning physician practices, or otherwise employing physicians to provide medical services. While most states have CPOM restrictions in place, there is no single definition of what constitutes the CPOM, and exemptions – such as for-profit hospitals, nonprofits, or federally qualified health centers – vary broadly. Each state's CPOM doctrine has been shaped uniquely over the years by a combination of statutes, regulations, court decisions, attorney general opinions and actions by medical licensing boards. Consequently, it is difficult to succinctly summarize the CPOM doctrine of every individual state. However, CPOM restrictions generally aim to avoid the commercialization of medical practice that might result when corporations own practices, to address any lack of alignment between a corporation's obligation to its shareholders and a physician's obligation to their patients, and to ensure that a physician's exercise of independent medical judgment is not threatened because they are employed by a corporate entity.

Types of corporate arrangements

There are several types of corporate structuring and financing of medical practices that can occur. One of the most common is investment by private equity firms. A private equity firm pools investments and uses leveraged buyouts to purchase an ownership stake in a physician practice or hospital. The private equity firm then cuts costs and drives up profit with the goal of selling the business for a profit in three to seven years.

In a 2024 Stanford Law Review analysis, Fuse Brown and Hall point out that private equity poses three risks:

> First, private equity investment spurs health care consolidation, which increases prices and potentially reduces quality and access. Second, the pressure from private equity investors to increase revenue can lead to exploitation of billing loopholes, overutilization, upcoding,

aggressive risk-coding, harming patients through unnecessary care, excessive bills, and increasing overall health spending. Third, physicians acquired by private equity companies may be subject to onerous employment terms and lose autonomy over clinical decisions.[8]

While private equity investors are often viewed as exploitative, they may not be substantially different from other entities who invest in or acquire physician practices. Private equity investment is not inherently bad but likely includes both good and bad actors as does any other investor arrangement in the health care sector, or other markets more broadly. Professional risks are not unique to corporate investment alone. Notably, however, according to a study from the Private Equity Stakeholder Project, more than 20 percent of health care bankruptcies in 2023 were private equity-backed companies. Due to the nature of the leveraged buyout strategy employed by private equity firms, debt levels on these leveraged buyouts reached a 15 year high of 7.1 times earnings in 2022. Average debt to earnings before interest, taxes, depreciation, and amortization are around three times earnings.[9]

Hedge funds are also used to invest in and acquire health care entities. A hedge fund differs from private equity in that it is an investment strategy while private equity is a source of capital. Hedge funds pool money from wealthy entities to make investments in the stock market and use different market and trading strategies to insulate investments from market volatility. In another corporate arrangement seen in recent years, corporations such as Amazon (via One Medical) and Walmart have entered directly into the health care space. In addition, health insurers have entered the market by directly employing physicians. For example, Optum, a subsidiary of UnitedHealth Group, employs about 10,000 physicians and is affiliated with another approximately 80,000 physicians. In addition to physicians, Optum employs or is affiliated with approximately 40,000 non-physician practitioners (NPPs).[10,11]

Impact on Cost

Most studies done on the effects of private equity investment conclude that these transactions have led to higher prices for patients. Recently, private equity's role in contributing to the United States' medical debt crisis has been highlighted. According to the Private Equity Stakeholder Project, private equity firms are both "creating and profiting from medical debt" by expanding into billing services and collecting payments for the health care entities they acquire.[12] Private equity owned health care entities have been increasingly outsourcing financial work to the private equity firms themselves, who have consolidated debt collecting, claims processing, and billing into an "end-to-end" service. The result is higher costs for patients, either through upcoding, higher interest rates on outstanding balances, or more aggressive bill collection practices.[13]

Impact on Patients

Evidence on corporate investor impact on quality of care is mixed. According to a 2023 *JAMA* study, hospital-acquired adverse events increased by approximately 25 percent following private equity acquisition. The rise in adverse events was impacted by an increase in the number of falls and central line associated bloodstream infections, along with a larger, but less statistically precise increase in surgical site infections. Other studies have found that private equity acquisition may improve care quality, but only under certain market and regulatory conditions.[14,15] Greater transparency is needed over private equity investment in and ownership of physician practices to help patients make informed decisions about their care. While the onus should not be put on patients to know the ownership status of a hospital or practice before receiving care, and in many cases patients may not have a choice on where they seek care, greater transparency would be beneficial for patients and communities if and when it allows for more informed decision-making.

Impact on Physicians

Physicians may value investment from corporate partners because : 1) it can offer a way for the practice to avoid selling to a health system; 2) the corporate partner can manage administrative, technical, and human resources aspects of the business; 3) the corporate partner can offer financially attractive deals for physician-owners wanting to retire or exit ownership; and 4) these investors can help with medical liability costs. Some risks of partnering with corporate investors include losing control of business decisions and/or clinical autonomy; drastic cost cutting measures, including replacing physicians with NPPs; non-compete agreements which can prevent physicians from easily moving to another job; and the possibility of debt or bankruptcy for the physician-owner after the corporate investor has extracted profits from the practice and exited the partnership.[16] The use of non-compete agreements, or restrictive covenants, by larger corporations has the potential to hamper physicians' ability to leave a practice in search of another position. This is especially true of corporations that have a large geographical footprint or those that are in concentrated markets. With more limited ability to leave for another opportunity, the physician's ability to advocate for better working conditions is undermined. In these scenarios, a physician's only choice may be to move to another geographic area entirely, often uprooting themselves and their families. For employed physicians, risks could also include loss of liability tail coverage or loss of pension or retirement funds if their facility comes under private equity ownership or ultimately goes bankrupt. Physicians may also be pressured to see more patients each day or meet lofty financial targets to maximize profitability. Financial targets could include sales goals, using lower cost supplies, or encouraging patients to seek optional or cosmetic procedures that are often lucrative, but not always necessary. Additionally, high levels of debt from leveraged buyouts or sale-leaseback arrangements can burden health care practices and increase the risk of failure.[17]

While private equity and corporate investment in health care is rightfully scrutinized, it cannot be ignored that many physicians willingly choose to partner with or sell their practices to corporate investors. Owning and managing a private practice has become increasingly challenging and corporate investment offers an alternative to being employed by a hospital or health system, or leaving the practice of medicine entirely. Additionally, when physicians sell a practice to a corporate entity, the money from the sale is taxed at capital gains rates which are more favorable than income tax rates, adding to the list of incentives for pursuing these transactions. Physician-owners choosing to enter these partnerships should be aware of risks and do their best to ensure that physician autonomy in clinical and operational decision-making is sustained.

In all types of medical practice, physician autonomy is of the utmost importance. Many physicians are rightfully concerned about the loss of professional control that could arise from partnering with a corporate entity. Almost 61 percent of physicians have a negative view of private equity and less than 11 percent have a positive view, according to a 2024 study.[18] There is also emerging evidence that trainees are less likely to join a practice backed by private equity and that these practices have higher staff turnover rates. In one specific case, dermatologists drawn to private equity backed practices by high salaries quit after being pressured to significantly cut costs and meet high financial targets.[19] A February 2025 *JAMA Health Forum* article found that physician turnover also increased when private equity companies sold the practice or facility they were invested in. Physicians employed by exiting private equity firms were 16.5 percentage points less likely to continue working in that practice two years after the private equity firm exited and 10.1 percentage points more likely to go on to be employed by a facility with more than 120 practicing physicians.[20]

According to the AMA's 2024 Physician Practice Benchmark survey, 57.4 percent of physicians were employees, 35.4 percent were owners, and 7.1 percent were independent contractors. Between 2012 and 2024, the share of physicians who worked in practices wholly owned by physicians – private practices – dropped by 18 percentage points from 60.1 percent to 42.2 percent. In 2024, 6.5 percent of physicians

were participants in private equity ownership or investment arrangements.[21] Many physicians that have left private practice have become employed by a hospital or health system, where they feel as if they have less autonomy in clinical decision making. In 2023, 56 percent of employed physicians said what they like least about their job is decreasing autonomy, which was up from 48 percent the year prior. According to a survey from National Opinion Research Center at the University of Chicago, approximately 61 percent of employed physicians said they have moderate or no autonomy to make referrals outside of their practice or ownership system, and 47 percent said they adjust patient treatments to reduce costs based on practice policies or incentives.[22]

Another concern is changing workplace composition and replacing physicians with NPPs who can often be hired at a lower salary than physicians, resulting in savings for the practice owner. A January 2023 study examined workforce composition changes in private equity acquired practices and found that in aggregate, the clinician replacement ratio was higher for private equity acquired practices compared to those not acquired by private equity. When compared to non-private equity acquired practices, those acquired by private equity had a significant yearly increase in the number of NPPs after acquisition. While the study claimed to be preliminary in nature, it supported the hypothesis that physicians may be more frequently replaced at private equity acquired practices versus those not acquired by private equity. However, the study also conceded that regardless of ownership, there was a statistically significant increase in NPPs at all practices examined, which could be in response to physician supply shortages, payment reforms, a shift to team-based care, or other factors.[23]

Impact on Consolidation and Market Concentration

A March 2024 *Health Affairs* study looked at private equity acquired practices and market penetration between 2012-2021. This study found that private equity acquired physician sites increased from 816 across 119 metropolitan statistical areas (MSA) in 2012 to 5,779 across 307 MSAs in 2021. The result was single private equity firms having a significant market share, exceeding 30 percent in 108 MSA specialty markets and exceeding 50 percent in 50 of those markets.[24] As can be seen in Appendices A and B of this report, gastroenterology, dermatology, urology, obstetrics and gynecology, ophthalmology, and radiology have seen the highest increases in private equity investment in recent years.

When private equity firms acquire multiple providers in the same specialty within a local or regional market (also known as a "roll-up"), those firms can gain significant market power, which can lead to higher prices or lower quality, or both, due to reduced competitive pressure.[25] An example of a roll-up is U.S. Anesthesia Partners, Inc. (USAP) in Texas. USAP, backed by private equity firm Welsh Carson, systematically bought up many large anesthesiology practices in Texas to create one dominant provider with the power to increase prices. USAP and Welsh Carson further drove up prices by entering into price-setting agreements with the remaining independent anesthesiology practices as well as paying a competing anesthesiology practice to stay out of USAP market territory. The Federal Trade Commission (FTC) sued USAP and Welsh Carson and, at the time this report was written, the case was still ongoing, although Welsh Carson has been dismissed from the case.[26]

Strengthening CPOM bans to protect the independent professional judgment of physicians

States are exploring legislation to protect the independent judgment of physicians by strengthening CPOM bans, in part by setting clearer requirements that lay entities (expressly including private equity firms) may not interfere with a physician's medical decision-making or independent judgment and defining what activities constitute medical decision-making. For example, legislation proposed in Washington State in 2025 would codify that the following be included in the "professional judgment or clinical decision-making" of a physician:

> "(a) The period of time a provider may spend with a patient, including the time permitted for a health care provider to triage patients in the emergency department or evaluate admitted patients; (b) The period of time within which a health care provider must discharge a patient; (c) The clinical status of the patient, including whether the patient should be admitted to inpatient status, whether the patient should be kept in observation status, whether the patient should receive palliative care, and whether and where the patient should be referred upon discharge; (d) The diagnoses, diagnostic terminology, or codes that are entered into the medical record by the health care provider; (e) The range of clinical orders available to a health care provider, including by configuring the medical record to prohibit or significantly limit the options available to the provider; or (f) Any other action specified by rule to constitute impermissible interference or control over the clinical judgment and decision making of a health care provider related to the diagnosis and treatment of a patient."[27]

Similar legislation has been introduced in California and Vermont this year, and in 2024, California's legislature considered CA AB 3129, which would have strengthened California's already-strong corporate practice ban through similar provisions and by limiting private equity companies or hedge funds from controlling or directing a physician practice.[28,29]

Imposing limitations on the structure of Management Service Organizations (MSOs) to insulate corporate investors from clinical decisions

The structure of existing CPOM laws allow for broad workarounds that make room for corporate investors to influence the provision of health care. Every state allows for the creation of a special type of physician-owned legal entity, often known as a professional services corporation (PC), to provide medical services if the PC is entirely owned by physicians, with many states, such as Arizona, only requiring partial ownership of a PC by physicians.[30] When CPOM restrictions limiting practice ownership to physician-owned PCs ban corporate investors from employing physicians or practicing medicine, these lay entities may pursue ownership of a management services organization (MSO) to contract with the physician-owned PC. The MSO may operate the nonclinical aspects of a physician practice and conduct administrative functions, handle practice financials, or provide other clinical support services to the practice. Under these arrangements, the PC ostensibly maintains ownership.

However, existing state laws do not prevent corporate investors from exercising influence on patient care via "friendly PC" arrangements. Friendly PC or friendly physician models allow lay entities to invest in and control physician practices indirectly, generally through an MSO. Commonly, the corporate investor secures a physician(s) to work in the practice who is sympathetic ("friendly") to the investor, while the MSO is compensated to provide services necessary for practice operations. Often the "friendly physician(s)" will serve on the board of directors for or have an ownership stake in the PC, the MSO, or both. These types of arrangements may allow corporations to effectively assume control of physician practices. Major corporate investors in health care, including Oak Street Health and One Medical, leverage the friendly PC model.

Novel legislation first proposed in 2024 aims to address the friendly PC model and insulate corporate investors from clinical operations by imposing certain structural limitations on MSOs. These types of provisions, first seen in 2024 in Oregon (HB 4130), challenge the friendly PC model by prohibiting a physician from serving as a shareholder, director, officer, or employee of both a health care practice and an MSO with which the practice contracts. Essentially, they aim to prevent lay entities from circumventing CPOM bans and limit comingling between MSOs and PCs by ensuring that a physician associated with the MSO cannot also direct or own shares in the PC.[31] This year, legislation imposing structural requirements on MSOs has once again been proposed in Oregon and is being considered as a matter of first impression in both Washington and Vermont.[32] Notably, these provisions are controversial

among physicians, in part because they could disrupt existing arrangements that are ostensibly working well, and also because they might prevent physicians who have equity in an MSO from benefitting financially in the event of a sale (i.e., from receiving "roll-over equity").

Improving transparency and oversight

Legislation to increase transparency and state oversight of transactions involving corporate investors is also being considered at the state level. Corporate acquisitions of physician practices often fall under the radar because they do not meet the monetary threshold for reporting and review by federal governing agencies. This is concerning, because many strategies employed by private equity firms have anticompetitive effects that may impact cost, quality, and access to care. When implemented thoughtfully, legislation to increase oversight may allow state governing bodies to identify and mitigate transactions that may have anticompetitive effects or other harmful impacts on patient care.

A handful of state laws impose requirements that certain transactions – namely those involving corporate investors and falling under a specified threshold below the one required by the Hart-Scott-Rodino Act – be reported to the state attorneys general (AG). Indiana, for example, passed such a law in 2024, and Connecticut, Vermont, and New Mexico are among states considering such legislation in the 2025 session.[33,34] More aggressive proposals go beyond transparency and grant the state AG authority to block any transaction it deems anticompetitive or otherwise inappropriate under statute. To that end, legislation may enumerate specific characteristics that constitute "anticompetitive effects," or, importantly, may name other factors that might render a transaction unlawful, such as compromised quality of care or decreased access to care for patients. California and Massachusetts considered such legislation in 2024.[35] In 2025, a bill passed in Massachusetts that, among other things, broadened the definition of "material change transaction" to include transactions involving private equity, real estate investment trusts, and MSOs, thereby subjecting them to market impact review and potential referral to the AG for determination as to whether there is unfair competition or anti-competitive behavior.[36]

The business model employed by corporate investors in health care often allows a firm to control an acquired entity while paying only a small fraction of the total purchase price upfront. The acquired health care practice or hospital is then forced to take on debt to cover the remaining cost. When this debt load is combined with cost-cutting efforts to increase short-term profits – efforts that are often high-risk strategies given the relatively small amount of capital at stake for the private equity firm – the results can be unsustainable.[37] In recent years, this has been particularly evident in private equity's acquisition of hospitals, where private equity ownership has led to bankruptcies, service reductions, and closures that restrict patient access to care. Examples of such casualties include the 2019 bankruptcy of Hahnemann University Hospital in Pennsylvania, the bankruptcy and closure of several Steward hospitals and related physician practices over the past several years in Massachusetts, and the recent devastation of Prospect Medical hospitals in California, Connecticut, Pennsylvania, and Rhode Island.[38] These closures have also led to the loss of liability tail coverage and/or employment for many physicians.

As proposed in CA AB 3129, access to care was included as a factor that attorney general offices might consider in determining whether to approve a proposed transaction. Other proposed legislative solutions to protect patient access to care following the acquisition of a hospital or health system are multifaceted.[39] While there has not been significant activity in state legislatures, proposed federal legislation may serve as a guide for policy solutions implementable at the state level. Senator Edward Markey's (D-MA) 2024 Health Over Wealth Act is instructive: legislation could mandate an acquired system to establish escrow accounts that would cover operating and capital expenditures for a specified period of time in case of a threatened closure or service reduction; it may impose notice requirements for any service disruptions; and, in order to increase an acquiring firm's stake in the transaction and reduce the debt load taken on by the acquired system, it could require that a minimum financial investment be made by investors upfront.[40]

AMA POLICY

Board of Trustees Report 9-I-24, "Corporate Practice of Medicine Prohibition," took a strong stance on restricting CPOM arrangements. The report amended Policy H-215.981 by adding three new clauses that ask the AMA to vigorously oppose any effort to pass legislation or regulation that removes or weakens state laws prohibiting CPOM; oppose CPOM and support the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups; and create a state CPOM template to assist state medical associations and national medical specialty societies as they navigate the intricacies of corporate investment in physician practices and health care generally at the state level and develop the most effective means of prohibiting CPOM in ways that are not detrimental to the sustainability of physician practices. In its report, the Board of Trustees recommended that AMA policy distinguish between corporate investment, corporate ownership, and corporate control in physician practices.

The Council has addressed this topic in three reports since 2013. In CMS 6-I-13 the Council discussed state CPOM doctrines and associated restrictions. Ultimately, the Council recommended the AMA maintain a balanced policy on CPOM and stated that the detrimental effects of CPOM can be mitigated by having strong policies in place to protect the independent medical judgment of physicians and patient-physician relationships. This report amended H-215.981 and reaffirmed other policies on physician employment. In CMS 11-A-19, the Council highlighted the risks and benefits of entering into corporate partnerships and noted that physician opinions vary regarding corporate investor involvement in physician practices. The report mentioned that although there has been a great deal of angst among physicians regarding private equity investment in practices, other physicians and physician groups have readily and successfully partnered with these firms. This report established Policy H-160.891, which created guidelines for physicians to consider when entering into corporate partnerships. In CMS 2-I-22, the Council provided a more detailed look at private equity investment in physician practices and shared emerging data on the impact these investments have had on physicians and patients. The report amended H-160.891 by adding two new clauses and established new Policy H-160.887.

The AMA has extensive policy on CPOM, consolidation, and related issues. Policy H-215.968 supports and encourages competition between and among health facilities as a means of promoting the delivery of high-quality, cost-effective health care. Policy H-160.960 states that when a private medical practice is purchased by corporate entities, patients going to that practice shall be informed of this ownership arrangement by the corporate entities and/or by the physician. Policy H-380.987 states that antitrust relief for physicians is a priority of the AMA.

Policy H-225.947 states that when physicians are seeking employment as their mode of practice they should strive for arrangements where physician clinical autonomy is preserved. Similarly, Policy D-225.977 states that the AMA will continue to assess the needs of employed physicians, ensuring autonomy in clinical decision-making and self-governance.

Policy H-285.951 supports physicians' right to enter into whatever contractual arrangement with health care systems, plans, groups, or hospital departments they deem desirable and necessary, but they should be aware of the potential for some types of systems, plans, groups, and hospital departments to create conflicts of interest, due to the use of financial incentives in the management of medical care. Additionally, this policy states that physicians should disclose any financial incentives that may induce a limitation of the diagnostic and therapeutic alternatives that are offered to patients, or restrict treatment or referral options.

Policy H-275.937 highlights the sanctity of the patient-physician relationship by stating that the relationship between a physician and a patient is fundamental and is not to be constrained or adversely

affected by any considerations other than what is best for the patient. The existence of other considerations, including financial or contractual concerns, is and must be secondary to the fundamental relationship. The policy also states that some models of medical practice may result in an inappropriate restriction of the physician's ability to practice quality medicine and this may create negative consequences for the public. Physicians must take actions they consider necessary to assure that medical practice models do not adversely affect the care that they render to their patients. Furthermore, Policy H-225.950 states that in any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority. Additionally, this policy notes that divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address. Policy H-140.978 states that physicians must not deny their patients access to appropriate medical services based upon the promise of personal financial reward, or the avoidance of financial penalties.

Related Policy H-385.926 states that the AMA supports the freedom of physicians to choose their method of earning a living (fee-for-service, salary, capitation, etc.), as long as physicians are charging patients fair fees and provide adequate fee information prior to the provision of services. This policy ensures physician autonomy in business decisions, but affirms that decisions, especially around pricing and fees, should be done in good conscience and be fair and transparent for patients.

DISCUSSION

The Council has recently written several reports, and the AMA has extensive policy to guide physician relationships with CPOM. In this report, the Council aims to strengthen existing guidelines for physicians considering corporate partnerships, support capital reserve requirements for firms interested in investing in the health care sector, and support increased enforcement of existing regulations on CPOM. It is important to note that CPOM is not new, but the recent rise in corporate investment in the health care sector raises cause for concern, particularly as it relates to patient safety and physician autonomy in clinical and operational decision-making.

There are risks and benefits associated with corporate investment and partnership. Corporate investment can offer a way for a practice to avoid selling to a hospital or health system, manage human resources, information technology and other administrative tasks on behalf of the practice, offer lucrative deals for physician-owners wanting to retire or sell their practice, and help with medical liability costs. Risks to physicians include a loss of control of business decisions and/or clinical autonomy, drastic cost cutting measures, loss of employment or replacement by NPPs, restrictive non-compete agreements, loss of liability tail coverage, or increased pressure to meet lofty financial targets. For physician-owners, there is the possibility of debt or bankruptcy after the corporate investor has extracted profits and exited the partnership.

The corporate investor could also go bankrupt, as has happened most recently with Prospect Medical Holdings in January 2025, and with Steward Health and Hahnemann University Hospital in recent years. The Council discussed the importance of financial stability of private equity firms and other investors before investments are made. Because the nature of private equity investment relies heavily on investing with debt (leveraged buyouts), investments can be risky and can lead to bankruptcy if not managed properly. Anecdotally, this has led to several hospital and practice closures around the country. The *Kaiser Health News* collection "Patients for Profit: How Private Equity Hijacked Health Care" provides several examples of where this has happened in the United States and the detrimental effect it can have on patients, physicians, and communities. While an important consideration, the Council believes that it is outside the purview of the AMA to dictate specific financial requirements for corporate investors. Instead, the Council stresses the importance of due diligence on the part of physician-owners considering these partnerships to ensure that an interested corporate investor has the resources required to support a

successful business relationship. With the intent to avoid future hospital closures, the Council recommends that the AMA support capital reserve requirements and leverage standards that preserve access to care for patients by preventing the closure of health care facilities and the limiting of essential health services.

Another consideration for physicians is control over final billing and coding designations. When administrative tasks are outsourced, there is opportunity for errors or intentional upcoding by third-party companies outside of the physician's direct supervision. As it is the physician's ultimate responsibility to ensure that billing and coding are accurate for the services provided, Policy H-385.939 outlines how false claims attributed to them could result in reputational, financial, or even criminal consequences.

During deliberations on this report, the Council discussed the relationship between NPPs and private equity. Theoretically, if physicians are reluctant to enter into corporate partnerships, private equity and other corporate entities may seek to instead invest in health care practices affiliated with NPPs, such as nurse practitioners and/or physicians assistants. The Council recognizes that this could be a result of physician resistance to corporate partnerships but ultimately believes it would be out of scope for the Council to recommend policy on business models for NPPs since the AMA is an organization representing physicians and not NPPs. Informally, the Council believes that like physicians, all allied health professionals should exercise due diligence when considering partnerships with corporate entities.

It is important to enforce regulations on transparency of these transactions as well as the ownership of group practices, hospitals, and health systems, including corporate and private equity ownership and relationships. Additionally, corporate and private equity acquisitions should be reviewed for their potential to disrupt access to care and conditions should be placed to ensure physician independence, quality of care, minimization of conflicts of interest, and avoidance of excess market consolidation. It is also important to support regulations that prevent the closure of essential services, such as emergency departments or labor and delivery units, whenever possible. The importance of transparency is highlighted in Policy H-160.960, which states that patients must be informed when a corporate entity purchases a private medical facility.

Because of the intricacies involved in corporate entity transactions, the Council believes it would be difficult to unwind the mergers and acquisitions that have already taken place, both by corporate investors as well as by nonprofit entities or other types of firms (i.e., nonprofit hospitals, health systems, independent practices). However, to boost competition in already consolidated markets, current laws on CPOM need to be enforced and new businesses need to be able to enter the market. Where possible, mergers and acquisitions should be scrutinized by the appropriate parties (FTC, Department of Justice, state attorneys general, etc.) to ensure they are following antitrust laws and to determine the effect the transaction may have on the market. Pursuing transparency in ownership of health care practices, as well as transparency in pricing, could boost competition as well as allow patients to make an informed choice when it comes to the care they receive.

Given the breadth and depth of AMA policy on this topic, the Council recommends strengthening existing guidelines to promote physician due diligence and protection when considering a relationship with a corporate entity. Specifically, the Council recommends broadening policy to include other corporate structuring, not just corporate investors, including language about conflict resolution, more explicitly stating which clinical and operational decisions should remain under the direction of physicians, including considerations and protections for billing and coding responsibility, supporting physician engagement in organizational governance following a merger or acquisition, and supporting enforcement of CPOM doctrines. The Council recommends supporting capital reserve requirements for corporate entities considering investment in health care facilities in order to provide stable financing in order to preserve access to care for patients and fulfillment of contractual obligations to physicians. Finally, the

Council recommends reaffirming policy on the importance of preserving physician autonomy and clinical decision-making.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted and the remainder of the report be filed:

1) That our American Medical Association (AMA) amend Policy H-160.891, "Corporate Investors," by addition and deletion, including a change in title:

   CORPORATE INVESTORS AND OTHER CORPORATE ENTITIES, H-160.891

   1) Our American Medical Association encourages physicians who are contemplating corporate investor partnerships or corporate entity relationships, including those under "friendly" physician professional corporation (PC) arrangements with Management Service Organizations (MSOs), to consider the following guidelines:
      a. Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor/entity.
      b. Due diligence should be conducted that includes, at minimum, review of the corporate investor/entity's business model, strategic plan, leadership and governance, and culture.
      c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor/entity transactions.
      d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
      e. Physicians should consider whether and how corporate ~~investor partnerships~~ relationships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
      f. Physicians should consider the potential impact of corporate ~~investor partnerships~~ relationships on physician and practice employee satisfaction and future physician recruitment.
      g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate ~~investor~~ relationships, and application of restrictive covenants, including any changes in the scope or implementation of any current or proposed restrictive covenants based on the corporate relationship ~~partnership~~.
      h. Physicians should consider corporate procedures ~~investor processes~~ for medical staff representation on the board of directors and medical staff leadership selection as well as processes for resolution of conflict between medical staff leadership and the corporate entity.
      i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and

physician due process under corporate ~~investor~~ relationships ~~partnerships~~.

j. Prior to entering into a relationship ~~partnership~~ with a corporate entity, physicians and the corporate entity should explicitly identify the types of clinical and business decisions that should remain in the ultimate control of the physician, including but not limited to:

i. Determining which diagnostic tests are appropriate;
ii. Determining the need for referrals to, or consultation with another physician or licensed health professional;
iii. Being responsible for the ultimate overall care of the patient, including treatment options available to the patient;
iv. Determining how many patients a physician shall see in a given period of time or how many hours a physician should work;
v. Determining the content of patient medical records;
vi. Selecting, hiring, or firing physicians, other licensed health care professionals, and/or other medical staff based on clinical competency or proficiency;
vii. Setting the parameters under which a physician or physician practice shall enter into contractual relationships with third-party entities;
viii. Making decisions regarding coding and billing procedures for patient care services; and
ix. Approving the selection of medical equipment and medical supplies.

k. ~~j.~~ Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non- physician practitioners.

l. Clear protection and dispute resolution processes for physicians advocating on patient care and quality issues should be incorporated into an agreement between physicians and corporate entities.

m. ~~k.~~ Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs.

2) Our AMA supports improved transparency regarding corporate investments in and/or relationships to physician practices, subsidiaries and/or related organizations that interact with the physician group and/or patients of the physicians, and subsequent changes in health care prices, quality, access, utilization, and physician payment.

3) Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor relationships ~~partnerships~~ on patients and the physicians in practicing in that specialty.

4) Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors/entities on the practice of medicine.

5) Our AMA supports meaningful physician representation in any corporate governance structure (e.g., seats on the board of directors, and/or other relevant leadership bodies) of any entity with which a physician practice, hospital, or other health care organization establishes a corporate relationship ~~partners~~. (Modify HOD Policy)

2) That our AMA amend Policy H-215.981, "Corporate Practice of Medicine," by addition:

CORPORATE PRACTICE OF MEDICINE, H-215.981

1) Our American Medical Association vigorously opposes any effort to pass federal legislation or regulation preempting state laws prohibiting the corporate practice of medicine.
2) Our AMA vigorously opposes any effort to pass legislation or regulation that removes or weakens state laws prohibiting the corporate practice of medicine.
3) Our AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups.
4) Our AMA, at the request of state medical associations, will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.
5) Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient centered care and other relevant issues.
6) Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the healthcare sector such that physician clinical autonomy and operational authority are preserved and protected.
7) Our AMA will create a state corporate practice of medicine template to assist state medical associations and national medical specialty societies as they navigate the intricacies of corporate investment in physician practices and health care generally at the state level and develop the most effective means of prohibiting the corporate practice of medicine in ways that are not detrimental to the sustainability of physician practices.
8) Our AMA supports enforcement of existing regulations and legislation pertaining to corporate control of practices in the health care sector to ensure that physician clinical autonomy and operational authority is preserved and protected.
9) Our AMA supports capital reserve requirements and leverage standards that preserve access to care for patients and fulfillment of contractual obligations to physicians and trainees by providing stable financing for hospitals, clinics, and other health care facilities. (Modify HOD Policy)

3) That our AMA reaffirm Policy H-285.910, The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community, which provides a

recommended clause to include in physician employment agreements and which states that in caring for patients physicians shall have the unfettered right to exercise independent and professional judgment and be guided by personal and professional beliefs as to what is in the best interests of patients, the profession, and the community. Furthermore, nothing in the employment agreement shall prevent physicians from exercising their own medical judgment and employers may not retaliate against the physician in any way based on the physician's right to exercise their medical judgment. (Reaffirm HOD Policy)

4) That our AMA rescind Policy D-160.904, as it is accomplished by this report. (Rescind HOD Policy)

5) That our AMA rescind Policy D-215.982, as it is accomplished by this report. (Rescind HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1]Ubel, Peter A. Private Equity Acquisition of Physician Practices – Looking for Ethical Guidance From Professional Societies. *JAMA Health Forum*. 2024;5(9):e242767. doi:10.1001/jamahealthforum.2024.2767. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2823384
[2]Singh, Y. and C. Whaley. Private Equity is Buying up Health Care, but the Real Problem is Why Doctors are Selling. *The Hill*. December 21, 2023. https://thehill.com/opinion/healthcare/4365741-private-equity-is-buying-up-health-care-but-the-real-problem-is-why-doctors-are-selling/
[3]Schrier, E., H. E. M. Schwartz, D. U. Himmelstein. Hospital Assets Before and After Private Equity Acquisition. *JAMA.* 2024;332(8):669-671. doi:10.1001/jama.2024.13555 https://jamanetwork.com/journals/jama/fullarticle/2821826
[4]Private Equity Stakeholder Project. Private Equity Hospital Tracker. Accessed: February 24, 2024. https://pestakeholder.org/private-equity-hospital-tracker/
[5]Gondi, S. and Z. Song. Potential Implications of Private Equity Investments in Health Care Delivery. *JAMA*. 2019 Feb 28:10.1001/jama.2019.1077. https://jamanetwork.com/journals/jama/fullarticle/2727259
[6]*Supra.* Note 3.
[7]*Supra*. Note 5.
[8]Fuse Brown, E. C. and M. A. Hall. Private Equity and the Corporatization of Health Care. *Stanford Law Review*. Volume 76. March 2024. https://review.law.stanford.edu/wp-content/uploads/sites/3/2024/03/Fuse-Brown-Hall-76-Stan.-L.-Rev.-527.pdf
[9]*Supra*. Note 4.
[10]Wilson, R. Optum now has 90,000 physicians. *Becker's Hospital Review*. November 29, 2023. https://www.beckershospitalreview.com/legal-regulatory-issues/optum-added-nearly-20-000-physicians-in-2023.html
[11]Herman, B. UnitedHealth Group now employs or is affiliated with 10% of all physicians in the U.S. *STAT Health News*. November 29, 2023. https://www.statnews.com/2023/11/29/unitedhealth-doctors-workforce/
[12]*Supra*. Note 4.
[13]Reed, T. Private Equity Drives up U.S. Medical Debt: Report. *Axios*. September 18, 2024. https://www.axios.com/2024/09/18/private-equity-us-medical-debt-report
[14]Kannan, S. J.D. Bruch, and Z. Song. 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 https://jamanetwork.com/journals/jama/fullarticle/2813379
[15]Fuse Brown, E. C., Y. Singh, C. Whaley, and J. Perkins. The Rise of Health Care Consolidation and What to Do About It. *Health Affairs*. September 9, 2024. https://www.healthaffairs.org/content/forefront/rise-health-care-consolidation-and-do
[16]AMA Board of Trustees Report 9-I-24. Corporate Practice of Medicine Prohibition.

[17]Abdelhadi, O., B.D. Fulton, L. Alexander, R.M. Scheffler. Private Equity-Acquired Physician Practices and Market Penetration Increased Substantially, 2012-21. *Health Affairs.* https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.00152
[18]Cumming, C. Doctors Organize to Push Back Against Private-Equity Takeovers. *Wall Street Journal*. September 22, 2024. https://www.wsj.com/articles/doctors-organize-to-push-back-against-private-equity-takeovers-16aa2c94
[19]*Ibid*.
[20]Berquist, Victoria, L. Klarnet, L. Dafny. Sale of Private Equity-Owned Physician Practices and Physician Turnover. *JAMA Health Forum*. February 2025. https://doi.org/10.1001/jamahealthforum.2024.5376
[21]Kane, Carol K. Policy Research Perspectives: Physician Practice Characteristics in 2024: Private Practices Account for Less Than Half of Physicians in Most Specialties. *American Medical Association*. 2024. https://www.ama-assn.org/system/files/2024-prp-pp-characteristics.pdf
[22]Newitt, P. What's At Stake When Physician Practices Cash Out. *Becker's ASC Review*. October 14, 2024. https://www.beckersasc.com/leadership/whats-at-stake-when-physician-practices-cash-out.html
[23]Bruch, J.D., C. Foot, Y. Singh, Z. Song, D. Polsky, J. Zhu. Workforce Composition in Private Equity-Acquired Versus Non-Private Equity-Acquired Physician Practices. *Health Affairs.* January 2023. https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00308
[24]*Supra*. Note 17.
[25]*Supra.* Note 17.
[26]FTC Press Release. FTC Challenges Private Equity Firm's Scheme to Suppress Competition in Anesthesiology Practices Across Texas. September 2023. https://www.ftc.gov/news-events/news/press-releases/2023/09/ftc-challenges-private-equity-firms-scheme-suppress-competition-anesthesiology-practices-across
[27]See WA SB 5387. 69th Legislature. Available at: https://lawfilesext.leg.wa.gov/biennium/2025-26/Htm/Bills/Senate%20Bills/5387.html
[28]See CA SB 351 (2025). Available at: https://s3.amazonaws.com/fn-document-service/file-by-sha384/8ecb6455d075c755cfdaba2ddce0e1c469bae9a10649c16f0a63a7387a557f7c10466a6e0dc86b732f5c5d6b73ba6358. See also VT H 71 (2025). Available at: https://legislature.vermont.gov/Documents/2026/Docs/BILLS/H-0071/H-0071%20As%20Introduced.pdf
[29]See CA AB 3129. 2024 Legislature. Available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB3129
[30]Ariz. Rev. Stat. § 10-2220(A). Lay entities may own up to 49% of a PC's shares.
[31]See OR HB 4130. 82nd Assembly (2024). Available at: https://olis.oregonlegislature.gov/liz/2024R1/Downloads/MeasureDocument/HB4130/Introduced
[32]See OR SB 951. 83rd Assembly (2025). Available at: https://olis.oregonlegislature.gov/liz/2025R1/Downloads/MeasureDocument/SB95. See also WA SB 5387. 69th Legislature. Available at: https://lawfilesext.leg.wa.gov/biennium/2025-26/Htm/Bills/Senate%20Bills/5387.html. See also VT H 71 (2025). Available at: https://legislature.vermont.gov/Documents/2026/Docs/BILLS/H-0071/H-0071%20As%20Introduced.pdf
[33]See IN SB 9. 123rd General Assembly (2024). Available at: https://legiscan.com/IN/text/SB0009/2024
[34]See CT HB 6873, 2025 General Assembly. Available at: https://www.cga.ct.gov/2025/TOB/H/PDF/2025HB-06873-R00-HB.PDF. See also NM SB 14. 57TH Legislature (2025). Available at: https://www.nmlegis.gov/Sessions/25%20Regular/bills/senate/SB0014.html. See also VT H 71 (2025). Available at: https://legislature.vermont.gov/Documents/2026/Docs/BILLS/H-0071/H-0071%20As%20Introduced.pdf
[35]See CA AB 3129. 2023-2024 Regular Session. Available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB3129. See also MA H 4653. 193rd General Session (2023-2024) Available at: https://malegislature.gov/Bills/193/H4643
[36]MA H 5159, Available at: https://malegislature.gov/Laws/SessionLaws/Acts/2024/Chapter343
[37]Comments of Eleven Attorneys General in Response to the February 29, 2024 Request for Information on Consolidation in Healthcare Market, June 2024, Available at: https://oag.ca.gov/system/files/attachments/press-docs/Comments%20by%2011%20Attorneys%20General%20in%20Response%20to%20Feb.%2029%20RFI%20on%20Consolidation%20in%20Healthcare%20%281%29%5B2%5D.pdf
[38]*Ibid*.
[39]CA AB 3129. 2024 Legislature. Available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB3129
[40]Health Over Wealth Act, 118th Congress, 2024. Full text available at: https://www.markey.senate.gov/imo/media/doc/health_over_wealth_act1.pdf.

Appendix A

Characteristics of private equity (PE)-acquired and non-PE-acquired practice sites for 10 physician specialties and by specialty, 2021

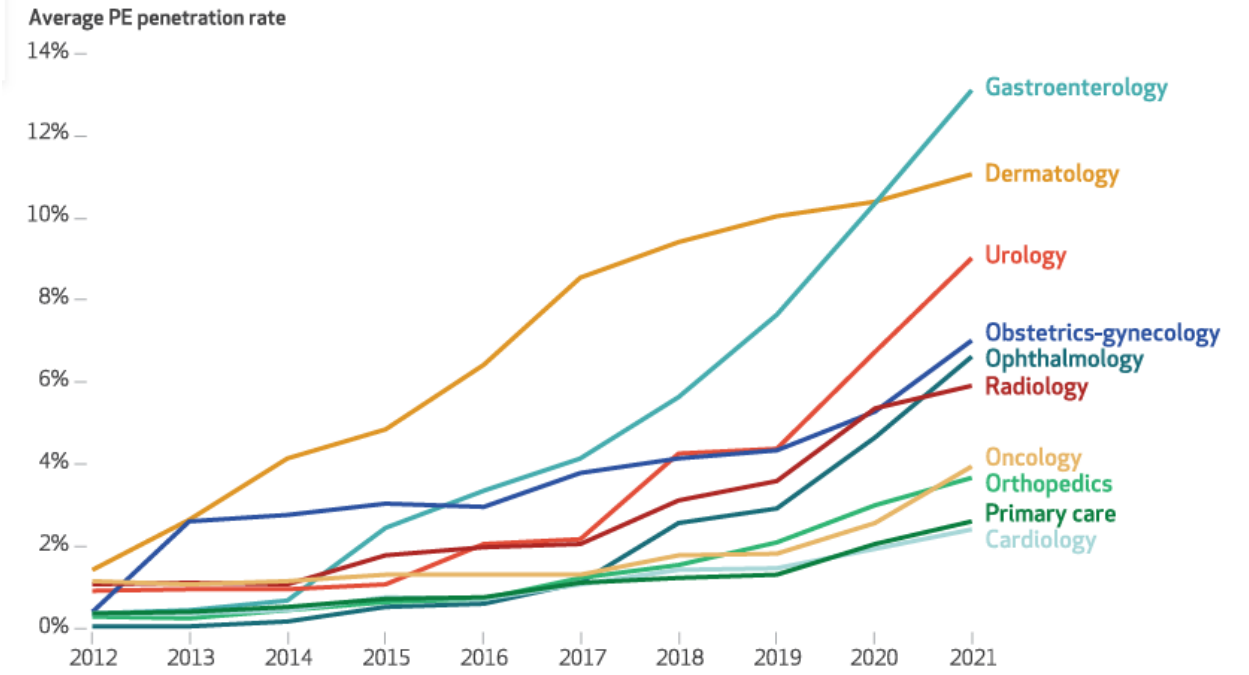
	PE-acquired practice sites (*N* = 5,779)		Non-PE-acquired practice sites (*N* = 131,552)	
Characteristics	**Number**	**Percent**	**Number**	**Percent**
No. of practice owners[a]	243	100.0	6,717	100.0
No. of physicians	14,656	100.0	328,335	100.0
No. of female physicians	5,372	36.7**	132,413	40.3
Age, years (SE)	53.3** (0.02)	—[b]	52.3 (0.09)	—[b]
Geographic region				
South	2,768	47.9	50,459	38.3
Northeast	1,157	20.0	29,212	22.2
Midwest	1,085	18.8	23,511	17.9
West	769	13.3	28,370	21.6
Specialty				
Primary care	1,440	24.9	72,412	55.1
Dermatology	827	14.3	5,818	4.4
Obstetrics-gynecology	798	13.8	10,944	8.3
Gastroenterology	697	12.1	4,468	3.4
Ophthalmology	648	11.2	8,966	6.8
Oncology	368	6.4	5,062	3.8
Urology	346	6.0	3,384	2.6
Radiology	257	4.4	4,991	3.8
Orthopedics	237	4.1	8,094	6.2
Cardiology	161	2.8	7,413	5.6

SOURCE Authors' analysis of data from the Irving Levin Associates Healthcare M&A Database, PitchBook private equity and merger and acquisition database, and OneKey Database provided by IQVIA. The PitchBook data presented here have not been reviewed by PitchBook analysts. The PitchBook database is dynamic; data for this exhibit are as of June 15, 2022. **NOTES** Specialties were identified at the physician level. Physicians who worked at multiple locations were counted as a fraction of physicians using full-time equivalents. If a practice included multiple specialties, counts were documented separately for each specialty, equivalent to each specialty being considered as a separate practice. We conducted a two-sample *t*-test on age and chi-square tests for the proportion of female physicians. [a]Practice owners are PE firms in the PE-acquired category and other corporate owners in the non-PE-acquired category. [b]Not applicable. **$p < 0.05$

Health Affairs. Private Equity-Acquired Physician Practices and Market Penetration Increased Substantially, 2012-21. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2023.00152

Appendix B

Trends in private equity (PE) penetration at the physician level in the US among 10 physician specialties, 2012–21



SOURCE Authors' analysis of data from the Irving Levin Associates Healthcare M&A Database, PitchBook private equity and merger and acquisition database, and OneKey Database provided by IQVIA (2020–21) and SK&A Office Based Physicians Database provided by IMS Health (now IQVIA) (2012–19). The PitchBook data presented here have not been reviewed by PitchBook analysts. The PitchBook database is dynamic; data for this figure are as of June 15, 2022. **NOTE** Average PE penetration rates at the physician level in each year by specialty were calculated by weighting each Metropolitan Statistical Area (MSA)-level market share by the number of full-time-equivalent physicians in that MSA by specialty, equivalent to the US penetration rate.

Health Affairs. Private Equity-Acquired Physician Practices and Market Penetration Increased Substantially, 2012-21. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2023.00152

Council on Medical Service Report 3-A-25
Regulation of Corporate Investment in the Health Care Sector
Policy Appendix

Corporate Investors, H-160.891

1. Our American Medical Association (AMA) encourages physicians who are contemplating corporate investor partnerships to consider the following guidelines:
    a. Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor.
    b. Due diligence should be conducted that includes, at minimum, review of the corporate investor's business model, strategic plan, leadership and governance, and culture.
    c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor transactions.
    d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
    e. Physicians should consider whether and how corporate investor partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
    f. Physicians should consider the potential impact of corporate investor partnerships on physician and practice employee satisfaction and future physician recruitment.
    g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants.
    h. Physicians should consider corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection.
    i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships.
    j. Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non- physician practitioners.
    k. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs.
2. Our AMA supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices.
3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty.
4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine.

(CMS Rep. 11, A-19; Appended: CMS Rep. 2, I-22; Reaffirmed: BOT Rep. 14, A-23)

Corporate Practice of Medicine, H-215.981

1. Our American Medical Association (AMA) vigorously opposes any effort to pass federal legislation or regulation preempting state laws prohibiting the corporate practice of medicine.
2. Our AMA vigorously opposes any effort to pass legislation or regulation that removes or weakens state laws prohibiting the corporate practice of medicine.

3. Our AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups.
4. Our AMA, at the request of state medical associations, will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.
5. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient centered care and other relevant issues.
6. Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the healthcare sector such that physician clinical autonomy and operational authority are preserved and protected.
7. Our AMA will create a state corporate practice of medicine template to assist state medical associations and national medical specialty societies as they navigate the intricacies of corporate investment in physician practices and health care generally at the state level and develop the most effective means of prohibiting the corporate practice of medicine in ways that are not detrimental to the sustainability of physician practices.
(Res. 247, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11; Modified: CMS Rep. 6, I-13; Reaffirmed: CMS Rep. 07, A-17; Modified: Res. 713, A-18; Reaffirmed: CMS Rep. 11, A-19; Reaffirmed: CME Rep. 01, I-22; Modified: Res. 710, A-24, Modified: BOT Rep. 09, I-24)

The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, H-285.910
Our American Medical Association endorses the following clause guaranteeing physician independence and recommends it for insertion into physician employment agreements and independent contractor agreements for physician services:

Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession, and the Community

In caring for patients and in all matters related to this Agreement, Physician shall have the unfettered right to exercise independent professional judgment and be guided by personal and professional beliefs as to what is in the best interests of patients, the profession, and the community. Nothing in this Agreement shall prevent or limit Physician's right or ability to advocate on behalf of patients' interests or on behalf of good patient care, or to exercise their own medical judgment. Physician shall not be deemed in breach of this Agreement, nor may Employer retaliate in any way, including but not limited to termination of this Agreement, commencement of any disciplinary action, or any other adverse action against Physician directly or indirectly, based on Physician's exercise of their rights under this paragraph.
(Res. 8, A-11; Reaffirmed: CEJA Rep.1, A-21; Modified: Speakers Rep. 02, I-24)

The Regulation of Private Equity in the Health Care Sector, D-160.904
Our American Medical Association will propose appropriate guidelines for the use of private equity in healthcare, ensuring that physician autonomy and operational authority in clinical care is preserved and protected.
(Res. 710, A-24)

The Corporate Practice of Medicine, Revisited, D-215.982
Our American Medical Association will revisit the concept of restrictions on the corporate practice of medicine, including, but not limited to, private equities, hedge funds and similar entities, review existing

state laws and study needed revisions and qualifications of such restrictions and/or allowances, in a new report that will study and report back by Annual 2025 with recommendations on how to increase competition, increase transparency, support physicians and physician autonomy, protect patients, and control costs in already consolidated health care markets; and to inform advocacy to protect the autonomy of physician-directed care, patient protections, medical staff employment and contract conflicts, and access of the public to quality health care, while containing health care costs.
(Res. 702, A-24)

Corporate Practice of Medicine, H-160.887
Our American Medical Association acknowledges that the corporate practice of medicine:

1. has the potential to erode the patient-physician relationship.
2. may create a conflict of interest between profit and best practices in residency and fellowship training.

(CMS Rep. 2, I-22)

Corporate Ownership of Established Private Medical Practices, H-160.960
When a private medical practice is purchased by corporate entities, patients going to that practice shall be informed of this ownership arrangement by the corporate entities and/or by the physician.
(Res. 3, I-92; Modified by CMS Rep. 1, A-95; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed: CMS Rep. 1, A-15; Reaffirmed: CMS Rep. 11, A-19)

Antitrust Relief as a Priority of the AMA, H-380.987
Our American Medical Association will continue its aggressive efforts to achieve appropriate negotiations rights and opportunities and necessary antitrust relief for physicians, by whatever means. Achieving this important goal will remain a top priority for the Association.
(Sub. Res. 223, A-93; Reaffirmed by BOT Rep. 33, A-96; Reaffirmation A-97; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-04; Reaffirmation A-05; Reaffirmed: BOT Rep. 10, I-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmation I-10; Reaffirmed: Res. 215, A-11; Reaffirmed: BOT action in response to referred for decision Res. 201, I-12; Reaffirmed in lieu of Res. 218, A-15; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: Res. 206, A-19)

Physician Employment Trends and Principles, H-225.947
1. Our American Medical Association (AMA) encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with the following principles: A. Physician clinical autonomy is preserved. B. Physicians are included and actively involved in integrated leadership opportunities. C. Physicians are encouraged and guaranteed the ability to organize under a formal self-governance and management structure. D. Physicians are encouraged and expected to work with others to deliver effective, efficient and appropriate care. E. A mechanism is provided for the open and transparent sharing of clinical and business information by all parties to improve care. F A clinical information system infrastructure exists that allows capture and reporting of key clinical quality and efficiency performance data for all participants and accountability across the system to those measures.
2. Our AMA encourages continued research on the effects of integrated health care delivery models (that employ physicians) on patients and the medical profession.
(CMS Rep. 5, I-15; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: CMS Rep. 07, A-19)

Physician Independence and Self-Governance, D-225.977

1. Our American Medical Association (AMA) will continue to assess the needs of employed physicians, ensuring autonomy in clinical decision-making and self-governance.
2. Our AMA will promote physician collaboration, teamwork, partnership, and leadership in emerging health care organizational structures, including but not limited to hospitals, health care

systems, medical groups, insurance company networks and accountable care organizations, in order to assure and be accountable for the delivery of quality health care.
(Res. 801, I-11; Modified: BOT Rep. 6, I-12; Reaffirmed: CCB/CLRPD Rep. 1, A-22)

Financial Incentives Utilized in the Management of Medical Care, H-285.951
Our American Medical Association believes that the use of financial incentives in the management of medical care should be guided by the following principles:

(1) Patient advocacy is a fundamental element of the physician-patient relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.
(2) Physicians should have the right to enter into whatever contractual arrangements with health care systems, plans, groups or hospital departments they deem desirable and necessary, but they should be aware of the potential for some types of systems, plans, group and hospital departments to create conflicts of interest, due to the use of financial incentives in the management of medical care.
(3) Financial incentives should enhance the provision of high quality, cost-effective medical care.
(4) Financial incentives should not result in the withholding of appropriate medical services or in the denial of patient access to such services.
(5) Any financial incentives that may induce a limitation of the medical services offered to patients, as well as treatment or referral options, should be fully disclosed by health plans to enrollees and prospective enrollees, and by health care groups, systems or closed hospital departments to patients and prospective patients.
(6) Physicians should disclose any financial incentives that may induce a limitation of the diagnostic and therapeutic alternatives that are offered to patients, or restrict treatment or referral options. Physicians may satisfy their disclosure obligations by assuring that the health plans with which they contract provide such disclosure to enrollees and prospective enrollees. Physicians may also satisfy their disclosure obligations by assuring that the health care group, system or hospital department with which they are affiliated provide such disclosure to patients seeking treatment.
(7) Financial incentives should not be based on the performance of physicians over short periods of time, nor should they be linked with individual treatment decisions over periods of time insufficient to identify patterns of care.
(8) Financial incentives generally should be based on the performance of groups of physicians rather than individual physicians. However, within a physician group, individual physician financial incentives may be related to quality of care, productivity, utilization of services, and overall performance of the physician group.
(9) The appropriateness and structure of a specific financial incentive should take into account a variety of factors such as the use and level of "stop-loss" insurance, and the adequacy of the base payments (not at-risk payments) to physicians and physician groups. The purpose of assessing the appropriateness of financial incentives is to avoid placing a physician or physician group at excessive risk which may induce the rationing of care.
(10) Physicians should consult with legal counsel prior to agreeing to any health plan contract or agreeing to join a group, delivery system or hospital department that uses financial incentives in a manner that could inappropriately influence their clinical judgment.
(11) Physicians agreeing to health plan contracts that contain financial incentives should seek the inclusion of provisions allowing for an independent annual audit to assure that the distribution of incentive payments is in keeping with the terms of the contract.
(12) Physicians should consider obtaining their own accountants when financial incentives are included in health plan contracts, to assure proper auditing and distribution of incentive payments.
(13) Physicians, other health care professionals, third party payers and health care delivery settings through their payment policies, should continue to encourage use of the most cost-effective care setting in which medical services can be provided safely with no detriment to quality.

(CMS Rep. 3, I-96; Reaffirmed by CMS Rep. 15, A-98; Reaffirmation: A-99; Reaffirmed: CMS Rep. 12, I-99; Reaffirmation: A-00; Reaffirmation: A-01; Reaffirmed in lieu of Resolution 901, I-05; Modified: BOT Rep. 38, A-06; Reaffirmed: CMS Rep. 01, A-16; Reaffirmed: CMS Rep. 11, A-19)

American Medical Association Principles for Physician Employment, H-225.950

1. **Addressing Conflicts of Interest**
    a. Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.
    b. In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.
    c. Employed physicians should be free to exercise their personal and professional judgment in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.
    d. A physician's paramount responsibility is to their patients. Additionally, given that an employed physician occupies a position of significant trust, they owe a duty of loyalty to their employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.
        i. No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to their religious beliefs or moral convictions.
        ii. No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because they either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates their religious beliefs or moral convictions.
    e. Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.

2. **Advocacy for Patients and the Profession**
    a. Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.
    b. Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. **Contracting**
    a. Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance

plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.

b. Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.
c. When a physician's compensation is related to the revenue they generate, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.
d. Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under their care. When a physician's employment status is unilaterally terminated by an employer, the physician and their employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in their new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of their patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.
e. Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.
f. Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.
g. Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.
h. Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. **Hospital Medical Staff Relations**
   a. Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.
   b. Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.
   c. Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.
   d. Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. **Peer Review and Performance Evaluations**
   a. All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.
   b. Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.
   c. Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.
   d. Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.
   e. Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.
   f. Upon termination of employment with or without cause, an employed physician generally should not be required to resign their hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the

medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:

i. The agreement is for the provision of services on an exclusive basis.
ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985.
iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.

Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements

a. Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.
b. Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.

(BOT Rep. 6, I-12; Reaffirmed: CMS Rep. 6, I-13; Modified in lieu of Res. 2, I-13; Modified: Res. 737, A-14; Reaffirmed: BOT Rep. 21, A-16; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: CMS Rep. 07, A-19; Reaffirmed: CMS Rep. 11, A-19; Modified: BOT Rep. 13, A-19; Reaffirmation: A-22; Reaffirmed: BOT Rep. 29, A-24; Modified: Speakers Rep. 02, I-24)