REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 02-I-22

Subject: Corporate Practice of Medicine
(Resolution 721-A-22)

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee J

At the 2022 Annual Meeting, the House of Delegates referred Resolution 721, "Amend Policy H-215.981, 'Corporate Practice of Medicine'," which was sponsored by the Resident and Fellow Section. Resolution 721-A-22 asked the American Medical Association (AMA) to "amend AMA Policy H-215.981, 'Corporate Practice of Medicine,' by addition of a fourth clause that reads: '<u>4. Our AMA acknowledges that the corporate practice of medicine has led to the erosion of the physician-patient relationship, erosion of physician-driven care and created a conflict of interest between profit and training the next generation of physicians.'"</u>

The referral of Resolution 721-A-22 included specific concern that the study should include the impact of the corporate practice of medicine on all practice types. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates. The Council notes that a related report is being presented by the Council on Medical Education at this meeting (CME Report 1-I-22 "The Impact of Private Equity on Medical Training"). The Council recognizes that private equity and corporate investors are becoming increasingly involved in graduate medical education, residencies, fellowships, and training of non-physician practitioner. We have chosen to focus this report on the general aspects of the corporate practice of medicine.

BACKGROUND

The Council recently prepared CMS Report 11 at the 2019 Annual Meeting which addressed a similar topic. The corporate practice of medicine is broadly defined as non-physician investment in medical practices. Two examples of corporate medicine include private equity investment funds and physician management groups. Private equity funds are pooled investments used to buy controlling shares of companies or other entities. After taking control, private equity funds typically streamline the business (which often includes cutting costs and reducing the ability for prior physician owners to make governance decisions) with the goal of selling the business for a profit in three to seven years. The types of investment range from venture capital (VC) firms that primarily invest in early-stage companies in exchange for minority ownership to more traditional private equity firms that borrow money to take a controlling stake in mature yet undervalued or underperforming companies through leveraged buyout deals.[1] Alternatively, a practice management company is a privately held or publicly traded for-profit company that manages the back-end administrative functions of medical practices, such as insurance contracting and billing. Many practice management companies, often referred to as staffing companies, also contract with hospitals and ambulatory surgical centers to provide professional staffing and management services. Investments in practice management companies by private equity funds have led to an increase in their utilization.[2]

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While the extent of corporate investment in physician practices is not precisely known, a growing number of physicians are employed by corporations including hospitals, health systems, and insurers. Concerns regarding these partnerships have primarily centered on the potential for subsequent increases in prices, service volume, and internal referrals, as well as the use of unsupervised non-physician practitioners. An array of factors has led to these changes, including changes in payment and delivery models, physician payment challenges, high costs of new technology and equipment, and increased administrative and regulatory burdens.

In addition to employment by hospitals, health systems, and insurers, private equity firms and publicly traded for-profit corporations may invest in physician practices. Increasingly, private equity firms have acquired majority and/or controlling interests in entities that manage physician practices. However, there is little peer-reviewed evidence regarding the impact of these arrangements on physicians, patients or health care prices, and physician opinions vary. Hospitals, health systems, academic medical centers, large multispecialty groups, and corporate buyers frequently compete with private equity investors for the same physician practice targets. Corporate buyers may also partner with private equity investors or form consortia of buyers to acquire highly sought-after practices. Increased competition for physician groups in some specialties has led price valuations of these practices to rise. Because many private equity transactions are not disclosed (non-disclosure agreements are commonly used), the degree of investment in physician practices, while believed to be relatively small overall, cannot be precisely determined. Incomplete data on corporate transactions involving physician practices is a significant impediment to determining the impact of corporate investors on physicians, patients, and the health care marketplace.[3]

State-by-State Differences

Generally, corporate practice of medicine doctrines prohibit corporations from practicing or interfering with the practice of medicine. The doctrines arise from state medical practice acts and are based on a number of public policy concerns, such as: (1) allowing corporations to practice medicine will result in the commercialization of the practice of medicine; (2) a corporation's obligation to its shareholders may not align with a physician's obligation to their patients; and (3) corporate interests may interfere with the physician's independent medical judgment.[4] It is important to note that while most states have a prohibition on the corporate practice of medicine, every state provides an exception for professional corporations and many states provide an exception for employment of physicians by certain entities. For example, some states explicitly permit hospitals to employ physicians, some states allow nonprofit hospitals to employ physicians, and other states recognize an unwritten exception to the corporate practice of medicine for hospitals employing physicians.[5] Many states that allow hospitals to employ physicians specifically prohibit the hospital from interfering with the independent medical judgment of the physician, thereby protecting the autonomy of the physician's clinical decision-making.[6] For example, in California and Indiana, clinics and hospitals may employ physicians as long as the entity does not direct or control independent medical acts, decisions or judgments of the licensed physician. On the other hand, in Colorado and Arkansas, all shareholders and officers of a medical corporation must be licensed physicians, consistent with each state's licensing laws. In Texas, state laws allow critical access hospitals, sole community hospitals, and hospitals in counties with fewer than 50,000 people to employ physicians, with the requirement that physicians must "retain independent medical judgment in providing care to patients at the hospital or other health care facilities owned or operated by the hospital and may not be disciplined for reasonably advocating for patient care."[7]

Recently, there have been complaints filed in state courts arguing that some of these firms have overstepped and are in violation of state corporate practice of medicine doctrines. One example of this is a lawsuit filed in California by the American Academy of Emergency Medicine Physician

Group (AAEM-PG) against Envision Healthcare Corporation. In its filing, AAEM-PG alleges that Envision is in violation of the state's corporate practice of medicine doctrine, as Envision either forms new medical groups with non-physician officers or "installs Envision executives or officers in pre-existing medical groups." Specifically, the lawsuit alleges that Envision: "decides how many and which physicians to hire, their compensation and work schedule…controls and influences advertising for physician vacancies, vetting physicians, establishing the terms of employment, the physician's rate of pay, scheduling the hours physicians will work, staffing levels, the number of patient encounters and working conditions…when to terminate physicians and denies them rights to appeal via traditional medical staffing mechanisms…negotiates the groups' contracts with third-party payers and health insurers and decides whether the group will agree to the terms…physicians are not made aware of the terms of their contracts with third-party payers." The lawsuit was originally filed in December 2021. In May 2022, a judge for the United States District Court for the Northern District of California denied Envision Healthcare's motion to dismiss the case; therefore, the case remains ongoing. The American College of Emergency Physicians and the California Medical Association have both filed amicus briefs in support of AAEM-PG.[8] Further details and copies of court documents can be found on https://www.aaem.org/envision-lawsuit.

As previously stated, there is limited data on the extent of physician practice acquisition by private equity firms; however, private equity acquisition of physician practices increased from 59 deals in 2013 to 136 deals in 2016.[9] In April 2022, *JAMA Health Forum* published data on the geographic variations in private equity penetration of physician practices (defined as the share of physicians in private equity-acquired practices) across six specialties: dermatology, gastroenterology, ophthalmology, obstetrics/gynecology, orthopaedics, and urology. Private equity penetration was highest in the Northeast (6.8 percent) and lowest in the Midwest (3.8 percent). Twelve states and the District of Columbia (DC) have an above average share of physicians in private equity practices, while eleven states have no identified acquisitions. States with the highest private equity penetration are Washington, DC (18.2 percent), Arizona (17.5 percent), New Jersey (13.6 percent), Maryland (13.1 percent), Connecticut (12.6 percent), and Florida (10.8 percent). By specialty, private equity penetration was highest in dermatology, followed by gastroenterology, ophthalmology, obstetrics/gynecology, and orthopaedics.[10]

Risks and Benefits

As with any practice type, there are risks and benefits associated with entering into corporate partnerships. Risks include loss of control over the physician practice and future revenues, loss of autonomy in decision-making, an emphasis on profit or meeting financial goals, potential conflicts of interest, and potential uncertainties for non-owner early and mid-career physicians. Additionally, after a buyout there could be added layers of bureaucracy that could add burdens to physicians. Examples could be new checks and balances or updated workflows. Benefits include financially lucrative deals for physicians looking to exit ownership of their practices, access to capital for practice expenses or expansions (which may relieve physicians' financial pressures), potentially fewer administrative and regulatory burdens on prior practice owners, and centralized resources for certain functions such as IT, marketing, and human resources.

There can also be risks to patients when physicians enter into these agreements. Recent evidence has shown a 10 percent increase in short-term mortality in private equity-owned nursing homes compared to non-private equity owned nursing homes. This is possibly due to decreases in nursing staff and declines in compliance with federal and state standards of care.[11] Another study evaluating private equity acquisitions of US hospitals demonstrated increased charges, increased net income, and increased patient risk scores, along with fewer Medicaid patients admitted, after private equity acquisition relative to control groups.[12] A third study showed that private

equity-owned dermatology practices were associated with 3 percent-5 percent higher prices for routine medical visits at 1.5 years after acquisition as compared with non-private equity-owned practices. Other studies have shown increased rates of surprise billing, overutilization of high-margin or low-value services, and pressure to up-code charges after private equity acquisition.[13]

Impact on Patient-Physician Relationship

Research is ongoing about the effects of corporate medicine investment on patient outcomes and cost-savings. A study of 176 hospitals acquired by private equity firms during 2005-2014 was conducted to compare financial performance to matched control hospitals.[14] Private equity acquisition of short-term acute care hospitals was associated with decreased costs per discharge and increased margins. The study highlights early findings on the impact private equity investment has on the health care system. Preliminary data show that financial performance improved after acquisition; however, patient utilization of services increased, and staffing decreased. Importantly, the study found that the decline in total costs per discharge was not adjusted for total full time hospital personnel, which suggests that hospitals cut costs in other dimensions, not only labor, after private equity acquisition. The authors of the study note that although improved financial performance occurred broadly, the findings are not evidence that gains in efficacy translate to improved patient outcomes or clinical experiences in either the short or long term.[15]

Under private equity investment, maintaining physician autonomy and a physician-led care team is crucial. Physicians should retain complete control of clinical decision making, as well as decisions regarding who is a member of their care team. Care provided by non-physician practitioners has been shown to be more costly than care provided by a physician-led team. An example of this is at the Hattiesburg Clinic in Mississippi. An examination of cost data for the South Mississippi system's accountable care organization (ACO) revealed that care provided by non-physician practitioners working on their own patient panels was more expensive than care delivered by physicians. The 2017-2019 Centers for Medicare & Medicaid Services (CMS) cost data on Medicare patients without end-stage renal disease and who were not in a nursing home showed that per-member, per-month spending was $43 higher for patients whose primary health professional was a nonphysician instead of a physician. This finding could translate to $10.3 million more in spending annually if all patients were followed by non-physician practitioners. Citing the results of the clinic's study, researchers found that "the results are consistent and clear: By allowing advanced practice providers to function with independent panels under physician supervision, we failed to meet our goals in the primary care setting of providing patients with an equivalent value-based experience." These findings underscore the importance of physician-led care teams, regardless of business model or private equity investment, both to control costs and improve patient outcomes.[16]

AMA POLICY

Long-standing AMA policy states that physicians are free to choose their mode of practice and enter into contractual agreements as they see fit.

Policy H-215.981 opposes federal legislation preempting state laws prohibiting the corporate practice of medicine; states that the AMA will continue monitoring the corporate practice of medicine and its effect on the patient-physician relationship, financial conflicts of interest, and patient-centered care; and directs the AMA to provide guidance, consultation, and model legislation regarding the corporate practice of medicine, at the request of state medical associations, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations.

Policy H-285.951 states that physicians should have the right to enter into whatever contractual arrangements they deem desirable and necessary but should be aware of potential conflicts of interest due to the use of financial incentives in the management of care.

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 care.

Policy H-225.947 encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with a series of principles, including: (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; and (f) a clinical information system infrastructure exists that allows capture and reporting of key clinical quality and efficiency performance data for all participants accountability across the system to those measures.

Policy H-160.960 states that when a private medical practice is purchased by corporate entities, patients shall be informed of the ownership arrangement by the corporate entities and/or physicians. Policy H-160.891 lists guidelines for physicians to consider when they are contemplating corporate investor partnerships. These guidelines include: (a) 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) 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) the potential impact of corporate investor partnerships on physician and practice employee satisfaction and future physician recruitment; (g) a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants; (h) corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection; and (i) retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships. Additionally, Policy H-160.891 states that the AMA supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices; encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians practicing in that specialty; and supports consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine.

DISCUSSION

The Council recognizes that private equity investment and the corporate practice of medicine are continuing to change the health care landscape. This report describes various investment opportunities and their impact on medical practice. Anecdotally, there have been challenges associated with the corporate practice of medicine and evidence that some investment firms have overstepped and could be in violation of state corporate practice of medicine doctrines. It is clear

that in order to control spending and provide optimal care for patients, care teams should be physician-led.

The AMA has long-standing policy that supports a physician's right to choose their mode of practice and type of employment, and we acknowledge that investor partnerships can be lucrative and successful. The AMA has published several resources and ethical opinions to guide physicians as they make the choice that is best for them.

The Council recommends new policy to address the concerns outlined in this report, including the potential to erode the patient-physician relationship and create conflicts of interest in medical education. In addition, the Council recognizes that the nature of corporate investor relationships could potentially change in the future and recommends amending Policy H-160.891 regarding corporate investors to strengthen the physician's role in clinical decision-making, medical education, and determining the composition of the care team.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 721-A-22, and the remainder of the report be filed:

1. That our American Medical Association (AMA) acknowledge that the corporate practice of medicine has the potential to erode the patient-physician relationship. (New HOD Policy)

2. That our AMA acknowledge that the corporate practice of medicine may create a conflict of interest between profit and best practices in residency and fellowship training. (New HOD Policy)

3. That our AMA amend Policy H-160.891 by addition of two new clauses, as follows:
   j. Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including the supervision of non-physician practitioners.
   k. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate and graduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as educational and disciplinary issues related to these programs. (Modify Current HOD Policy)

Fiscal Note: Less than $500.

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