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Is Private Equity in Healthcare on Trial? Confusion over the Corporate Practice of Medicine

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Physician practice has experienced a profound transformation in recent decades. The era of solo and small practice medicine has faded away as the norm, as physicians have migrated to larger-scale organizational models, including hospital-affiliated and health system-affiliated groups, as well as practices managed by physician practice management companies (PPMCs) and management service organizations (MSOs). In 2020, an AMA study revealed that for the first time, the majority of physicians worked outside of physician-owned practices. This transformation to newer, more complex arrangements has reshaped the roles of doctors within many healthcare organizations.

In the midst of this transformation, the prohibition on the corporate practice of medicine (CPOM) has been a challenge. CPOM laws, which remain in place in approximately half of U.S. states, prevent non-physicians and non-physician-owned entities from practicing medicine or employing physicians to deliver medical services. This viewpoint originated from a historical suspicion that non-physicians would prioritize profit over patient care, in contrast to doctors, who could be trusted to adhere to the Hippocratic Oath and focus on achieving the best medical outcomes for patients.

The CPOM legal doctrine has waned in nearly half of all states. Among other factors, CPOM has faced pressure from health systems and payors seeking greater ability to coordinate care and drive value-based care by integrating the direct provision of professional services into their operations.

In addition, an impending physician shortage, projected to result in a deficit of over 120,000 physicians in America within the decade, has spurred the need for new models and increased efficiency, enabling existing physicians to practice more effectively. Parallel to these developments, the transition over the past two decades from a provider-centric healthcare system to a patient-directed one has challenged CPOM. This change has been driven by the demand for a patient “consumer” experience that aligns medical practice with the consumer-oriented standards observed in other industries.

The demand for and opportunities presented with healthcare organizational scale have also driven a demand for capital and an interest in investment in healthcare professional services by private equity, venture capital, and public markets, aiming to acquire and unlock value within the sector. It is impossible to scale or to compete in the modern healthcare environment without the capital to develop recognized healthcare brands and develop patient experience that matches consumer brands and experience in other facets of our economy.

Simultaneously, healthcare policy has recognized that physicians’ financial motivations are not significantly different from those of non-physicians. This acknowledgment of physicians being equally susceptible to potential conflicts of interest regarding patient care is evident in the growing body of laws and regulations aimed at limiting physician financial relationships. These include Stark regulations, anti-kickback laws, and Sunshine Act requirements.

All of the above have contributed to a growing perception of CPOM as an anachronistic concept. In states that continue to have strong CPOM laws, systemic changes throughout the modern healthcare landscape have led to widespread adoption of business structures that simultaneously preserve physician decision-making while protecting non-physician investments and control over non-clinical aspects of physician enterprises. This evolution has progressed towards large-scale business operations, requiring substantial investment capital and non-physician expertise. To compete, large-scale healthcare organizations not only need physician leadership, but also experts in business administration, technology, user experience, patient acquisition, branding, capital planning, revenue cycle management, as well as space and personnel management.

The legal response to the CPOM challenge in the states that have retained the doctrine has bifurcated between nonprofit and for-profit models. The for-profit model, utilized in a wide range of settings, is frequently referred to as the "PC-MSO" model. Lay-owned PPMCs or MSOs furnish administrative, management, and other crucial services to physician organizations (PCs). These structures seek to ensure physician control over medical decision-making, while reserving non-clinical, business functions (including return on investment) to the MSO or PPMC. The model allows healthcare organizations to scale up alongside affiliated "friendly" medical groups, keeping medical decisions in the hands of doctors while enabling investors and non-physician founders and executive leadership to drive organizational growth. This model has infused billions of dollars of capital into physician practices, as investors acquire assets and intellectual property and, in exchange for their investments, secure the rights to return on investment from the profits of healthcare organizations. In recent years, companies employing this model have grown into large publicly traded enterprises, ranging from telehealth platforms like Teladoc and BetterHealth to brick-and-mortar providers such as CVS MinuteClinic and One Medical (recently acquired by Amazon). Given that the only viable competing alternative to support large-scale healthcare systems is a non-profit model with challenges of its own, the PC-MSO model has come to be virtually ubiquitous in for-profit healthcare models delivering professional services.

Despite the overwhelming success of this business model in generating billions of dollars in shareholder value, it continues to encounter tensions. In general, state laws and regulations have struggled to keep pace with the rapid transformation of the healthcare landscape. The business world has quickly adapted to market demands, while state regulatory authorities have largely remained silent (limiting its involvement to noticeable areas where the model jeopardizes patient safety or results in fraud). Although the IRS has adapted tax rules to accommodate the model (permitting affiliated professional entities to be treated as Variable Interest Entities (VIEs) that consolidate their revenue with MSOs), state medical licensing boards have generally not adjusted to the model's pervasiveness, primarily addressing CPOM only when non-physicians encroach upon and interfere with physician decision-making.

In recent years, new sources of confusion have emerged as opponents of private equity in healthcare have introduced legislation attempting to "roll back" the model. In California, in 2021, a group of progressive legislators introduced a bill (SB 642) that would have upended the model by limiting non-physician MSO or PPMC control over assets and business operations. In New York, earlier this year, the State Executive Budget featured a bill (Article 45-A of the Public Health Law) that would have mandated PC-MSO transactions (above a financial impact threshold) to obtain state Department of Health (DOH) regulatory approval. (The Legislature ultimately enacted a rule require DOH review, but not approval.) Although SB 642 stalled and the New York rule was softened into a mere notification requirement rather than a need for government approval, they reflect a hostility towards the PC-MSO model and the expansion of private equity in healthcare that it has facilitated. Thus, the latest battles over CPOM are a manifestation of a larger fight over the impact of private equity and for-profit forces in the healthcare sector.

One notable challenge to the PC-MSO model is the 2022 lawsuit filed in the U.S. District Court for the Northern District of California against Envision HealthCare, a prominent MSO specializing in emergency medical services, by the American Academy of Emergency Medicine Physician Group (AAEM-PG). AAEM-PG's complaint contends that Envision, as an MSO/PPMC (despite its physician leadership), breached California's CPOM laws by developing a network of affiliated (friendly-PC) professional entities that supplanted independent groups like AAEM-PG, among other allegations. AAEM-PG contends that the Medical Board of California is unable to police the PC-MSO model, forcing it to seek court intervention. Its underlying argument is that the PC-MSO structure inherently limits physician choices by the degree of non-clinical control that investors demand.

The healthcare community's keen interest in the trial stems from the implications of AAEM-PG's attempt to challenge widespread healthcare industry practices. Although AAEM-PG tries to characterize Envision's degree of control as excessive and inconsistent with CPOM norms, the arrangement as described conforms to normative practices adopted by thousands, if not tens of thousands, of organizations nationwide. A decision on issues as to which state medical boards have remained silent until now could challenge the legal framework that underpins the entire healthcare industry. The ramifications of a decision in AAEM's favor would be seismic, potentially necessitating significant legal restructuring throughout the healthcare industry and disrupting tax structures approved by the IRS and standard principles of accounting. The case is scheduled for trial before Judge Charles Breyer in early 2024.

Testing the boundaries of CPOM structures in a civil trial between two for-profit entities also creates a fresh battleground in the long-standing debate surrounding the future of CPOM doctrine. Historically, advocacy battles took place in state legislatures, with stakeholders attempting to influence state representatives and regulators.

As attorneys with two decades of deep involvement in utilizing and refining these structures, we believe that the opponents of the PC-MSO model are missing the extent to which the "horse has fled the barn" with respect to the

PC-MSO model. It is much too late to bar the doors. While American healthcare would benefit from modernizing regulations to align with the realities necessary to deliver healthcare in today's economy, the focus should be on patient safety and quality care rather than the financial mechanisms by which investors negotiate with physicians in search of return on investment. While it is crucial to ensure that clinicians drive clinical decision-making, undermining the investment model that has spurred significant innovation would be counterproductive. The notion that large-scale medical practices cannot function on a for-profit model may resonate with those advocating for more socialized medicine systems, but it could hinder the progress of U.S. healthcare. At the very least, it could choke off the capital structures that continue to support the growth of America's healthcare infrastructure. The nostalgic longing for a return to a bygone era of old-school family doctors, deeply rooted in their local communities, is undoubtedly captivating. However, chasing such a vision may prove perilous if it jeopardizes the vital capital inflows fueling innovation and efficiency in U.S. healthcare. While CPOM may need some updating, the PC-MSO model is here to stay.

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