DEPARTMENT OF JUSTICE

FEDERAL TRADE COMMISSION

Request for Information on Corporate Consolidation Through Serial Acquisitions and Roll-Up Strategies

Submitted 2024

Organization Submitting Comments:

Coalition for Patient-Centered Care

I. Introduction

The Coalition for Patient-Centered Care (CPCC) appreciates the Justice Department's Antitrust Division (DOJ) and the Federal Trade Commission (FTC) joint public Request for Information (RFI) inquiry on corporate consolidation through serial acquisitions and roll-up strategies. We strongly believe that any discussion about serial acquisitions and roll-up strategies is also about private equity in healthcare. We appreciate the FTC's efforts in their lawsuit against U.S. Anesthesia Partners, Inc. Overall, we believe that patient care and the wellbeing of workers in the healthcare sector must consider the harmful impact of private equity firms' acquisitions of physicians and other healthcare providers.

CPCC represents a diverse group of healthcare industry stakeholders who stand together in opposition to private equity's acquisition and influence over independent physicians that can result in an emphasis on profits and revenue growth over patient interests. Currently, our coalition is comprised of over 13,000 physicians from all 50 states, as well as other stakeholders who share the views set forth in this statement.

Overall, our member groups face many federal and state policy issues that impact their ability to provide quality and cost-effective care to their patients. In response to this, we are committed to developing and supporting policies that serve to strengthen and defend the independent practice of medicine. In doing so, we place the highest priority on patient access, efficient treatment processes, and reduced costs.

II. Overview of the Private Equity in Healthcare

We believe that everyone benefits when physicians have the freedom to exercise their best judgment as to the delivery of care and can work directly with their patients to make medical decisions and deliver patient-centered care. Private equity firms do not share this ideal.

They seem to be more concerned with maximizing investor profits than advocating for patients. Unfortunately, current U.S. tax law incentivizes private equity firms to acquire healthcare providers and gives them an advantage over other would-be acquisition partners by providing the firms with substantial tax breaks.

Private equity firms have been particularly active in acquiring independent physician groups. More than half of all specialists in several U.S. markets are owned by private equity firms, according to a recent study by the American Antitrust Institute, the Petris Center at the University of California, Berkeley, and the Washington Center for Equitable Growth.[1] As the *New York Times* summarized, the study found that "[i]n more than a quarter of local markets — in places like Tucson, Ariz.; Columbus, Ohio; and Providence, R.I. — a single private equity firm owned more than 30 percent of practices in a given specialty in 2021."[2] The article added, "[i]n 13 percent of the markets, the firms owned groups employing more than half the local specialists."[3]

CPCC members' experience—consistent with independent research, public reports, and even a recent investigation by the FTC[4]—is that, after a private equity firm takes over an independent physician group there are generally adverse effects. These effects often include decreased quality of care for patients, increased cost of care for public and private payors, and deteriorating working conditions for employees.

Regarding higher costs, there is significant evidence that private equity acquisitions of healthcare providers result in higher prices without any evidence of an increase in quality or access to care. For example, a recent study concluded that, after hospital outpatient departments and ambulatory surgery centers contracted with a physician management company (PMC), prices paid to anesthesiologists increased, and were substantially higher if the PMC received private equity investment.[5] Consistent with the study's findings, the FTC recently brought a lawsuit against private equity firm Welsh Carson, highlighting the harmful price effects of private equity acquisitions of independent physician groups. According to FTC Chair Lina Khan, "private

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[1] Richard M. Scheffler et al., Monetizing Medicine: Private Equity and Competition in Physician Practice Markets (July 10, 2023), https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf.

[2] Reed Abelson & Margot Sanger-Katz, *Who Employs Your Doctor? Increasingly, a Private Equity Firm.*, The New York Times (July 10, 2023), https://www.nytimes.com/2023/07/10/upshot/private-equity-doctors-offices.html?auth=login-google1tap.

[3] *Id*.

[4] Press Release, Federal Trade Commission, FTC Challenges Private Equity Firm's Scheme to Suppress Competition in Anesthesiology Practices Across Texas (Sept. 21, 2023), https://www.ftc.gov/news-events/news/press-releases/2023/09/ftc-challenges-private-equity-firms-scheme-suppress-competition-anesthesiology-practices-across.

[5] Ambar La Forgia et al., *Association of Physician Management Companies and Private Equity Investment With Commercial Health Care Prices Paid to Anesthesia Practitioners*, 182 JAMA Intern Med. 396, (2022), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2789280.

equity firm Welsh Carson spearheaded a roll-up strategy and created [U.S. Anesthesia Partners (USAP)] to buy out nearly every large anesthesiology practice in Texas. . . . [T]hese tactics enabled USAP and Welsh Carson to raise prices for anesthesia services—raking in tens of millions of extra dollars for these executives at the expense of Texas patients and businesses."[6]

As for decreased quality and access to care, while there are many examples, the 2021 sale of an independent physician group at Dartmouth College to private equity-backed One Medical, is instructive. In 2012, Dartmouth Health Connect, a primary care physicians office, was opened by the college in connection with Boston startup Iora Health. The office was originally intended to offer accessible and affordable healthcare to college students and the surrounding area. It began with two full-time physicians, a nurse, and other health professionals. After the private equity-backed takeover of the group, however, all that remains is one physician assistant with responsibility for approximately 1,300 patients.[7]

In our experience, aggressive cuts in staff-to-patient ratios result in decreased quality of and access to care for patients. Furthermore, they result in job losses and increase stress for healthcare sector workers, contributing to burnout, among other negative impacts. As a CPCC member, who needs to stay anonymous, says: "I've seen firsthand that private equity isn't just bad for patients and care, it's also a bad business model."

III. Testimonials

CPCC has a wealth of knowledge and experience with a diverse set of voices in healthcare. To showcase these voices, we have three distinct types of testimonials: 1) why independent practices are worth fighting for; 2) physician experiences with private equity in their practices; 3) industry experience and observations with private equity in healthcare.

A. Why the Independent Practice of Medicine Is Worth Fighting For

1. Karen Simonton – CEO of The OrthoForum[8]

The OrthoForum and its sister organization OrthoConnect, make up a network of independent musculoskeletal (MSK) physicians—5,000 physicians strong in 45 states. The

[6] Fed. Trade Comm'n, *supra* note 4.

[7] Douglas Farrago, *The Metamorphisis and Transformation of a DINO*, DPC News (Oct. 6, 2023), https://dpcnews.com/uncategorized/the-metamorphosis-and-transformation-of-a-dino/.

[8] Karen Simonton is a certified public accountant who has been working with independent practice groups in various C-suite roles for 30+ years. She is now the CEO of The OrthoForum, which is the largest independent association of musculoskeletal practices in the United States. The OrthoForum is also a founding member of CPCC. This testimonial is adapted from Karen's participation in a recent FTC workshop. *See* Federal Trade Commission, Transcript of "Private Capital, Public Impact: An FTC Workshop on Private Equity in Health Care" (March 5, 2024), https://www.ftc.gov/system/files/ftc_gov/pdf/final-trancsript-ftc-opp-be-private-equity-healthcare-workshop-3-5-24.pdf.

OrthoForum will soon celebrate its 25th anniversary of supporting independent community-based physician practices. Our physician members lead community centers of excellence, delivering access and cost-effective care to their respective communities. They get people back to their families, their employers, and their lives. They get us back to moving.

We are a founding member of the Coalition for Patient-Centered Care (CPCC). CPCC represents a diverse group of independent physicians and their allies who stand together in opposition to private equity's acquisition and subsequent control of independent physician groups, which upends the sacred physician-patient contract by emphasizing profits and revenue growth over patient care, as well as moving decision-making outside of the communities where we serve. We fundamentally believe that physicians' autonomy leads to better patient care.

We care because we have experienced the termination of several of our own members, about a dozen, who've been acquired by PE because, to be in The OrthoForum and OrthoConnect, you must be fully independent and in control of your practice. We knew someone had to begin educating the public and government on how PE, something that is not part of the local community, negatively impacts our patients and the communities where we're serving. Private equity interferes with the social contract between the doctor and the patient, and that interference has far-reaching consequences to the community.

There is not a community across the nation that has not been impacted by PE's work in the anesthesia space, and anesthesia is an integral partner of our MSK physicians. Without them, we can't perform surgeries, and we can't get people back to their activities of daily living. Reduced anesthesia access takes the form of long-term community anesthesiologists who must move out of town to find a place to serve their patients directly, or anesthesiologists who are not allowed to serve in specific facilities or may be out of network due to third-party contracting that is no longer in the control of the physicians and done in the interest of the community.

For 22 years, I lived in one of these community centers of excellence, in Virginia, and I saw firsthand how our physicians worked directly with other stakeholders in the community with the singular goal of serving patients. This means sideline coverage of youth sports and serving in the ER for trauma coverage, on safety panels for industry and manufacturing employer partners, and on nonprofit boards to enhance the community's quality of life.

Our independent physicians and their clinical teams worked with other primary care and facility partners to build quality and efficiency into all plans of care. This hard work is done in the spirit of the community's greater good, not as a paycheck. Their work supported the vibrancy of the businesses, but also their families and friends, because we are of the community as independents. And every community is different. Staffing and facility decisions have to be made at the community center of excellence level, not by a third party who is disinterested in the community. They have to be made in the interest of patients and outcomes and not spreadsheets and income statements.

So why is all of this independence worth preserving? Because independent physicians are the foundation of a healthy community. Ask any employer who is getting ready to expand their business footprint. Healthcare resources in a community are part of that decision-making process

for expansion, and we are tax-paying members of the community. We pay Business, Professions and Operational (BPOL) and real estate and personal property taxes. Independent physicians embody Main Street, not Wall Street. Further, we are in it for the long haul. Some of our members are more than 100 years old, predating even insurance carriers/payers and we stand in the gap, keeping our communities healthy and vibrant. We are community stewards for the long haul.

B. Physician Experiences with Private Equity

1. Doug Lundy, MD[9]

In 2017, I was president of one of the largest orthopaedic practices in the United States. In that role, I was approached by a senior partner in my practice who had a friendly chance meeting with his neighbor who is also a private equity (PE) principal. Following that meeting, my partner came to me and said, "We are sitting on a gold mine," and that we should consider selling the company to PE for a massive windfall. After extensive discussions with senior leadership, I made the decision to engage the PE/investment banker only enough to demonstrate to the shareholders how deleterious the decision to move forward with that option would be. I believed that my fellow shareholders would see the futility and short-sighted focus of going down the PE path and quickly turn away. In retrospect, I made a foolish decision.

Our group had essentially no debt and was in no need of capital for investment. We owned every ancillary service imaginable, and our physicians were compensated very well for their work and investment in the company. The stated objective of the investment bankers and PE principals was clear and essentially consisted of the following: "You should be bearish about your ability to earn the kind of money in the future that you are earning now. Things are only going to get worse for you. You should acquire your future cash stream now through PE acquisition and pay long-term capital gains on that revenue rather than regular income tax." Foreshadowing what was to come, there was no mention of capital investment in needed services or other avenues of investment back into the company. This message, focused on cash up front, was intoxicating to the shareholders, and they rushed in headlong.

I was wholesale against this decision because we already had a tremendous organization with an incredible culture and no major threats on the horizon. We were able to recruit new talent very successfully, and we were extremely stable and profitable financially. Giving up control of this entity to an investment firm solely focused on expanding the platform in preparation for a subsequent sale in five to seven years provided absolutely no value from my perspective.

Our expenses were very carefully controlled, and our insurance contracts were extremely good. There was very little margin for revenue enhancement or expense reduction other than eliminating staff that our organization believed provided value to the patient experience. Since

[9] Dr. Douglas W. Lundy is an orthopedic surgeon who specializes in acute/reconstructive trauma, fracture and limb-lengthening surgery and chair of St. Luke's University Health Network's Department of Orthopedics. Before joining SLUHN, he was co-president of Resurgens Orthopedics. He has treated patients for more than 25 years.

newly recruited physicians would have no access to the private equity distributions but would still be taxed with the PE "scrape," I believed that physician recruitment would be exceptionally difficult after the transaction. It was very hard for me to conceive of any scenario where patient care would not be significantly damaged after the transaction and change in company focus.

Although I led the Board of Directors in defeating the momentum toward PE acquisition, a bout with cancer caused me to second-guess my professional direction and seek a more fulfilling professional role. After recovering from cancer surgery, I resigned as president of the company and returned to my role as an orthopaedic surgeon. With my objections out of the way, the company sped quickly into the PE acquisition. Since our corporate organization and financial practices were not conducive to acquisition, my successor spent a tremendous amount of time cleaning up EBITDA and reorganizing the company under shell organizations. When the time for sale came due, the very small minority of physicians not participating in the sale, including me, were forced to leave the company and seek employment elsewhere. This minority consisted of the three orthopaedic trauma surgeons who were forced to leave since the hospital system refused to work with my former group and stated that they would hire their own trauma surgeons.

2. Stephen McCollam, MD[10]

Working in a large orthopaedic practice with 150,000 patient visits per year, I and my physician co-owners value being an independent physician group. We take pride in the social contract we promised to fulfill upon graduation from medical school when we took an oath to always place the patients' interests first and foremost in our decision-making process. Today, I see the trends of private equity (PE) consolidation of independent orthopaedic practices through PE purchases and hospital system mergers and worry about the future of private practice groups and the welfare of our patients.

Our practice carefully evaluated private equity over a period of two years. With the help of an investment banker, we investigated several private equity entities, all of whom promised to partner with us through the creation of an intermediary medical services company (MSO), in order to bypass the prohibition on corporate ownership of medical practice laws here in Georgia. When we finally received the contract documents, it was clear as day that this was a takeover attempt where near complete control would need to be ceded to the PE entity by way of the MSO. At the end of the day, PE's mandate was to boost our revenue by whatever means necessary so they could sell the MSO within 5-7 years to return a profit to their investors. It was also clear that there would be no input from us when the PE entity would sell the MSO and that it would be sold to whomever would pay the highest sales price. In addition, the deal would have gutted our operating agreements by giving the PE entity the ability to (1) assign 10 shareholder votes to an MD of their choice, (2) stack the executive committee with their members, and (3) empower the executive committee to fire and hire doctors—all of which drastically reduced

[10] Dr. Steve McCollam is a practicing orthopaedic surgeon for the past 35 years in a large group multispecialty practice in the Atlanta area.

physician employment protections. All of this was to protect their investors. Ultimately, we realized their goal was to make revenue growth their first priority in direct contradistinction to the social contract we pledged and still believe in.

Additionally, extensive market consolidation within the hospital systems in Atlanta has resulted in aggressive pressure tactics by the hospitals to pressure us into selling a majority interest in our ambulatory surgery centers to their hospital systems. This pressure comes in many forms, like the hospital offering a possible increase in our ambulatory surgery center (ASC) rates to offset the reduced revenue we would receive if we allowed them to purchased majority control. Another hard-fisted tactic is gaining majority interest in the medical office building or the land it sits on where our ASCs are located and pressuring the office owners not to renew our ASC lease thereby shuttering our lower cost ASCs. This would result in patients being forced to have their surgery at the hospital where they would pay higher out of pocket costs, ultimately, resulting in increased costs to employers through higher insurance costs.

Another example of the challenges of remaining an independent practice is increased difficulties over the past few years in obtaining independent anesthesia coverage in several of our ASCs. Some of the hospital or PE-acquired anesthesia groups have stopped offering services to our ASCs as an indirect method of restricting our ability to perform surgeries in our own ASCs.

Our independence allows us to provide high quality care at a lower cost to our patients. Based on the explanation of benefits (EOB) forms from insurance companies that we have collected from our patients, the hospital reimbursement rates for the same surgery in their outpatient facilities are 100-300% higher when performed at the hospital compared to when we perform them in our ASCs. They can leverage their CON (certificate of need) protected beds and large “cannot do without” market share to negotiate higher surgery facility rates.

I hope this inquiry will result in much-needed regulatory changes to level the playing field and protect the high-quality care at a lower cost that we can provide. Our practice has been in the Atlanta market since 1953 but without protections against the above pressures, such as a neutral site of service payment structure, we may be forced to align with a bigger entity to ensure our survival and care for our patients. This realignment would result in higher costs to our patients and their employers. Please protect independent orthopaedic specialty practices by promoting free and fair competition so that we can continue to provide cost-efficient, high-quality care to the tens of thousands of patients we treat every year in the Atlanta market.

3. R. James Toussaint, MD[11]

Part I: The Road to PE

The partners at my previous physician group were feeling the pressures of decreasing reimbursement from insurance companies coupled with the increased burden of pre-approval requirements from insurers, as well as intense competition from the academic orthopaedic group. They felt that an infusion of capital was necessary to remain competitive. As a result, my previous physician group held a request for proposal (RFP) to various private equity firms. During this time, the practice also hired a law firm and an investment bank to advise its physicians on the private equity deal process. The practice eventually decided to proceed with a private equity firm based in California because of the promises they made, which were meant to impress the physicians. Some of the promises included terms such as (1) management expertise in orthopedics; (2) no interference with physicians' clinical practice; (3) cost-savings from synergies; (4) physician income repair; and, finally, (5) an attractive "second bite" sale in three to five years.

The preliminary terms of the deal included a high-dollar value based on the data collected at the preliminary phase of the deal. However, as the process proceeded, the practice and the partners incurred more and more legal expenses, detracting from the initial sale price and increasing the pressure to continue with the deal partly because of the sunk legal costs. As a result, the physicians signed onto the deal despite multiple purchase price adjustments downward by the private equity group that the group blamed on various theoretical risks that never materialized.

Part II: After the Deal (The Deadend)

One of the private equity group's first steps taken after the deal was set was to install its own board and management team. The promise was that the new management team would have years of orthopaedic expertise. Unfortunately, none of the new leadership had any notable experience with running an orthopaedic practice thereby adding nothing of value on this measure, beyond what was already in the board room, prior to the deal.

Within months after the deal's closing date, the morale of the physicians and their staff changed for the worse. Many of the long-time employees that were directly under the supervision of each physician were laid-off or fired to make room for new hires by the private equity group. This led to significant disruptions in the physicians' day-to-day clinical practice and patient dissatisfaction.

Next, instead of cost-savings from synergies, the practice's overhead burden increased significantly. The increase consisted of more layers of administrators, management fees, and

[11] Rull James Toussaint, MD FAAOS is currently the Division Chief of Foot and Ankle Surgery within the Department of Orthopaedic Surgery at the University of Florida in Gainesville. Prior to joining the University of Florida, he was in private practice. He also holds an economics degree from the University of Chicago and worked on Wall Street doing healthcare investment banking for Credit Suisse.

millions of dollars of debt. The overhead increased so substantially, that some physicians not only did not receive a paycheck, but instead actually paid the group to work. This was despite having the physician take on all the risks and responsibilities of patient care. After endless complaints from the physicians about the insurmountable overhead expenses, the private equity group finally responded. To the physicians' dismay, however, one of the methods of cost savings was to change malpractice coverage to a lower-tier, less-expensive insurance carrier.

Furthermore, the physician take-home pay decreased dramatically on a monthly basis. As previously mentioned, some doctors indeed had to pay for the privilege to work. Unfortunately, other doctors stretched their indications to treat patients to maintain income. All the while, the cost to the patients, however, continued to rise while they noticed their quality of care decrease. I had many patients complain to me about surprises, unexpected increases in their medical bills, yet they were unhappy with their treatment outcomes.

Part III: Decision to Leave (The Exit Ramp)

My previous physician group was once known as the premier orthopaedic practice in the region. It brought first-class musculoskeletal care to its rural and suburban population in north central Florida. It was notable that none of the group's partners had left except for because of death or retirement. Since the private equity deal closed, nearly half of the group's original partners left the group. Indeed, a large portion of the practice's original partners decided to leave rather than continue to work in the toxic environment that was caused by the private equity deal. To save face, the private equity group's management team would lie to patients and say that the doctor retired, even though they did not stop practicing medicine. In my case, I was disillusioned by the mismanagement of the group and the private equity group's focus on dollars instead of quality. I eventually put in my resignation letter highlighting my intention to leave private practice and join academic medicine at the University of Florida since the university did not have a specialist orthopaedic surgeon performing complex foot and ankle surgeries. In fact, I was the only orthopedic surgeon trained to do some of these complex surgeries in the entire region. Despite this, the private equity group sued to enforce a non-compete agreement that would prevent me from practicing in the region and within many miles of any of their facilities. It did not matter to them that the community would not have a specialist surgeon to care for their injured patients. Thankfully, a legal settlement was achieved, and I was able to join the faculty at the University. Not surprisingly, and not infrequently, my legacy patients from the private practice who seek my care at the university tell me they found me via the internet and that the private equity group lied to them and said that I retired.

C. Industry Experience and Observations with Private Equity in Healthcare

1. Marty Nichols – Co-Founder, Physicians First Bancorp, Inc.

I am the Co-Founder of Physicians First Bancorp, Inc (PFBI), a company that allows physicians to receive access to funding and financial services. Our business focuses on the musculoskeletal (MSK) market, including the MSK patient and physician, without requiring physicians give up 20-30% of their revenue to entities such as private equity (PE). We founded this company as an alternative to other capital sources, including PE, to allow physicians to

spend more time with their patients and provide better care at a lower cost to the system. Over the years, we have observed that orthopaedic physicians often need a reliable source of capital, but do not want to relinquish control of their practice to access this funding. We have been able to assist many physicians in this way allowing them to avoid the practice disruption and expense that is associated with PE funding.

When I started in the industry, an orthopaedic surgeon was paid $5,250 for a total joint replacement (TJA), the patient was kept in the hospital for ten to fourteen days and then discharged to physical therapy (PT). The physician was also paid to render follow-up care in the hospital as well for post-op visits. Physicians, at that time, saw ten to fifteen patients per day in their clinics and would spend as much as 45 minutes to 1 hour with each patient. A busy orthopedic surgeon would do 90-110 TJA's per year.

Today, an orthopaedic surgeon gets paid $1,004 for a Medicare TJA, may treat as many as fifty to seventy patients per day in clinic, and perform 250-400 TJAs per year with the busier surgeons doing more like 700-1000 per year….all just to maintain their income. Of these patients, 40% are now discharged home on day one and rarely does a patient stay more than two days. The $1,004 covers the next ninety days of care (global fee) and a physician is lucky to get to spend twenty minutes with a patient during follow up visits. Almost all the advances that have made this possible have been driven by the physicians that perform these procedures, but PE, insurers, hospitals and manufacturers have benefitted from these improvements to drive up their own profits.

This brings us to the real concerns of private equity (PE) and its negative impact in healthcare, especially in the ownership of physicians' practices.

PE's primary means of increasing the revenue to a physician comes from increasing volume, both in terms of patients treated as well as ancillary services provided. In a new or startup industry this may be a viable solution but in orthopedics, a very mature market, the increase in volume comes at a terrible price to the patient and the physician.

The next method is cutting staff and services. These cuts rarely happen in the billing and collections department because collecting revenue is PE's primary focus. This means the cuts are made to patient services moving them from the primary physician to into the hands of "mid-level providers." In some instances, the first time a physician sees a patient is in the pre-op holding room before surgery. Although mid-level providers can play a vital role in the delivery of care, they are not properly or fully trained to replace a physician's skills and knowledge. Yet, this tactic is employed because of the enhanced profitability it creates.

The final means for PE to increase revenue for an orthopedic practice group is to increase the cost of the care. Everyone agrees we are at a breaking point when it comes to the high and increasing cost of delivering care in the U.S.

Based on my experience, the solution to providing better care at a lower cost is not in allowing or incentivizing extra administrative layers such as PE to profit from the services that physicians provide. For example, PE should not be allowed to benefit from extra incentives (like tax breaks), or a reduced regulatory burden compared to physicians. Instead, high-value care will come from leveling the playing field for physician-owned healthcare entities compared to other types of ownership and allowing physicians to have a larger control of the total episode of care.

By doing this you also gain more transparency and accountability for outcomes because there are fewer layers of bureaucracy and ways of obfuscating the responsible entity or person.

IV. Recommendations

We are at this moment because PE is not playing on the same terms and conditions that independent physician practices are working on. CPCC believes that in order to level the playing field, we need to implement these four recommendations: 1) Eliminate tax breaks for PE acquisitions of physicians; 2) close loopholes that allow PE to circumvent the ban on the corporate practice of medicine; 3) ensure PE-backed MSO's are subject to the same requirements and regulations as independent physician practices such as Stark and Fraud and Abuse laws; 4) increased reporting and transparency requirements for PE acquisitions of physician practices.

A. Eliminate tax breaks for PE acquisitions of physicians

PE acquisitions of physician practices have become increasingly common. As referenced in *Private Equity and the Corporatization of Health Care*, "the profitability of PE investment is enhanced by tax breaks."[12] We agree with the authors' assessment that tax reform is needed because current tax policy favors capital over labor and corporate profit over professional independence. We recognize that these reforms will not eliminate PE investments in healthcare but these reforms are needed to cool PE's pace of acquisitions.

B. Close loopholes that allow PE to circumvent the ban on the corporate practice of medicine

Closing loopholes that enable private equity firms to bypass the ban on the corporate practice of medicine is crucial to safeguarding the integrity of healthcare delivery. By eliminating these loopholes, we can promote transparency, and foster a healthcare environment where patient interests and quality of care take precedence over anything else.

The MSO model is one of the most common ways to circumvent the corporate practice of medicine bans.[13] The model allows an MSO owned and controlled by a PE firm contracting with a physician-owned professional corporation to provide administrative and other services for a fee.

We recognize the difficulty of creating a definition strong enough to take on PE investments while also accounting for the reality of our independent businesses. We highly encourage the wording of legislation that focuses on the holder of the assets, not the owner of the clinical practice. We suggest this because in the MSO model, the professional corporations (PC) always remain majority owned (usually entirely owned) by the physicians. On the other hand, the MSO which holds all the assets and makes all the financial and strategic decisions is always

[12] Erin Fuse Brown & Mark A Hall, *Private Equity and the Corporatization of Health Care*, 76 Stanford L.R. 527, 590 (2024) (discussing tax treatment of private equity firms), https://review.law.stanford.edu/wp-content/uploads/sites/3/2024/04/Fuse-Brown-Hall-76-Stan.-L.-Rev.-527.pdf.

[13] *Id*. at 566.

controlled by non-physicians appointed by the PE firm. So, the wording of the bill needs to focus on the holder of the assets, not the owner of the clinical practice.

C. Ensure PE-backed MSO's are subject to the same requirements and regulations as independent physician practices such as Stark and Fraud and Abuse laws

It is imperative to subject private equity acquisitions to the same stringent regulations as physician acquisitions, including Stark and Fraud and Abuse laws, to uphold fairness, transparency, and ethical standards in healthcare. Ensuring parity in regulations prevents potential discrepancies that could compromise patient care quality, financial integrity, and ethical conduct, safeguarding against undue influence and preserving the sanctity of healthcare decision-making for the benefit of patients and the healthcare system.

Currently, this is not happening. When it comes to Fraud and Abuse, PE firms drive to increase the revenues of acquired portfolio practices that can result in the adoption of illegal billing practices, like overutilization, inappropriate billing, medically unnecessary care and prohibited self-referrals for ancillary services.[14] Applying the Stark Law to PE acquired physician practices would also help level the playing field. By doing so, it will target another revenue strategy of PE-acquired physician practices, like self-referrals for ancillary, wrap-around services with the PE's portfolio practices.[15]

D. Increased reporting and transparency requirements for PE acquisitions of physician practices

Increasing reporting and transparency requirements for Private Equity acquisitions of physician practices is essential to provide visibility into potential impacts on patient care, financial practices, and healthcare quality. Enhanced reporting ensures stakeholders, including patients, regulators, and healthcare providers, have access to crucial information, promoting accountability, identifying potential conflicts of interest, and safeguarding against any adverse effects on patient outcomes. This transparency fosters trust, aids informed decision-making, and upholds the integrity of healthcare services amidst evolving ownership structures.

E. Federal Legislation

We are encouraged to see Members of Congress, including both Democrats and Republicans, expressing interest and concerns with private equity investment in healthcare. In April, the Senate Homeland Security and Governmental Affairs Committee, chaired by Senator Gary Peters (D.-Mich), issued subpoenas to three of the nation's largest private equity firms seeking information about hospital emergency department staffing businesses.[16] In December, the Senate Budget Committee launched a bipartisan investigation led by Senators Sheldon

[14] *Id*. at 552.

[15] *Id*. at 558.

[16] Press Release, United States Senate Committee on Homeland Security & Governmental Affairs, Peters Seeks Information About Private Equity Run Emergency Departments And Impact On Patient Care (Apr. 1, 2024), https://www.hsgac.senate.gov/media/dems/peters-seeks-information-about-private-equity-run-emergency-departments-and-impact-on-patient-care/.

Whitehouse (D.-R.I.) and Charles Grassley (R-Iowa) into two hospital systems associated with private equity firms.[17] We hope to see additional legislation come from this interest and concern.

Recently, Senator Ed Markey (D-Mass) released draft legislation titled the "Health Over Wealth Act" (the Proposed Bill).[18] CPCC submitted comments on the draft legislation stating that we appreciate Senator Markey's efforts with the Wealth Over Health Act to require greater transparency regarding private equity firms' ownership of healthcare entities; put safeguards in place to protect workers and preserve access to healthcare; and elevate the voices of workers and communities in regulating healthcare and monitoring hospital closures and service reductions. We strongly believe that any discussion about patient care and the wellbeing of workers in the healthcare sector must consider the harmful impact of private equity firms' acquisitions of physicians and other healthcare providers. [19]

Representative Pramila Jayapal's "Healthcare Ownership Transparency (HOT) Act" is another piece of legislation that looks to take on PE's investment in healthcare.[20] The HOT Act intends to "shine a light on the dangers of private equity in our health care system and move us toward accountability for providers and patients." The two main parts involving PE in healthcare are: 1) directing the Secretary of the HHS to create a task force to identify best practices and provide regulatory and legislative recommendations to Congress to address the adverse effects of private equity's involvement in healthcare. 2) Allow the Secretary to prohibit private equity firms from gaining control of covered healthcare firms until the effects of private equity ownership on healthcare entities are understood by the task force.

F. State Action

We often, because of inaction at the Federal level, see States as laboratories of democracy. That is what is currently happening in addressing private equity acquisitions in healthcare. There are several states that have bills addressing our concerns. The two pieces of legislation that we want to highlight are HB 4130 in Oregon and AB 3129 in California.

When the Oregon House of Representatives held a hearing on HB 4130, a CPCC member, a practicing physician, submitted a comment in support of the bill stating:[21]

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[17] Press Release, Office of Senator Chuck Grassley, Senate Budget Committee Digs Into Impact Of Private Equity Ownership In America's Hospitals (Dec. 6, 2023), https://www.grassley.senate.gov/news/news-releases/senate-budget-committee-digs-into-impact-of-private-equity-ownership-in-americas-hospitals.

[18] Office of United States Senator Ed Markey, The Health Over Wealth Act (Apr. 3, 2024), https://www.markey.senate.gov/healthoverwealth#:~:text=The%20Health%20over%20Wealth%20Act%20would%20require%20greater%20transparency%20in,hospital%20closures%20and%20service%20reductions.

[19] Coalition for Patient-Centered Care, CPCC Comments To Sen. Markey Health Over Wealth Act (May 15, 2024), https://patientcenteredcare.com/cpcc-comments-to-sen-markey-health-over-wealth-act/.

[20] Office of Congresswoman Pramila Jayapal, Jayapal Introduces Bill To Improve Transparency In Health Care, (Mar. 23, 2024), https://jayapal.house.gov/2023/03/23/jayapal-introduces-bill-to-improve-transparency-in-health-care/.

[21] The OrthoForum, Submission Re: Hearing on HB 4130 (Feb. 6, 2024), https://olis.oregonlegislature.gov/liz/2024R1/Downloads/PublicTestimonyDocument/103236.

> "The State of Oregon is not exempt from the national trend of private equity's entry into the healthcare system. I support HB 4130 and the efforts to try to close the loopholes in Oregon's corporate practice of medicine law. As a physician, my primary focus is the care provided to my patients. But time after time when private equity gets involved, we see a shift in focus to maximizing profits for shareholders and costs going up for patients. This bill is a big step in the right direction for the State of Oregon and our patients."

In California, AB 3129 has passed out of the Assembly and is currently in the Senate. CPCC is supportive of this bill, especially the language focused on oversight and restricting private equity from gaining control of physician practices.

Just as AB 3129 would give more oversight to the Attorney General of the State of California, we encourage State Attorney General offices to take a more active role overseeing private equity acquisitions in healthcare. Unlike trying to get legislation to become law, Attorney General offices often have existing authority. That authority can be used to scrutinize or disapprove PE acquisitions or hold PE firms accountable in the case of PE bankruptcies or exits.

In Rhode Island, the Attorney General has the authority under the State's Hospital Conversions Act both to block mergers and to issue conditions on them. Attorney General Peter F. Neronha has used this authority several times, including in 2021 by issuing strong conditions necessary to a hospital merger "ensuring the delivery of quality, accessible, and affordable healthcare for all Rhode Islanders."[22]

State agencies also have a strong role to play. A good example of this is from earlier this year in Massachusetts, the Massachusetts Health Policy Commission (HPC) participated in a special hearing of the Legislature's Joint Committee on Health Care Financing, *Examination of the Effects of Private Equity Ownership and Investment in Health Care.*[23] In this hearing, the HPC Executive Director educated legislators and suggested policy recommendations to increase oversight and transparency of private equity investment in healthcare.[24]

G. Federal Agencies

CPCC commends the FTC and the DOJ for this joint inquiry on corporate consolidation through serial acquisitions and roll-up.

We support the FTC efforts to educate and raise awareness of these critical issues. We appreciated the *Private Capital, Public Impact: An FTC Workshop on Private Equity in Health*

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[22] Press Release, State of Rhode Island Attorney General Peter F. Neronha, Attorney General Imposes Unprecedented Conditions On Hospital Ownership Change To Ensure Future Operations (Jun. 1, 2021), https://riag.ri.gov/press-releases/attorney-general-imposes-unprecedented-conditions-hospital-ownership-change-ensure.

[23] Press Release, Massachusetts Health Policy Commission, HPC Executive Director Testifies Before Special Hearing On Private Equity (Mar. 25, 2024), https://www.mass.gov/news/hpc-executive-director-testifies-before-special-hearing-on-private-equity.

[24] *Id*.

Care[25] and are grateful for the opportunity to participate in the event. We are watching closely and support the litigation against U.S. Anesthesia Partners, Inc.[26]

We support the DOJ efforts to educate and raise awareness of these critical issues. We appreciate the DOJ Antitrust Division's Task Force on Health Care Monopolies and Collusion (HCMC) and are interested in following the enforcement strategy and policy approach in healthcare. We are watching closely and support the False Claims Act litigation targeting private equity firms.[27]

V. Conclusion

CPCC commends the FTC and the DOJ for the joint public RFI inquiry on corporate consolidation through serial acquisitions and roll-up strategies and for engaging in this important discussion with affected stakeholders. We are eager to continue this conversation and would be pleased to serve as a resource. Please do not hesitate to contact us.

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[redacted]
https://patientcenteredcare.com/

[25] Fed. Trade Comm'n, Private Capital, Public Impact: An FTC Workshop on Private Equity in Health Care (Mar. 5, 2024), https://www.ftc.gov/news-events/events/2024/03/private-capital-public-impact-ftc-workshop-private-equity-health-care.

[26] Federal Trade Commission v. U. S. Anesthesia Partners, Inc. *et al*., No. 4:23-CV-03560 (S.D. Tex. Sept. 21, 2023), https://www.ftc.gov/system/files/ftc_gov/pdf/2010031usapcomplaintpublic.pdf.

[27] Nathan J. Andrisani, Eric W. Sitarchuk & Matthew D. Klayman, *DOJ Targeting Private Equity Firms in False Claims Act Litigation*, The Temple 10-Q, https://www2.law.temple.edu/10q/doj-targeting-private-equity-firms-in-false-claims-act-litigation/.