

REPORT 11 OF THE COUNCIL ON MEDICAL SERVICE (A-19)
Corporate Investors
(Reference Committee G)

EXECUTIVE SUMMARY

While the extent of corporate investment in physician practices is not precisely known, growing numbers of physicians are employed by corporations including hospitals, health systems and insurers. Increasingly, private equity firms have also 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 experiences and opinions vary.

There are risks and benefits of partnering with any corporate investor, including a private equity firm. Risks include loss of control over the physician practice and its future and future revenues; loss of some 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. 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 physicians; and centralized resources for certain functions such as IT, marketing or human resources. 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 providers.

Longstanding AMA policy states that physicians are free to choose their mode of practice and enter into contractual arrangements as they see fit. This report recommends a series of guidelines that should be considered by physicians who are contemplating corporate investor partnerships; supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices; and encourages further study by affected national medical specialty societies.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 11-A-19

Subject: Corporate Investors

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee G
(Rodney Trytko, MD, Chair)

1 At the 2018 Annual Meeting, the House of Delegates adopted Policy D-383.979, “Corporate
2 Investors.” This policy states that our American Medical Association (AMA) will study, with
3 report back at the 2019 Annual Meeting, the effects on the health care marketplace of corporate
4 investors (e.g., public companies, venture capital/private equity firms, insurance companies and
5 health systems) acquiring a majority and/or controlling interest in entities that manage physician
6 practices, such as the degree of corporate investor penetration and investment in the health care
7 marketplace; the impact on physician practice and independence; patient access; resultant trends in
8 the use of non-physician extenders; long term financial viability of practices; effects of ownership
9 turnovers and bankruptcies on patients and practice patterns; effectiveness of methodologies
10 employed by unpurchased private independent, small group and large group practices to compete
11 for insurance contracts in consolidated marketplaces; and the relative impact corporate investor
12 transactions have on the paths and durations of junior, mid-career and senior physicians.

13
14 This report describes physician practice consolidation with corporate investors, including private
15 equity investment in physician practices; discusses the corporate practice of medicine; summarizes
16 relevant AMA policy; and makes policy recommendations.

17 18 BACKGROUND

19
20 Consolidation among health care entities, including consolidation involving physician practices, is
21 closely monitored by the AMA. An array of factors—including changes in payment and delivery
22 models, physician payment challenges, high costs of new technology and equipment, and increased
23 administrative and regulatory burdens—have driven some physicians to be employed by, merge
24 with or join hospitals, health systems and insurers. Increasingly, private equity partnerships/firms,
25 which pool funds to invest in companies with the goal of running them more efficiently and selling
26 them at a profit, have also acquired majority and/or controlling interests in entities that manage
27 physician practices.

28
29 While the extent of corporate investment in health care is not precisely known, increasing numbers
30 of physicians are employed by corporations, including hospitals, health systems and health
31 insurers.¹ Data from the 2018 Health Care Services Acquisition Report demonstrates corporate
32 investor interest in physician practices. The report documented that 2017 saw the highest annual
33 number of transactions (166 deals) involving physician medical groups since 1998 (264 deals). Of
34 the 10 largest physician medical group transactions completed between 2013 and 2017, two were
35 acquisitions of large physician groups by UnitedHealth’s Optum unit, and another two involved
36 private equity firms. Many of the largest transactions involved public companies.²

1 The long-term trend away from physicians being practice owners and toward physicians being
 2 employees has been documented via the AMA’s Physician Practice Benchmark Surveys, which
 3 yield nationally representative samples of non-federal physicians providing at least 20 hours of
 4 patient care. These surveys, conducted biennially, have found that physician ownership dropped by
 5 seven percentage points (from 53.2 percent to 45.9 percent) between 2012 and 2018.³ Notably, the
 6 year 2018 was the first time that the percentage of physician owners was less than the percentage of
 7 physician employees (47.4 percent).⁴

8
 9 *Private Equity Investment in Physician Practices*

10
 11 Private equity firms, which acquire equity in businesses with funds from private investors, vary in
 12 terms of size, structure, business model and investment thesis. Venture capital is typically used to
 13 invest in emerging or early stage businesses such as start-ups. Buyout or leveraged buyout firms
 14 typically invest in mature or later-stage businesses, often taking a controlling interest.

15
 16 Private equity investment in dermatology, radiology, anesthesiology, urology, gastroenterology,
 17 cardiology, orthopedic, radiology and ophthalmology practices, among other specialties, has
 18 garnered substantial publicity and attention from the physician community. Growth in the demand
 19 for health care services, coupled with an aging population and the development of innovative
 20 treatments, have made the health care sector attractive to private equity investors. Globally, total
 21 disclosed value of deals in the sector exceeded \$63 billion in 2018, the most since 2006, with much
 22 of this activity concentrated in North America and the US in particular.⁵ Providers and related
 23 services, including physician practice management, accounted for the most deals in 2018, with
 24 increased activity observed in anesthesia, radiology and behavioral health.⁶ A reported 84 private
 25 equity deals involving providers (including but not limited to physician practices) were
 26 consummated in 2018, totaling \$23 billion.⁷ Private equity firms have also invested in hospitals,
 27 ambulatory surgical centers, retail health, health information technology (IT), home care and
 28 hospice, among many other services.⁸

29
 30 Hospitals, health systems, academic medical centers, large multispecialty groups, and corporate
 31 buyers frequently compete with private equity firms for the same physician practice targets.
 32 Corporate buyers may also partner with private equity investors or form consortia of buyers to
 33 acquire highly sought-after practices. Increased competition for physician groups in some
 34 specialties has led price valuations of these practices to rise.

35
 36 Because many private equity transactions are not disclosed (nondisclosure agreements are
 37 commonly used during negotiations),⁹ the degree of investment in physician practices, while
 38 believed to be relatively small overall, cannot be precisely determined. Incomplete data on
 39 corporate transactions involving physician practices is in fact a significant impediment to
 40 determining the impact of corporate investors on physicians, patients, and the health care
 41 marketplace. That said, there is evidence that physician practices are being acquired, not only by
 42 private equity firms but also by hospitals, health systems, academic medical centers, insurers, and
 43 large physician groups. Transactions involving private equity investors are occurring with some
 44 regularity. Consequently, affected physician specialties are attempting to understand these practice
 45 shifts as well as the risks and benefits of this practice model.

46
 47 Dermatology is one such specialty, having experienced a surge in private equity deals involving
 48 dermatology-related practices in the last three to five years. Fifteen percent of recent private
 49 equity/physician practice transactions have been “dermatology-related,” although dermatologists
 50 make up only one percent of US physicians.¹⁰ As noted in a recent commentary in *JAMA*

51 *Dermatology:*

1 Consolidation of practices fueled by private equity investments has begun to transform
2 dermatology ... Existing dermatologists are encouraged to stay after the sale through equity
3 stakes or deferred payouts, but in some cases, the investors may accept departures because the
4 buyout recipients can sometimes be replaced by younger dermatologists or physician assistants
5 who are paid at a lower level.¹¹

6
7 Private equity firms have also shown interest in ophthalmology practices, as described in *Review of*
8 *Ophthalmology*:

9
10 The basic premise is that a private equity firm offers to form a partnership with an
11 ophthalmology practice that it believes has the potential to grow. It provides funding to the
12 practice owners, including an upfront payment in cash and/or stock, in exchange for a
13 percentage of future profits. Ultimately, the goal is to increase the value of the practice by
14 investing in its growth—often partly by consolidating it with other practices—so that in a few
15 years it can be resold to another private equity firm for a significant profit.¹²

16
17 Noted researcher Lawrence Casalino, MD, et al. described the phenomenon as follows:

18
19 These investors anticipate average annual returns of 20 percent or more. To achieve such
20 returns, private equity firms focus on acquiring “platform practices” that are large, well
21 managed, and reputable in their community. The firms sell these practices after augmenting
22 their value by recruiting additional physicians, acquiring smaller practices to merge with the
23 larger practice, increasing revenue (for example, by bringing pathology services into a
24 dermatology practice), and decreasing costs (for example, by substituting physician assistants
25 for physicians). Growth makes it possible to spread fixed costs, exploit synergies across
26 merged practices, expand ancillary revenues, and increase negotiating leverage with health
27 insurers.¹³

28
29 A recent *JAMA Viewpoint* concluded:

30
31 Even though consolidation may create economies of scale and layoffs and other cost-cutting
32 measures may reduce operating costs, increased market power over price negotiations with
33 insurers and boosting volume for ancillary revenue streams may increase spending. Empirical
34 analysis is needed to understand the net consequences and to compare spending among private
35 equity-owned, hospital-owned, and independent practices.¹⁴

36
37 *Risks and Benefits of Partnering with Corporate Investors*

38
39 There is little peer-reviewed evidence regarding the impact of corporate investors on physicians,
40 physician autonomy, patients or health care prices. Anecdotal information suggests an increase in
41 the use of non-physician extenders by some private equity firms and other challenges facing
42 physicians working for practices affiliated with private equity firms. The experiences of practices
43 entering employment arrangements with hospitals, health systems, academic medical centers and
44 insurers may differ from private equity investors because these entities function in the health care
45 marketplace and frequently have existing physician leadership in place. Additionally, in contrast to
46 private-equity backed practices, hospitals, health systems and academic medical centers may use
47 some of their revenues to provide uncompensated care and/or contribute to medical education and
48 training.¹⁵

1 There are risks and benefits of partnering with any corporate investor, including a private equity
2 firm. Risks include loss of control over the physician practice and its future and future revenues;
3 loss of some autonomy in decision-making; an emphasis on profit or meeting financial goals;
4 potential conflicts of interest; and potential uncertainties for non-owner early and mid-career
5 physicians. Benefits include financially lucrative deals for physicians looking to exit ownership of
6 their practices; access to capital for practice expenses or expansions, which may relieve physicians'
7 financial pressures; potentially fewer administrative and regulatory burdens on physicians; and
8 centralized resources for certain functions such as IT, marketing or human resources. Concerns
9 regarding these partnerships have primarily centered on the potential for subsequent increases in
10 prices, service volume, and internal referrals, as well as the use of unsupervised non-physician
11 providers.¹⁶ Importantly, corporate investors are obviously not all the same and may differ
12 significantly in terms of their business models and culture. Some are centralized and physician-led,
13 while others are centralized but not physician-led; the degree of physician autonomy in decision
14 making also varies.

15

16 AMA ACTIVITY

17

18 In monitoring mergers and acquisitions, the AMA's position is that each health care entity
19 consolidation must be examined individually, taking into account case-specific variables related to
20 market power and patient needs. AMA policy strongly supports and encourages competition in all
21 health care markets to provide patients with more choices while improving care and lowering the
22 costs of that care. Markets should be sufficiently competitive to allow physicians to have adequate
23 practice options. The AMA also recognizes that employment preferences vary greatly among
24 physicians, and that employment by large systems can be an attractive practice option for some
25 physicians. A 2013 AMA-RAND study on professional satisfaction found that physicians in
26 physician-owned practices were more satisfied than physicians in other ownership models (e.g.,
27 hospital or corporate ownership), but that work controls and opportunities to participate in strategic
28 decisions mediate the effect of practice ownership on overall professional satisfaction.¹⁷

29

30 The AMA promotes physician leadership in integrated structures and has developed policies and
31 resources intended to help safeguard physicians employed by large systems. The AMA has also
32 developed several [resources](#) intended to help physicians understand employment contracts. These
33 include the Annotated Model Co-Management Service Line Agreement, Annotated Model
34 Physician-Group Practice Employment Agreement, and the Annotated Model Physician-Hospital
35 Employment Agreement as well as a Making the Rounds podcast on contracts. For physicians
36 considering a practice setting change or looking for an alignment strategy with an integrated health
37 system, the AMA developed the guide [Joining or Aligning with a Physician-led Integrated Health
38 System](#). The AMA has also made available a set of resources called "Unwinding Existing
39 Arrangements" that guides employed physicians on how to "unwind" from their organization,
40 factoring in operational, financial, and strategic considerations.

41

42 At the time that this report was written, the AMA was planning to release, mid-year in 2019,
43 resources related to venture capital and private equity investments that highlight the main issues
44 physicians may encounter when engaging with such firms, including modifications to
45 compensation, investment in infrastructure, how to evaluate contractual agreements, and hands-on
46 management. A related checklist was also planned that will offer specific considerations such as
47 terms-of-sale for the practice, standardization techniques and economies of scale, and unwinding
48 terms.

1 *Corporate Practice of Medicine*

2
3 The term “corporate practice of medicine” encompasses complex legal issues that may mean
4 different things to different people and vary widely by state. The corporate practice of medicine
5 can, for example, prohibit a lay corporation from practicing medicine or employing physicians, or
6 prohibit non-physicians or lay organizations from having an ownership interest in a physician
7 practice. The doctrine is based on concerns that: (1) allowing corporations to practice medicine or
8 employ physicians will result in the commercialization of the practice of medicine; (2) a
9 corporation’s obligation to its shareholders may not align with a physician’s obligations to his or
10 her patients; and (3) employment of a physician by a corporation may interfere with the physician’s
11 independent medical judgement.¹⁸

12
13 As delivery systems and physician employment arrangements have evolved over the years, so too
14 has the corporate practice of medicine doctrine. The health care environment is shifting toward
15 increased integration of care, with growth in both the number of employed physicians and
16 acquisitions of physician practices. These trends have led to formalized employment relationships
17 between physicians and non-physician entities, arrangements that in certain states may run afoul of
18 corporate practice of medicine policies. Council on Medical Service Report 6-I-13 addressed the
19 corporate practice of medicine.

20
21 **RELEVANT AMA POLICY**

22
23 Policy H-215.981 opposes federal legislation preempting state laws prohibiting the corporate
24 practice of medicine; states that the AMA will continue monitoring the corporate practice of
25 medicine and its effect on the patient-physician relationship, financial conflicts of interest, and
26 patient-centered care; and directs the AMA to provide guidance, consultation and model legislation
27 regarding the corporate practice of medicine, at the request of state medical associations, to ensure
28 the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and
29 physicians contracting with corporately-owned management service organizations. Under Policy
30 D-225.977, the AMA continues to assess the needs of employed physicians, ensuring physician
31 clinical autonomy and self-governance. Policy H-285.951 states that physicians should have the
32 right to enter into whatever contractual arrangements they deem desirable and necessary but should
33 be aware of potential conflicts of interest due to the use of financial incentives in the management
34 of care. Policy H-215.968 supports and encourages competition between and among health
35 facilities as a means of promoting the delivery of high-quality, cost-effective care. Antitrust relief
36 is a top AMA priority under Policy H-380.987.

37
38 AMA Principles for Physician Employment are outlined in Policy H-225.950. Policy H-225.997
39 addresses physician-hospital relationships, and Policy H-225.942 outlines physician and medical
40 staff rights and responsibilities. Policy H-225.947 encourages physicians who seek employment as
41 their mode of practice to strive for employment arrangements consistent with a series of principles,
42 including that: (a) physician clinical autonomy is preserved; (b) physicians are included and
43 actively involved in integrated leadership opportunities; (c) physicians are encouraged and
44 guaranteed the ability to organize under a formal self-governance and management structure;
45 (d) physicians are encouraged and expected to work with others to deliver effective, efficient and
46 appropriate care; (e) a mechanism is provided for the open and transparent sharing of clinical and
47 business information by all parties to improve care; and (f) a clinical information system
48 infrastructure exists that allows capture and reporting of key clinical quality and efficiency
49 performance data for all participants and accountability across the system to those measures. Policy
50 H-160.960 states that when a private medical practice is purchased by corporate entities, patients

1 shall be informed of the ownership arrangement by the corporate entities and/or the physician.
2 Truth in advertising is addressed by Policies H-410.951 and H-405.969.

3
4 AMA policy does not prohibit the application of restrictive covenants in the physician employment
5 context generally, although Policy H-225.950, “Principles for Physician Employment,” discourage
6 physicians from entering into agreements that restrict the physician’s right to practice medicine for
7 a specified period of time or in a specified area upon termination of employment. AMA Code of
8 Medical Ethics Opinion 11.2.3.1 states that covenants-not-to-compete restrict competition, can
9 disrupt continuity of care, and may limit access to care. Accordingly, physicians should not enter
10 into covenants that: (a) unreasonably restrict the right of a physician to practice medicine for a
11 specified period of time or in a specified geographic area on termination of a contractual
12 relationship; and (b) do not make reasonable accommodation for patients’ choice of physician. This
13 opinion also states that physicians in training should not be asked to sign covenants not to compete
14 as a condition of entry into any residency or fellowship program.

15
16 Policy H-140.984 opposes an across-the-board ban on self-referrals because of benefits to patients
17 including increased access to competition, and includes standards to ensure ethical and acceptable
18 financial arrangements. This policy states that the opportunity to invest in the medical or health
19 care facility established by a health care services financial arrangement should be open to all
20 individuals who are financially able and interested in an investment.

21 22 DISCUSSION

23
24 The Council’s study of corporate investors acquiring majority and/or controlling interest in entities
25 that manage physician practices was hindered by the lack of empirical evidence regarding the
26 impact of these practice models on physicians, patients, medical practice, and the costs and quality
27 of care. Although anecdotal information is available from affected specialties, there is not sufficient
28 data to draw meaningful or actionable conclusions. Nonetheless, the Council underscores the
29 paramount importance to this discussion of safeguarding patient-centered care, clinical governance
30 and physician autonomy in all physician practice arrangements, including those involving
31 corporate investors.

32
33 The Council also believes it is worth noting that physician opinions vary regarding corporate
34 investor involvement in physician practices. Although there has been a great deal of angst among
35 many physicians regarding private equity investments in practices, other physicians and physician
36 groups have readily partnered with these firms. Long-standing policy states that physicians are free
37 to choose their mode of practice and enter into contractual arrangements as they see fit, and it is
38 essential that the AMA maintain a leadership role that is uniting and supportive of all physicians
39 and care delivery models.

40
41 The Council recommends, therefore, reaffirmation of four existing AMA policies—on the
42 corporate practice of medicine, financial incentives, physician employment, and corporate
43 ownership of private medical practices—that are relevant to corporate investor relationships with
44 physician practices. Because physicians appear to be looking for guidance and solutions, the
45 Council also recommends a series of guidelines that it believes should be considered by physicians
46 who are contemplating corporate investor partnerships.

47
48 As previously noted, nondisclosure agreements are commonly used in private equity and corporate
49 investor transactions, and the Council believes that more information is needed regarding the
50 degree of corporate investment in physician practices and what this means for health care prices.
51 The lack of complete and accurate information may prevent health care markets from operating

1 efficiently and preclude patients from making informed decisions regarding low-cost, high-value
2 care. Accordingly, the Council recommends supporting improved transparency regarding corporate
3 investment in physician practices and subsequent changes in health care prices.

4
5 The Council recognizes that further study is needed on the impact of corporate investors, and
6 recommends encouraging national medical specialty societies to research and develop tools and
7 resources on the impact of corporate investor partnerships on patients and physicians.

8
9 Finally, the Council recommends rescinding Policy D-383.979, which led to the development of
10 this report.

11 RECOMMENDATIONS

12
13
14 The Council on Medical Service recommends that the following be adopted and the remainder of
15 the report be filed:

- 16
17 1. That our American Medical Association (AMA) reaffirm Policy H-215.981, which opposes
18 federal legislation preempting state laws prohibiting the corporate practice of medicine; states
19 that the AMA will continue monitoring the corporate practice of medicine and its effect on the
20 patient-physician relationship, financial conflicts of interest, and patient-centered care; and
21 directs the AMA to provide guidance, consultation and model legislation regarding the
22 corporate practice of medicine, at the request of state medical associations, to ensure the
23 autonomy of hospital medical staffs, employed physicians in non-hospital settings, and
24 physicians contracting with corporately-owned management service organizations. (Reaffirm
25 HOD Policy)
- 26
27 2. That our AMA reaffirm Policy H-225.950, which affirms that a physician's paramount
28 responsibility is to his or her patients, and which outlines principles related to conflicts of
29 interest and contracting. (Reaffirm HOD Policy)
- 30
31 3. That our AMA reaffirm Policy H-285.951, which states that physicians should have the right to
32 enter into whatever contractual arrangements they deem desirable and necessary but should be
33 aware of potential conflicts of interest due to the use of financial incentives in the management
34 of medical care. (Reaffirm HOD Policy)
- 35
36 4. That our AMA reaffirm Policy H-160.960, which states that when a private medical practice is
37 purchased by corporate entities, patients shall be informed of the ownership arrangement by the
38 corporate entities and/or the physician. (Reaffirm HOD Policy)
- 39
40 5. That our AMA encourage physicians who are contemplating corporate investor partnerships to
41 consider the following guidelines:
 - 42
43 a. Physicians should consider how the practice's current mission, vision, and long-term
44 goals align with those of the corporate investor.
 - 45
46 b. Due diligence should be conducted that includes, at minimum, review of the corporate
47 investor's business model, strategic plan, leadership and governance, and culture.
 - 48
49 c. External legal, accounting and/or business counsels should be obtained to advise
50 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.

- 1 e. Physicians should consider whether and how corporate investor partnerships may
2 require physicians to cede varying degrees of control over practice decision-making
3 and day-to-day management.
- 4 f. Physicians should consider the potential impact of corporate investor partnerships on
5 physician and practice employee satisfaction and future physician recruitment.
- 6 g. Physicians should have a clear understanding of compensation agreements,
7 mechanisms for conflict resolution, processes for exiting corporate investor
8 partnerships, and application of restrictive covenants.
- 9 h. Physicians should consider corporate investor processes for medical staff
10 representation on the board of directors and medical staff leadership selection.
- 11 i. Physicians should retain responsibility for clinical governance, patient welfare and
12 outcomes, physician clinical autonomy, and physician due process under corporate
13 investor partnerships. (New HOD Policy)
- 14
- 15 6. That our AMA support improved transparency regarding corporate investment in physician
16 practices and subsequent changes in health care prices. (New HOD Policy)
- 17
- 18 7. That our AMA encourage national medical specialty societies to research and develop tools
19 and resources on the impact of corporate investor partnerships on patients and the physicians in
20 practicing in that specialty. (New HOD Policy)
- 21
- 22 8. That our AMA support consideration of options for gathering information on the impact of
23 private equity and corporate investors on the practice of medicine. (New HOD Policy)
- 24
- 25 9. That our AMA rescind Policy D-383.979, which requested this report. (Rescind HOD Policy)

Fiscal Note: Less than \$500.

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https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/arc/corporate-practice-of-medicine-issue-brief_1.pdf.

APPENDIX

Corporate Practice of Medicine H-215.981

1. Our AMA vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine. 2. At the request of state medical associations, our AMA 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. 3. 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.

AMA Principles for Physician Employment H-225.950

1. Addressing Conflicts of Interest

a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her 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. b) Employed physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter 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. c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority. d) 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. (i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and (ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her 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 he or she generates, 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 his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her 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 his or her 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 his or her 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 his or her 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; and 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; and 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.

Financial Incentives Utilized in the Management of Medical Care H-285.951

Our AMA 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.

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.