

Investor Ownership and Influence in Healthcare Working Group

November 6, 2026

Today's Objectives

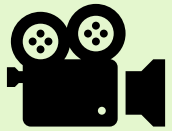
- Review what is currently known about **private equity activity and reach in Minnesota's healthcare system**
- Outline the **current landscape** of physician practices and other outpatient facilities in Minnesota, including trends in consolidation and declines in independent ownership
- Review the **current Minnesota policy landscape** relevant to investor ownership and influence in healthcare, including corporate practice of medicine and healthcare transaction oversight laws
- Identify the range of short- and longer-term **policy options** for addressing issues and concerns related to investor ownership and influence in Minnesota's healthcare market

Today's Agenda

- Welcome and Introduction – CHCA
- Working Group Status Update and Roadmap – CHCA
- What We Know, What We Can Track, and Current Oversight in Minnesota – CAHPR
- Landscape of Physician Practices and Other Outpatient Facilities in Minnesota – Mathematica
- Break
- State Policy Options to Improve Oversight of Investor Influence in Outpatient Clinics – CAHPR
- Closing and Next Steps – CHCA

Housekeeping

- Slides will be available on the Center's website
- Bathrooms are outside the room at the end of the hallway
- Please remain on mute when not speaking
- Tech problems? Please try logging back in, or email Health.Affordability@state.mn.us.



This meeting is being recorded.



Closed captioning is available.

Key Takeaways from September Meeting

- The working group's interest is increasingly centered on problematic behaviors and market effects, **not on regulating a particular entity or ownership type**
- The working group should remain focused, at least in the short term, on **non-hospital settings**. Broader implications can be discussed where a behavior or policy response extends beyond that scope
- The working group members want a balanced discussion that recognizes **potential benefits of private investment as well as documented risks** and avoids assuming all investor-backed arrangements operate in the same way
- The working group needs to better understand **what we know and don't know about investor influence** in Minnesota
- The group must be aware of **unintended consequences of any policy**, such as whether restrictions in one part of the market or targeted to one specific financial entity (e.g. private equity) could shift consolidation toward hospitals, insurers, or other corporate owners

Working Group Roadmap

- **Meeting 1 (September 24):** Level-set on private equity and other forms of investor influence, including ownership and management structures, evidence on impacts, and Minnesota-specific context
- **Meeting 2 (November 6, Today):** Focus on what is known about Minnesota's non-hospital commercial market; review current oversight and data gaps; and introduce potential policy responses for discussion
- **Meeting 3 (December 9):** Refine and compare policy options, including short- and longer-term approaches, and decide on policy recommendations

Preview: State Policy Options to Address Investor Influence Over Physicians

	Policy Approach	Policy Concerns
	**1. Health Care Transaction Oversight Authority**	Consolidation, change of control, price increases, affordability
	**2. Strengthening the Prohibition on Corporate Practice of Medicine**	Professional autonomy, workforce effects, interference with clinical decision-making
	**3. Ownership Transparency**	Opacity, lack of accountability
	**4. Site-Neutral Payment Policies**	Added fees from vertical physician consolidation

NASHP Resources: Model Law to Address Consolidation, CPOM, Transparency ; Model Law on Site-Neutral Payment

CAHPR CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH

Questions for Discussion: Key Takeaways and Roadmap

- What questions do you have about the key takeaways from the September meeting and roadmap?



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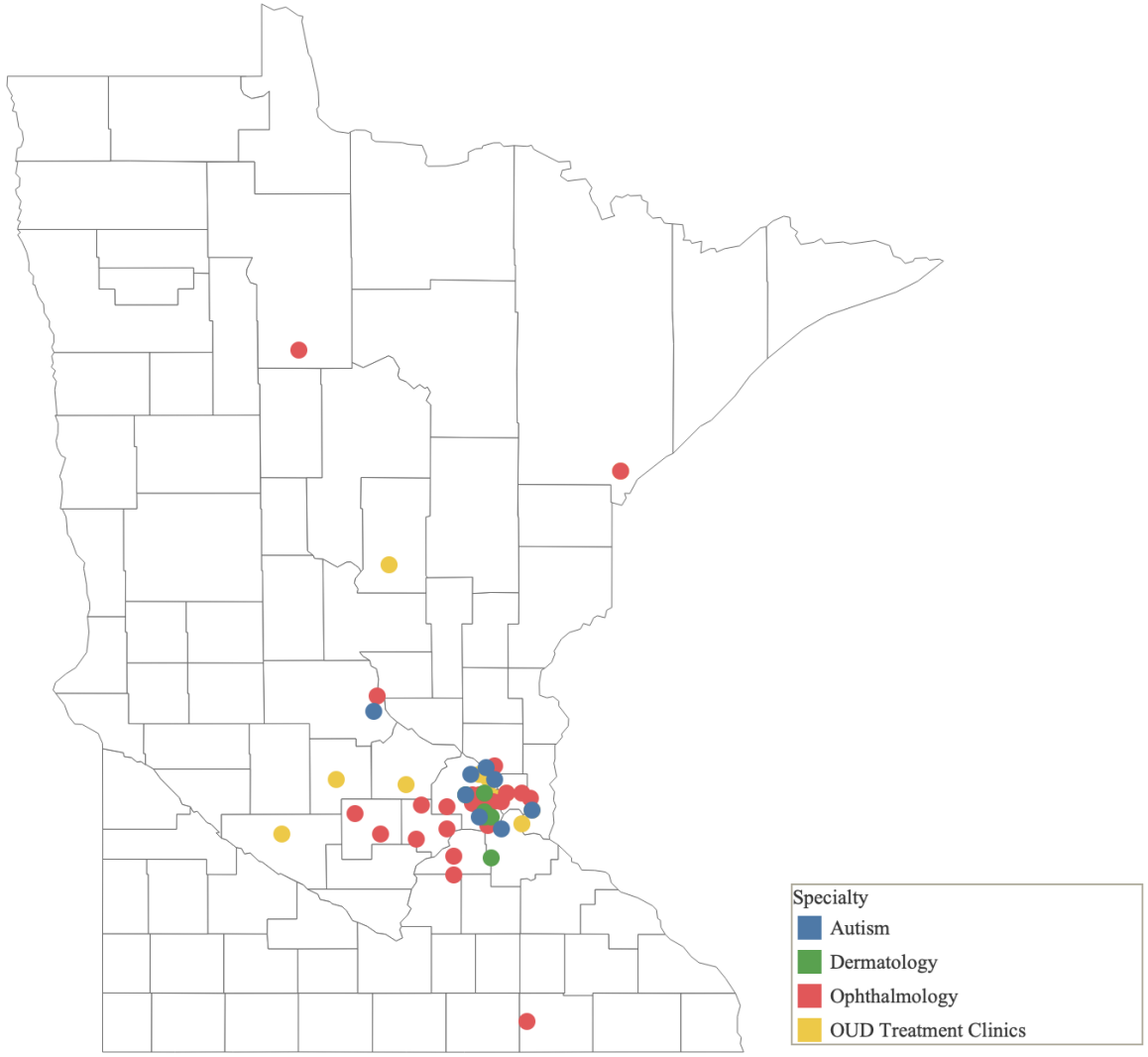
School of Public Health
BROWN UNIVERSITY

What We Know, What We Can Track, and Current Oversight in Minnesota

November 6, 2026

Yashaswini Singh, PhD
Center for Advancing Health Policy Through Research (CAHPR)
Brown University School of Public Health

Geographic distribution of PE-acquired outpatient locations in Minnesota, 2015 to present



Specialty	Locations	Counties
Ophthalmology	27	11
Opioid use disorder (OUD) treatment	13	9
Autism therapy	9	5
Dermatology	7	2
Total	**56**	**16**

- **16 of 87** Minnesota counties have at least one PE-acquired location.
- **43 of 56 locations (77%)** are in the seven-county Twin Cities metro, home to about 55% of Minnesotans.
- Outside the Twin Cities metro, **13 locations**, mostly OUD treatment and ophthalmology, in St. Cloud, Duluth, Bemidji, Brainerd, Austin and nearby small towns.

Twin Cities metro = the seven counties surrounding Minneapolis and St. Paul: Hennepin (includes Minneapolis), Ramsey (includes St. Paul), Anoka, Carver, Dakota, Scott and Washington. Source: CAHPR PE acquisition dataset, 2015 to 2026; U.S. Census Bureau population estimates.

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PE acquisitions were identified in 4 of 12 outpatient specialties examined

Minnesota, 2015 to present

PE acquisitions identified in

Specialty	Locations
Ophthalmology	27
OUD treatment	13
Autism therapy (ABA)	9
Dermatology	7

No PE acquisitions identified in

Specialty	Specialty
Radiology	Primary care
Gastroenterology	Orthopedics
Cardiology	Physical therapy
Oncology	Obstetrics and gynecology

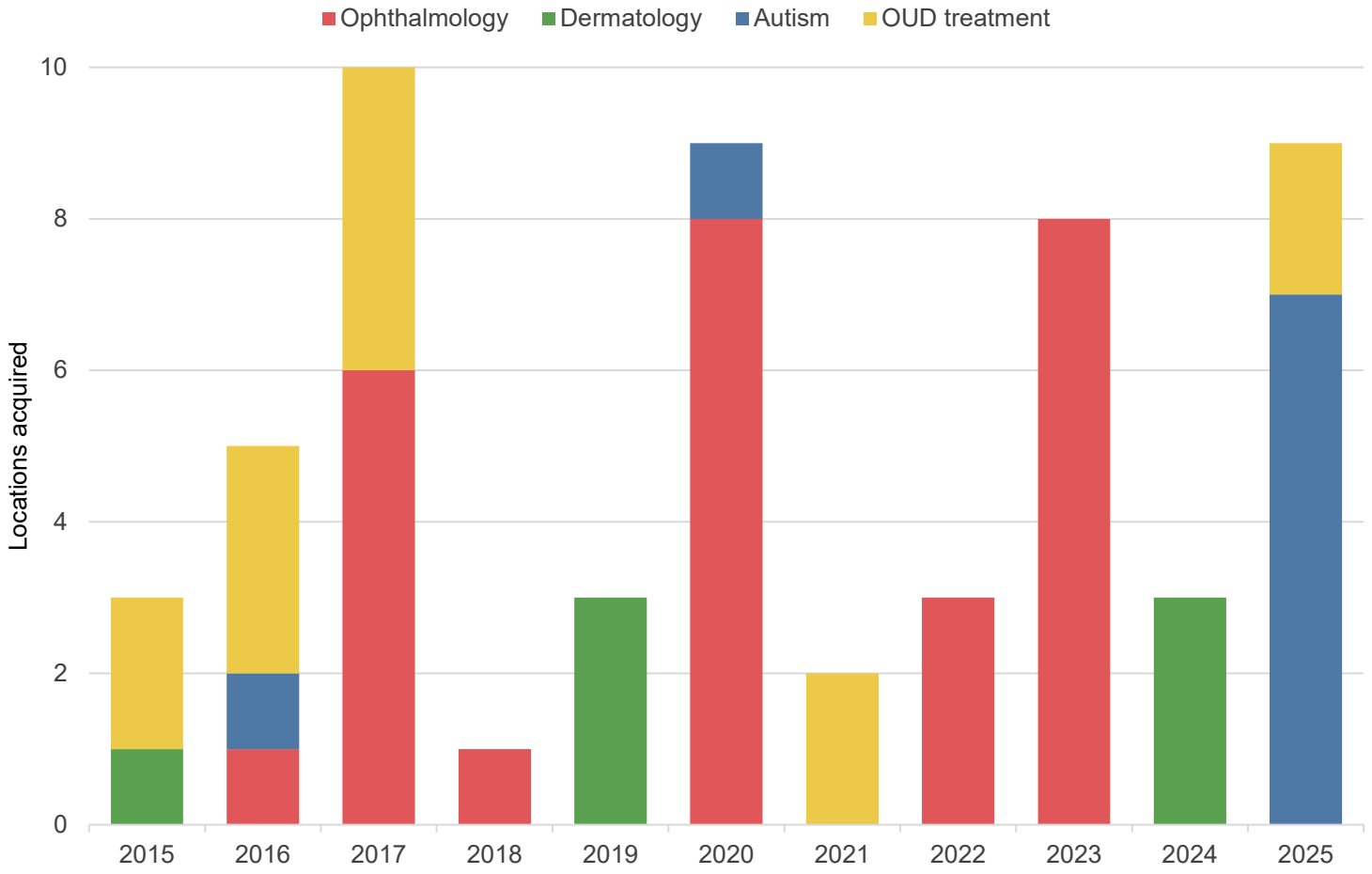
- Nationally, dermatology, gastroenterology and ophthalmology have the highest PE penetration among physician specialties, and penetration is lowest in the Midwest (Singh et al., 2022).
- "Not identified" means no transaction was found in available sources (i.e., Pitchbook and other secondary sources such as press releases and industry reports).

Source: CAHPR PE acquisition dataset (PitchBook, press releases, company websites), 2015 to 2026.

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PE acquisitions of outpatient locations in Minnesota by year, 2015 to 2025

Number of locations acquired each year, by specialty; one transaction can include several locations or add-ons



Largest acquisition years

- **2017 (10):** Minnesota Eye Consultants (6 locations); New Beginnings OUD clinics (4)
- **2020 (9):** Vitreoretinal Surgery, a retina practice (8)
- **2023 (8):** Southwest Eye Care (8)
- **2025 (9):** Behavior Frontiers autism centers (7); Gateway Recovery Center OUD clinics (2)

No 2026 acquisitions recorded as of October 2026. Source: CAHPR PE acquisition dataset, 2015 to 2026.

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PE-acquired outpatient locations by specialty and region

Minnesota, locations acquired 2015 to present

Specialty	Locations	Counties	Twin Cities metro	Rest of Minnesota	Resold or closed
Ophthalmology	27	11	21	6	13
OUD treatment	13	9	7	6	9
Autism therapy	9	5	8	1	1
Dermatology	7	2	7	0	4
Total	**56**	**16**	**43**	**13**	**27**

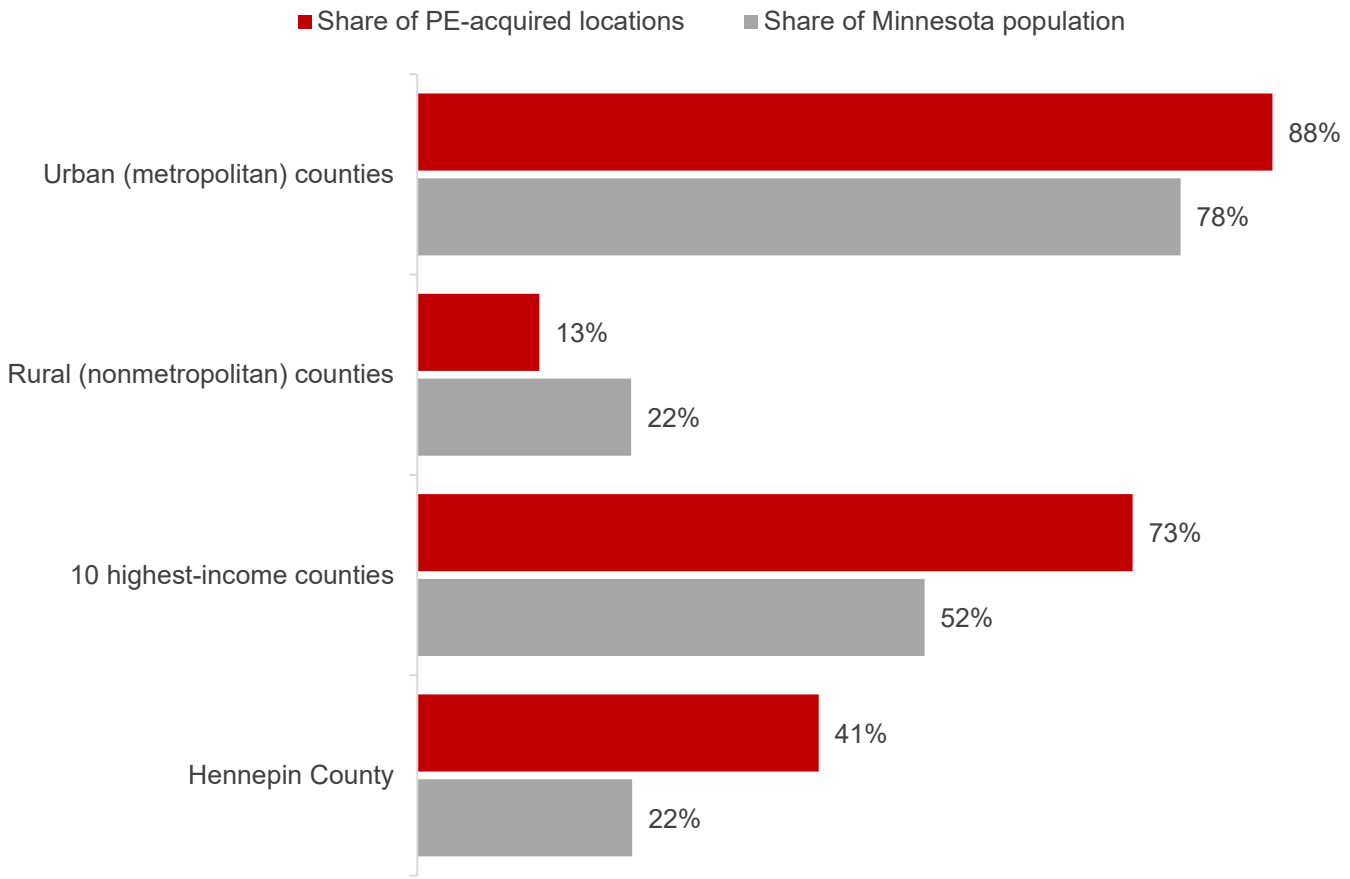
- Ophthalmology accounts for nearly half of all locations (27 of 56) and has the widest geographic reach (11 counties).
- Dermatology and autism therapy are almost entirely in the Twin Cities suburbs; OUD treatment is split evenly between the metro and the rest of the state.
- 27 of 56 locations have already been sold to a new owner or closed.

Source: CAHPR PE acquisition dataset, 2015 to 2026.

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PE-acquired locations are concentrated in urban and higher-income counties

Share of PE-acquired locations (n = 56) compared with share of Minnesota population



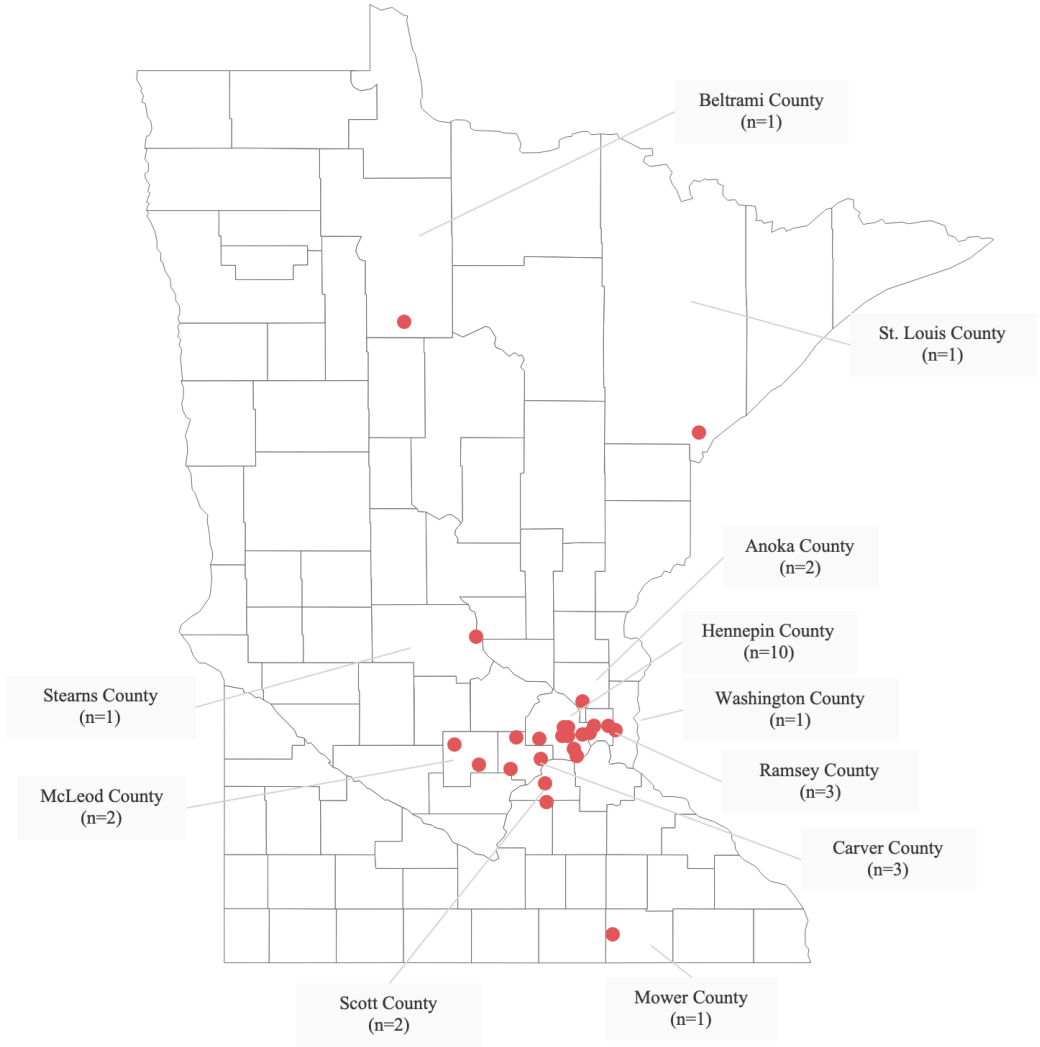
- **Urban areas:** 88% of PE-acquired locations are in urban counties, where 78% of Minnesotans live. Only 7 locations are in rural counties.
- **Higher-income counties:** the 10 highest-income counties have about half the state's population but nearly three quarters of the locations.
- **Hennepin County:** it has 22% of the state's population but 41% of the locations. Most are in suburbs such as Edina, Bloomington and Plymouth rather than in Minneapolis.

Sources: CAHPR PE acquisition dataset; urban/rural from OMB 2023 metropolitan area delineations; population from U.S. Census Bureau county estimates; income from American Community Survey 2020 to 2024 5-year estimates.

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Ophthalmology: the largest PE presence in Minnesota

Ophthalmology locations acquired 2015 to present



27 locations

11 counties

6 outside Twin Cities metro

PE platforms and acquisitions

Platform Company	Year Acquired	No. of PE affiliated locations	Exit Status
Unifeye Vision Partners	2017-23	16	Under Same PE ; 3 locations closed
Retina Consultants of America	2020	8	Sale to Strategic, 2025
Shopko Optical	2022	2	Sold to Strategic, 2024
Vision Group Holdings	2016	1	Under Same PE

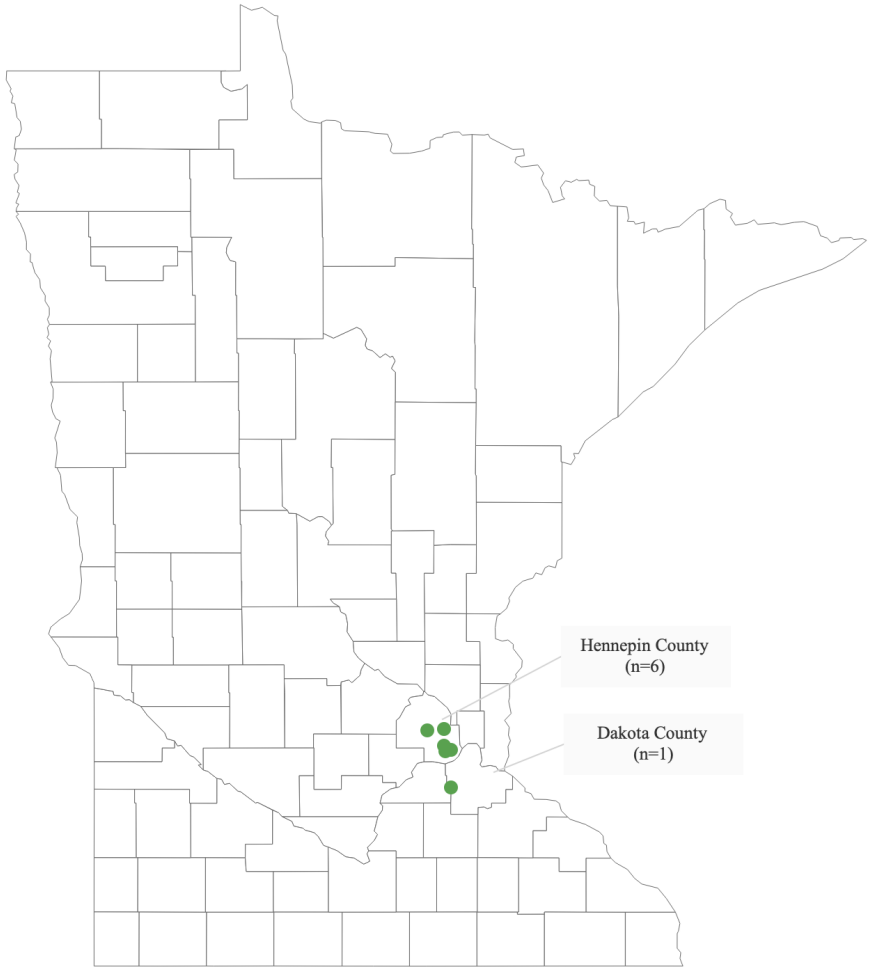
- **Twin Cities metro (21):** mostly suburbs: Bloomington, Edina, Minnetonka, Plymouth, Blaine, Chaska.
- **Rest of state (6):** St. Cloud, Hermantown (Duluth area), Bemidji, Austin, Hutchinson, Glencoe.

Source: CAHPR PE acquisition dataset (PitchBook, press releases, company websites).

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Dermatology: PE presence limited to Twin Cities suburbs

Dermatology locations acquired 2015 to present



7 locations

2 counties

0 outside Twin Cities metro

PE platforms and acquisitions

Platform Company	Year Acquired	No. of PE affiliated locations	Exit Status
United Skin Specialists	2015	1	Sale to PE, 2023
Pinnacle Dermatology	2019	3	Sale to PE, 2021
Schweiger Dermatology Group	2024	2	Under Same PE
Epiphany Dermatology	2024	1	Under Same PE

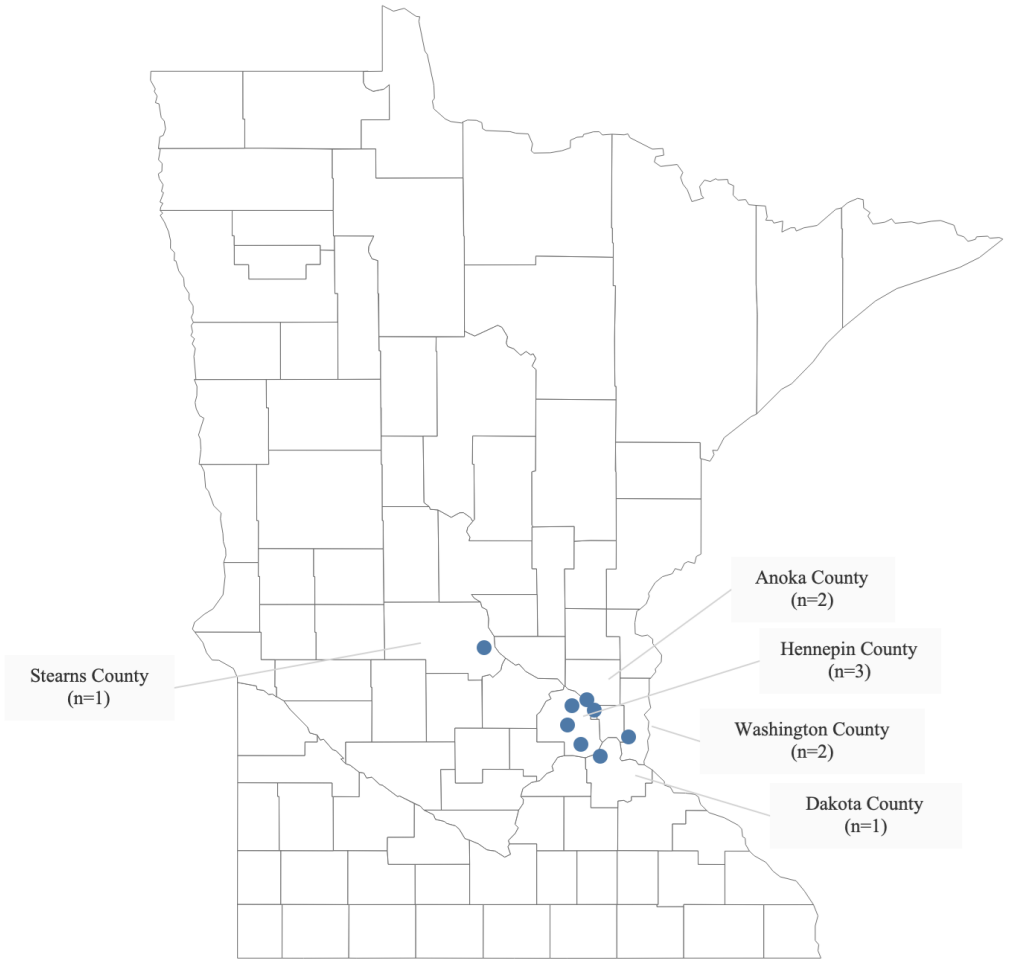
- **All 7 locations are suburban:** Edina (3), Plymouth, Crystal, Richfield (Hennepin); Lakeville (Dakota). Both counties rank in the top 10 for median household income.
- 4 of 7 locations have already been sold from one PE firm to another.

Source: CAHPR PE acquisition dataset (PitchBook, press releases, company websites).

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Autism therapy: rapid PE entry since 2025

Applied behavior analysis (ABA) therapy locations acquired 2015 to present



Note: Two Washington County locations overlap and may appear as one map point.

9 locations

5 counties

7 added in 2025

PE platforms and acquisitions

Platform Company	Year Acquired	No. of PE affiliated locations	Exit Status
Behavior Frontiers	2025	7	Under Same PE
The Family Treatment	2016	1	Under Same PE
Caravel Autism Health	2020	1	Sale to PE, 2024

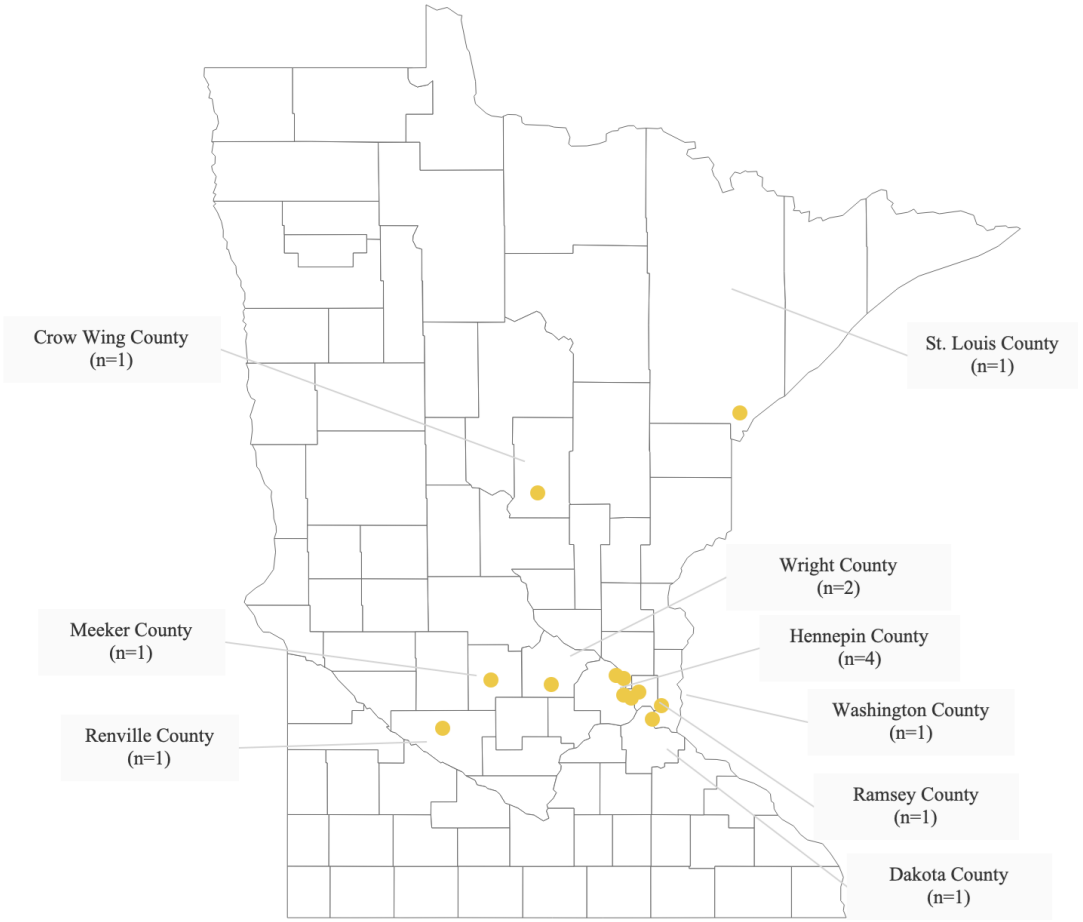
- **Twin Cities suburbs (8):** Plymouth, Maple Grove, Edina, Coon Rapids, Fridley, Eagan, Woodbury (2). None in Minneapolis or St. Paul.
- **Rest of state (1):** St. Cloud.

Source: CAHPR PE acquisition dataset (PitchBook, press releases, company websites).

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OUD treatment: widest PE reach outside the Twin Cities

OUD treatment clinic locations acquired 2015 to present (excludes 4 locations PE-owned since 2001)



Note: Two Wright County locations overlap and may appear as one map point

13 locations

9 counties

6 outside Twin Cities metro

PE platforms and acquisitions

Platform Company	Year Acquired	No. of PE affiliated locations	Exit Status
Behavioral Health Group	2015	2	Sale to PE, 2018; 1 location closed
EOSIS (Valhalla Place)	2016	3	Sale to PE (Behavioral Health Group), 2021
EOSIS (New Beginnings)	2017	4	Sale to PE (Renovus Capital), 2023
Community Medical Services	2021	2	Under Same PE

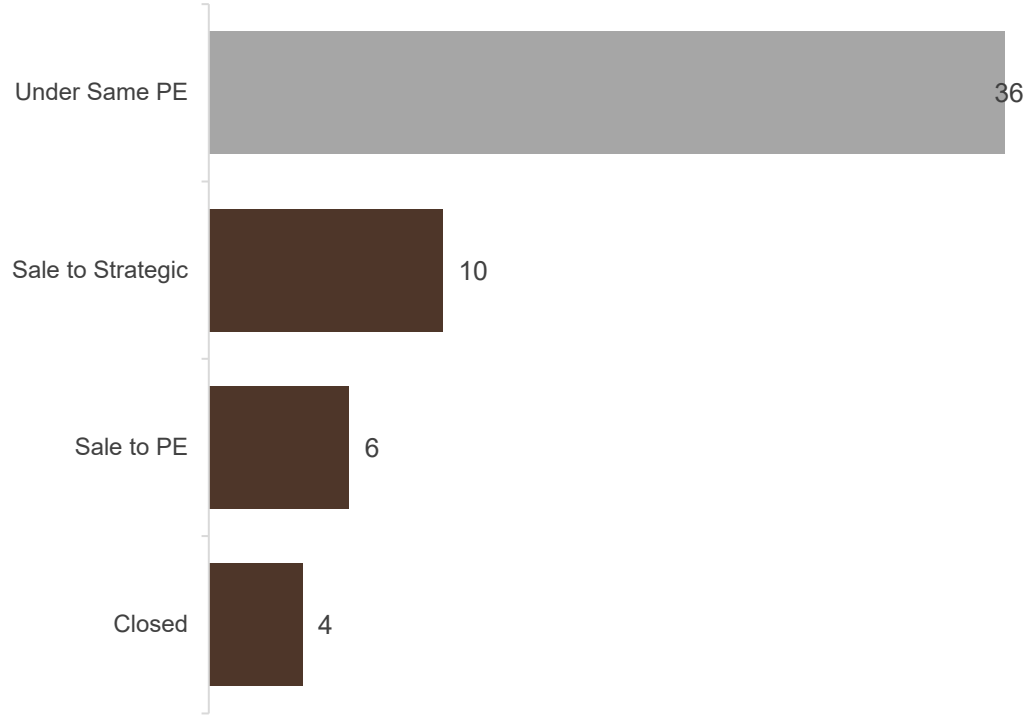
- **Twin Cities metro (7):** Minneapolis (2), Brooklyn Park (2), Roseville, Woodbury, Inver Grove Heights.
- **Rest of state (6):** Brainerd, Waverly (2), Litchfield, Olivia, Duluth (closed).
- In small counties such as Renville (Olivia) and Meeker (Litchfield), a single clinic may represent much of local treatment capacity.

Source: CAHPR PE acquisition dataset (PitchBook, press releases, company websites).

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Nearly half of PE-acquired locations have been resold or closed

Ownership status of the 56 locations acquired 2015 to present



Closed: 3 Minnesota Eye Consultants locations (Maplewood, Minneapolis, Falcon Heights) and Lake Superior Treatment Center (Duluth).

Platform Company	Exit Type	Year	Years held	Loc.
Retina Consultants of America	Sale to Strategic	2025	4.3	8
EOSIS (New Beginnings sites)	Sale to PE	2023	5.9	4
EOSIS (Valhalla Place sites)	Sale to PE	2021	5.4	3
Pinnacle Dermatology	Sale to PE	2021	1.8-2.0	3
Shopko Optical	Sale to Strategic	2024	2.3	2
United Skin Specialists	Sale to PE	2023	8.3	1
Behavioral Health Group	Sale to PE	2018	3.7	1

- Most resales occurred 2 to 4.5 years after acquisition, consistent with typical PE holding periods.

Source: CAHPR PE acquisition dataset (PitchBook, press releases, company websites).

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What the evidence can and cannot tell us, by specialty

National studies of price and spending effects, and Minnesota-specific evidence

Specialty	Minnesota presence	National evidence on prices and spending
Ophthalmology	27 locations; acquisitions through 2023	Retina: higher Medicare spending on injectable drugs (Singh 2023). General ophthalmology: little change in Medicare spending (Braun 2024). Pooled with dermatology and GI: commercial prices +11% (Singh 2022)
Dermatology	7 suburban locations	Routine visit prices +3% to 5% (Braun 2021); pooled +11% (Singh 2022)
Autism therapy	9 locations; 7 since 2025	National growth documented (Singh 2026); effects on prices or spending not yet studied
OUD treatment	13 locations; widest reach outside metro	No change in methadone supply or opioid mortality after acquisition; prices not studied (Singh 2025)

References:

- Singh Y, Aderman CM, Song Z, Polsky D, Zhu JM. Increases in Medicare spending and utilization following private equity acquisition of retina practices. *Ophthalmology*. Published online August 7, 2023.
- Braun RT, Lelli GJ, Pandey A, Zhang M, Winebrake JP, Casalino LP. Association of private equity firm acquisition of ophthalmology practices with Medicare spending and utilization of ophthalmology services. *Ophthalmology*. 2024;131(3):360-369. doi:10.1016/j.ophtha.2023.09.029
- Braun RT, Bond AM, Qian Y, Zhang M, Casalino LP. Private equity in dermatology: effect on price, utilization, and spending. *Health Affairs*. 2021;40(5):727-735. doi:10.1377/hlthaff.2020.02062
- Singh Y, Song Z, Polsky D, Bruch JD, Zhu JM. Association of private equity acquisition of physician practices with changes in health care spending and utilization. *JAMA Health Forum*. 2022;3(9):e222886. doi:10.1001/jamahealthforum.2022.2886
- Singh Y, et al. Private equity in autism services. *JAMA Pediatrics*. Published online January 5, 2026. doi:10.1001/jamapediatrics.2025.5443
- Singh Y, Cantor JH, Whaley CM, Shuey B, Bilden RC, Donahoe JT. Private equity acquiring large shares of the opioid treatment market without changing market-level methadone supply. *Health Affairs*. 2025;44(9):1181-1189. doi:10.1377/hlthaff.2025.00326

Data gaps limit a Minnesota-specific assessment

What prevents a clear assessment of the risks and impacts of PE ownership in Minnesota

Gap	Why it matters
No ownership registry	Minnesota has no public, comprehensive record of who owns outpatient practices. Our counts rely on commercial databases, press releases and websites, and are a lower bound.
Transaction notices	Minn. Stat. 145D.01 and 145D.02 (2023) require advance notice of certain health care transactions to the Attorney General and/or MDH, but submitted information is generally nonpublic.
No denominators	Without a count of all practices in each specialty linked to ownership, PE market share cannot be calculated.
No Minnesota price analysis yet	National studies use commercial and Medicare claims. Minnesota's All Payer Claims Database (MN APCD) has not been linked to ownership data yet.
Opaque exits and structures	Management services organization (MSO) arrangements can obscure who controls a practice.
Outcomes beyond price	Quality, access, staffing and wait times at PE-owned Minnesota locations have not been measured.

Summary

- **Limited but active:** 56 PE-acquired outpatient locations since 2015, in 4 of 12 specialties examined and 16 of 87 counties; 9 locations were acquired in 2025.
- **Geographically concentrated:** 77% of locations are in the seven-county Twin Cities metro (55% of Minnesotans); Hennepin County holds 41%, mostly in suburbs.
- **Urban and higher-income:** 88% of locations are in urban counties and 73% in the 10 highest-income counties.
- **Outside the metro:** mainly OUD treatment and ophthalmology, in regional cities and small towns.
- **Rapid ownership change:** 27 of 56 locations have been resold or closed.
- **Evidence gap:** national studies show price increases in physician specialties; Minnesota-specific effects, and effects in autism and OUD treatment, are not yet measured.

Questions for Discussion: What We Know About Private Equity Involvement

- What questions do you have about the presentation?
- What would you be interested in learning more about?



Landscape of Physician Practices and Other Outpatient Facilities in Minnesota

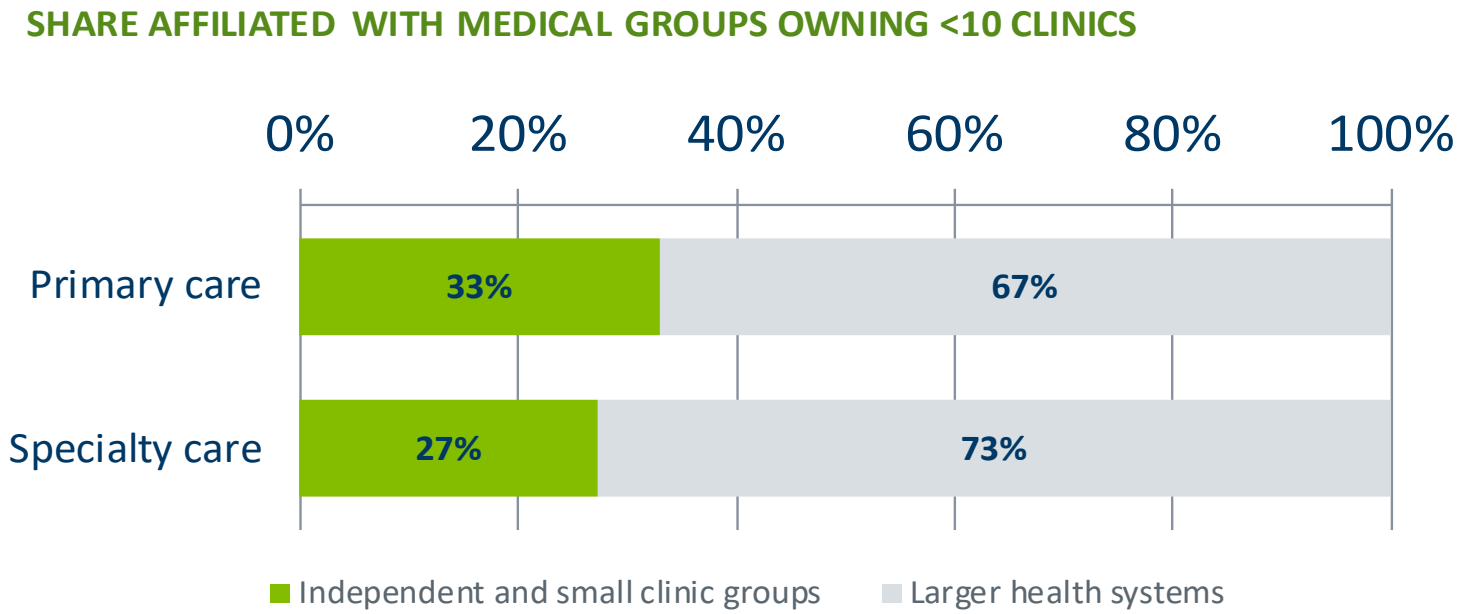
Julie Sonier | Mathematica

Understanding Minnesota's Oversight of Physician Clinics

- Physician clinics are not required to be licensed in Minnesota, so there is no comprehensive oversight and reporting as there is with other types of facilities
- Data about physician clinics comes mainly from Minnesota's Statewide Quality Reporting and Measurement System (SQRMS), which requires physician clinics to report annually on clinic locations and specialties
- This data provides little insight into ownership structures, affiliations, and the influence of investors or other corporate entities

What We Know About Minnesota Physician Clinics

- In 2023 there were more than **1,500 registered clinics** in Minnesota
  - **599** are primary care and are owned by 102 different medical groups
  - **925** are specialty care and are owned by 122 different medical groups

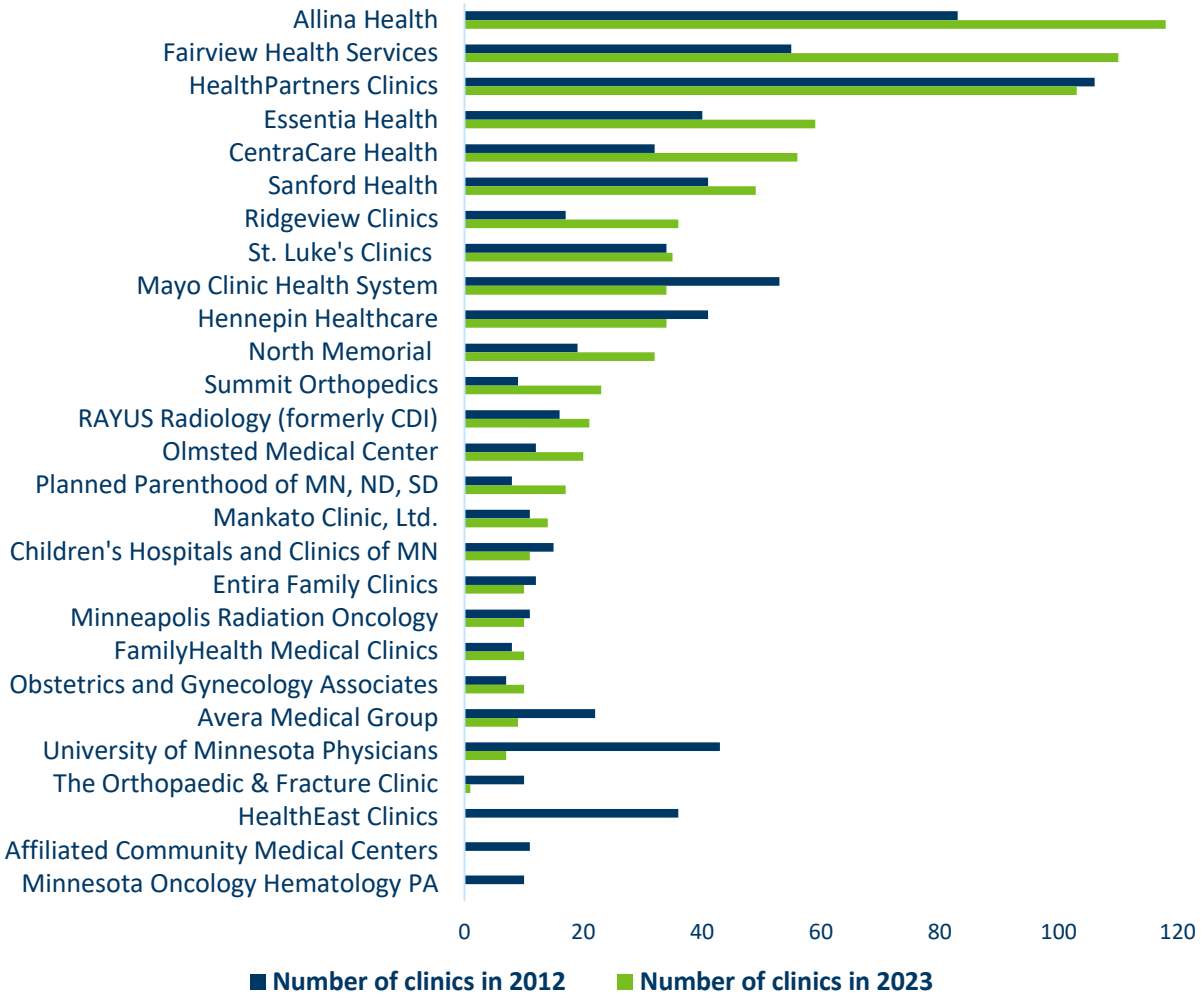


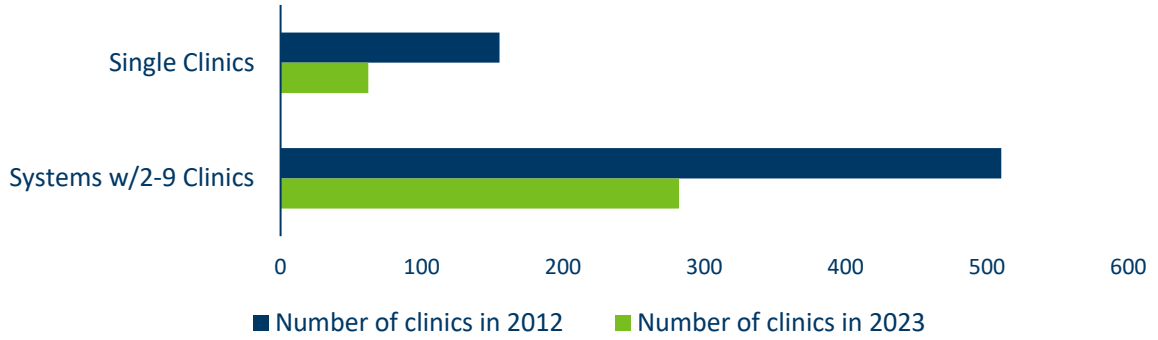
40% **of primary-care clinics are affiliated with the five largest systems**

Allina • Fairview • Essentia • CentraCare • HealthPartners*

Notes: HealthPartners Clinics include Park Nicollet Health Services.
Source: MDH Health Economics Program analysis of the 2023 Physician Clinic Registry collected under Minnesota Statutes, Section 62U.02, Oct. 2024.

Physician Clinic Consolidation, 2012 to 2023



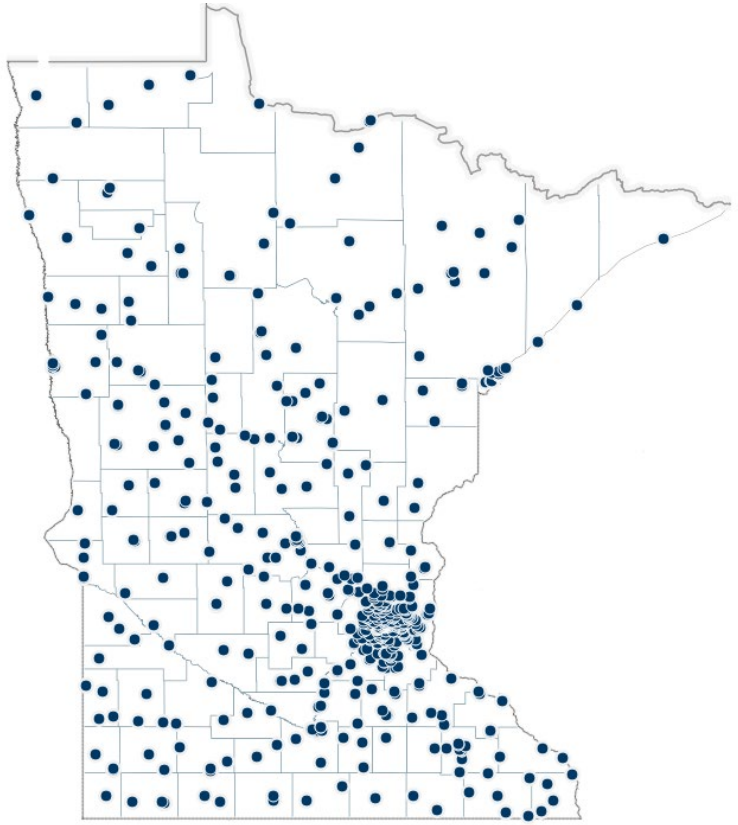


- Between 2012 and 2023, larger health systems (10 or more clinics) increased the overall share of clinics they own.
- At the same time, there has been a notable decrease in independent clinics (not aligned with medical group networks) (decreasing 60%) and clinics affiliated with small clinic groups (2-9 clinics) (decreasing 45%).

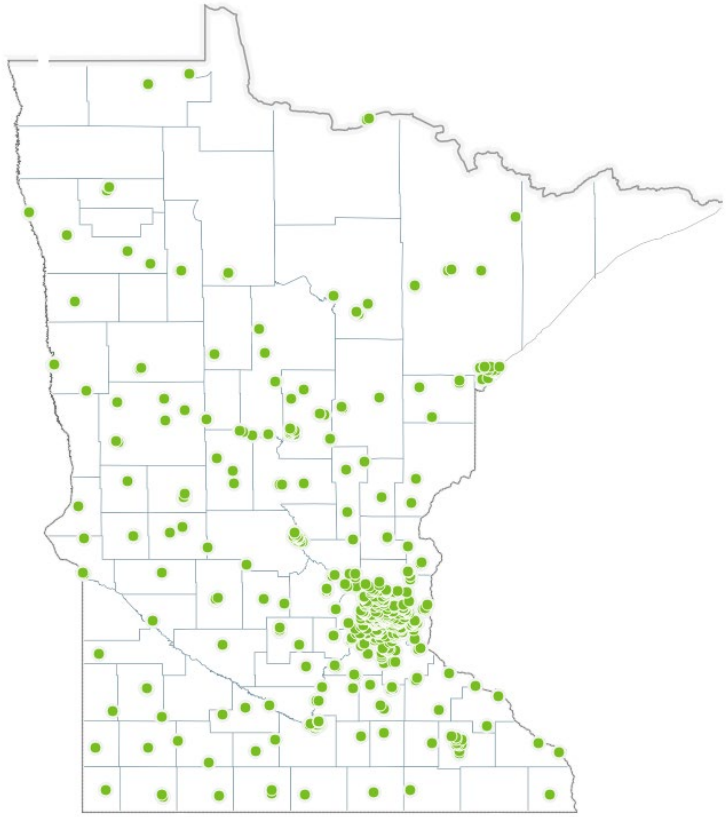
Notes: HealthPartners Clinics include Park Nicollet Health Services.
Source: MDH Health Economics Program analysis of the 2012 and 2023 Physician Clinic Registries collected under Minnesota Statutes, Section 62U.02.

Primary and specialty clinics are available throughout Minnesota

Primary Care Clinics, 2023



Specialty Care Clinics, 2023



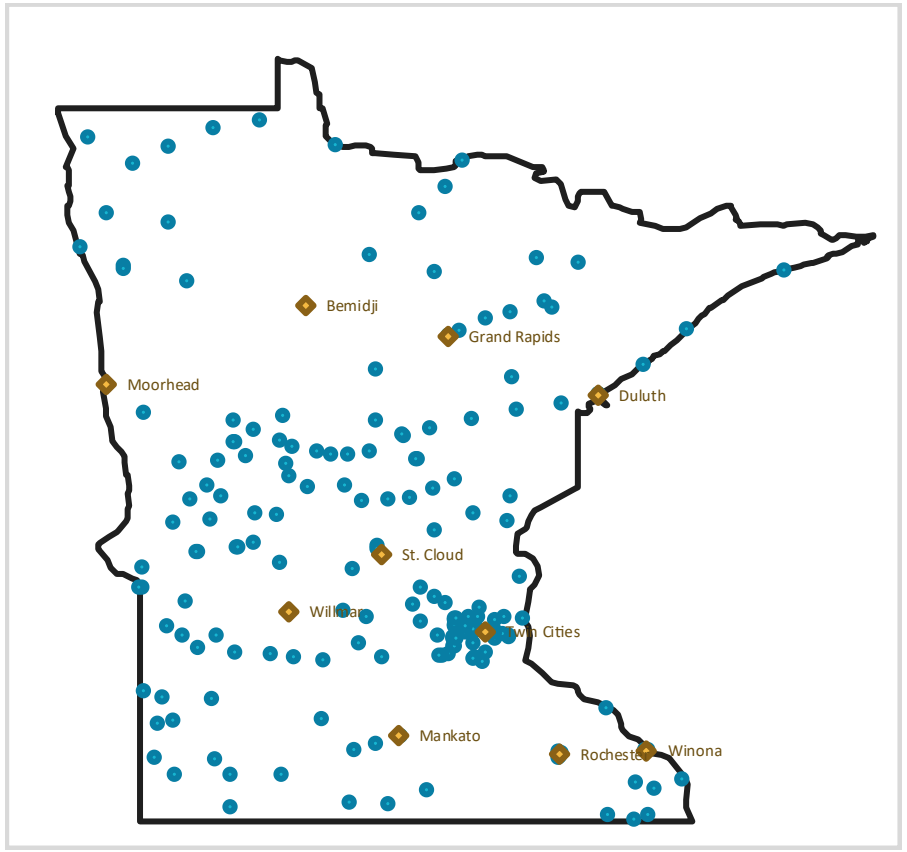
- 40% (241) of all primary care clinics (599) are located in rural areas.[1]
- 22% (196) of all specialty care clinics (907) are located in rural areas. [1]

Map notes: Each dot represents one clinic. This does not account for patient population or number of practicing physicians. Primary care clinics include clinics that provide family medicine, internal medicine, and/or pediatrics. Specialty care clinics include clinics that provide one or more non-primary care specialty. Clinics that provide both a primary care specialty and a non-primary care specialty are included in both groups of clinics.

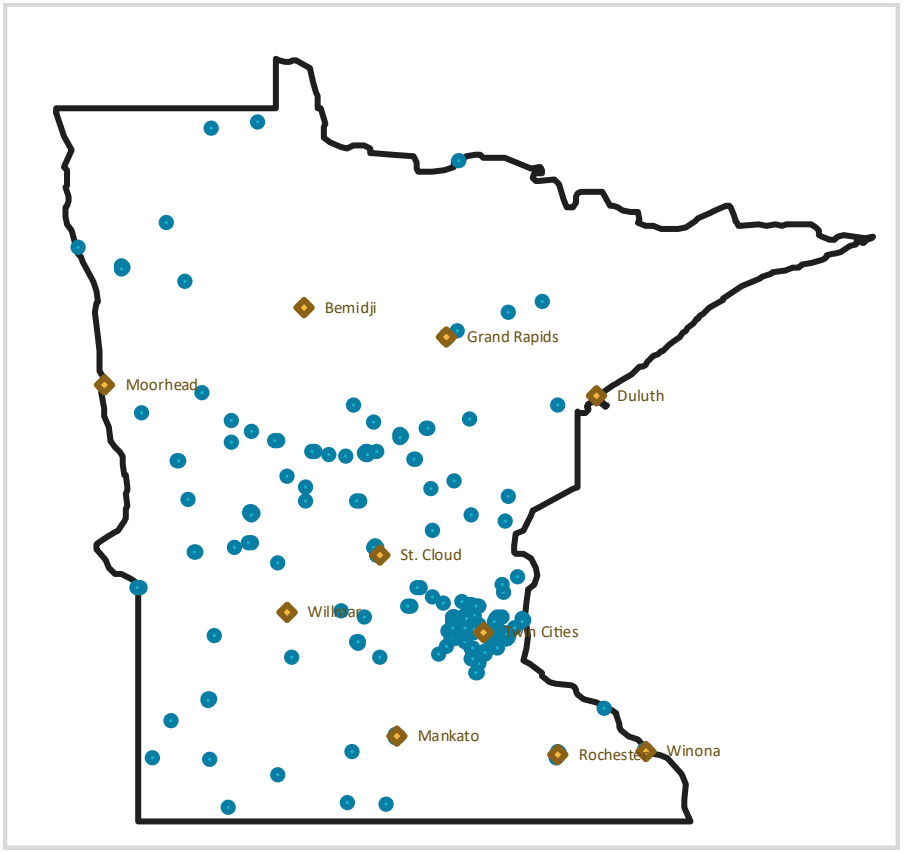
[1] Source: MDH Health Economics Program analysis of the Minnesota Statewide Quality Reporting and Measurement System 2023 Physician Clinic Registry; also source for maps.

Geographic Distribution of Primary Care and Specialty Clinics for Medical Groups with Fewer Than 10 Clinics, 2023

Primary care clinics in medical groups with fewer than 10 clinics



Specialty care clinics in medical groups with fewer than 10 clinics



Source: MDH Health Economics Program analysis of the 2023 Physician Clinic Registries collected under Minnesota Statutes, Section 62U.02.

What We Know About Ownership of Surgical Centers and Diagnostic Imaging Centers

- MDH annually collects data from all freestanding outpatient surgical centers (FOSC) and diagnostic imaging facilities
  - Currently, there are over **80 FOSCs** and over **250 diagnostic imaging facilities**
- As part of this data collection, MDH receives data related to:
  - Facility type
  - Facility name
  - Affiliation
  - Geographic location

Source: MDH

What We Don't Know About Ownership of Physician Practices and Other Outpatient Facilities

- Ownership and affiliations are opaque and challenging to discern
- Other existing data sources can sometimes supplement the MDH data to identify the parent company, agent, or manager of an organization
  - Can be a starting point for investigation but it is time consuming and resource intensive to determine affiliations with private equity or other corporate interests if they are not listed as a parent company, agent, or manager
  - Often owners are listed as LLCs or not at all
- Individuals with 10 percent or greater financial or economic interest in an imaging facility are required to report to MDH
  - Offers additional opportunities to review financial stake in centers, but may not fully capture the extent of investor involvement

Key Takeaways

- Physician clinic ownership is concentrated among **larger non-profit health systems**
- Consolidation has increased since 2012, while the **number of independent and smaller medical groups has declined**
- Many clinics remain part of smaller medical groups and **could be targets for acquisition or affiliation** with larger health systems or other corporate entities
- Available information on freestanding outpatient surgical centers and diagnostic imaging facilities provides **limited insight into their ultimate ownership, affiliations, and relationships with investors**
- Existing data provide a starting point, but important gaps remain. Additional information on ownership and management relationships is needed to assess the **extent of investor involvement and identify facilities that may be susceptible to future acquisitions**

Questions for Discussion: Landscape of Physician Clinics and Other Outpatient Facilities

- What questions does the group have?
- Did anything stand out to you or was surprising to hear?



Break

CAHPR CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH

School of Public Health BROWN UNIVERSITY

State Policy Options to Improve Oversight of Investor Influence in Outpatient Clinics

Minnesota Investor Ownership and Influence in Health Care Working Group: Meeting 2
Nov. 6, 2026

Erin C. Fuse Brown, JD, MPH
Professor of Health Services, Policy & Practice
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State Policy Options to Address Investor Influence Over Physicians

	Policy Approach	Policy Concerns
	**1. Health Care Transaction Oversight Authority**	Consolidation, change of control, price increases, affordability
	**2. Strengthening the Prohibition on Corporate Practice of Medicine**	Professional autonomy, workforce effects, interference with clinical decision-making
	**3. Ownership Transparency**	Opacity, lack of accountability
	**4. Site-Neutral Payment Policies**	Added fees from vertical physician consolidation

NASHP Resources: Model Law to Address Consolidation, CPOM, Transparency ; Model Law on Site-Neutral Payment

CAHPR CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH

Policy 1: Enhanced Transaction Oversight

Policy Concern

Traditional antitrust tools can be inadequate to investor-backed transactions, including private equity and other corporate MSO agreements, serial practice acquisitions too small to trigger review

Response

Expand existing oversight authority over larger facility transactions to outpatient provider organizations:

- Lower **dollar threshold** for material change transactions, including cumulative value of serial transactions
- **Expand types of transactions subject to review**, including PE, vertical hospital or insurer acquisitions, joint ventures, MSO contracts, changes of control
- Scrutinize **out-of-state holdings** and **conduct**
- Enable authority to **block or impose conditions** upon the transaction without a court order



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Transaction Oversight Laws Cover Certain Ownership Changes, But Gaps Remain

- Minnesota Statutes Chapter 145D (passed 2023) is the primary legal framework by which the state can track changes in ownership of healthcare entities
- It establishes reporting and oversight requirements for certain health care transactions, including changes in ownership and control:
  - **Advance notification**: Qualifying transactions involving entities with $10M–$80M in annual revenue generally require 30-day notice to MDH; those involving $80M+ generally require 60-day notice to MDH and the Attorney General
  - **Broad definition of control**: Covered transactions can include mergers, ownership transfers, and changes in control through governance or contractual arrangements
  - **Regulatory authority**: MDH may analyze cumulative impact of smaller transactions over time; the Attorney General may investigate and seek judicial relief for transactions that violate applicable standards or are contrary to the public interest

Many Types of Transactions Fall Outside the Scope of Chapter 145D

- **Revenue thresholds:** Transactions may fall outside reporting requirements when neither the entities involved nor the resulting entity meet the **$10 million annual revenue threshold**

- **Provider coverage:** The law focuses on hospitals, physician group practices, and related entities. Certain provider types, including **dentists and pharmacists**, are not specifically included in its definition of health care provider

- **Statutory exclusions:** Transactions involving nursing homes, assisted living facilities, and other specified settings are excluded, although separate oversight requirements may apply

Policy 2: Strengthening the CPOM Prohibition

Policy Concern

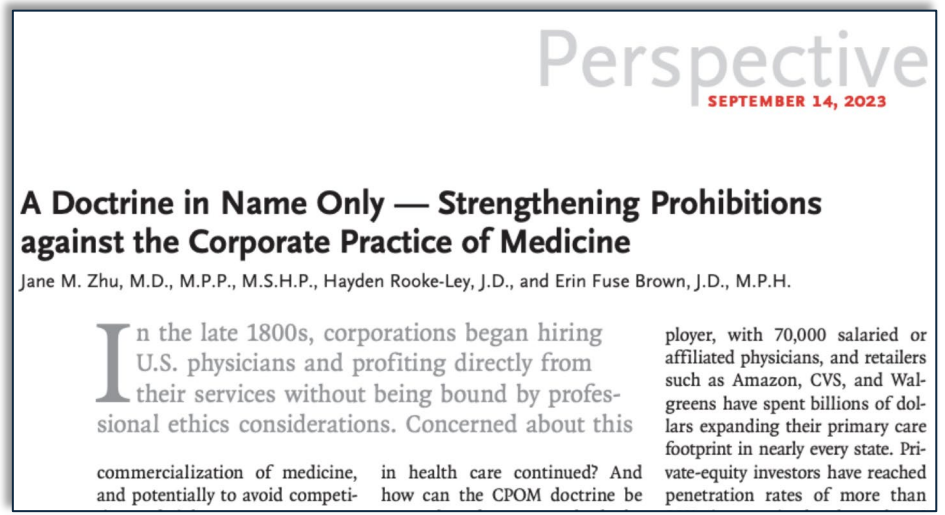
Corporate control over physicians and other independent practitioners (e.g., PE, Optum, etc)

What it is?

The Corporate Practice of Medicine (CPOM) doctrine generally bans unlicensed lay entities from owning, employing, or controlling medical practices. Stems from bans on the unlicensed practice of medicine.

Why strengthen it?

- CPOM laws eroded over time, coinciding with the “managed care” revolution, with exceptions (HMOs, Hospitals) and nonenforcement.
- Corporations contractually circumvent CPOM bans to exert *de facto* control over a medical practice they did not formally own through MSOs and “friendly PCs”.



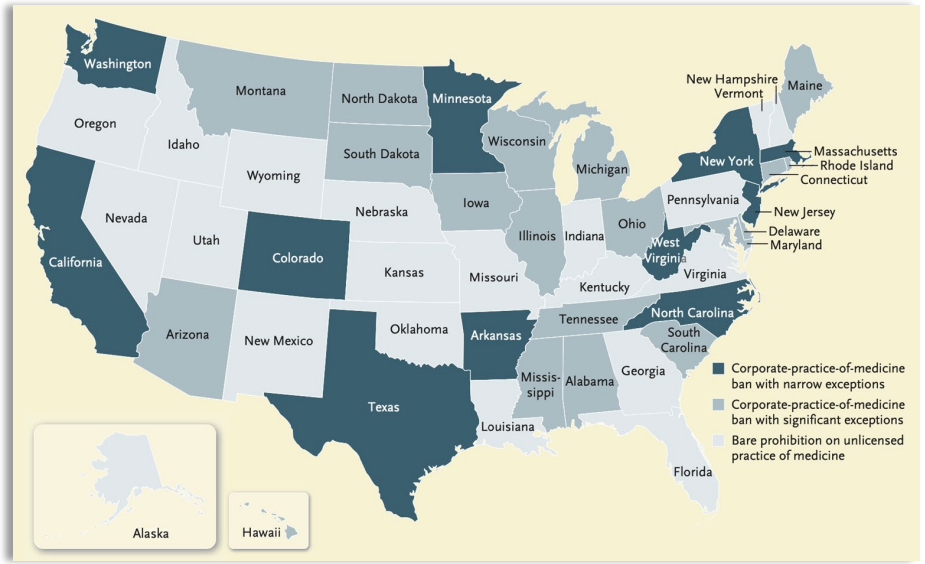
Perspective

SEPTEMBER 14, 2023

A Doctrine in Name Only — Strengthening Prohibitions against the Corporate Practice of Medicine

Jane M. Zhu, M.D., M.P.P., M.S.H.P., Hayden Rooke-Ley, J.D., and Erin Fuse Brown, J.D., M.P.H.

In the late 1800s, corporations began hiring U.S. physicians and profiting directly from their services without being bound by professional ethics considerations. Concerned about this commercialization of medicine, and potentially to avoid competi- in health care continued? And how can the CPOM doctrine be ployer, with 70,000 salaried or affiliated physicians, and retailers such as Amazon, CVS, and Walgreens have spent billions of dollars expanding their primary care footprint in nearly every state. Private-equity investors have reached penetration rates of more than



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Policy 2: Minnesota's current CPOM Law

Common Law

- Minnesota courts have held that lay corporations may not practice medicine by employing licensed physicians to provide medical services or interfere with professional judgment.
- Applies to some, but not all non-physician licensed professionals.
- But contracts that violate CPOM are not automatically void, only those intentionally entered in violation.

Granger v. Adson, 190 Minn. 23, 250 N.W. 722 (1933); *Isles Wellness, Inc. v. Progressive Northern Insurance Co.,* 703 N.W.2d 513 (Minn. 2005); 725 N.W.2d 90 (Minn. 2006) (Isles Wellness I and II)

Statutes

- **Professional Firms Act**: Ownership and investment in medical practices restricted to licensed professionals. Minn. Stat. § 319B.07
- Governance of medical practices restricted to licensed professionals (except for nonprofits and surviving spouses). Operations may be delegated to nonprofessionals, but not decisions involving exercise of professional judgement. Minn. Stat. § 319B.09.
- Medical Practice Act updated in 2026 to make it unlawful for a non-natural person (a corporation) to practice medicine (HF 3825, to be codified at Minn. Stat 147.081)
- SF 2939/HF 2778 was introduced in 2026, would have extended CPOM to cover MSOs, but did not pass

Policy 2: Minnesota's current law on noncompetes

Current Law

- **Minn. Stat. § 181.988, effective July 1, 2023**
- **Scope**: Employers cannot enter into agreements restricting an employee's ability, after termination, to work for another employer or operate a competing business. Covers all employees, including physicians and other health care workers.
- **No geographic and temporal restrictions allowed.**
- **Prospective only:** The 2023 law generally does not retroactively apply to noncompetes entered into before July 1, 2023.
- **Choice-of-law restrictions:** Employers cannot require Minnesota-based employees to waive Minnesota substantive protections or adjudicate employment disputes outside Minnesota as a condition of employment.

Gaps

- Physician sells ownership interest in a practice or dissolution of physician partnership or practice
- Physician employment contracts signed before July 1, 2023
- Nonsolicitation of patients, nondisparagement clauses still permitted

Policy 3: Transparency of Ownership/Control

Policy Concern

Opacity of complex ownership and control structures of health care entities. You cannot oversee what you cannot see.

Response

1. Require all existing health care entities to report information on owners, controlling entities, and business structure, including the ultimate owners or controlling parent, subsidiaries, entities under common control, and any management services organizations
2. Require all health care entities to report any changes to ownership or control (would also constitute a material change transaction for notice and review purposes)
3. Make this information available to the public

State Examples

Massachusetts Registration of Provider Organizations, Indiana (facilities) (2025), New Mexico (2025), Maine LD 2201 (PE-backed entities) (2026), Vermont H. 583 (PE-backed entities) (2026)

Policy 3: Existing MN Data Sources on Ownership/Control

Agency / System	Providers Covered	Information Collected
DHS – Medicaid enrollment	Medicaid-enrolled providers, including physician practices	Owners ≥5% (direct/indirect); managing employees; officers and directors. Nonpublic.
MDH – Facility licensure	Hospitals, nursing homes, assisted living, home care, outpatient surgical centers. Physician clinics are not licensed.	Licensees; owners; controlling individuals/persons; changes of ownership
MDH – Hospital & surgical center financial reports (HCCIS)	Hospitals; freestanding outpatient surgical centers	Annual financial statements; Medicare cost reports; bylaw changes; changes in ownership or control
DHS – Nursing facility cost reports	Medicaid-participating nursing facilities	Statement of ownership; audited financials; related organizations (≥5% common ownership) supplying the facility; lease and real-estate costs
AGO / MDH – Transaction notices (Ch. 145D)	Hospitals, health systems, and provider group practices with ≥$10M revenue; most nursing home deals excluded	Parties; leadership; ownership structure; governing documents; deal agreements. ≥$80M: AG + MDH, 60 days, AG may sue to block. $10–80M: MDH only, 30 days. Nonpublic.
Secretary of State	Corporations, LLCs, professional firms (MSOs file as ordinary corporations or LLCs)	Entity name; registered agent and office; certain officers. No member or shareholder disclosure.
Federal CMS – Medicare enrollment	Medicare-enrolled providers and suppliers	Owners ≥5%; managing control. Public ownership files cover only hospitals, SNFs, hospice, home health, FQHCs, RHCs; SNFs also flag PE/REIT owners.

TAKEAWAY: Minnesota collects substantial ownership information, but across fragmented systems with differing thresholds, and most of it is nonpublic.

Sources: 42 C.F.R. §455.104; Minn. Stat. §§ 144.50–.56, 144A, 144G, 144.698, 256R.08, ch. 145D, chs. 302A/322C/319B; CMS-855 and CMS public ownership data (data.cms.gov).

Policy 3: Principal Gaps in MN Ownership Transparency

Gap	What's Missing
Physician practices	No ownership reporting for clinics; no linkage of physician NPIs, practice TINs, corporate owners, and affiliates
MSOs & contractual control	Routine disclosure of MSO relationships, management agreements, and non-equity control
Private equity / investor owners	Standardized identification of PE sponsors, funds, investors, (CMS flags PE/REIT owners only for nursing homes)
Corporate structures, ultimate owners	Complete charts connecting parents, subsidiaries, affiliates, and commonly controlled entities, and ultimate controlling persons
Related-party transactions	Consistent reporting of management fees, leases, intercompany loans, and affiliate transfers outside nursing homes (which report related organizations to DHS)
Ongoing changes	No annual ownership reporting; transactions involving entities under $10M revenue, and most nursing home deals, fall outside Ch. 145D
Public access	Medicaid enrollment data and Ch. 145D transaction filings are nonpublic; CMS public ownership files exclude physician groups

TAKEAWAY: Minnesota lacks a unified, regularly updated database linking providers → practices → MSOs → corporate parents → ultimate owners.

Legislative note: SF 2939 / HF 2779 (2025–26) would have required annual ownership and control reporting to MDH, including MSOs and significant equity investors, with public annual reports, plus corporate practice of medicine and MSO limits. It cleared Senate HHS in March 2026 but did not pass before the 2026 session adjourned.

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Policy 4: Site-Neutral Payment in Commercial Market

Policy Concern

Hospital-physician consolidation is a major driver of affordability challenges, driven by higher prices and spending

What it is?

Eliminate site of service differentials for outpatient services that can be safely provided in lower cost settings. Site-neutral payments equalize reimbursement for certain outpatient services regardless of care setting. Payments are pegged to a multiple of Medicare non-hospital payment rate (physician office or ASC).

Principle

Patients and purchasers should pay the same price for the same services, regardless of where the service is provided



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Advance access publication: December 19, 2025
Research Article

Health Affairs Scholar
EMERGING & GLOBAL HEALTH POLICY
OXFORD

Site-neutral payment for routine services could save commercial purchasers and patients billions

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Abstract

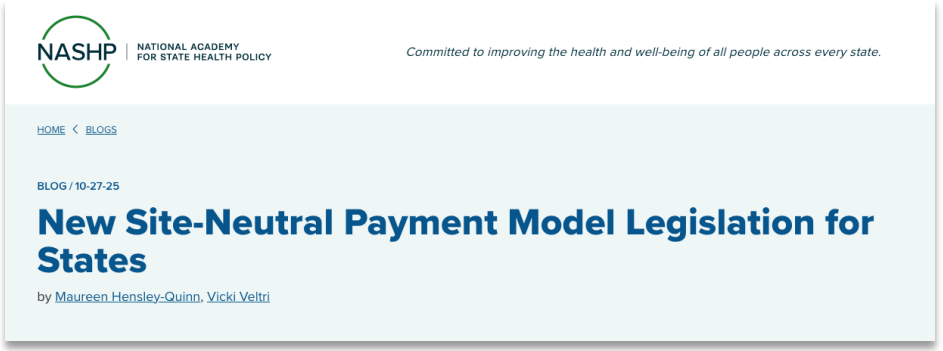
Introduction: Medicare and commercial payers pay more for services delivered in hospital outpatient departments than in physicians' offices or ambulatory surgery centers. These "site-of-care" payment differentials contribute to rising health care spending and drive hospital acquisition of physician practices. Because many non-hospital settings can provide equivalent or higher-quality care at lower costs, site-neutral payment has gained traction in Medicare, with the potential to save patients and taxpayers billions. A growing number of states are exploring similar policies in the commercial market by capping payments for routine services at a percentage of the Medicare payment in non-hospital settings. The impact of such policies for commercial purchasers and patients has not yet been modeled.

Methods: This study uses 2022 commercial claims data from the Health Care Cost Institute and estimates potential savings by capping prices for 2561 routine services (Current Procedural Terminology codes) at 150% of the Medicare payment in hospital, office, and ambulatory surgery center settings.

Results: Site-neutral payment for commercial purchasers and patients could save $10.8 billion across 48 states and Washington, D.C. State level aggregate hospital operating margins would decline modestly.

Conclusion: Site-neutral policies could yield substantial savings but require ongoing monitoring for unintended effects.

Key words: site-neutral payment; health care spending; hospital prices.



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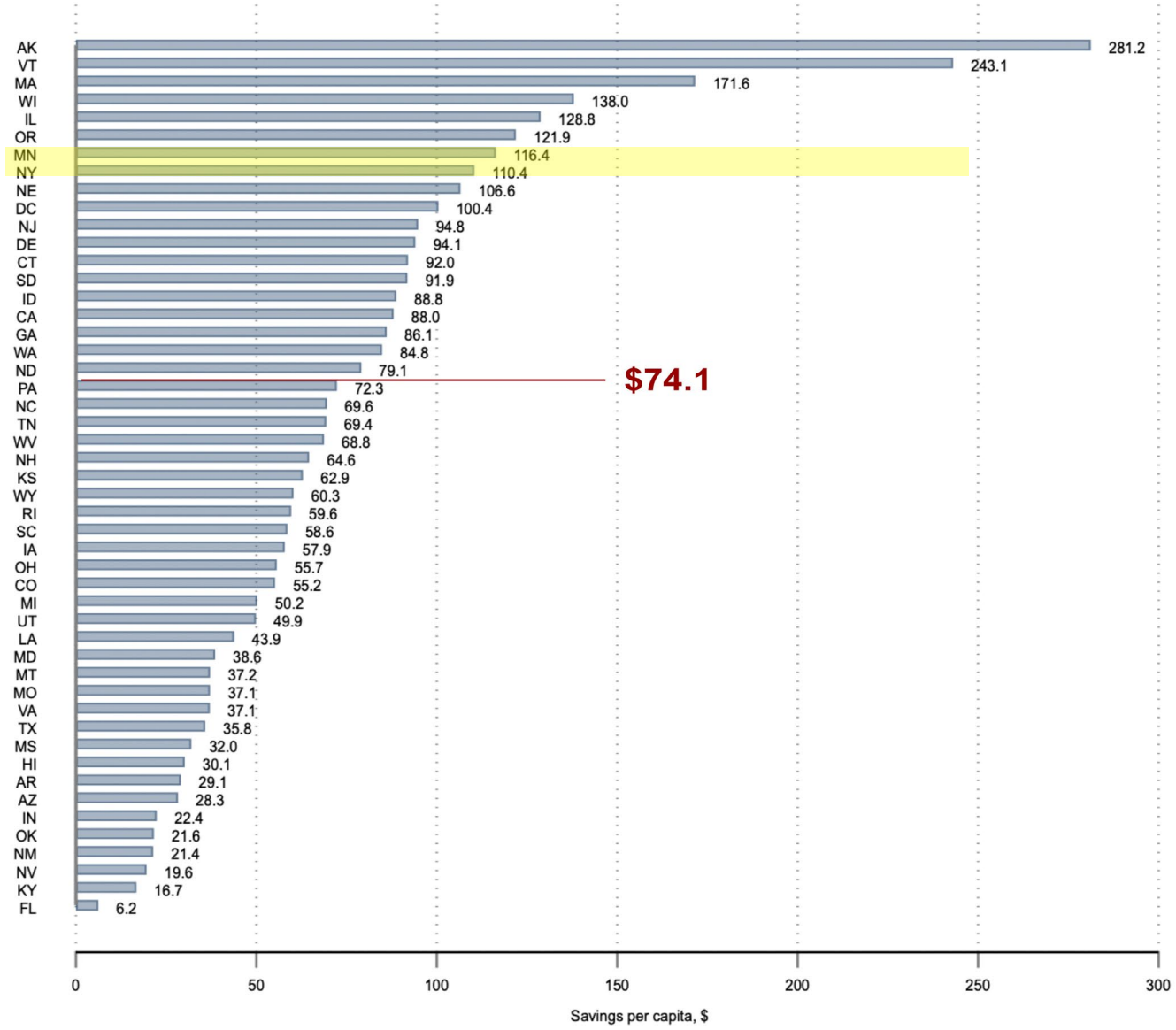
BLOG / 10-27-25

New Site-Neutral Payment Model Legislation for States

by Maureen Hensley-Quinn, Vicki Veltri

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Figure 2. Estimated per capita savings from site-neutral payments (capped at 150% of the Medicare non-hospital rate)



Study using HCCI (2022) data estimated that states would have saved a total of $10.8 billion, $72.10 per commercially insured person on average, in 2022 by implementing site-neutral payment.

MN has the seventh highest per capita estimated savings: $116.40 per person.

Murray R, Janjua H, Whaley C, *Health Affairs Scholar*, Volume 3, Issue 12, December 2025, qxaf241, https://doi.org/10.1093/haschl/qxaf24

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Questions for Discussion: State Policy Options

- Which state policy options seem most relevant to the gaps or risks the group has identified so far?
- What is your perspective on separate recommendations based on short-term and long-term goals?
- Are there other considerations or unintended consequences we should consider?



Next Steps

What: Health Care Affordability Advisory Task Force Meeting

When: November 20, 1 pm to 4 pm

Where: Wilder Foundation, Auditorium A



Stay tuned for:

- Commercial Healthcare Prices Working Group Meeting on December 2 from 9 am to 12 pm

Thank You!

Center for Health Care Affordability

Health.Affordability@state.mn.us