Articles + Publications | April 16, 2024

California's AB 3129: Implications for Private Equity Investments in Physician Practices

WRITTEN BY

Erin S. Whaley | Joseph F. Kadlec | Ashley L. Taylor, Jr. | Kevin R. Miserez | Blake R. Christopher | Christopher Carlson

A recently introduced California Assembly Bill (AB 3129), targeting private equity (PE) physician practice investments, is currently making its way through the legislative process. Introduced by California Attorney General (AG) Rob Bonta and Assembly Speaker pro Tempore Jim Wood, the bill seeks to curtail "harmful transactions" and "practices that undermine the practice of medicine" by granting the AG approval authority over PE groups' physician practice acquisitions and imposing substantial restrictions on their ability to control acquired practices. If enacted, the bill's pre-closing approval requirements could significantly delay, if not altogether stymie, PE group acquisitions (and potentially divestitures) of California physician practices. Beyond the transaction process itself, the bill's proposed restrictions on the management and control of physician practices by PE groups raise serious economic questions and concerns for PE groups' current and future physician practice investments in California.

On April 9, the bill was re-referred to the Committee on Judiciary after being recommended for passage (as amended) by the Committee on Health. The vote to re-refer was 12-4. The bill is currently scheduled to be heard by the Judiciary Committee on April 23.

Introducing the "Not-So-Private" Equity Purchase of Physician Practices

Notice and Consent: The bill would require PE groups — defined broadly as "an investor or group of investors who engage in the raising or returning of capital and who invests, develops, or disposes of specified assets" — to provide written notice to the California AG prior to an acquisition or change of control between a PE group and a health care facility or group practice (both physician and nonphysician groups consisting of two or more licensed professionals and meeting certain annual revenue thresholds). The terms "acquisition" and "change of control" are defined under the bill such that they would capture typical MSO-PC transaction structures (*e.g.*, the purchase of a material amount of the practice's assets, establishing a change in governance and/or acquiring direct/indirect control over practice operations).

The bill would also require PE groups to obtain written consent from the AG in the case of an acquisition or change of control transaction in which the target company is any of the following:

1. *Health care facility* – defined as a facility, nonprofit or for-profit corporation, institution, clinic, place, or building where health-related physician, surgery, or laboratory services are provided (*e.g.*, hospital, clinic, long-term care facility, ambulatory surgery center, treatment center, or laboratory or physician office located outside of a hospital).

2. *Provider group* consisting of 10 or more licensed health professionals. (Note that this definition is not limited to *physician* groups, but also extends to groups of other licensed professionals — dentists, optometrists, pharmacists, physician assistants, advance practice registered nurses, psychologists, and certain other nonphysician mental health professionals.)

3. *Provider group* consisting of two to nine licensed health professionals and that generates $10 million or more of annual revenue.

The bill would not require consent from, but would still require notice to, the AG for PE group transactions targeting (i) nonphysician provider groups with annual revenue of more than $4 million or (ii) provider groups consisting of two to nine licensed health professionals and with annual revenue between $4 million and $10 million. Meanwhile, transactions targeting solo practices or physician/nonphysician groups with less than $4 million would not be subject to either notice or consent requirement. This bill also authorizes the AG to grant PE groups a waiver of the notice/consent requirements in limited cases in which the target practice faces immediate risk of business failure.

Timeframes for Notice/Approval: The requisite notice must be submitted to the AG at least 90 days prior to acquisition. However, this does not mean the parties to the transaction would necessarily receive the AG's consent (or lack thereof) prior to the expiration of such 90-day period, as such period may be extended an additional 45 days under certain circumstances (*e.g.*, additional information is needed, the transaction is substantially modified, or the target involves multiple facilities/entities), plus an additional 14 days if the AG decides to hold a public meeting (or a second public meeting if the transaction is later substantially modified). On top of that, the AG has discretion to stay the acquisition during the pendency of any other state or federal agency review of the transaction.

Authority to Grant, Deny, or Impose Conditions: For transactions subject to the consent requirements, the bill authorizes the AG to deny or impose conditions on transactions if the AG determines the subject transaction "may have a substantial likelihood of anticompetitive effects or may create a significant effect on the access or availability of health care services to the affected community." Such determination would be made by the AG by applying the "public interest" standard — that is, "being in the interests of the public in protecting competitive and accessible health care markets for prices, quality, choice, accessibility, and availability of all health care services for local communities, regions, or the state as a whole" — and with no presumption of efficiency being afforded to the transaction. Any party to the acquisition or change of control can apply back to the AG to reconsider the decision and to modify, amend, or revoke the AG's prior decision. If the AG denies consent or gives conditional consent, the party can seek subsequent judicial review.

The bill would not apply to acquisitions or control changes entered into prior to January 1, 2025 (including subsequent renewals), absent such transactions undergoing a "material change" (not defined) in the corporate relationship between the PE group and physician practice on or after such date.

Congratulations, the AG Approved Your Transaction – Now What?

Even if the AG signs off on a PE group's acquisition of a physician practice, the bill may still leave the PE group hamstrung when it comes to managing that investment.

PE groups acquiring physician practices must already be cognizant of California's well-established corporate practice of medicine (CPOM) doctrine. Generally, the CPOM doctrine seeks to prohibit or otherwise restrict laypersons and lay-owned entities from practicing medicine. These CPOM prohibitions are commonly carried out by preventing nonphysicians from owning medical practices, preventing lay-owed entities from employing physicians to perform medical services, and/or imposing varying levels of restrictions against laypersons and lay-owned entities exercising or influencing control over physicians' professional services or interfering with physicians' clinical judgment.

To mitigate CPOM risk, PE group acquisitions typically acquire all of the nonclinical assets of the target physician professional corporation (the PC), while the equity in the PC is retained by the PC's existing physician owner(s) or purchased separately by another friendly physician or other professional entity affiliated with the PE group. The PE group then forms (if not already existing) a management services organization (MSO) that enters into a management services agreement (MSA) with the PC. Under the MSA, the MSO manages all nonclinical aspects of the PC via a full suite of management and administrative services, while the PC and its physicians retain control over all clinical affairs of the PC. In exchange for the MSO's services, the PC pays a management fee to MSO, the structure of which will vary depending on the state in which the PC is located.

Despite California's already rigid and highly enforced CPOM doctrine, the bill seeks to impose additional barriers, if not sound the death knell, for the prototypical MSO-PC model utilized by PE groups. For example, the bill would prevent PE-backed MSOs from influencing or entering into contracts on behalf of a practice with any "third party" — not, by contrast, with any third-party "payor" as presently prohibited by the California Board of Medicine. The most critical aspect of the bill for MSO-PC arrangements, however, is its express ban on any physician practice from entering into any agreement or arrangement with any entity (*i.e.*, an MSO) controlled in part or in whole, directly or indirectly, by a PE group in which that PE group "manages <u>any</u> of the affairs" of the practice in "exchange for a fee." Oddly, however, the bill apparently "does <u>not</u> bar revenue-sharing" between any such practice and private equity group (however, revenue-sharing would still present compliance risks under California's existing CPOM doctrine).

It is currently unclear whether the January 1, 2025, timeline applicable to the bill's AG notice and consent requirements would extend equally to MSAs entered into before such date. If not, and absent any other grandfathering provisions to be implemented, the bill (if enacted) will necessitate PE groups going back to the drawing board with respect to their existing MSO-PC arrangements. It is also unclear whether MSAs and other MSO-PC ancillary documents (*e.g.*, operating agreements, shareholder agreements, etc.) will be reviewed by the AG in connection with its transaction approval process, and, if so, how those documents may factor into the AG's decision to approve, deny, or impose conditions on the underlying acquisition.

Ultimately, there are a lot of unknowns surrounding the AG's review process, and impacted parties may be left waiting for implementing regulations to be adopted by the AG before many of their key question and concerns are effectively addressed. However, if enacted, it is clear that the bill will compel PE groups to reassess their overall transaction posture (both acquisitions and divestitures) with respect to California physician practice investments. Regardless of whether the bill passes, at a minimum, it serves as an unambiguous signal of the continuing increase in government scrutiny and oversight of PE group investments in the sector.

Troutman Pepper will continue to monitor the developments and progress concerning this bill, as well as similar

legislative initiatives by other states impacting PE group investments in health care sector.

RELATED INDUSTRIES + PRACTICES

- Corporate
- Health Care + Life Sciences
- Health Care Transactions
- Private Equity
- Regulatory Investigations, Strategy + Enforcement
- State Attorneys General