MARYLAND
Health Care
Commission

Marcia Boyle, Acting Chair
Douglas Jacobs, MD, MPH, Executive Director

2026 SESSION
POSITION PAPER

BILL NUMBER: **SB 494**

COMMITTEE: **Finance**

POSITION: **Support**

TITLE: **Maryland Health Care Commission – Certificates of Need and Material Change Transactions**

BILL ANALYSIS

SB 494 – Maryland Health Care Commission – Certificates of Need and Material Change Transactions requires a person, prior to completing a material change transaction related to a health care entity, to provide certain notice to the Maryland Health Care Commission and to the public within a specified period of time. It establishes a public interest review process, including the criteria for a public interest review, the requirements for approval, approval with conditions, or denial of a transaction, and establishes appeal rights, judicial review, and penalties related material change transactions.

POSITION AND RATIONALE

The Maryland Health Care Commission (MHCC) is in support of *SB 494* as it establishes a process for transparent oversight over multiple types of health care entities that is parallel to the nursing home public interest review process passed into law in *SB 1000/HB 1122 – Health Care Facilities – Nursing Homes – Acquisitions and Licensure*, in the 2024 legislative session. This bill would authorize MHCC as the designated regulatory oversight agency to also review large scale transactions involving non-acute care hospitals, facilities, and provider organizations.

This legislation would protect consumers, support health and safety oversight, and allow transactions to occur with transparency and accountability. It would ensure that health care transactions advance – not undermine – the State's goals for affordability, access, quality, equity, and system stability, in ways that traditional antitrust and licensing frameworks cannot. This includes oversight of the potential rapid price inflation and consolidation that can occur following private equity acquisitions and mergers. It also aligns with Maryland's participation in CMS's AHEAD model focusing on accountability to drive population-level spending and health outcomes. A **well-designed public interest review process**, as established by *SB 494* **allows**

Marylanders to govern the structure of our health care system intentionally – rather than discovering consequences after consolidation has already reshaped it.

This legislation would establish a **streamlined process**, focusing attention on transactions that are highly likely to adversely affect the **health**, **safety**, and **affordability of health care** for Marylanders and establish a streamlined process for transactions that do not present these concerns. The initial Public Notice phase included in the legislation would require entities to provide notice for planned transactions. This notice allows MHCC, the designated regulatory agency, an opportunity to view the notice and assess, within 30 days, whether a public interest review process is needed. The majority of transactions would proceed without further review. If deemed appropriate, MHCC would then conduct a 60-day public interest review, ultimately issuing a decision to approve, approve with conditions, or deny a transaction to ensure that any transactions or terms are structured in ways that preserve health, safety, and affordability. The entire process would last *at most* 90 days.

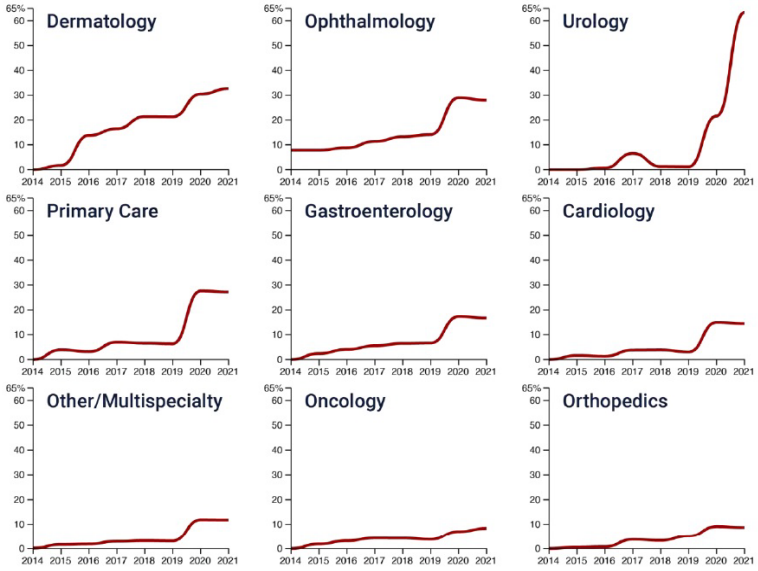
This process enables **early warning** of potentially harmful actions, with leverage to negotiate **enforceable conditions** and establishes **statewide data on ownership** and control. It also supports an evolving decision-making process that can adapt, **meeting the needs of acquiring entities who are seeking to support health care delivery** in Maryland and **protecting the stability and resilience** of our health care delivery system.

Consolidation and private equity ownership is a growing trend in Maryland, and it disproportionately affects some specialties and communities. Consolidation across health care markets is widespread in Maryland, increasing at a higher rate than the national average, as facilities and providers merge. This leads to a more consolidated health care system with fewer independent practices and facility owners and operators.

Across the state, **ownership of physician practices and facilities has shifted**, with **private equity driving much of this trend**. These effects are more pronounced among particular communities and specialties.

Figure 1 illustrates this, showing the share of Maryland physicians across specialty types who are affiliated with private-equity ownership from 2014 through 2021. **Private equity acquisitions are most**

Figure 1: Share of Physicians in PE-Affiliated Practices in Maryland, by Physician Specialty (2014-2021)



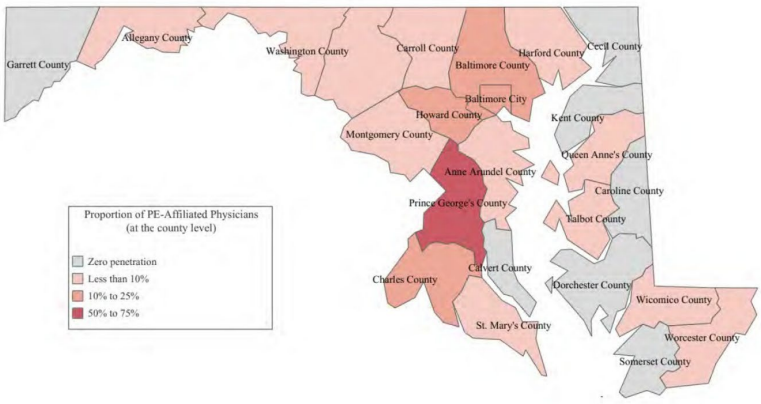
Source: Singh, Y., Murray, R., Reddy, M., Perkins, J., Mehta, N., Whaley, C. & Fuse Brown, E. (2025, January 22). Private equity investments in physician practices in Maryland. Providence, RI: Center For Advancing Health Policy Through Research, Brown University.

pronounced in certain specialties – urology, dermatology, ophthalmology, for example. Of note, **Maryland has significantly higher private equity penetration across physician specialties than the national average** – for example, in urology, private equity penetration was 63.3% in Maryland and only estimated at 8% nationally, and primary care was 27.3% in Maryland but estimated at 2% nationally.[1]

This illustrates the pattern of private equity investment's initial focus on **high-margin, office-based procedural specialties**, and its later expansion into **specialties like primary care and cardiology**. We see growing numbers of private equity physicians affiliated with HMOs (versus lower numbers in PPOs), particularly in Medicare Advantage, with high in-network participation. This means that patients with certain types of coverage are more likely to only have private-equity affiliated physicians available to them when they need care.[2] This growing presence of private equity ownership interests in medical care has several potential **harmful downstream effects** – capturing markets to **drive up prices**, changing staffing models in ways that **diminish quality and safety of care**, and affecting physicians' clinical decision-making to **put profit – not patient health – at the center of care**.[3,4] Concentration in these market means that certain patients are more likely to experience these effects.

This trend is not monolithic across Maryland, however. A 2025 MHCC report found that **private equity presence is higher in communities with a lower share of white residents** compared to communities with lower private equity penetration, a **higher proportion of individuals enrolled in Medicaid**, and a higher proportion of urban residents, suggesting **private equity investment is more concentrated in more urban and diverse communities**.[5]

Figure 2: Geographic Variation in Private Equity Penetration in Maryland, 2021



Source: Singh, Y., Murray, R., Reddy, M., Perkins, J., Mehta, N., Whaley, C. & Fuse Brown, E. (2025, January 22). *Private Equity Investments in Physician Practices in Maryland.* Providence, RI: Center For Advancing Health Policy Through Research, Brown University.

Each county paints a slightly different picture of large-scale transactions and consolidation.

Figure 2 shows the geographic variation of private equity consolidation across Maryland counties, with **over half of physician practices seen by Prince George's County residents** affiliated with a private equity firm.

<u>This legislation ensures health, quality, and safety oversight</u>, not market interference. Some transactions are designed to protect access and serve the public interest – for example, when an existing facility or entity facing financial distress is acquired to ensure ongoing operations and availability of services. However, other transactions may lead to closure of service lines or facilities, limitations in staffing that decrease facility capacity, or reduced participation in

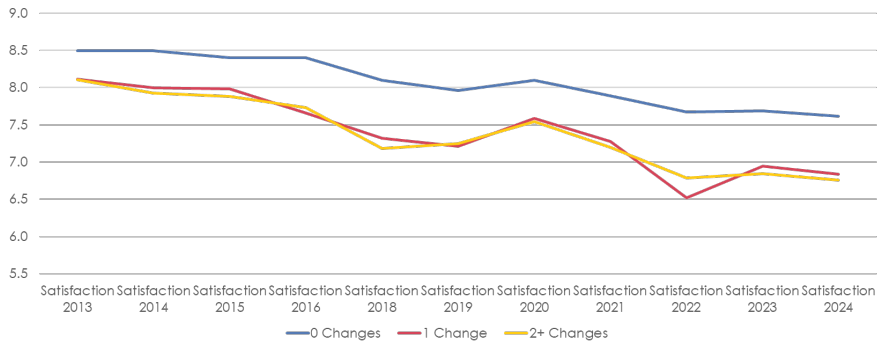
Medicaid or acceptance of uninsured patients.[6] Maryland currently has no oversight process to sort these transactions in most health care settings.

Maryland recently passed legislation to **address this challenge related to nursing homes**. Evidence shows that as nursing homes shifted to private equity ownership, there are increases in mortality, hospital visits, and increased deficiency findings post-acquisition. Private equity ownership is linked to reduced staffing, specifically lower nursing hours, and private-equity owned nursing homes tend to bill Medicare more but do not consistently improve financial margins.[7] In turn, this lowers patient satisfaction rates and jeopardizes patient safety, and quality of care.

For example, Genesis Health Care, with nursing homes in Maryland and other states, faces over 200 malpractice, wrongful death, and injury lawsuits. When it filed for bankruptcy in 2025, it carried more than $2 billion in debt, with $259 million tied up in patients' legal claims. Through the bankruptcy process, information was revealed that private equity owners had extracted value from the company using various tactics – sale and lease-back deals, layered debt – while the company struggled to continue to operate and staffing levels and patient care declined.[8] Bankruptcy itself is associated with declines in quality of care: the National Bureau of Economic Research's recent report shows that bankruptcy filings in nursing homes **immediately increase staff turnover**, replacing skilled workers with less skilled staff, and **increase hospitalizations** by 4% among residents within 90 days of admission.[9]

For nursing homes, **as acquisitions go up, patient satisfaction goes down**. Figure 3 reflects this trend, across Maryland's nursing homes. It shows the declining patient satisfaction levels among nursing homes in the state, from 2013 through 2024. The nursing homes that faced one or more changes in ownership over time have statistically **significantly lower patient satisfaction** rates than those with no changes, who maintained consistent ownership and were not acquired by private equity or other interests.

Figure 3: Nursing Home Acquisitions and Patient Satisfaction (2013 – 2024)



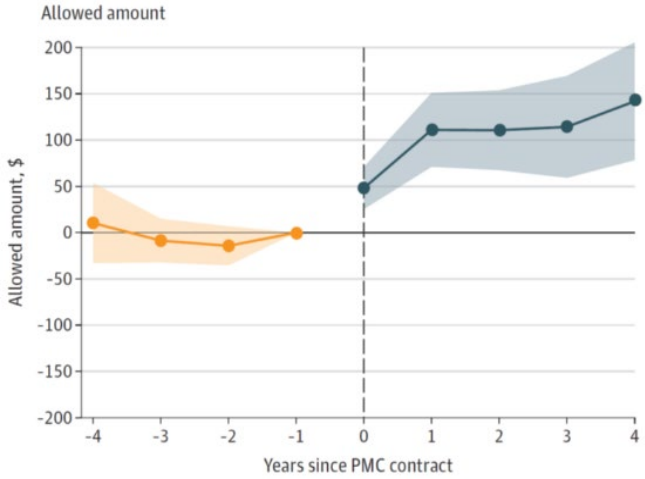
Source: Maryland Health Care Commission, Nursing Home Satisfaction Survey, administered annually.

These trends are reflected more broadly than nursing homes, though: there is strong evidence that changes in governance and ownership across facility types, for example, hospice, specialty practices like urology, and home health agencies, can **impact staffing levels, adherence to clinical protocols, and infrastructure investments**, which may lead to **negative impacts on quality and safety**.[10,11,12,13,14,15,16] Private equity acquisitions can also lead to more centralized

care and consolidation, which can adversely and **disproportionately impact smaller and rural communities**, and increase costs impacting consumer health insurance premiums.[17,18,19,20] If private equity transactions accelerate for other facility types and medical group practices without additional oversight, we can expect to begin to see similar issues that have already transpired in nursing homes.

SB 494 is the right solution for Maryland, at the right time. A 2022 study looked at the changes that occurred in U.S. physician practices specializing in dermatology, gastroenterology, and ophthalmology – **three of the specialties in which Maryland private equity acquisitions are increasing** (see Figure 1, above).[21] Private equity-acquired physician practices were matched with control practices that had similar patients, encounters, risk scores, out of network services billed, and spending. It found that compared to non-acquired practices, **private equity acquired physician practices showed an increase of $71 charged per claim**.

Figure 4: Differences in Physician Allowed Amounts Per Claim Before and After Private Equity Acquisition



Source: La Forgia, A., Bond, A., Braun, R., Yao, L., Kjaer, K., Zhang, M., Casalino, L.. (2022). Association of Physician Management Companies and Private Equity Investment with Commercial Health Care Prices Paid to Anesthesia Practitioners. JAMA Internal Medicine.

Figure 4 shows the changes in allowed amounts per claim associated with private equity acquired physician practices in dermatology, gastroenterology, and ophthalmology, before and after the change of ownership. It illustrates that **after physicians were acquired by private equity, their charges went up significantly**. These costs are passed on to patients in copays and higher premium costs. In tandem with increased claim costs, these practices increased their patient volume by 25% more than un-acquired practices, with both more new patients and a higher number of encounters per patient, and office visits were billed for longer periods of time, costing more and stretching the already-thin health care workforce.

Despite these increases, patients in these practices weren't sicker, or at higher risk to help explain the increased costs, and there are no significant differences in patient outcomes across practices. Put simply, **patients in private equity acquired practices paid more and spent more time at medical visits without any significant improvements in care**.

Private equity investments and acquisitions without appropriate oversight also **risks exacerbating existing challenges in Maryland** – particularly related to **emergency department wait times**. Evidence indicates that private equity ownership of home-based care such as home health and hospice, is associated with patient selection toward lower acuity, longer-stay, and more profitable patients.[22] This type of cherry-picking can leave more complex patients without the right support to manage their conditions – **stuck in the emergency or inpatient rooms of**

hospitals awaiting discharge with no private-equity owned post-acute care providers willing to accept them. While private equity owned home health agencies do show some favorable quality improvements over non-acquired entities, initiating care quickly and improving patient self-care, **they underperform non-acquired entities in longer term outcomes** – for example, timely physician recommended medication actions, preventable readmission rates, and discharge to the community.[23] This means that patients in these acquired home health settings may be **more likely to end up back in the emergency room** or inpatient care, and **less likely to transition into a home or community based setting** where they can successfully manage their health.

In Maryland, where emergency rooms are over capacity and wait times are a growing challenge, **we need more care settings for high acuity patients with Medicaid coverage – not fewer**. Private equity investment in Maryland is more concentrated in areas with higher Medicaid-enrolled residents, and emergency rooms and hospitals statewide are struggling to safely discharge high acuity patients into post-acute care. We simply **cannot afford changes to our health care system that may be more likely to bring patients back into the emergency room** because their care was sub-par.

A public interest review process would **explicitly assess impacts of transactions on geographic access, continuity of care, and service mix and capacity**. This is critically important if large investors acquire smaller community providers where shorter-term financial incentives may not match local health care and community needs. This legislation also allows regulators to **assess past quality ratings**, the ownership history of proposed acquirers, and whether any of the proposed strategies or actions included in acquisition plans **may risk degrading quality of care**. The review and condition process included in this legislation can help ensure that as transactions proceed while minimum staffing levels and quality and safety standards are met, **without interfering in the health care market or halting transactions** that will ultimately help ensure access to care is maintained.

Maryland's experience with nursing homes following private equity investment highlighted the need for legislation – after our communities were already experiencing the negative effects of unmonitored changes in ownership. We are faced with fixing problems after quality, safety, and health care access have already declined. Health care consolidation is strongly associated with higher prices and spending, with little or no associated improvement in health care quality or outcomes.[24,25,26,27,28] **Building the infrastructure for a notice and public interest review process now**, before large-scale purchases, consolidation, or changes in ownership of health care entities (or "material change transactions) reshape local health systems unchecked provides a **pathway for prudent oversight**. It gives Marylanders the tools we need **to ensure the changes to our health care system maintain or improve cost, access, quality, equity, and system stability**, rather than risk their degradation.

SB 494 provides a pathway for Marylanders to have oversight and understanding of the transactions that can reshape our health care system, when it matters. It equips regulators with a mechanism to help ensure that we can identify transactions that may harm the quality, safety, and affordability of care and protect the stability and resilience of our health care system

now, and in the future. For these reasons, the Maryland Health Care Commission requests a favorable report on SB 494.

---

[1] Singh, Y., Murray, R., Reddy, M., Perkins, J., Mehta, N., Whaley, C., Fuse Brown, E. (2025). Private Equity Investments in Physician Practices in Maryland: A Report Prepared for the Maryland Health Care Commission. https://mhcc.maryland.gov/mhcc/pages/home/meeting_schedule/documents/presentations/2025/20250116/agd4a_mhcc_pe_singh_rpt.pdf.

[2] Singh, Y., Murray, R., Reddy, M., Perkins, J., Mehta, N., Whaley, C., Fuse Brown, E. (2025). Private Equity Investments in Physician Practices in Maryland: A Report Prepared for the Maryland Health Care Commission. https://mhcc.maryland.gov/mhcc/pages/home/meeting_schedule/documents/presentations/2025/20250116/agd4a_mhcc_pe_singh_rpt.pdf.

[3] Schlafly A. (2024). The Harm from Private Equity's Takeover of Medical Practices and Hospitals. Mo Med. https://pmc.ncbi.nlm.nih.gov/articles/PMC11482842/.

[4] Singh Y, Song Z, Polsky D, Bruch JD, Zhu JM. (2022). Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization. JAMA Health Forum. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2795946.

[5] Singh, Y., Murray, R., Reddy, M., Perkins, J., Mehta, N., Whaley, C., Fuse Brown, E. (2025). Private Equity Investments in Physician Practices in Maryland: A Report Prepared for the Maryland Health Care Commission. https://mhcc.maryland.gov/mhcc/pages/home/meeting_schedule/documents/presentations/2025/20250116/agd4a_mhcc_pe_singh_rpt.pdf.

[6] Kannan S, Song Z. (2024). Financial and Clinical Characteristics of Hospitals Targeted by Private Equity Firms. JAMA Intern Med. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2821710.

[7] Orewa, G., Karabukayeva, A., Pradhan, R., Jimah, I., Weech-Maldonado, R. (2025). The effects of private equity ownership in U.S. ursing homes quality and financial performance: A systematic review. https://doi.org/10.1016/j.healthpol.2025.105388.

[8] Fenee, M., O'Grady, E., Bugbee., M. (2025). Private Equity is Continuing to Acquire – and Bankrupt – Nursing Homes. Private Equity Stakeholder Project. https://pestakeholder.org/wp-content/uploads/2025/04/PESP_Report_NursingHomes_April2025.pdf.

[9] Antill, S., Bai, J., Ghandi, A., Sabety, A. (2025). Healthcare Provider Bankruptcies. National Bureau of Economic Research. https://www.nber.org/papers/w33763.

[10] Soltoff, A., Williams, D., Braun, R. (2025). Private Equity-Owned Hpspices Report Highest Profits, Lowest Patient Care Spending Compared with Other Ownership Models. Health Affairs. https://doi.org/10.1377/hlthaff.2025.00327.

[11] Borsa A, Bejarano G, Ellen M, Bruch JD. (2023). Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: systematic review. BMJ. https://pmc.ncbi.nlm.nih.gov/articles/PMC10354830/.

[12] Faraj KS, Kaufman SR, Herrel LA, Maganty A, Oerline M, Caram MEV, et al. (2023). Acquisition of Urology Practices by Private Equity Firms and Performance in the Merit-based Incentive Payment System. Urology Practice.

[13] Zhang Z, Li K, Wang S, Fashaw-Walters S, Hou Y. (2024). Change of Ownership and Quality of Home Health Agency Care. *JAMA Health Forum.* doi:10.1001/jamahealthforum.2024.3767.

[14] Elevance Health Public Policy Institute. (2023). Costs & Quality After Independent Hospitals are Acquired by Health Systems https://www.elevancehealth.com/content/dam/elevancehealth/articles/ppi_assets/63/EH_Hospital%20Merger_R6_7-21-2023_FINAL.pdf

[15] Berenson R. (2020). "Addressing Health Care Market Consolidation and High Prices." Urban Institute

[16] Kessler, D. and McClellan, M. (2000). Is hospital competition socially wasteful? Quarterly Journal of Economics, 115(2):577615. See also, Martin Gaynor. "Diagnosing the Problem: Exploring the Effects of Consolidation and Anticompetitive Conduct in Health Care Markets." Statement before the Committee on the Judiciary Subcommittee on Antitrust, Commercial, and Administrative Law, U.S. House of Representatives. March 7, 2019. https://www.congress.gov/116/meeting/house/109024/witnesses/HHRG-116-JU05-BioGaynorM-20190307.pdf.

[17] O'Hanlon, C., Kranz, A. DeYoreo, M., Mahmud, A., L. Damberg, C., & Timbie, J., (2019). Access, Quality, And Financial Performance Of Rural Hospitals Following Health System Affiliation. Health Affairs 38 (12): 2095–2104.
[18] Henke R., Fingar K., Jiang J., Liang L., and Gibson T. (2021). Access To Obstetric, Behavioral Health, And Surgical Inpatient Services After Hospital Mergers In Rural Areas. Health Affairs 40:10, 1627-1636. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2021.00160
[19] Joseph, A., Davis, BS., Kahn, J. (2023). Association Between Hospital Consolidation and Loss of Pediatric Inpatient Services. JAMA Pediatr. https://jamanetwork.com/journals/jamapediatrics/fullarticle/2806301.
[20] Sirota, S. (2023). The Harms of Hospital Mergers and How to Stop Them. American Economic Liberties Project. https://www.economicliberties.us/our-work/the-harms-of-hospitalmergers-and-how-to-stop-them/.
[21] Singh Y, Song Z, Polsky D, Bruch JD, Zhu JM. (2022). Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization. *JAMA Health Forum.* https://jamanetwork.com/journals/jama-health-forum/fullarticle/2795946.
[22] Aldridge MD, Hunt LJ, Halloran Z, Harrison KL. (2025). Private Equity Acquisitions Of Hospices Are Increasing; Ownership Remains Opaque. Health Aff (Millwood). https://pmc.ncbi.nlm.nih.gov/articles/PMC12674456/
[23] Rahman MI. (2025). Understanding private equity-owned HHAs in the U.S.: A performance comparison between pe-owned and non-pe-owned agencies. Health Policy. https://pubmed.ncbi.nlm.nih.gov/39847920/
[24] Cooper Z, Doyle JJ, Graves JA, Gruber J. Do Higher-Priced Hospitals Deliver Higher Quality Care. (2022). NBER Working Paper Series; Working Paper 29809.
[25] Godwin J. et al. (2021). The Association between Hospital-Physician Vertical Integration and Outpatient Physician Prices Paid by Commercial Insurers: New Evidence. INQUIRY: The Journal of Health Care Organization, Provision, and Financing. https://doi.org/10.1177%2F00469580219912 76.
[26] Lewis M., Pflum K. (2017). "Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions." The RAND Journal of Economics.
[27] Arnold DR, King JS, Fulton BD, Montague AD, Gudiksen KL, Greaney TL, Scheffler RM. (2025). New evidence on the impacts of cross-market hospital mergers on commercial prices and measures of quality. Health Serv Res.
[28] U.S. Department of Health and Human Services (2024). HHS Consolidation in Health Care Markets RFI Response. https://www.hhs.gov/sites/default/files/hhs-consolidation-health-care-markets-rfi-response-report.pdf.