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Private Equity in Healthcare: Pivot, Not Retreat

Commentary through the first half of 2026 has described private equity as retreating from healthcare. The data supports a narrower conclusion. Investment in physician practice management companies (PPMCs) has fallen sharply from its 2021 peak, but aggregate private equity deal counts and disclosed capital deployed across the industry have both risen year over year. Private equity has not left healthcare. It has instead pivoted away from the leveraged physician roll-up and toward larger, later-stage, and asset-backed targets. This Health Capital Topics article examines past and current private equity activity in healthcare.

Private equity investment in physician services accelerated after 2015 on a repeatable model: acquire a platform practice in a fragmented specialty, form a management services organization (MSO) to hold the non-clinical assets, finance a series of add-on acquisitions with leverage, and sell the assembled platform to a larger sponsor at a higher multiple than the constituent practices individually commanded. Anesthesiology, emergency medicine, family practice, and dermatology drew the heaviest acquisition activity in the model's early years, and dentistry has since become the most active single specialty by deal count.[1] The model depended on cheap debt, a deep pool of successor buyers, and state corporate practice of medicine doctrines that tolerated management services arrangements (MSAs).

The pattern has a precedent. PPMCs of the mid-1990s assembled large group practices and independent practice associations through practice ownership, management agreements, or both, financed by public equity and debt rather than private funds.[2] Caremark International's 1996 merger with MedPartners/Mullikin produced the largest such company of its era, with 7,250 physicians and 1.5 million prepaid enrollees.[3] The unwinding came quickly. Shareholder litigation over securities filings and the withdrawal of bank credit pushed PhyCor, MedPartners, and FPA Medical Management out of the model within a few years, and by 1998 MedPartners had renamed itself Caremark and abandoned everything except pharmacy benefit management.[4] By 2012, only 17 publicly traded PPMCs remained, and co-management and similar arrangements had largely supplanted the traditional PPMC structure.[5]

The parallels are structural rather than superficial. Both cycles paired a fragmented supply of physician practices with an external capital source that paid for scale it did not create, and both depended on an exit premised on the assumption that the next buyer would pay more. The differences are instructive. The 1990s vehicles were publicly traded, so their collapse registered in quarterly filings, securities litigation, and share prices. Today's platforms are privately held, and their repricing surfaces through extended hold periods and continuation vehicles rather than earnings misses, which makes the current adjustment harder to observe rather than milder. The earlier failure did not end outside investment in physician services – it redirected it.[6]

The 2026 transaction data show that unwinding, though not in the direction the headlines suggest. LevinPro HC reported 459 publicly announced healthcare transactions in the second quarter of 2026, down from 553 in the first quarter and 503 in the second quarter of 2025.[7] Disclosed spending moved in the opposite direction. The 78 transactions with published prices totaled $95.3 billion, compared with $28.7 billion in the second quarter of 2025, and 21 transactions exceeded $1 billion, up from 13 in the prior quarter.[8]

Private equity accounted for 151 of those 459 transactions, roughly 33% of reported activity, compared with 133 transactions in the second quarter of 2025.[9] Fewer deals, more capital, larger targets, and a rising private equity share seem to describe not a market in retreat, but a market that has become more selective.

Within that aggregate, one segment has contracted severely. PitchBook data reported in August 2026 show private equity investment in PPMCs falling from 851 transactions in 2021 to 105 in the first half of 2026, with full-year 2026 activity tracking approximately 50% below 2025.[10]

Physician medical groups nonetheless remain the largest single category of healthcare transactions by count. LevinPro recorded 106 physician medical group deals in the second quarter of 2026, 54 of which were in dentistry, and physician medical groups absorbed 59 of the quarter's 151 private equity transactions.[11] The two data sets (Levin and PitchBook) do not conflict; they measure different metrics. Transaction counts capture small add-on acquisitions to existing platforms, which remain plentiful and inexpensive in fragmented specialties such

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as dentistry. The PitchBook figures track investment into the PPMCs themselves, meaning the platform formation and recapitalization activity that powers the roll-up model. Platform creation has slowed while existing platforms continue to tuck in practices.

The capital behind those platforms has not left healthcare, but it has changed destination. PwC data reported in June 2026 counted approximately 300 health services transactions and $18 billion in deal value in the first quarter of 2026, with eHealth and healthcare technology accounting for 61% of disclosed first-quarter value.[12] Dan Farrell, health services deals leader at PwC US, described the shift as follows: "We're not seeing a retreat from healthcare deals. We're seeing a repricing of risk. Capital remains available, but investors are demanding more proof points before committing."[13]

The second-quarter sector breakdown reflects that repricing. Medical outpatient buildings comprised 51 transactions, trailing only physician medical groups and eHealth, while home health and hospice recorded 20 and behavioral health 18.[14] Real estate, technology platforms carrying recurring revenue, and service lines less exposed to annual Medicare physician fee schedule volatility have absorbed capital that in the prior cycle would have funded specialty roll-ups.

Regulatory cost explains part of the pivot. More than a dozen states now impose notice, review, or corporate practice of medicine restrictions on healthcare transactions involving private equity, and the requirements continue to expand. Maine will require 180 days advance notice of private equity acquisitions of healthcare entities beginning in January 2027, California has proposed extending its review authority to investments exceeding 5% ownership and to sale-leaseback transactions, and Oregon and Washington have adopted filing fees ranging from $25,000 to $350,000.[15]

The federal government also shapes enforcement risk. On March 20, 2026, Federal Trade Commission Chairman Andrew Ferguson launched a Healthcare Task Force to coordinate competition and consumer protection enforcement across the agency's bureaus.[16] The announcement did not name private equity, though the task force consolidates the investigative capacity behind the agency's serial acquisition theories, including its action against the anesthesiology platform U.S. Anesthesia Partners.[17] The practical effect of the combined state and federal regime is duration. A transaction that once closed in 60 days may now require pre-closing notice in several states, and that burden falls hardest on the multi-state platforms private equity spent the last cycle assembling.

Those pressures reach valuation directly. The market is bifurcating rather than deflating. Scaled platforms with diversified payor mix, clean corporate structures, and demonstrated organic growth continue to attract competitive processes. Smaller single-specialty groups, particularly those operating in states with restrictive corporate practice of medicine statutes, face thinner buyer pools.

Deal structure has absorbed part of the adjustment. Higher financing costs and lengthening hold periods have pushed buyers toward larger seller rollover positions, earnouts tied to post-closing performance, and minority or structured equity in place of outright control. Reimbursement compounds the effect. Practices with Medicare-concentrated revenue carry projected cash flows sensitive to annual fee schedule updates, a sensitivity that buyers now price explicitly rather than assume away through growth projections. The premium once paid for scale alone has narrowed toward the premium paid for demonstrated margin durability.

The first half of 2026 closes a distinct chapter in healthcare private equity. The roll-up model that produced 851 PPMC transactions in 2021 rested on inexpensive debt, permissive state law, and the assumption that assembled scale would command a multiple at exit. None of those conditions holds. What has replaced the model is a more selective market that concentrates more capital in fewer and larger assets, prices regulatory exposure explicitly, and favors targets with contracted or property-backed revenue over those dependent on physician productivity.

Whether the pivot proves durable turns on the exit environment. The platforms assembled during the 2021 peak still require buyers, and their eventual disposition, whether by sale, continuation vehicle, or restructuring, will test the valuations recorded when they were built. Those outcomes, rather than quarterly deal counts, will show what the last cycle was worth.

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