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Private Equity Moves into Medical Practice

But the shift has raised concerns about a focus on profits over patients

By Howard Wolinsky

BACK IN 2003, urologist and entrepreneur Richard Harris, MD, and his colleagues started organizing what became UroPartners in 2005, a roll-up of several Chicago-area urology practices. It grew into being the largest urology practice in Illinois and the Midwest with 90 providers caring for 100,000 unique patients each year.

"We're massive," Dr. Harris said of UroPartners. "We extend from downtown Chicago all the way into Southern Wisconsin, from the Lakefront all the way out to Wheaton. And we have a practice presence in the far South Suburbs around Orland Park."

But massive proved to be not big enough without a national presence.

"We always felt that surviving as a small entity of one or two or even three or four was going to become increasingly challenging," Dr. Harris said. "We felt that just being a bigger-sized group would allow us to get some economies of scale and share overhead."

Gaining Economies of Scale

The move proved to be prescient as small practices would be overwhelmed in dealing with such changes as electronic health records and byzantine complications in Medicare compensation.

In February, UroPartners got even bigger and went national, merging with Fort Lauderdale-based Solaris Health, the biggest urology group in the United States. These sort of mergers—backed by private equity investors—are becoming common throughout medicine. Private practitioners such as Dr. Harris have decided that to maintain their independence they needed to partner with a private equity firm rather than selling to hospital systems.

The private equity footprint is relatively small in most markets, about 5% of physicians nationally and in the Chicago metro area work for practices in which private equity firms have invested.

But these transactions are big enough and common enough now that they have attracted the attention of the American Medical Association, health service researchers, populist critics, and members of Congress. Private equity involvement goes up as high as 30% in some markets.

Go Big or Go Home?

In the gambling and sports worlds, it's said one needs to go big or go home. Entrepreneurial physicians have advocated this philosophy over the past 20 years.

At the turn of this century, some medical specialists recognized that the old solo/duo model like "Marcus Welby, MD," the 1970s television doctor who worked with a young associate destined to take over the practice, wasn't working for them, said Gary Kirsh, MD, CEO of Ft. Lauderdale-based Solaris Health Partners, the largest private equity backed, independent practice in any specialty in the United States.

Things were just getting bigger as regional practices transformed into national powerhouses. Plus these days, the Dr. Steven Kileys, Dr. Welby's protege, are so mired in medical school debt that they find it difficult to take over practices.

Cincinnati-based Kirsh, a graduate of the University of Chicago Pritzker School of Medicine, said many specialists found that small practices were not viable.

He said that in the 1990s, urologists in private practice "were very happy and satisfied."

"They made a reasonable income for a doctor, sent their kids to college, took a vacation," Dr. Kirsh said. "They did what they considered then one major surgery a day, which today we wouldn't consider major, just cleaning out the prostate, a TURP (transurethral resection of the prostate). If they saw 10 patients in the office and did one TURP five days a week, they considered themselves satisfied financially. Not rich, satisfied."

But that bubble began to burst over the years as Medicare reduced what it paid to perform a TURP from about $2,500 to about $400. "So not only has it not gone up with inflation, it declined like 80 to 90% adjusted for inflation," he said.

Similar scenarios were playing out in other healthcare specialties with physicians banding together to build larger regional practices.

"They started aggregating because the onesies

LEFT TO RIGHT: Ezra Simons, co-founder and managing partner of Physician Growth Partners, a Chicago-based investment bank that advises physician groups; Gary Kirsh, MD, president and chief executive officer of Solaris Health Partners.

and twosies couldn't make a living that way anymore," Dr. Kirsh said. "When they aggregated, they had access to professional management. They had access to capital. Medicine was becoming more complex, and reimbursement was going down. And they were able to get into new ventures such as ambulatory, surgery centers, laboratory services, and others."

Dr. Kirsh, one of the founders of the Large Urology Group Practice Association, maintained that physicians and patients benefited from this growth. "Instead of having two doctors at this hospital and three doctors at that hospital, when they came under one umbrella, you started to have doctors who subspecialized such as in urologic oncology, or urologic reconstruction," he said. "And so, there was actually an elevation of care in the community outside of certain academic centers like the Mayo Clinic that you had to go far away for."

What Is Private Equity Anyway?

Private equity investment may be best known for buying up—and then selling off—companies in information technology, discretionary consumer products such as clothing, travel and entertainment, business process outsourcing firms, janitorial services, real estate, media, telecommunications. and, lately, healthcare, including hospital systems, pharmaceutical companies, health technology developers, and nursing homes.

The involvement of private equity in the healthcare industry has raised a number of concerns. Some critics worry that private equity firms will focus on profits at the expense of patient care. Others worry that private equity firms will consolidate the healthcare industry and make it more difficult for patients to access care. There have also been concerns raised about increased costs to patients and the potential for fraud from legislators.

Enter the Dentists and Dermatologists

Some dentists and dermatologists have what are dubbed "retail practices." They often are situated in strip malls. They are not heavily reliant on hospital referrals. Patients often pay them out of pocket so insurers play a minimal role. Private equity firms liked their strong revenue flow and began buying these businesses.

Dr. Kirsh said successes got the attention of independent practitioners in other specialties who were worried about the survival of their businesses.

LEFT TO RIGHT: Richard Harris, MD, co-founder of UroPartners; and Sidney S. Welch a healthcare law expert and a partner with Bradley Arant Boult Cummings, LLP.

AMA Examines Private Equity

The growing presence of private equity got the attention of the American Medical Association, which traditionally has viewed itself as the guardian of private practice.

In July, the AMA reported the biggest shift in the past decade was the share of MDs working in private practice, which dropped by 13 percentage points to 46.7% from 60.1% from 2012 to 2022. The share of physicians working in practices at least partially owned by a hospital or health system increased from 23.4% to 31.3% between 2012 and 2022.

The AMA found that physicians working in private equity-owned practices remained at 4.5% between 2020 and 2022.

But these national numbers may not reflect what's happening in smaller or large metropolitan areas.

"The AMA analysis shows that the shift away from independent practices is emblematic of the fiscal uncertainty and economic stress many physicians face due to statutory payment cuts in Medicare, rising practice costs, and intrusive administrative burdens," said AMA President Jesse M. Ehrenfeld, MD, MPH.

However, Dr. Kirsh said, "PE-backed practices are independent as long as the docs are paid on the same fee schedule as legacy independents and as long as they have equity in the practice."

Private Equity Isn't for Everyone

Dr. Harris said UroPartners over several years took a deliberative approach, working with the Chicago-based investment bank, Physician Growth Partners, as a guide, to find its private equity partner, Solaris Health. "Private equity isn't for everybody," Dr. Harris said.

A researcher from a study done by the Petris Center at the University of California, Berkeley, and the Washington Center for Equitable Growth, a progressive think tank in Washington, DC, told *Chicago Medicine* they found several private equity firms had stakes in practices with significant market shares.

In gastroenterology, for example, 9% of the market is held by Illinois Gastroenterology Group, 8.1% by GI Partners of Illinois and 6.8% by DuPage Medical Group, the research showed.

(These numbers are based on a Petris Center analysis of PitchBook Data, Inc., as of June 15, 2022, and OneKey and SK&A Office Based Physicians Database provided by IQVIA. PitchBook data has not been reviewed by PitchBook analysts.)

In contrast, researchers found that in more than a quarter of local markets such Tucson, Arizona; Columbus, Ohio; and Providence, Rhode Island—a single private equity firm owned more than 30% of practices in a given specialty in 2021. In 13% of the markets, the firms owned groups employing more than half the local specialists.

Clearly, the old prototype of a physician hanging out his or her shingle as a solo practitioner or joining a small group practice is disappearing.

Nearly three-quarters of physicians are now employed by hospitals, health systems, and corporate entities, according to a recent analysis from the Physicians Advocacy Institute. The researchers found that the COVID-19 pandemic only hastened this change.

Acquired vs. Backed

Physicians are sensitive about descriptions of the private equity transactions. Do the doctors sell their practices? Do private equity firms acquire them or do they merely "back" them?

The deals often involve creation of healthcare management services organizations (MSOs), also known as medical management companies, to provide non-clinical, administrative support services to physician groups to work around state laws banning corporatization of medical practices.

"The docs sell a portion of their net profit (often 25 or 30%) in perpetuity—currently being paid to them in salary—in exchange for a multiple on that dollar figure (something like 10x up front) and entering into a long-term management agreement with the MSO (Solaris in this case)," Dr. Kirsh said.

"The payment (10x the 30% of net profit in this example) is called the enterprise value, and this is paid to the docs in a mix of cash and stock in the new company.

"The fact that they are getting stock is key: The MSO and the PE firm are tightly aligned since all are equity holders and everyone wishes for the equity to become more valuable over time. If the doctor invests the cash portion of the proceeds conservatively, and the MSO can deliver even modest new revenue streams or practice efficiencies through better management, and the stock grows in value, the doc comes out financially ahead versus legacy independent practice (or even hospital employment), and is protected by the resources and scale of the new MSO relationship. The doc is still 'independent,' as opposed to being employed (by a hospital) because the sine qua non of independence is equity ownership in their business."

Dr. Kirsh added that in almost all cases the practice entity continues to exist since the private equity firm did not acquire it. In Illinois and most other states, the MSO can't "practice medicine" due to laws prohibiting the "corporate practice of medicine."

Dr. Kirsh explained that all licensed medical professionals are still employed by the same medical group. It's just that the medical group is now "managed" by the MSO by contract as part of the deal. If the foundational terms between the doctors' group and the MSO are right, the docs still retain meaningful local autonomy.

"Private equity firms offer physicians an alternative to selling their practices to hospitals They can provide physicians with capital, outsourced management, and access to new markets," said Sidney Welch, a healthcare law expert and a partner with Bradley Arant Boult & Cummings LLP, a national law firm, based in Atlanta.

On-Ramp for Retirement or Expansion

For many retiring physicians who have spent decades building their practices, private equity investment is a way to realize return on their investment, which simply isn't otherwise present in today's marketplace. For other physicians who intend to continue practicing, it's a way to fund expansion and growth for future long term survival, said attorney Welch.

Dr. Kirsh added that private equity deals are often seen as the on-ramp for older physicians to get a lump sum to launch their retirement. But he said for the deals to work, whatever the specialty, the needs of younger physicians in the practice need to be considered.

"Young doctors who want to participate in the future of independent practice will need to join private equity practices," he said. "We believe that our purpose is to continue to innovate and lead the field of urology into the future, for future generations. It's not to get rich. Our equity backers tell me that my job is to build the best urology company in the world. They never tell a doctor to work harder, make more money, never."

Welch said physicians considering private equity investment must be aware that part of the goal for private equity firms is to operate the practice more efficiently than how the practice is currently operating. In the worst-case scenario, that would mean that the private equity investor is going to trim employees and overhead. Done well, that won't be noticeable. In fact, that will be more efficient, and the patients will benefit from that as well as the practice and the providers. Done poorly, the physicians and patients may see some of that in delivery," she said.

Dr. Kirsh maintained: "Higher prices for patients caused by PE-backed consolidation, if they exist, pale in comparison to the cost increases that have been caused by hospital purchases of physician practices. This a really significant upward driver of healthcare costs that has been well documented." Welch notes that, due to differences in reimbursement, hospitals have the ability to capture a significant delta between hospital and physician charges that is the driver for those deals. At this point in time, Welch said, "hospital deals still occur, but the private equity deals are much more popular and significant in number as

an alternative because they have more flexibility for physicians."

Welch said the firms are attracted to physician practices because healthcare investments have held good rates of return generally and practices are often profitable businesses with strong cash flow. She said the management companies created by PE firms can standardize back office support, create group purchasing avenues, and implement policies that promote efficiencies and boost revenue, including evaluation of billing and coding practices, revenue cycle management, and electronic medical record keeping, but physicians remain the ultimate clinical decision makers.

Ezra Simons, co-founder and managing partner of Physician Growth Partners, a Chicago-based sell-side investment bank that advises physician groups, including UroPartners, on making deals with private equity firms, said, "Physician leadership needs to sit down with any potential private equity partner before a transaction and discuss where they want the business to be in five years, what their goals are, and ultimately determine if the goals/strategy is aligned."

He said generally the goal is building the practice to regional or national presence to achieve a level of scale around benefits, costs, ancillary services, and payors, which "most independent physician groups are not ultimately equipped to do on their own."

Getting the Best 'Help'

Simons said doctors with a practice sale in mind need to get help from experienced brokers and attorneys. "It's all about getting the right help and putting together your transaction team correctly. I can't say that enough. Whether you work with PGP or another investment bank with similar experience, the key is working with folks who do this every day for physicians. You are going up against sophisticated investors who understand what they're doing. If you don't get the right help, you have no idea what questions to ask. If you don't know how to position the opportunity the right way, you're going to leave a lot of value on the table—you don't know what you don't know" he said. He further stated that he views the legal component similarly "Same thing on the legal side. This is not a project for a jack-of-all-trades lawyer. This is a job for a specialist who focuses on healthcare M&A to ensure you are properly protected and the transaction is structured correctly."

"Every doctor has a friend who has done something like this. Doctors need to talk to their colleagues about their experiences. Getting educated is something that a lot of people don't take the time to do: Doctors need to learn, to ask, to watch videos, to go to the webinars and invest in getting themselves educated so they have some idea of what's going on and if it's something they should be pursuing or learning more about."

Welch compares this process to hiring home inspectors in real estate deals:

"If you're going to put your house on the market, you want to have a sense of what your value is and where your flaws are and do a pre-inspection inspection so that you use that pre-inspection inspection to make a list of the things that you need to prioritize and fix before you go to market, right? Then you need to hire the right agent before going to market and making sure you have the market comparables. Otherwise, you risk devaluing your practice in this process."

She said the right counsel and the right investment banker don't view the practice as a commodity and a source of income once the deal is done.

"You have to know the ins and outs of physician practices in order to be able to effectively do the deal in the best interest of the client. And that means that there are corporate lawyers out there who do deals all the time but don't do healthcare deals, and they can get bitten by the healthcare regulatory limitations. There are healthcare lawyers out there who may have represented hospitals, and now private equity deals are the latest hot thing, but they don't know the nuances and specifics of physician practices. Or they may have been well-versed in cardiology deals but not know the oncology space, which has a whole bunch of different considerations, including treatment of drug inventory, the value of protocols, and other specialty specifics."

It's the Law

Welch said the legal ramifications, in addition to the operational issues and the specialty-specific considerations, should be considered. "And a step beyond that, they need to consider the nuances with various specialty practices and how those translate into important legal and business terms," she said.

She said that in addition to federal healthcare statutes and regulations, state laws and regulations drive these deals. This especially revolves around the corporate practice of medicine doctrines, established by statute and/or case law, stating that a corporation can't own a medical practice, and fee-splitting doctrines stating that physicians can't split fees derived from the practice of medicine with a non-licensed individual. She noted laws and enforcement vary by jurisdiction.

For example, Illinois has both a corporate practice of medicine doctrine and a state-specific anti-kickback statute. She noted that the involvement of private equity firms is accompanied by increased regulatory scrutiny of medical practices, such as anti-kickback legislation. PE firms are prohibited from direct ownership of physician practices.

This is where MSOs fit in.

She noted that these deals can be done on an extremely accelerated basis or it can take a year for these deals to be completed, particularly with thoughtful pre-market planning.

In his field of urology, Dr. Kirsh estimates that 50% of urologists now work for hospitals, which view urology as just another specialty they need to offer, while independent groups like his are specialty-centric. He said doctors who sell their to hospitals may be shocked at their loss of autonomy and by the fact that they may be shown the door after a short time.

He said autonomy is a concern in the private equity environment, too. "Whenever they scale up, doctors are concerned about autonomy," he said. The involvement of outside investors also highlights this issue.

Simons, whose bank has represented women's health, pain management, urology, and dermatology practices, said the degree of autonomy depends on how deals are negotiated and structured.

"Before a transaction, you're starting from a position of having 100% control and no other people at the decision-making table except for you and the people you've been partners with for the last X number of years. Through a transaction, you're introducing an additional person into the dynamic," he said.

"So what does that mean? It's totally dependent on what the expectations were, and what the legal documents say, and what the strategy with the private equity group is. It means something different in every transaction. All buyers/investors view the goals/strategy differently. Welch points out that this all highlights the importance of choosing the right partner. "Look at what investors are trying to accomplish, which helps convey to the physician side what's realistic. What's the mission and the goals? What are the philosophies and realities in control and management? How is expansion treated? What has the track record been?

Simons elaborates: "Most investors we would want our clients to do business with are forthcoming in their position of not being at all interested in how you manage the day-to-day practice and clinical decision-making. Many buyers/investors are more focused on building scale to share common infrastructure (recruiting, revenue cycle, purchasing), seeking to gain leverage with suppliers, payors, and benefits providers, and ultimately building out shared services among partner groups.

"Moreover, they want to continue to push the recruitment pipeline and bring on clinically excellent providers who can grow the practice and enhance its reputation. That is a very hands-off model. At the same time, there are other clients I have who look at it and say, 'I don't want to manage my business anymore. I want help. I want support.' They're looking for a buyer/investor who offers those things on a day-to-day basis versus somebody who has a completely hands-off approach and says, look, you've built a great business, you don't need our help. Let's just get better on purchasing. Let's get better on payor rates, and let's create value that way—those are two completely different types of deals."

Solaris' Dr. Kirsh said, "We've tried to bake into our agreements certain guarantees for the doctor that preserve their autonomy so investors and management companies can't interfere with their clinical practice and can't them move their office more than a mile. We can't make them go in with another doctor they don't want to practice with. We can't acquire another group of doctors in their practice area without their permission."

What about Patients?

There are different views of where patients fit in.

Dr. Kirsh said patients generally won't see a difference in care and often are not informed about the financial dealings of the practices.

Welch agrees but points out that "patients may be concerned about the impact of private equity investment on the quality of care they receive." Advocacy groups are vigilant in watching the impact of this trend and encourage patients to stay informed about the ownership structure of their physician practices and to advocate for their own interests.

Dr. Kirsh also cautions doctors considering partnering with private equity to resist giving up too much control as this could lead to higher costs and lower quality of care. Research is mixed on whether patients in private equity-owned practices pay more.

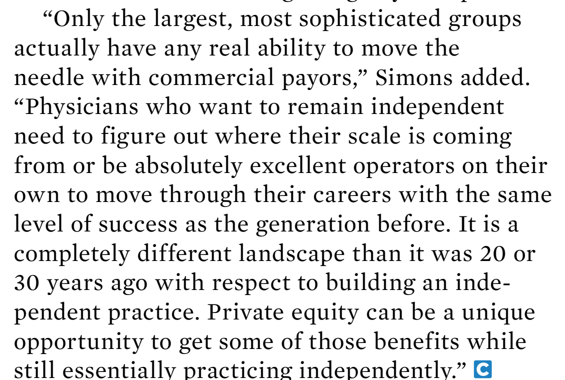
The recent Petris research found that when a firm owned more than 30% of the market, the cost of care in three specialties—gastroenterology, dermatology, and obstetrics and gynecology—increased by double digits.

Dr. Kirsh noted media articles often say private equity has driven up healthcare costs. "I can tell you we have a private equity backed platform and we haven't driven up the cost of care anywhere."

The Future

"It is not getting any easier for the traditional independent private practice. Look at it from any angle," Simons said. "The Medicare fee schedule is not getting better, the level of competition in the market is not getting weaker, and the costs to run the business are not getting any cheaper.

"Only the largest, most sophisticated groups actually have any real ability to move the needle with commercial payors," Simons added. "Physicians who want to remain independent need to figure out where their scale is coming from or be absolutely excellent operators on their own to move through their careers with the same level of success as the generation before. It is a completely different landscape than it was 20 or 30 years ago with respect to building an independent practice. Private equity can be a unique opportunity to get some of those benefits while still essentially practicing independently."



Private Equity's Critics Mount

Researchers warn about the impact of private equity on healthcare **By Howard Wolinsky**

PRIVATE EQUITY involvement in healthcare, from medical practices to nursing homes and health systems, may be a small but growing feature of American medicine.

Legislators and regulators at the state and federal levels already are looking at the phenomenon and discussing, what if anything, to do about it.

In August, Illinois Governor JB Pritzker signed House Bill (HB) 2222 into law to enhance state Attorney General (AG) oversight of mergers and acquisitions among healthcare entities. The law amends the Illinois Antitrust Act, the Illinois Health Facilities Planning Act, and the State Finance Act, requiring healthcare entities to provide notice to the AG of any mergers or acquisition activity 30 days prior to the closing or transaction effective date.

"Currently, many healthcare mergers and acquisitions are not reviewed at the state or federal level," Illinois Attorney General Kwame Raoul said. "Without proper review, these transactions can lead to diminished options for individuals who are already struggling to access health care services in their communities."

Raoul said the new legislation gives his office more tools to protect Illinoisans from proposed mergers that lessen competition and increase health disparities. However, while the law allows the attorney general to question deals, it does not empower him to stop them.

Some federal legislation has been discussed as well.

For example, Sen. Elizabeth Warren (D-Mass.), has promoted the Stop Wall Street Looting Act since 2019 to regulate debt-heavy deals that can lead to layoffs, bankruptcies and other problems while exposing private equity firms to few risks. The bill would tax capital gains as regular income, ban dividends in the first two years a private equity firm owns a portfolio company, and hold firms responsible for debt and legal obligations incurred at portfolio companies under their ownership, among other outcomes. The bill never got out of committee.

Private Equity Involvement Underreported

Nationally, the American Medical Association, which is examining the issue, said in a recent report that only 5% of American physicians are employed in practices where private equity firms are involved.

But some researchers are warning these are early days and private equity in the long run could pose risks to an already teetering healthcare system.

Primary care physician and health services researcher Jane Zhu, MD, associate professor of medicine at the Oregon Health & Science University, told *Chicago Medicine*: "Private equity transactions are not transparent. When you're looking at physician penetration across these ownership types, we're probably underestimating it as well.

"Averages definitely mask extremes and variation across specialties. We see that there is variation in terms of where private equity is going for physician specialties. Obviously, private equity firms have been very active in dermatology and other high-volume procedural specialties for some time now. The penetration that we've seen based on our research has varied between 5% and 10%."

Private Equity Grows

In a report released in July, "Monetizing Medicine: Private Equity and Competition in Physician Practice Markets," researchers from the Petris Center at the University of California, Berkeley, and the Washington Center for Equitable Growth, a progressive think tank in Washington, DC, found:

- Private equity acquisitions of physician practices are rising. They noted there were 481 PE deals in 2021 compared with 175 deals in 2012.
- Private equity firms are amassing high market shares in local physician practice markets. In 28% of metropolitan statistical areas (MSAs), a single PE firm has more than 30% market share by full-time-equivalent physicians, and in 13% of MSAs, the single PE firm market share exceeds 50%.
- Private equity acquisitions are associated with price and expenditure increases. In 8 of the 10 physician practice specialties, they found statistically significant price increases associated with PE's acquisition of a practice. These price increases range from 16% in oncology to 4% in primary care and dermatology. PE acquisitions are also associated with per-patient expenditure increases for 6 of 10 specialties, ranging from 4% to 16% depending on the specialty.

Destroying the Health System?

Laura Katz Olson, PhD, a political scientist at Lehigh University, wrote the 2022 book, "Ethically Challenged: Private Equity Storms U.S. Health Care," (Johns Hopkins University Press), which focuses on how private equity firms are "gobbling up" medical and dental practices, nursing homes, hospices, and more.

"Private equity companies are basically destroying our healthcare system," Olson said. "They're taking pieces of our healthcare system and destroying them."

She warned that private equity firms are predatory, opportunistic and short-term players by definition. "They load companies with debt, cut costs, and sell off assets, which can lead to job losses, reduced investment in innovation, and lower quality of products and services for consumers. They are focused on generating short-term profits, even if it comes at the expense of long-term performance.

"They are very flexible, and can abandon markets that are not good, and remain in those that are very lucrative."

Olson said these firms typically invest in medical practices by leveraging debt and then selling off their interest in five to seven years to the next investor. She argues that private equity firms have led to higher prices, lower quality care, and fewer choices for consumers in the healthcare industry.

Does Private Equity Increase Costs?

One of the major questions regarding practices in which private equity firms are involved is whether they increase costs.

Zhu, Bruch and colleagues examined a total of 578 physician practices specializing in dermatology, gastroenterology, and ophthalmology that were acquired by private equity firms across the U.S. from 2016 to 2020. They reported in *JAMA Health Forum* last year that private equity

LEFT: Ambar La Forgia, an assistant professor in the management of organizations group, Haas School of Business, University of California, Berkeley. RIGHT: Jane Zhu, MD, associate professor of medicine, the Oregon Health and Science University in Portland.

acquisition of physician-owned medical practices increase prices charged to insurers, allowed amounts paid by insurers, volume of services, and volume of new patients seen.

They say their study did not examine whether these practices hurt clinical outcomes for patients. However, the findings raise concerning parallels with the rapid growth of private equity acquisition of nursing homes and hospital systems, they said.

"To the extent that these results suggest increased access, this may be a positive effect. But if higher healthcare spending is not for necessary care, then this could be a problem. The reason for concern to patients and policymakers is that private equity is often driven by profit margins of 20% or more," said Zhu. "To do that, they have to generate higher revenues or reduce costs. Increasing private equity in these physician practices may be a symptom of the continuing corporatization of healthcare."

Joseph Bruch, PhD, a health policy researcher at the University of Chicago, said: "What we found in a recent systematic review is that you do see higher increases in prices and charges at private equity-owned healthcare settings. This could pose a particular issue for those who are uninsured and underinsured."

He said that private equity firms may be more skilled at negotiating reimbursement rates or may find ways to charge patients more.

Bruch also mentioned research by Ashvin Gandhi and colleagues at UCLA showing that private equity-owned facilities increase the quality of care in highly competitive markets and reduce the quality of care in less competitive markets. "But there are still larger questions about what private equity means over the long term if so much of our health system is owned by entities with short-term profit motives," Bruch said.

Bringing AMA CEJA into the Debate

Francis Crosson, MD, senior instructor in health policy for the Kaiser Permanente Bernard J. Tyson School of Medicine in Pasadena, California, is a pediatric infectious disease specialist who in recent years has written about health policy issues, such as private equity. He launched the AMA's Integrated Physician Practice Section.

A year ago, he helped raise concerns about private equity at the AMA House of Delegates that led the AMA to start monitoring the growth of private equity.

Dr. Crosson said private equity has flown under the radar of legislators and policymakers in medicine because its focus has been on lucrative specialties with smaller numbers of doctors, especially procedural specialties and those with high margins, such as emergency medicine, oncology, anesthesia, and dermatology, which has has morphed from a medical speciality to a surgical specialty with all the cosmetic procedures.

"I haven't seen much, for example, about private equity in pediatrics or general internal medicine or general surgery or psychiatry," he said.

Dr. Crosson said private equity is changing the nature of medical practice in different ways for older physicians facing retirement and wanting to cash out and younger physicians coming into practice.

"What advice would I give to a 69-year-old physician, who happens to own part of a practice and wants to stop practicing, and if the practice is sold that person can walk away with 4 or 5 million dollars? Well, good luck to you. It's not responsible on some level given the sense of duty that one might feel to the other physicians, but that's a private decision," he said.

He said physicians in their 30s and 40s who are entering practice in this new environment need to consider the downsides to private equity investment. "If you have an opportunity to join the game, and maybe you need it for the future financial health of your practice. But I think physicians who are going to do that need to understand the environment of their practice may change materially, and their ability to have an environment that was supportive of physician professionalism may erode over time."

Private Equity and Prices

Healthcare services researchers have been looking at aspects of private equity and medicine with varying results.

LEFT: Joseph Bruch, PhD, a health policy researcher at the University of Chicago. RIGHT: Laura Katz Olson, a political scientist at Lehigh University, wrote the 2022 book, "Ethically Challenged: Private Equity Storms U.S. Health Care."

Ambar La Forgia, PhD, assistant professor, Management of Organizations, Haas School of Business, University of California, Berkeley, said that her research has shown in anesthesia, for example, private equity involvement has led to high increases in prices.

"This means that the insurers are paying out much more after a group becomes affiliated with a private equity organization or that is acquired by private equity. And so not only is the insurer paying more, but the patient ends up paying more through co-pays. And eventually the patient is going to pay more in higher premiums because the insurance company is paying more than they would otherwise."

In February 2022, La Forgia and colleagues reported in *JAMA Internal Medicine* that prices paid to anesthesia practitioners increased after hospital outpatient departments and ambulatory surgery centers contracted with physician management companies (PMC), and were substantially higher if the PMC had received PE investment.

In an editorial accompanying the La Forgia article, Dr. Crosson said: "Such added cost is unwelcome at a time when lack of healthcare affordability is a national disgrace. We also need to understand the potential influence of private equity investments in healthcare on the quality and appropriateness of care delivered and the potential threat to physician professionalism."

He noted that continued investment by private equity firms in single speciality practices, such as anesthesiology, dermatology and ophthalmology, suggests they are financial winners, but he questions whether this formula will work in multi-speciality practices, where there have been notable bankruptcies.

"Opportunities to extract costs and add revenue are not infinite. Investors, however, might expect that they should be," Dr. Crosson added.

"Payers will find ways to push back. Government intervention is possible through antitrust laws and Stark anti–self-referral regulations. And younger physicians in the practices, who may not have profited by the sale of the practice, may balk in the future at paying management fees or at attempts by PMCs to influence their practice decisions. Business failures of these enterprises risk instability for both physicians and patients."

Dr. Crosson, who with La Forgia testified at the AMA House of Delegates last year, told *Chicago Medicine*: "Basically, the game here to avoid scrutiny or potential antitrust considerations is to buy practices at less than the FTC trigger, and just keep rolling them up together into larger and larger entities. And one might speculate that the purpose of that then is to gain market traction in a particular market in a particular specialty. For example, buying all the small anesthesia practices in order to get a big one, but not requiring reporting to the FTC, because each practice acquisition is less than the trigger level."

Dr. Crosson urged that the Federal Trade Commission, which is concerned about market concentrations such as those that can result in roll-ups within specialties, might pay closer scrutiny to private equity investments,

The FTC has a threshold of $94 million, so many individual deals are not reportable.

AMA's CEJA: Patients Come First

At the AMA House of Delegates annual meeting this year, the AMA Council on Ethical and Judicial Affairs proposed new guidance to physicians that emphasized that patient welfare should come first. The proposed guidance said physicians should not engage in contracts that compromise their ability to fulfill their fiduciary obligations to patients.

An AMA spokesman said the House of Delegates voted to refer CEJA Report 02-A-23 back to CEJA with a request for a report back at the next Interim Meeting.

CEJA recommended: "When physicians enter into arrangements with partners who may later sell the practice, physicians should seek explicit commitments that subsequent partners will sustain fidelity to patients and respect physicians' professional ethical obligations."