A Wider and Brighter Anesthesiology Landscape

Private Equity in Anesthesia: Background and Long-Term Implications

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Gordon Gekko, the brilliant but ruthless corporate titan at the center of Oliver Stone's 1987 film "Wall Street," was a private equity investor, whose tactics earned him millions in the cutthroat world of mergers and acquisitions. The classic quote was "Greed is Good!" But is it? The answer matters because private equity ownership of anesthesia groups has been a reality for decades, with increasing prominence in recent years.

A recent editorial in the *New England Journal of Medicine* discussed the expanding role of private equity in acquiring physician practices (*N Engl J Med* 2021;384:981-3). Private equity (PE) firms use capital sourced from pension funds, sovereign wealth funds, high net-worth individuals, and endowments to invest in promising businesses. PE investors typically seek a return of at least 20% to offset the risks involved, as future growth cannot be predicted with 100% accuracy (*Ann Intern Med* 2019;171:78). Investment in physician groups begins with acquisition of a "platform" or well-run practice that is often a regional or market leader in services, followed by acquisition of smaller practices under that label (*Ann Intern Med* 2019;171:78). The PE investor aims to optimize the combined practice through economies of scale, using tools such as streamlined billing, reduced overhead, and optimization of staffing to make the group as efficient as possible. Ideally, the application of business expertise increases the profitability of the practice, with benefits for all concerned. In a perfect world, the result would be win-win, with the PE investor earning money from operating an efficient business, while creating more value for the practice partners than was there in the first place.

Not surprisingly, there are detrimental effects of PE investment. PE firms target businesses with the potential for rapid growth, with the intention of exiting the investment in three to five years; in contrast, most physicians hope to remain with a chosen practice for an entire career. A recent publication examining ophthalmology and optometry practices showed the median holding period for a medical practice platform company was 3.5 years before it was sold or recapitalized to new investors (*Ophthalmology* 2020;127:445-55). The rapid pace of practice acquisition has also created new regional, multi-state, and multi-specialty entities, the impact of which is still unknown (*Ophthalmology* 2020;127:445-55). This is an important consideration when assessing the future of anesthesiology; in 2013-2016 more investments were made in anesthesia practices than in any other specialty, comprising 19.4% of all groups and 33.1% of all physicians acquired (*JAMA* 2020;323:663-5). Other specialties have been focused more recently, while investments in anesthesia groups have slowed and evolved.

Anesthesia practices were viewed as a promising investment because the volume of procedural services has grown steadily for decades and because anesthesia physician groups were already more aggregated than other specialties. Revenue cycle management and regulatory compliance can benefit from investment in sophisticated information technology, while clinical coverage of multiple sites of care can increase staffing flexibility in larger practices (*Milbank Q* 2014;92:542-67). Investment in a nationwide recruiting infrastructure might also help to fuel growth in a highly competitive market for clinicians.

The COVID-19 epidemic further disrupted a complex landscape by increasing demand for poorly compensated critical care services and reducing demand for elective surgery (*Int J Health Policy Manag* 2020;9:423-8). Both hospitals and anesthesia practices saw wide swings in revenue in 2020, bringing greater uncertainty to financial projections.

The risks of private equity investment

For partners in an anesthesiology practice the decision to join a larger organization is momentous. As in clinical practice, both risks and benefits must be weighed. Table 1 presents a summary of major factors to consider, but the discussion should begin with an internal assessment of goals. For senior physicians in the group, a sale represents the opportunity to capitalize on years of work in building the practice. For more junior members, with longer anticipated careers in clinical practice, the primary goal might be long-term stability: the opportunity to focus on patient care, confidence in the efficiency of practice management, and a fair financial return over time for the work invested. The latter point is the most important, as there is typically a short-term fall in compensation with the change from partnership to an employment model. Against these benefits must be set the potential risks.

The most important risk of PE investment is loss of control over important decisions. In some domains this is reasonable, as when a sophisticated business team negotiates better managed care contracts, lower malpractice insurance premiums, or a higher return on the practice pension fund. In other domains a loss of control is unlikely – day to day clinical care of individual patients remains the responsibility of the clinicians involved, and a PE investor will not dictate the choice of one medication over another in the operating room. The areas in-between is where risk becomes most real: negotiation of hospital contracts, for example, or hiring and clinical coverage decisions. Existing market pressure towards a leveraged care team model can be exacerbated by PE pressure towards 'efficient' staffing – fewer anesthesiologists supervising more rooms – with potential for abrupt shifts in group culture and risk of a decrease in the quality of care.

A subtler risk is demotivation of the anesthesiologist partners. Many PE sales result in the partners exchanging the entire future earnings of their group for a substantial up-front payment and subsequent salaried employment. While rewarding in the short-term, over longer periods the shift from owner to employee can warp the perspective of clinicians. There is less incentive for uncompensated work on hospital committees, expanding to new areas of service, or staying late to cover add-on cases. Over time this demotivation affects relations between the group and the hospital. This can lead the hospital to seek a change of anesthesia groups.

Another consideration is change of business partners over time, caused by the mismatch in investment horizons described above. There are several ways for private equity investors to make money from an acquisition. The first,

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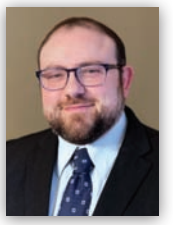

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and generally most common, is to hold the company for a time and then re-sell it to another investor, either whole or in components. Most PE firms have a well-defined time horizon for investments, based on their internal expertise at creating value, and most will seek to exit the investment when this horizon is reached. The second approach is to take the company public and benefit from selling stock to the public. Rarely, the practice can be sold back to the physicians. This happened recently when US Acute Care Solutions – an emergency medicine and hospitalist aggregator – took on debt financing to close out their relationship with an equity investor. The final approach is to improve the functionality and efficiency of the firm to create steady profits over a longer period, with an indefinite investment horizon.

The trend for health care companies has been to remain private, ruling out a public listing. And hospital-based clinician firms have few physical assets like property, patents, or intellectual property, making a component sale less likely. In most cases, the original PE firm exits by selling the entire business to another private investor.

Consider the case of a hypothetical anesthesia practice acquired by Sheridan Healthcare in 2012, which then saw Sheridan acquired by Amsurg in January 2015. In June 2016, Amsurg then merged into Envision Healthcare, which was then purchased by KKR, a large PE firm, in 2018. Similarly, many anesthesiology groups were acquired in the past decade by American Anesthesiology, a division of Mednax (a multispecialty practice management company). Mednax sold this entire business in 2020 to North American Partners in Anesthesia (NAPA), which in turn had been recapitalized in 2016 by American Securities. NorthStar Anesthesia PA, owned at the time by TPG Growth, acquired Anesthesia Management Solutions in December 2014. Then in June of 2018, Cranemere acquired Northstar Anesthesia from TPG. Resolute Anesthesia, previously a management company that featured Goldman Sachs as its primary partner, sold to Sheridan Healthcare in 2016, only three years after its formation. Phymed Healthcare Group was originally owned by Excellere Partners but sold in 2014 to Teachers' Private Capital, funded by the Ontario, Canada, teachers' pension program. US Anesthesia Partners was originally formed by Welch Carson Anderson & Stowe in 2013 but recapitalized in 2018 by bringing in other investors. It is now common for physician anesthesiologists to be employees of an acquiring firm they have never met, with little input regarding future sales and acquisitions of their practice. Table 2 is a list of some of the biggest anesthesia practices and their private equity partners or parent companies today.

Table 1: Potential risks and benefits for a private practice group considering acquisition by an anesthesia services firm, possibly with private equity backing

Benefits	Risks
Clinicians can focus on patient care, leaving practice management to professionals	Frequent change in management/leadership
Decreased overhead costs (billing, compliance, quality, admin, etc.)	New priorities for operational efficiency
Overhead burden shifted to parent company	Distant (not local) leadership
Improved quality metrics/ initiatives, and the chance to invest in improvement activities	Changes in billing/payer relationships, especially with the hospital and system
Potentially guaranteed salaries	Potential changes to staffing
Access to capital for investment opportunities	Changes in quality/productivity metrics
	Threat of further sales/ acquisitions
	Susceptibility to financial stress on the investor

Table 2: A sampling of prominent anesthesia service firms and their private equity partners and/or parent companies

Anesthesia Services Firm	Private Equity Partner/ Parent Company
Envision	KKR and Co. Inc
Epix Healthcare	ASHLAR CAPITAL
National Partners in Healthcare/ Metropolitan Anes. Consultants	Archimedes Health Investors, BlueMountain Capital Management
NAPA/American Anesthesiology	American Securities
NorthStar Anesthesia PA/ Anesthesia Management Solutions	Cranemere
Phymed Healthcare Group	Teachers' Private Capital
TeamHealth	Blackstone
US Anesthesia Partners	Welsh Carson Anderson & Stowe, Berkshire Partners, and GIC

The long-term implications of the deals and partnerships listed in Table 2 will play out in the next few years. KKR's purchase of Envision was completed in 2018, and (based upon recent history of similar companies) a change in ownership may occur in the next several years. American Anesthesiology was absorbed into NAPA in 2020, and the influence of American Securities on their operations is yet to be determined. As private practices consider sale to a management company, it is important to consider the underlying partner or owner, as well as the recent sales history. Although rare, there are also some notable anesthesia aggregators – mostly based around CRNAs – with no current private equity link, such as ApolloMD, Capital Anesthesia Solutions, Premier Anesthesia, and Somnia Anesthesia.

Resale risk can be mitigated at the time of the transaction by having a clear understanding of the PE investor's history, time horizon, and exit strategy. How long are they planning to remain involved? What are their resources and how hard will they work to increase the value of the practice? How and when do they anticipate selling their investment? Private equity companies have fewer required disclosures to the Securities and Exchange Commission than publicly traded companies, and their financial statements are not public information. It can be difficult to understand their financial health before a deal and their ongoing health after an acquisition. Due diligence on the part of the physician partners is highly recommended, along with a clear understanding of physician partner rights – if any – in future transactions.

The benefits of private equity investment

PE acquisitions are often driven by the immediate financial benefits. Ownership of an anesthesia private practice is an illiquid asset which can be difficult to capitalize; the opportunity to do so, while reinvesting the money elsewhere, is a useful diversification of an individual anesthesiologist's portfolio, especially when the proceeds are taxed as capital gains rather than ordinary income. Except for partners who are close to retirement, however, the cash proceeds of a sale should not be the greatest motivation for a deal; rather, it is the future value of the PE investment that should be the most important consideration.

Access to PE capital enables growth, which in turn creates economies of scale. Larger groups, serving more facilities, can use staff more efficiently. They can make expensive investments in information technology. They can afford to hire better executive talent and can invest in more expansive clinician recruitment. A larger retirement fund will enjoy better rates of return and a larger practice can negotiate lower costs for everything from educational products to paper clips. A PE-fueled business, like any good practice management company, should "have the clinician's back" by managing business, regulatory, and bureaucratic details that distract from clinical care. Perhaps most important to financial health, however, an aggregated anesthesia practice can negotiate on a stronger footing with the real behemoths of the health care landscape: hospital systems and commercial insurance companies. Even in an era of physician practice aggregation, health systems and insurance companies are 50-100 times larger than the largest anesthesia companies. The *New England Journal of Medicine* article cited above makes the case that PE investment in physician practices is a strategy to avoid direct acquisition by the hospital, which for anesthesia groups often represents the disadvantages of an employment model without any reward for the years spent building the practice.

Variations in PE deals can work in favor of the practice partners, mitigating risks. Models that preserve financial and quality

incentives for partner anesthesiologists are especially powerful because all parties continue to have "skin in the game." For example, if the PE investor acquires 100% of the future income of the practice, then the salaried clinical work force becomes an expense of the business. The investor is incentivized to keep staff lean, while the physicians themselves have minimal incentive to work beyond their contracted hours. If, on the other hand, the investor buys only a minority fraction of future earnings, then both the PE firm and the anesthesiologists are strongly incentivized to grow the business. The anesthesiologists take home the immediate gains from doing more work and having a better reputation with the hospital, while both parties reap the long-term benefits of growing the business.

PE deals can be structured to give physicians ownership of key clinical decisions, such as hospital contracts, staffing model, and clinical recruitment. Partial, rather than full, capitalization creates a partnership between PE owners and physician partners that gives both parties a voice in the future of the business. When constructed appropriately, this kind of deal makes it harder for the PE investor to cut and run, because they must have the consent of the physicians to do so. At the same time, a partnership preserves the culture of the group and their motivation to make good decisions.

While upfront cash payment to the partners is not as large in a partial capitalization deal, the long-term alignment of incentives will produce greater returns over time. Skin in the game following a PE deal motivates mutual investment in the quality of the clinical practice, since it is a shared brand. Capital can be put to work to increase – and publicly demonstrate – the quality and safety of patient care. Routine measurement, analysis, and improvement of patient satisfaction is one example of this (*Anesth Analg* 2019;129:951-9). It is no accident that the most sophisticated systems for quality data capture and clinician feedback in anesthesia are not in academic centers but rather in PE-fueled private practices with strong incentives to deliver high-quality care and the ability to invest in quality improvement infrastructure such as a patient satisfaction measurement system. Anecdotally, partially capitalized anesthesia practices appear to have weathered the COVID crisis better than fully employed practices, with greater retention of their clinical workforce.

The future of anesthesia practice consolidation

Given the pressures on independent anesthesia practices today, aggregation is likely to continue. The need for sophisticated information technology to optimize revenue cycle management and regulatory reporting, the difficult negotiating position of small groups versus large managed care companies, the challenges of recruiting in a tight labor market, and the daily pressure to provide more points of service for the hospital system all make practice management difficult and invite external support. Aggregation may take the form of hospital employment, purchase by a large staffing company, or partnership with PE. Alternatively, the group can remain independent but combine with others for services through offerings of the ASA or billing service vendors. None of these options are perfect, but the better the group understands the risks and benefits involved, the more likely they are to succeed. Focusing beyond the immediate financial returns, the most pertinent questions for anesthesiologists to consider are the day-to-day implications of private equity partnership and the future of the practice beyond the PE investment horizon. ■

Disclosure: *Dr. Dutton holds stock in US Anesthesia Partners.*

The Perks and Pressures of Private Practice Anesthesia

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In a recent analysis of factors that influence an anesthesia resident's career decisions, investigators found that of the 263 CA-3s from a large tertiary care academic institution over 15 years, 110 (41.8%) went into private practice upon completion of their residency. In contrast, 120 (45.6%) pursued advanced fellowship training, and the rest (12.6%) stayed in academic anesthesiology (*J Educ Perioper Med* 2018;20:E616). The authors suggest that the low incidence of residents accepting academic positions is somehow related to the fact that many academic posts require fellowship training. Speaking from experience, we believe that the most significant driver of a decision between academic and private practice anesthesiology is economical, or at least, the perception that the financial rewards in private practice anesthesia are significantly greater. We say "perception" because the days when a private practice anesthesiologist in a physician-owned hospital-based group practice could make a large amount of money are disappearing and being replaced by for-profit national practice management corporations. There are perks to this changing landscape in private practice anesthesia as well as some pressures to consider before the leap.

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Unlike academic anesthesiology, a large part of the time and energy that goes into being a successful independent private practice anesthesiologist is managing the *business* of anesthesiology. As most physicians did not pursue medicine as a business interest, the idea of being a business owner often becomes a source of stress and consternation. The pressure of being a small business owner, and all that goes with growing and sustaining a viable business model, has driven some small to medium-sized private practice groups to consolidate with other similarly sized groups, while others have joined a larger health system and the rest consider selling their business to a large practice management company (asamonitor.pub/2UNQgPk). The latter two options function as anesthesia group practices emphasizing management by the participating physicians (e.g., OAG) and those that operate more as management companies emphasizing financial outcomes (e.g., NAPA) (asamonitor.pub/3hDkMEz).

Anesthesiologists have always been at the mercy of surgeons and proceduralists regarding income and lifestyle. As surgeons and proceduralists have abandoned hospital-based practices to establish more lucrative, suburban-based, and ambulatory surgical centers, hospital-based anesthesia groups that had traditionally limited their practice to hospitals were at risk of decreased revenue. As this surgical practice pattern changed, independent private practice anesthesia groups understood that larger organizations with wider geographic footprints would translate literally into greater leverage during negotiations with surgeons, hospitals, and insurance companies. Anesthesia services generate more than $19 billion in revenue annually. That number is likely to grow as the need for surgical procedures increases in parallel with increased life expectancy in baby boomers who are now reaching retirement age (asamonitor.pub/3kgHuEo). To remain competitive in a market that has so much financial incentive, traditional

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