American Society of Anesthesiologists

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June 16, 2010

Inspector General Daniel R. Levinson
Office of Inspector General
United States Department of Health and Human Services
Room 5541 Cohen Building
330 Independence Avenue, SW
Washington, DC 20201

Dear Mr. Levinson:

The American Society of Anesthesiologists (ASA), on behalf of its over 44,000 members, first brought the issue of an economic model, referred to as the "company model," to the attention of the Office of Inspector General (OIG) in a letter dated March 19, 2009. In our letter we illustrated our concerns that the "company model" potentially violates the Federal anti-kickback provisions of the Social Security Act (the Act) (section 1128B), and/or the prohibition of self-referrals of the Act (section 1877). Mr. Lewis Morris, Chief Counsel to the Inspector General, acknowledged receipt of ASA's letter in a letter ASA received on April 23, 2009. Since this time, and despite the best efforts of ASA to determine the status of our request, OIG has not taken action. In light of a recent article, independent of the ASA, that examines the issue of the "company model" as it relates to anesthesia providers, the ASA renews its request to the OIG to issue a Special Advisory Bulletin on the "company model."

As stated in the ASA's previous letter, in recent years, physician-owned facilities, especially those owned by gastroenterologists, have been moving away from the traditional fee-for-service model and turning to the "company model" to increase their revenue stream for anesthesia services. The "company model" involves the establishment of a separate anesthesia company under the same ownership as the facility where the anesthesia company employs the facility's anesthesia providers for the sole purposes of providing anesthesia services to the facility. Establishment of a separate company permits the facility to bill for facility fees and anesthesia services fees through the same billing/administrative company. The owners of the facility and the anesthesia company then share in the profits generated by the facility fees and the anesthesia service fees.

The independent article (*Profiting from Anesthesia Services: An Analysis of Emerging Compensation Arrangements Between Ambulatory Surgery Centers and Anesthesiologists*, CCH Health Care Compliance Letter, March 23, 2010 – see attached) raises similar concerns as were discussed in our previous letter and are discussed here, including the issues of illegal kickbacks, self-referrals, and the negative consequences of certain health care joint ventures. Specifically, the article mentions the serious risk of contract termination that anesthesia providers face if they refuse to agree to the "company model." The article also highlights the threats to patient safety and quality of care that are likely to result from the incentive on the part of the facility owners for overutilization of services.

Our stated concerns regarding the "company model" remain and have increased since our March 19, 2009 letter. In the last year we have heard from a number of additional members whose practices have been threatened or who have lost contracts due to refusing to acquiesce to this potentially illegal model.

We still believe this issue should be of utmost concern to the OIG given its prior statement on joint ventures:

> *Distributions from the joint venture may be disguised remuneration paid in return for referrals. Like any kickback scheme, such arrangements can lead to overutilization of services, increased costs for federal health care programs, corruption of professional judgment, and unfair competition.*

First, under the "company model," since the owners of the facility also own the anesthesia company and have a stake in the profits of this separate company, they have an incentive to increase utilization of anesthesia services, which will result in an increase in federal health care costs. When the surgeons or gastroenterologists performing procedures in the facility are the owners, they are making clinical judgments about the necessity of anesthesia services for their procedures in the context of a financial interest in the volume of anesthesia services provided in the facility. It is hard to imagine a more obvious conflict of interest or illustration of the hazards of self-referral. Such hazards obviously include the costs of care but also the potential for subjecting patients to unnecessary anesthesia.

In addition, under the "company model," anesthesia providers are required to pay remuneration to the facility for their services. These profits distributed to the facility owners are estimated to be as high as 40% of the anesthesia fees. The fees paid to anesthesia providers are often less than what they would have earned under a fee-for-service model where they would bill directly. Anesthesia providers are unable to economically compete with the "company model" and are forced to provide an illegal kickback to the facility should they accept pressures from facilities to contract accordingly.

Because of the continuing increased pressures that anesthesiology group practices face in complying with the "company model" and in light of the enclosed legal article highlighting concerns with the model, we respectfully request the Office of Inspector General to issue a Special Advisory Bulletin regarding this model.

If you need any additional information from ASA, please contact Jason Byrd, JD, Director of Practice Management, Quality and Regulatory Affairs or Chip Amoe, JD, MPA, Assistant Director of Federal Affairs, at (202) 289-2222.

Sincerely,

Alexander A. Hannenberg, M.D.
President
American Society of Anesthesiologists

cc: Lewis Morris, Chief Counsel

Enclosures

On The Front Lines

Profiting from Anesthesia Services: An Analysis of Emerging Compensation Arrangements Between Ambulatory Surgery Centers and Anesthesiologists

by Paul R. DeMuro, CPA, MBA, JD, CHC, Katherine A. Lauer, JD, and Benjamin E. Huston, JD

Increased regulatory pressures along with the tightening of reimbursement levels have strained ambulatory surgical center (ASC) profits over recent years, leading many ASC owners to consider alternative ways to generate more revenue. Two emerging business models involving compensation arrangements between ASCs and anesthesiologists have gained significant traction by allowing ASC owners to capture a portion of the profits from the provision of anesthesia services. As these new business models continue to proliferate, anesthesiologists are facing increased pressure to either participate in these questionable practices or risk losing existing and potential business opportunities.

Since 1982, when Medicare approved reimbursement for ASC services, physician-owners have consistently sought new models to enhance the profitability of their ASCs. While this pursuit has largely benefitted ASCs as well as their patients, it has also led some ASCs to adopt risky and potentially illegal business models in order to remain competitive. For example, in 2007, when changed rules to the ASC payment system resulted in a widening of the gap between hospital and ASC reimbursement rates, a number of ASC owners engaged in questionable joint venture models with hospitals (e.g., the "under arrangements" model) in order to take advantage of the more generous hospital-based payment rates.

Today, many ASCs are exhibiting similar risky behavior as they attempt to tap into the revenue stream of the anesthesia services industry. Two growing trends in compensation arrangements between ASCs and anesthesiologists have shifted a large portion of the revenues generated by anesthesia providers to the ASC and its owners. Under these arrangements, anesthesiologists either are forced to, or offer to, share their professional fees with owners of the ASC in order to obtain the right to provide anesthesiology services at the ASC. These arrangements arise in two basic business models – (1) the "company model," and (2) suspect compensation arrangements.

While ASC owners have largely welcomed these new models and their resulting increase in profits, many anesthesia groups and other healthcare professionals have expressed concern over the regulatory risks posed by these compensation arrangements. In light of these competing considerations, this article provides a detailed description of these two business models, highlighting the reasons why they have become popular and why they pose risk.

The "Company Model"

The first business model, often referred to as the "company model," involves the establishment of a separate company under the same or similar ownership as the ASC, formed for the sole purpose of employing the ASC's anesthesia providers and allowing the owners of the ASC to share in the professional fees and profits earned by the anesthesiologists in providing services to the ASC's patients. Under the "company model," the licensed ASC bills for the ASC facility fees, and the newly formed separate company owned by the ASC owners employs the anesthesiologists and bills for the professional anesthesia services. The owners of the entities then share in the profits generated both by the facility fees and the professional fees. Under the "company model," the anesthesiologists are forced to become employees of the new entity and to share a portion of their professional fees with the owners of the ASC in order to obtain access to anesthesia referrals from the ASCs.

Suspect Compensation Arrangements

The second business model involves compensation arrangements between anesthesiologists and ASCs under which anesthesiologists pay remuneration to the ASCs in which they are providing services. These arrangements frequently involve the payment of remuneration – often at amounts

that appear to exceed fair market value – for space, items and services that may not be legitimately required by the anesthesiologists in order to provide services at the ASC. Indeed, the types of space, items and services that are common to these arrangements strongly suggest that there is no legitimate business purpose for many of these arrangements, and that they frequently involve payment by the anesthesiologists for personnel, space and supplies that are already included in the facility fee paid to the ASC.

Common examples include "lease" arrangements under which anesthesiologists rent space in the ASC to "store" supplies, or pay rent for use of the ASC's locker room and lunch room, and for office space in which the anesthesiologists purportedly conduct their "private" practice (even though many of these groups operate exclusively as providers of services to the ASC and/or have their own private office space off-site where they conduct business unrelated to providing professional services to ASC patients). In other arrangements, anesthesia providers "lease" technicians, administrative office staff and other employees from the ASC, purportedly in order to provide some "heightened quality" of professional service – even though the employees already provide such services as part of the ASC's technical component and are compensated under the ASC's facility fee (and even though in the absence of the arrangement the anesthesiologists would not hire their own employee to provide such services).

The Regulatory Framework

The Anti-kickback Statute ("AKS") makes it unlawful for any person to offer or pay, or to solicit or receive, any remuneration in order to induce or reward business reimbursable under the health care programs. Violation of this provision is punishable criminally by up to five years imprisonment, a fine of $25,000, or both, and by exclusion from participation in the Medicare and Medicaid programs, as well as other potential administrative and civil penalties.[1]

The OIG has noted that compensation arrangements between facilities and facility-based physicians such as anesthesiologists raise unique concerns under the AKS.[2] That is, under these arrangements, it is typically the facility (often a hospital, although in this case, the ASC) that is in a position to influence the flow of business to the physicians, rather than the more traditional situation where physicians make referrals to the hospital or ASC. Thus, if the facility solicits or receives something of value in exchange for access to the hospital's federal health care program business, such arrangement may violate the AKS. Specifically, the OIG has noted that potential illegal kickbacks include: (1) a hospital compensating physicians less than fair market value for goods/services provided to the hospital, and (2) a hospital requiring physicians to pay more than fair market value for services provided by the hospital to the physicians.[3]

The Provision of Anesthesia Services in ASCs: Recent Market Transitions

Traditionally, arrangements between anesthesia groups and ASCs have been structured under a fee-for-service model, which generally raises few compliance concerns under the AKS. Under this model, an anesthesia group contracts with an ASC to provide anesthesia services, while remaining relatively independent. The anesthesia group directly bills and collects for the services it provides, while the ASC separately and on its own behalf bills for the facility component of the ASC services provided. While such arrangements sometimes involve the anesthesia provider having the exclusive right to provide anesthesia services at the ASC (which may, under certain circumstances, have a value to the anesthesia group[4]), so long as there is no excess remuneration provided to the ASC owners by the anesthesiologists in order to obtain access to the business, the risk that such arrangements would violate the AKS is typically low.

In recent years, however, ASCs have increasingly expanded their efforts to capture profits from anesthesia providers in exchange for access to the ASC referral stream. One of the ways that ASCs have used to reach these profits is by implementing the "company model." As discussed above, under the "company model," owners of the ASC form a separate anesthesia company also owned by the ASC's owners. The new company employs the anesthesiologists and exists solely to provide the ASC with anesthesia services. The revenues from the facility fees and professional fees, minus the compensation paid to the anesthesiologists, are distributed to the ASC owners. By creating a separate owned entity to both administer anesthesia services and collect the anesthesia professional fees, the "company model" provides ASC owners the opportunity to obtain part of the profits from anesthesia services. As a result of this profit opportunity, there has been a growing transition away from the traditional fee-for-service model toward the more lucrative (for the ASC owners) "company model." Indeed, numerous industry articles and other published sources have cited the growing prevalence of this model among ASCs.[5] In a recent letter to the OIG, the American Society of Anesthesiologists not only reiterated the growing popularity of the "company model," but noted that the model has become so favored among ASC owners that several anesthesia group practices have had their contracts terminated for failing to agree to it.[6]

Along with the rise of the "company model," there has also been an increase in the number of arrangements between ASCs and anesthesiologists where anesthesia providers lease and/or purchase space, equipment, employees or other items or services from the ASCs. Many of these arrangements involve the payment by anesthesia providers for services or items that are not necessary for the provision of the professional component of

anesthesia services, and that often include the "lease" of space, equipment, or administrative and technical services that are already provided by the ASC in connection with ASC facility services (and thus for which the ASC is already compensated as part of its earned facility fees). In some cases, the ASC insists that the anesthesiology provider agree to provide remuneration pursuant to such agreements in order to be allowed to provide services to the ASC's patients. In other cases, it may be the anesthesia groups that offer such remuneration to the ASC in order to induce the ASC to select the anesthesia group willing to enter into such arrangements as the exclusive provider of services for the surgery center.

Compliance Risks

Both of these practices present significant compliance issues under the AKS. With respect to the "company model," the OIG has previously warned against suspect contractual joint ventures where an existing supplier (e.g., the anesthesia group) gives a referral source (e.g., the ASC owners) the opportunity to generate a profit.[7] Under the "company model," this profit opportunity for ASC owners is created by anesthesia providers signing over their professional fees in exchange for a steady flow of referrals and the salary provided by the ASC pursuant to the anesthesiologists' employment agreements. According to estimates provided by the American Society of Anesthesiologists, under this model, up to 40 percent of the anesthesia professional fees are distributed to the ASC owners, and in most cases, the fees paid to the anesthesia providers are less than they could earn under a fee-for-service model. Under the "company model," ASC owners are able to expand into the business of providing anesthesia services, and the volume of anesthesia services provided depends on referrals from the ASC. The end result is that ASCs are oftentimes securing anesthesia services from anesthesiologists at below-market rates in exchange for access to the ASC's federal health care program and other business. Although profitable for ASC owners, such arrangements present a significant risk of violating the AKS.

Similarly, arrangements that require anesthesia providers to pay ASCs remuneration for certain items or services that are potentially unnecessary or that are at rates above the fair market value in exchange for access to the ASCs' referral stream also present a significant risk of violating the AKS, as do offers or payment by anesthesia providers to ASC owners in order to secure their business. Examples include requiring providers to pay full-time rates for administrative staff when the group only operates two or three times a week, or charging for the use of locker or lunch room space when such services are not needed by the anesthesia provider and such expenses are already covered by the facility fee paid to the ASC. As noted above, the OIG has specifically stated that hospitals requiring physicians to pay more than fair market value for services provided to the hospital can constitute illegal kickbacks. This logic is equally applicable in the ASC context and suggests that ASCs as well as anesthesia groups participating in these types of arrangements may face considerable risk.

Policy Concerns

In addition to representing potential violations of the AKS, these business models may also result in a variety of negative consequences for federal health care programs, including the overutilization of health services, the corruption of professional judgment, and an overall decrease in the quality of services provided. Discussing suspect joint ventures in a 2003 OIG Advisory Opinion, the OIG expressed similar concerns:

> This Office has long expressed concern about health care joint ventures in which investors are sources of referrals for, or suppliers of items or services to, the joint venture or other co-investors. Distributions from the joint venture may be disguised remuneration paid in return for referrals. Like any kickback scheme, such arrangements can lead to overutilization of services, increased costs for federal health care programs, corruption of professional judgment, and unfair competition.[8]

First, the "company model" may lead to an overutilization of anesthesia services and an increase in federal health care costs. Under the "company model," the owners of the ASC (generally surgeons or other physicians performing procedures in the ASC) are also the owners of the anesthesia company. As such, they have an incentive to increase the use of anesthesia services, to write orders for more expensive anesthesia services or to order a higher level of anesthesia services than may be medically necessary (e.g., general anesthesia rather than local anesthesia) to drive up their profits. This may not only lead to patients receiving unnecessary and potentially harmful services, but it may also increase costs to federal health care programs.

Second, the "company model" may corrupt the professional judgment of anesthesiologists. Given the profit incentives of the "company model," ASC owners are likely to be motivated to influence or persuade anesthesiologists to administer more services or more expensive services than might otherwise be appropriate. And as employees of the ASC owners' new company, rather than as independent practitioners, anesthesiologists may feel pressured to do so or risk losing their jobs. This dynamic raises serious concerns about patient safety, as well as overutilization and increased costs.

Finally, the rise of the "company model" as well as increasing demands for anesthesia groups to pay remuneration for certain services in exchange for access to the ASC's business may negatively impact the overall quality of care provided to patients. Under the traditional fee-for-service model, anesthesia groups operate relatively independently from the facility. The anesthesiologists are able to make clinical decisions without considering how those decisions will affect the ASC's profit margin or their own job security. In addition, the fee-for-service model creates certain constraints to ensure patient care and safety are prioritized. For example, contracts between anesthesia groups and ASCs will often specify what levels of anesthesia services are appropriate for particular procedures. Such built-in protections serve to optimize patient care as well as minimize unnecessary expenditures.

However, the "company model" creates an incentive structure that rewards overutilization and increased costs while potentially decreasing the overall quality of care. By allowing ASC owners to generate a profit from anesthesia services, the needs of pa-

tients and the goals of the federal health care program may be subordinated to the profit motives of ASCs. For example, under the "company model," ASCs presumably will select anesthesiologists that are willing to contract with the new company, rather than selecting the most competent anesthesia group. Similarly, ASCs may select anesthesia providers based on which groups are willing to pay for the most items or services (supplies, lunch room space, locker space, etc.), as opposed to considering which anesthesia group provides the highest quality service. These compensation models could create, in effect, a race to the bottom among anesthesia providers as they compete for the ASCs' business. While these trends are undeniably profitable for ASCs, they may ultimately result in an increase in federal health care costs and a decrease in the quality of patient care.

The potential for these negative consequences should give ASCs and anesthesia providers pause before agreeing to participate in these types of business models. As these practices become more widespread and their effects more pronounced, there is an increased likelihood that the OIG will take notice of these arrangements and their potential for abuse. ASC owners must also consider how the adoption of these business models and their associated risks will affect the ASC's long-term business plan. For example, an ASC that is a potential acquisition target may be rendered unattractive to potential suitors who fear that the ASC is not in compliance, or that there is simply too much risk.

Conclusion

With the continued growth of these types of compensation arrangements, ASC owners and anesthesia providers will have to undergo individualized cost-benefit analyses to determine whether these business models are compatible with their companies' short and long-term goals. However, in the absence of further OIG guidance, both parties should be aware that implementation of either of these models will involve considerable legal risk. ■

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[1] *See* 42 U.S.C. §1320a-7(b), 31 U.S.C. §§3729-3733, and 42 U.S.C. §1320a-7(a).

[2] OIG Supplemental Compliance Program Guidance for Hospitals, 70 FR 4858 (Jan. 31, 2005).

[3] *Id*.

[4] *Id*.

[5] Bruce Armon and Franklin Dexter, MD, *Contracting With Your Anesthesia Group*, Oct. 2009; Scott Becker, *3 Core Models for Delivering Anesthesia Services: Trends, Legal Issues and Observations*, April 28, 2009; Joshua Kaye, *Five Ways Your ASC Can Profit From Anesthesia Services*, May 2005; Mark Manigan, *Can Surgery Centers Profit from Anesthesia?*, April 2004.

[6] American Society of Anesthesiologists Letter to OIG, March 19, 2009.

[7] OIG Advisory Opinion No. 03-13, June 16, 2003.

[8] *Id*.

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