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TWO'S COMPANY, THREE'S A CROWD: COMPANY MODEL DEALS IN THE HOSPITAL SETTING

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As readers of *Anesthesiology News* undoubtedly are aware, for the past four decades, the predominant relationship between anesthesiologists and hospitals has been through anesthesia groups, which more often than not hold an exclusive contract for all anesthesia services at the hospital.

And whether or not there's a group, and whether or not there is an exclusive contract, the relationship between anesthesiologists and hospitals has predominantly been direct, with no middleman.

My previous articles addressing the so-called "company model" situation reveal that those anesthesia companies are essentially middlemen between anesthesiologists and ambulatory surgery centers (ASCs), as well as in the economic relationship between anesthesiologists and payers.

Despite the regulatory uncertainty of the company model, including an unfavorable advisory opinion from the Office of Inspector General (OIG) of Medicare, as discussed below, the model in the ASC context appears to be gaining steam. As if that were not troubling enough for anesthesiologists, what if company model structures jump the barrier between outpatient and inpatient facilities and were to be instituted within hospitals?

You don't need to wonder—it's already starting to happen.

The Company Model Business Model

Let's begin with a quick primer on the company model in the ASC setting so that we have a basic level of understanding, before discussing the model's leap to the hospital domain.

In its most direct form, the company model involves the formation, by the surgeon-owners of an ASC, of an anesthesia services company to provide all of the anesthesia services for the center. Before the formation of the company, all anesthesia services were provided by anesthesiologists either for their separate accounts or for the account of their anesthesia group. After the formation of the company, anesthesiologists are employed or subcontracted, with a significant share of the anesthesia fee being redirected to the company model's owners, the surgeons.

Key Compliance Issues

The federal anti-kickback statute (AKS) prohibits the offer of, demand for, payment of, or acceptance of any remuneration for referrals of Medicare or Medicaid patients. There are exceptions, most notably regulatory "safe harbors," that describe certain arrangements not subject to the AKS because they are unlikely to result in fraud or abuse.

Broad OIG Guidance

The OIG of the U.S. Department of Health and Human Services, the agency charged with regulating and enforcing the AKS, has issued two fraud alerts applicable to the analysis of company model deals: its 1989 Special Fraud Alert on Joint Venture Arrangements, which was republished in 1994, and a 2003 Special Advisory Bulletin on Contractual Joint Ventures. Note that the term “joint venture,” as used by the OIG in the alerts, is not limited to the creation of a legal entity; rather, it covers any arrangement, whether contractual or involving a new legal entity, between parties in a position to refer business and those providing items or services for which Medicare or Medicaid pays.

The OIG has made clear that compliance with both the form and the substance of a safe harbor is required in order for it to provide protection. The OIG demands that if one underlying intention is to obtain a benefit for the referral of patients, the safe harbor would be unavailable and the AKS would be violated.

Although each alert is illustrative of the regulatory posture of the OIG, the 2003 Special Advisory Bulletin is particularly on point in connection with analyzing company model structures. In it, the OIG focuses on arrangements in which a health care provider in an initial line of business (for example, a surgeon) expands into a related business (such as anesthesiology) by contracting with an existing provider of the item or service (anesthesiologists or nurse anesthetists) to provide the new item or service to the owner’s existing patient population.

The 2003 bulletin lists some of the common elements of these problematic structures in general—neither of the alerts are anesthesia- or any other specialty-specific. In the points that follow, I have substituted words such as "surgeon" and "anesthesiologist," all in brackets, for the broader terms used by the OIG.

- The surgeon expands into [an anesthesia business] that is dependent on direct or indirect referrals from, or on other business generated by, the owner's existing business [such as the surgeon's practice or ASC].
- The surgeon does not operate the [anesthesia] business—the [anesthesiologist] does—and does not commit substantial funds or human resources to it.
- Absent participation in the joint venture, the [anesthesiologist] would be a competitor [of the surgeon's anesthesia company], providing services, billing and collecting [for the anesthesiologist's own benefit].
- The [surgeon] and the [anesthesiologist] share in the economic benefit of the [surgeon's] new [anesthesia] business.
- The aggregate payments to the [surgeon] vary based on the [surgeon's] referrals to the new [anesthesia] business.

2012 Advisory Opinion 12-06

The OIG's first pronouncement directly on the propriety of the company model came in June 2012, when it issued Advisory Opinion 12-06.

The anesthesia group requesting the opinion presented two alternative proposed scenarios, one a management fee deal and the other a company model structure.

In the proposed company model structure, the surgeons, or their ASC, would set up an anesthesia company to hold the exclusive anesthesia contract at the ASC. The anesthesia company would engage the anesthesia group at a negotiated rate as an independent contractor to provide the actual anesthesia care and certain related services. The anesthesia company would retain any profit.

In its Opinion 12-06, the OIG stated that there was no safe harbor available in respect of the distributions that the surgeons would receive from their anesthesia company. The ASC safe harbor does not apply to protect distributions of anesthesia profits.
Even if the safe harbor for payment to employees applied, or if the safe harbor for personal services contracts applied, those safe harbors would protect payments to the anesthesiologists. But they would not apply to the company model profits that would be distributed to the surgeons, and such remuneration would be prohibited under the AKS if one purpose of the remuneration is to generate or reward referrals for anesthesia services.

Because the failure to qualify for a safe harbor does not automatically render an arrangement a violation of the AKS, the OIG then turned to an analysis pursuant to the 2003 Special Advisory Bulletin and found that the physician-owners of the proposed company model entity would be in almost the exact same position as the suspect joint venture described in the bulletin: that is, in a position to receive indirectly what they cannot legally receive directly—a share of the anesthesiologists’ fees in return for referrals.

Therefore, the OIG stated that the proposed company model venture could potentially generate prohibited remuneration under the AKS, and the OIG potentially could impose administrative sanctions on the requestor.

Leaping, Perhaps Without Looking

Despite the fact that company model deals in the ASC setting are, to say the least, problematic, we are beginning to see related models appearing in the hospital context.

One category of these arrangements is almost exactly analogous to the company model, but with an additional compliance twist. The hospital, generally in the context of a renewal of an anesthesiology group's exclusive contract, grants a carve-out, either immediate or contingent (in other words, an option) in favor of a referring physician, "Dr. X" or his group. Dr. X is permitted, pursuant to the terms of the carve-out, to use an entity to engage his own anesthesiologists. Sometimes, the existing anesthesia group is given a right of first negotiation to allow it to try to come to terms with Dr. X to provide those anesthesiologists.

This scheme places Dr. X in the position of being able to engage his own anesthesiologists at a wholesale rate, thus being able to profit from the difference between wholesale and retail, whether that anesthesia coverage ends up coming from newly recruited anesthesiologists or from the existing anesthesia group itself pursuant to the right of first negotiation.

A second category involves a carve-out as well, but with a slightly different twist. Here, the hospital attracts a new referring physician, "Dr. Y," often in the context of a new service line. As a part of Dr. Y's willingness to relocate, she requires that she be able to bring along her own

anesthesiologists, with whom she has worked for years and who are intimately familiar with her procedures and the way she works. Although much harder to discover without loose lips on either Dr. Y's part (not very likely) or on the part of Dr. Y's anesthesiologists (more likely after a glass or two of wine), it is sometimes the case that those anesthesiologists are engaged directly or indirectly by Dr. Y.

Of course, either of those arrangements, the first more demonstrably so, is the functional equivalent of a company model deal imported to the hospital setting.

Note that there is an additional, extremely serious compliance issue presented here: Is the hospital's award of the carve-out to Dr. X or Dr. Y itself a kickback to induce him or her to continue to refer, as in Dr. X's case, or to begin to refer, as in Dr. Y's case? That is, is the contractual right in favor of either of those physicians, enabling him or her to profit from anesthesia services, itself remuneration in violation of the AKS?

The answer, of course, turns on the facts, but sometimes rules of thumb like "where there's smoke, there's fire" turn out to be very handy.

As hinted at in connection with the Dr. Y example, it's common for the arrangement between the hospital and the referring physician to be dressed up in terms of quality: There is a need, after all, the documents argue, for Dr. X to have a dedicated, small group of anesthesiologists aligned with him to achieve the world's highest quality, say, left nostril surgery, to patients.

But of course, a pig in a skirt is still a pig.

As a bonus, there is a related non-company model, kickback-suspicious model that must be mentioned.

In addition to addressing a company model arrangement, Advisory Opinion 12-06 dealt with a second proposed arrangement, one in which the ASC would charge the anesthesia provider a so-called "management fee."

In similar fashion, we are seeing hospitals requiring that anesthesia groups obtain "services" from the hospital's related management company as a condition of their exclusive contract. Although the fee in this context is not a duplication of what the facility already is being reimbursed for by payers (which was an issue in Advisory Opinion 12-06), query what the anesthesiologists are really paying for.

Conclusion

As the economics of health care become more acute, it is likely that more in the position to refer will attempt, legally or illegally, to profit from those referrals.

The company model in the ASC setting is simply one variant of this attempt.

Although the issue is contentious from the anesthesiologist's viewpoint, and although Advisory Opinion 12-06 denied regulatory approval to one such deal, the issue is far from settled as more and more referring physicians and facilities are attempting to plan around the opinion.

At the same time, the aggressiveness previously confined to the outpatient setting is beginning to take hold in the hospital context.

And unfortunately, anesthesiologists under pressure—often combined with an unwillingness to invest in fighting off the overture—sometimes give in rather than challenge.

No matter the setting, inpatient facility or outpatient, company model deals, and management fee deals, raise hugely significant compliance concerns: jail, fines, civil penalties and debarment.

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