Owning Anesthesia

Makes Sense and Cents

By Bergein (Gene) F. Overholt, MD

As gastroenterologists face downward pressure on reimbursements, the need for ancillary revenues is an important topic in facilities and practices around the country. CMS cut diagnostic colonoscopy reimbursement by approximately 12% in 2016[1]. In 2018 another decrease is scheduled. The widespread impact of reimbursement cuts has led — or may soon lead — to practice-level layoffs, further mergers between groups to share costs, seeking alternative salary-based employment, and even early retirements.

As expected, physicians strive to offset their professional and facility fee reductions. Incorporating ancillary revenue streams into the practice is one option that is increasingly important. However, it is important to recognize before adopting any ancillary revenue stream, a primary goal of the practice should be aiming ancillary services at improving the quality and efficiency of patient services. Revenue, although important, is secondary to quality and efficiency.

Incorporating anesthesia services is an important ancillary opportunity for the practice. For those practices with an ASC, providing anesthesia services meets the goal of improving quality of care and efficiency for patients while also producing an additional revenue stream for the practice. The revenue stream not only helps offset reimbursement reductions, but it also builds financial and equity value in the practice and positions it for the possibility of monetizing with a partner in the future.

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Being Smart

Bringing anesthesia in-house is smart. Anesthetics, techniques, skills of anesthesia professionals, and the monitoring of anesthesia have all improved significantly over the past 15 years. Propofol has now become the anesthetic of choice for the outpatient gastroenterology setting. In 2001, only 11% of screening colonoscopies were sedated by an anesthesia professional. Today that is closer to 55% (percentage can vary based on geography)[2]. This trend will continue to increase as more procedures are performed in the outpatient setting, as lower costs drive more procedures to the outpatient setting, and patient preferences favor a more convenient outpatient setting.

Legal Clarity

Recent qui tam cases have caused confusion among healthcare attorneys and physicians researching anesthesia. The

question being asked: "Can gastroenterologists legally own their anesthesia?" is right, but there is confusion with the answer. Most often the practice decision depends on legal counsel, but as the saying goes, ask ten attorneys, and you will get ten different answers. In contrast, when a decision comes from the ruling government legal body — the Office of the Inspector General (OIG) — there is no gray area. Opinions are either dismissed and deemed compliant or not. The reality is that every unsealed OIG opinion regarding the company model has been dismissed. The company model is one where an anesthesia entity operates separately outside the GI practice but provides services to the ASC.

However, as in any new venture, if setting out to start anesthesia in your ASC, I would recommend getting several opinions or perhaps even better, bring in attorneys and consultants who have set up GI anesthesia entities before to benefit from their experience in compliance and operational issues.

Structuring for the Future

There are different avenues to arrive at the same destination when it comes to structuring GI anesthesia entities. The best example I can provide is the one that has worked for myself and my partners for the last fifteen years.

Create a separate company owned by the practice (or ASC) so that it allows all partners to benefit from owning anesthesia. As new partners come and old partners retire, have bylaws in place allowing physicians to buy in and be bought out as time requires. Hire anesthesia providers (CRNAs or anesthesiologists), and a billing/collections team. Contracting with insurance companies, while laborious, is crucial, as well as participation in Medicare and state-specific government plans.

Whether you are in the planning phase of owning anesthesia or your group has benefited from ownership for years, there will likely come a time when you will want to monetize your intangible assets by bringing on a business partner.

If you are building your anesthesia program from the ground up, you might want to find a partner who will take a small ownership fee up front and then purchase their agreed upon ownership based upon earning multiples after the first or second year of operation. You will receive value in 3 ways: (1) the expertise of the partner in setting up the entity; (2) the benefit from their billing/collections operations from day one; (3) the benefit of a transaction paid out at a multiple of earnings taxed as long-term capital gains[3]. When looking to sell, make sure that a future partner will bring something to the table beyond just a check on the date of the transaction.

An important future point to consider is that CMS is changing the anesthesia landscape. Effective January 1, 2018, CMS will reduce all lower endoscopy procedures by one base unit from five to four and has hinted at an even further reduction for all screening colonoscopies. With these and further changes likely coming to anesthesia, one consideration is to sell sooner and maximize your ROI. But choose whom you sell to carefully.

Lastly, when exploring a sale of your anesthesia business, thoroughly ask questions such as: What is your track record with current and past partners? Where do you expect us to be financially in five or ten years? What are contingencies for bundling or anesthesia reimbursement cuts?

Hard questions should be asked early. And check references!

Final Thoughts

Establishing an anesthesia service in your ASC offers many advantages for patients, physicians, and the practice. Obtaining expert advice before and during the anesthesia start-up is essential. Planning from the beginning to allow for new physicians and retirements is critical. All physicians who have or will have anesthesia services in their ASC should build in a process in which an outside entity can buy into the anesthesia operation, allowing for physicians to capitalize, if desired, on the value of the entity they have established.

Sources:

[1] Becker's ASC Review. "How Medicare colonoscopy reimbursement cuts could impact GI in 2016 and beyond." 24 November 2015. Becker's GI & Endoscopy. http://www.beckersasc.com/gastroenterology-and-endoscopy/how-medicare-colonoscopy-reimbursement-cuts-could-impact-gi-in-2016-beyond.html

[2] John J. Vargo, Paul J. Niklewski, J. Lucas Williams, James F. Martin, Douglas O. Faigel. "Patient safety during sedation by anesthesia professionals during routine upper endoscopy and colonoscopy: an analysis of 1.38 million procedures." Gastrointestinal Endoscopy January 2017: 101-108.

[3] Kreger, J. (2017, July 19) CRH Anesthesia

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