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FEATURED FOCUS

The “Under-Arrangement” Transaction: Proceed with Caution

D. Louis Glaser, Craig E. Holm, and Alan M. Zuckerman

Over the past five to 10 years, many factors, including the competitive forces between hospitals and physicians and the expansion of the Stark Law’s constraints, have made it more difficult for hospitals and physicians to form joint ventures and other partnerships. Recently, however, hospitals and physicians are

increasingly considering an alternative to equity model joint ventures called an “under-arrangement” transaction. This transaction is an entity created under established Medicare payment rules, yet the structure, its reimbursement implications, and legal risks are often misunderstood and inappropriately applied.

Given the enormous risks involved in establishing a joint venture that fails to withstand legal and regulatory scrutiny, it is critical to understand the structure of under-arrangement transactions, clarify when the structure can be used, and appreciate the legal challenges involved.

“Under Arrangement” Defined

A hospital may provide services for its patients either directly or “under arrangement” with another provider. In essence, a hospital may contract with a third-party provider of services to deliver specific services to the hospital’s inpatients and outpatients.

BENCHMARKING IN BRIEF

Benchmarking, Public Scrutiny, and Process Improvement

With the advent of public reporting, balanced scorecards, and numerous quality initiatives by healthcare purchasers and payers, many hospitals are seeing increased public scrutiny of their ability to improve the quality of care and control costs. The sheer volume of hospital data that are now available to the public can affect payment, market share, and in some cases, local perception of the community hospital as a community asset. Benchmarking is one of the best ways hospitals can prepare for the increase in public scrutiny.

One of the earliest U.S. advocates of benchmarking among hospitals was Ernest Codman, MD, a Boston surgeon. In 1934, Codman said, “Until we freely make therapeutic comparisons, we cannot claim that a given hospital is efficient, for efficiency implies that the results have been looked into.” Codman’s unique contribution was his effort to link specific interventions with their effects on patients, showing that the efficiency and effectiveness of the care process of can be monitored by evaluating outcomes.

Healthcare providers have used internal analysis to document substantial improvements in processes and patient outcomes, but the track record for external benchmarking is spottier, in part due to the lack of industry-accepted data standards and lack of agreement on adjustment methodologies.

In response to the growing demand for public disclosure, providers need to take the lead in educating the public about the value and meaning of comparative

In a typical under-arrangement joint venture, a hospital and physicians will form a joint venture entity to be a service provider. For example, a hospital and a group of cardiologists will form a limited liability company to own and operate a freestanding cardiac catheterization lab. The LLC, in turn, enters into a contract with the hospital to provide cardiac catheterization procedures to the hospital’s patients, and the hospital agrees to pay the LLC on a fee-for-service basis according to a mutually agreed upon,

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predetermined fee schedule. The LLC also may remain free to provide cardiac catheterization procedures to patients referred directly to the LLC—i.e., not by the hospital—who are not registered as hospital patients.

The under-arrangement aspect of the venture, however, only refers to the services provided by the LLC for the hospital's patients. Since the venture is a separately licensed entity, it may operate as a freestanding provider with respect to nonhospital patients; however, the venture's ability to operate as a freestanding provider may be limited by state law. Using the cardiac catheterization lab example, certain states permit only diagnostic catheterizations to be performed in a freestanding, nonhospital facility. Questions arise when state law is vague or silent regarding a freestanding facility's ability to perform services that traditionally have been performed only in hospitals.

Limitations and Requirements

Under-arrangement transactions have several critical limitations and requirements. First, the patients who the hospital refers to the LLC to receive services must be registered as hospital inpatients or outpatients. Second, the hospital ultimately remains responsible for the clinical oversight of the patients. Third, because the service provider (the LLC in the previous example) is a third party, separate and apart from the hospital, the service provider must meet all applicable state licensure requirements.

With respect to payment, the hospital must bill and

collect for the services provided to the patients. For inpatients, this means that payment is covered by the DRG paid to the hospital. For outpatients, Medicare pays the hospital under ambulatory payment classifications for the service. For services rendered by the joint venture to the hospital, the hospital pays the joint venture a negotiated fee, typically based upon a predetermined fee schedule. Finally, for services the joint venture provides to nonhospital patients, the venture bills and collects amounts from third-party payers.

One of the primary reasons for the increased interest in under-arrangement transactions is that hospital payment is often greater than what a freestanding entity might receive for the same services, and in an under-arrangement transaction, the hospital is the party that must bill for hospital patients receiving services provided by the venture.

For example, in some cases, the hospital's payment is higher under APCs than what the freestanding entity would receive under the Medicare Part B fee schedule. This payment differential also may be true of some commercial payers. In addition, a number of services have payment codes that are hospital codes and for which there is no corresponding freestanding code. Thus, if the services were performed by a freestanding entity, the entity might not be paid. However, by having the hospital bill for the services, the hospital can employ a hospital code in an attempt to receive payment even though the service is rendered by a third party. Thus,

given the favorable payment they appear to present, it is not surprising that these under-arrangement structures are attractive to hospitals and physicians.

Regulatory Flexibility for Under Arrangements?

Another reason for the increase in popularity of under-arrangement transactions is the perceived regulatory flexibility these structures present. Specifically, although the Stark Law defines all hospital inpatient and outpatient services as designated health services, the regulations under the law expressly treat under-arrangement transactions as a compensation arrangement between the hospital and an entity providing DHS. Because of this treatment, physicians who own an investment interest in an entity that provides services to a hospital under arrangement will have their ownership interest treated as an indirect compensation arrangement. This arrangement will satisfy the indirect compensation exception under the Stark Law if the following conditions are met:

- The hospital's payments to the joint venture for services provided are based on a fee schedule that represents fair market value for the services provided.
- The fee schedule is not modified during the course of the arrangement to take into account referrals of DHS or other business generated.
- The arrangement is put in writing.
- The arrangement does not violate the anti-kickback statute.

Arguably, the fourth of these conditions provides

the government with broad latitude to challenge an arrangement on the basis that it violates the anti-kickback statute. In fact, the Office of Inspector General expressly recognized the potential for abuse and violation of the anti-kickback statute in these types of transactions when it stated the following in the Stark Law Phase I regulations:

We are concerned that the provision of services "under arrangements" could be used to circumvent the prohibition in section 1877(c)(3) of the Act of physician ownership of parts of hospitals. We understand that some hospitals are leasing hospital space to physician groups, which the groups then use to provide services "under arrangements" that the hospital had previously provided directly. These arrangements, especially when they involve particularly lucrative lines

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of business, raise significant issues under section 1877 of the Act, as well as the anti-kickback statute.

In sum, for purposes of section 1877 of the Act, we will treat "under arrangements" financial arrangements between hospitals and physician-owned entities as compensation and not ownership relationships. We will, however, monitor these arrangements and may reconsider our decision if it

appears that the arrangements are abused. We also caution physician groups and hospitals that these arrangements remain subject to the Federal anti-kickback statute.

This commentary indicates that the OIG believes that arrangements involving a hospital billing for services provided by an outside

entity for the hospital's patients can be viewed as an ownership or investment interest in the hospital. The OIG, however, decided to take a different approach with respect to under-arrangement transactions. The regulations under the Stark Law specify that the following is not an ownership

or investment interest:

An "under arrangements" contract between a hospital and an entity owned by one or more physicians (or a group of physicians) providing DHS "under arrangements" with the hospital (such a contract is a compensation arrangement as defined [elsewhere in these regulations]).

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COST SAVINGS TIPS

Top 5 Costly Invoice Mistakes

Susan M. Kruk

Medical equipment maintenance invoices can be filled with errors and overcharges that often go unnoticed. According to a recent analysis, the following are the five most common types of equipment repair invoicing errors.

1. Data entry and billing. The largest dollar amount of invoicing errors comes from common mistakes like typographical or inputting inaccuracies. For example, a vendor might work for two hours but accidentally charge for 32 hours. Another common overcharge occurs when the facility is billed more than once for the same service call.

2. Part warranties. A typical warranty period for parts is 60 days. If a part is replaced within that timeframe, a healthcare organization should not be charged or a warranty credit should be provided. However, the vendor doing the repairs may not realize the part is still under warranty and bill the hospital for the part.

3. Labor rates. There are two types of labor rate overcharges. The first type occurs when a vendor increases its rates but charges the facility the new, higher rate before the rate actually goes into effect. For example, a vendor may increase rates on July 1, and bill for work performed in June at the new rate even though the repair was before the rate increase.

The second type of overcharge occurs when overtime is billed, but the service was performed during regular hours. If the service report shows the engineer working 2 p.m. to 7 p.m. on a Monday, the facility should be billed for three hours of regular time and only two hours of overtime. Occasionally, the facility is charged the overtime rate for the whole five hours.

4. Travel. Travel overcharges have the potential to cause many invoicing errors. Such errors typically occur when a service company calls in a nonlocal service engineer because a local engineer is not available

for the repair. This practice obviously increases the travel charge to the service company, but the healthcare organization should not be responsible for paying these extra costs. The facility should only be charged from the vendor's closest service center, not from the actual location of the service engineer.

Another type of travel overcharge occurs when the service engineer charges duplicate travel on the same day at the same facility. For example, if a vendor performs preventive maintenance on two different pieces of equipment, the vendor's billing department may automatically include a zone travel charge on each invoice. However, only one zone charge should be included on the invoice.

5. Parts provided. Sometimes healthcare organizations are billed for parts on their invoices, but there is no record of the parts being replaced on the service report. At times, parts are billed to one facility, but actually installed at another.

Those who have approved the service should make sure they are only paying for the parts actually replaced on their equipment.

Although it is challenging to catch invoice errors, it sometimes is even more difficult to receive a credit on a timely basis. If an error is discovered, call the company right away and explain the error. If the vendor agrees that the healthcare organization can pay the bill less the amount of the error, get the person's name and title and include a note on the bill stating this decision with the date that the person agreed to credit the error internally with your payment. If the vendor insists on sending an invoice credit, mark your calendar for when you expect the credit memo, and continue to follow up. ■

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Comprehensive Balance Programs: A Patient Care and Revenue Opportunity

John Whitman

Balance disorders are a major health problem for millions of Americans. Health issues resulting from balance disorders are prevalent in an estimated 30 percent of the senior population and nearly 2 percent of young adults. It has further been estimated that 65 percent of individuals over 60 years of age experience dizziness or loss of balance, often on a daily basis. Research indicates that dizziness and balance issues are the number one reason seniors visit their physicians and that injuries from falls are the number one killer of elderly Americans. The quality-of-life implications for patients suffering from dizziness and the financial implications of unresolved balance issues for our healthcare system are staggering.

Chronic balance disorders are often poorly managed within the current healthcare system, and not without just cause: There are more than 240 documented medical reasons why an individual could be experiencing balance problems. Balance disorders also typically result from multiple factors within multiple medical disciplines (such as ophthalmology, ENT, cardiology, and neurology), which contributes to the difficulties many patients have in being quickly and effectively diagnosed and treated.

Although the number of individuals suffering from balance disorders is significant and the problem complex, clinical research over the past 10 years has clearly

shown that a broad spectrum of patients can benefit from a comprehensive, multidisciplinary balance program. To be effective, these programs involve multiple clinical areas and utilize sophisticated diagnostic equipment that can, in many cases, quickly and effectively pinpoint a patient's problems. Once a patient is accurately diagnosed, effective treatment options can then be implemented.

This improved process of diagnosing and treating individuals with balance disorders can quickly and effectively restore an individual's independence and dramatically reduce the risk of falls. It can also save time and money for the patient and reduce cost for the healthcare system by avoiding unnecessary tests while reducing falls and the medical problems that so often follow. In addition to the improved quality of care for patients, balance programs can offer hospitals a significant revenue-generating opportunity.

Financial Implications

In essence, developing a comprehensive balance program involves streamlining and improving existing diagnostic testing capabilities, coordinating the input from multiple physicians, and adding a specialized piece of equipment called computerized dynamic posturography. CDP is a unique assessment technique used to objectively quantify and differentiate among the wide variety of possible sensory, motor, and

central adaptive impairments to balance control. As such, CDP is complementary to clinical tests designed to localize and categorize pathological mechanisms of balance disorders.

Hospitals that have developed comprehensive balance programs have encountered no licensing or regulatory issues. In addition, payment for the services provided is already available through existing payment channels.

If properly marketed, a new comprehensive balance program in a community hospital should break even by the end of year one, and by year two, profits in excess of \$150,000 are obtainable. As the program builds, profits in excess of \$300,000 can be achieved.

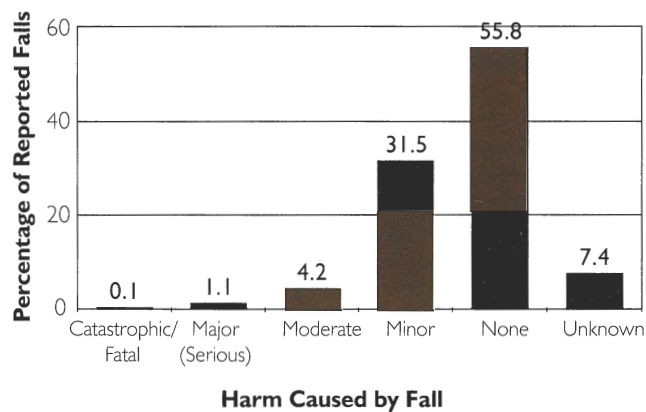
The only current exception to payment is with the CDP

test. Although the Centers for Medicare and Medicaid Services has approved this test for payment, some fiscal intermediaries still classify it as "experimental" and are refusing to pay for this test. This discrepancy is currently being contested and should ultimately be eliminated. Even without reimbursement for this one test, a comprehensive Balance program is still a financially viable program for community hospitals and worthy of implementation consideration.

Marketing

If the balance program is developed through a community hospital, it should be possible to market the program aggressively to a large degree through existing marketing channels. Because of the program's unique nature, marketing should be directed to separate, yet simultaneous areas.

Seriousness of Reported Patient Falls



Quantros data from Aug. 1, 2003, to Aug. 1, 2005, indicate that 17 percent of incident reports (8,433 out of 49,706 events) involve patient falls. Of these, 1.2 percent involve catastrophic/fatal or major injuries.

Source: Quantros Safety and Risk Research Database.

The first is toward your hospital's physicians—your family practitioners and selected specialists can be wonderful referral sources. The second is toward the general population: As with most programs targeted for the elderly, marketing efforts should be directed not only to the elderly experiencing balance concerns, but to their children as well.

Implementing an effective marketing program several months prior to a program's start date can help assure a respectable caseload even in the first week of operation.

Physician Relations

Properly designed and implemented, balance programs can serve as a valuable resource to physicians and should not be seen as a competitive threat. Generally

speaking, physicians often regard balance patients as "difficult" patients, because diagnosing the root of their problem is challenging, time-consuming, and often elusive. However, a comprehensive balance program offers a quick and highly effective path for finding the solution to an individual patient's balance disorders.

Also, because of the extensive marketing that typically follows the establishment of a balance program, new referrals to ENTs, neurologists, and cardiologists often follow. In addition, new patients for primary care physicians are often found.

As with any new hospital program, developing effective communication channels with your physicians is critical—especially when you have treated one of

their patients through the program. Direct follow-up with the patient's physician—including findings, recommendations, and, of course, a referral of the patient back to the primary care physician—is a must.

Market and Feasibility

As with any new program, a detailed feasibility study of your specific market situation is highly recommended. Specifically consider demand, physician acceptance, competition (real and perceived), startup costs, regulatory implications, timing, staffing, and detailed financial performance over a minimum of three years.

Given the large and ever-growing senior population served by most community hospitals, the high percentage of elderly suffering from

balance disorders, the lack of coordinated services within the current health-care system to address these needs, the life-changing impact such a program can have on the lives of those suffering from these disorders, and the fact that balance programs can be a positive cash business with limited barriers, it is likely that more and more community hospitals will be evaluating the feasibility of establishing their own comprehensive balance programs. ■

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Benchmarking, Public Scrutiny, and Process Improvement

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data. Healthcare leaders can turn public performance reporting into a strategic opportunity by using it to create messages that are easily understood and meaningful to people in their communities. These messages, should convey the following information:

- Comparative analysis is part of the organization's culture and is used to improve both clinical and operational performance.
- Comparisons between hospitals must take into account the severity of the patient population. The severity of a patient's illness significantly influences the hospital's length of stay, mortality, complications,

and readmissions.

- Each hospital's characteristics (e.g., number of beds, teaching status, mix of services, and geographic location) should be considered before drawing conclusions.
- Publicly reported comparisons that don't take these characteristics into account should be seriously questioned.

Several healthcare information companies, decision support companies, membership organizations, consulting firms, and group purchasing organizations provide comparative industry information, including, in some cases, methodologies, content, and tools to support clinical and operational benchmarking to meet the

comparative analysis and process improvement needs of the healthcare industry. On the clinical side, it is useful to benchmark both the outcomes of patient care as well as the process of care. Benchmarking both outcomes and process allows hospitals to identify the root cause of a variance and evaluate the impact of the change process.

What should you do to prepare for increased public scrutiny? Use available information to compare your organization with others in the industry and work to improve your processes and outcomes and educate consumers about the meaning of the data. If you invest the time and resources, public reporting may turn out to be good news for your organization. ■

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The "Under-Arrangement" Transaction

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This definition within the Stark Law means under-arrangement transactions can meet the Stark Law's indirect compensation arrangement exception.

This is not to say, however, that all under-arrangement transactions are free from legal risk. There is the potential for parties to structure these transactions so that the hospital is nothing more than a billing conduit for the joint venture, with the goal of obtaining higher payment. This situation is particularly relevant to cases in which hospital payment is higher than freestanding facility payment.

Under Arrangements in the Real World

To better understand under-arrangement transactions, let's review characteristics of an existing ambulatory surgery center joint venture between a hospital and physicians. In this situation, the ambulatory surgery center joint venture has

operated for a period of time, receiving payment from all payers, including Medicare. The case mix at the ambulatory surgery center is examined, and it is determined that if the patients received the same services at the hospital and were billed under APCs, then payment would nearly double.

The joint venture enters into an under-arrangement transaction with the hospital, and all patients will now be registered as hospital outpatients but treated at the ambulatory surgery center. The hospital will bill and collect for services under APCs. Because the hospital's APC payment is higher, the hospital agrees to pay the ambulatory surgery center for its services on a fee schedule that is higher than what the ambulatory surgery center was receiving on its own. The result is that the hospital keeps the difference between the APC rate and the fee paid to the ambulatory surgery center and the ambulatory surgery center

achieves a higher level of payment than it did as an independent entity.

Proceed with Caution

Hospitals and physicians need to consider carefully the motivation for establishing under-arrangement transactions. Hospitals and physicians should document the quality and efficiency rationales that lead to an under-arrangement transaction. If the motivation is purely economic, the transaction is likely to present a high degree of risk.

In addition, hospitals and physicians need to consider whether the venture will treat only hospital patients or whether the venture will provide services directly to nonhospital patients. If the venture treats hospital patients exclusively, it will involve a higher degree of legal risk because it may be viewed to exclude certain categories of patients. Although the decision to allow the venture to treat nonhospital patients helps lower this risk, it reintroduces

a Stark Law risk, meaning that physicians will be making referrals directly to the entity. As a result, physician ownership or investment interest in the entity must be examined on its own and the venture will not be treated the same as an under-arrangement transaction.

Last, hospitals and physicians must consider the degree to which the venture is simply taking a hospital service and recreating it as an under-arrangement transaction. As set forth in the Stark Law commentary, doing so raises significant legal concerns. ■

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