

## Restructuring "Under Arrangement" Transactions in Light of Regulatory Changes

On October 1, 2009, several significant healthcare regulatory changes will take effect, including one that will force numerous relationships between physicians and hospitals, commonly known as "under arrangement" transactions, to be either restructured or unwound.

In a traditional "under arrangement" transaction, a hospital contracts with another entity (which may be owned by physicians in whole or in part) to provide certain services on the hospital's behalf. The earliest "under arrangement" transactions generally related to Part A pathology technical services. Typically, a hospital bills inpatients (or their third-party payors) under a DRG or provider-based payment arrangement. The contracted entity, which cannot bill for its services independently, provides specific services "under arrangements" which may include equipment, space, staff, management and/or supplies.

However, in recent years, the concept of "under arrangement" transactions has been vastly expanded to a wide array of new or existing services to allow physicians to assist in the provision of care, as well as share in the resulting economic returns generated from the technical component of the case. Examples include outpatient surgery, radiation therapy and cardiac catheterization. The typical model involves the creation of a jointly or wholly owned physician management entity, established to provide all or a portion of the technical component of the service as well as the related management and oversight. The hospital bills for the service, and the management company typically receives a "per case" or fixed fee designed to cover the cost of providing the technical services and allow the manager to realize a profit margin.

Recently, the Center for Medicare and Medicaid Services ("CMS") has revised its interpretation of the Federal Physician Self-referral law (commonly known as the "Stark" law) regarding "under arrangement" transactions, and its modified regulations reflect a shift in how such arrangements are treated with respect to furnishing "designated health services" (or "DHS") as defined under Stark. In particular, the new regulation changes the definition of the term "entity" to include both the entity that bills Medicare for the DHS and the entity that "performs" the DHS. (Note, the precise definition of the term "entity" is found in *42 CFR § 411.351*, and the full CMS commentary regarding the changes can be found at *73 F.R. 48721 through 48733, August 19, 2008*.)

The effect of this change is that in any situation where the physician-owned entity is construed to "perform DHS" pursuant to an "under arrangement" transaction, the entity will be considered a DHS entity. While it is somewhat unclear what it means to "perform DHS" within the new interpretation, it apparently depends on the specific nature of the services which are provided by the non-hospital entity, and most agree that many existing entities would fit within the new meaning. Physician ownership of DHS entities to which they also refer patients for DHS services is generally prohibited under the Stark law (with only limited exceptions), and thus, most "under arrangement" transactions, as commonly structured until now, will be prohibited after the change takes effect.

### FMV Pitfall

Failure to appropriately re-evaluate the services provided through "under arrangement" transaction models could leave many hospitals with non-compliant arrangements. It is required that hospitals restructure or unwind most existing "under arrangement" transactions to comply with the new regulations.