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Structuring Exclusive Contracts Between Hospitals and Physician Groups
Negotiating Exclusivity, Performance Standards, Payor Contracting, Restrictive Covenants and Other Key Provisions; Ensuring Stark Law, AKS and Tax-Exemption Compliance

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Structuring Exclusive Contracts Between Hospitals and Physician Groups

August 30, 2017

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Introduction

- Will be presented from both the hospital and the physician perspectives.
- Why exclusive contracts between hospitals and physician groups are proliferating, and the advantages and disadvantages.
- Key legal considerations.
- Nuts and bolts:
  - Basic provisions of exclusive contracts, and hot button issues.
  - Process to get the deal done.
  - Dialogues heard during negotiations.
Why Exclusive Contracts?
An Environment of Change

- Perhaps at no other time in history has health care experienced the recent volume and velocity of change.

- The drivers:
  - Health care "reform."
  - Federal regulatory and financial scrutiny of various types of services.
  - Reimbursement pressure from all governmental and non-governmental payors.
  - More and more (expensive) technology.
  - Heightened tension resulting from hospital’s efforts to acquire (or consolidate) physician practices.
  - Accountable care organizations, clinically integrated networks and other integrative efforts.
  - “Investor-owned” businesses.
Why Exclusive Contracts Are Proliferating

- Hospitals and medical staffs both strive to provide consistently high quality care for patients.
- Alignment between the two is essential to successfully meeting patient needs.
- It’s critical that a hospital have robust, well-designed relationships with certain of its physician groups, particularly its hospital-based specialties.
- The answer for many hospitals is an exclusive contract.
- Hospitals have historically had contracts with radiology, anesthesiology, pathology and emergency room groups to provide clinical services for those departments.
- Recently, the industry is seeing some extension of “exclusive-like” contracts to other specialties.
  - This can become *de facto* as a hospital acquires or closely affiliates with significant numbers of physicians in the community.
Advantages and Disadvantages of Exclusive Contracts

- **Advantages:**
  - The parties to the exclusive contract can rationally and proactively design a mutually beneficial relationship that’s designed to evolve with the changing environment.
  - The hospital gets a level of commitment to service from the physician group that may help the hospital operate more efficiently and compete more effectively.
  - The physician group gains a modicum of security and, if it has chosen its partner well, it will be better positioned to face the consolidation wave.

- **Disadvantages:**
  - “If it ain’t broke, don’t fix it!”
  - And an exclusive contract can change a longstanding, and otherwise effective, relationship into one that turns too much on what a contract says.
Key Legal Considerations
Health Care Laws

- Stark Law.
  - Don’t ignore Stark Law compliance just because the contract involves a physician specialty that generally doesn’t make “referrals” for designated health services (e.g., radiology and pathology).
  - Fit the contract within a Stark Law exception:
    - Probably the exception for personal services arrangements.
    - Possibly lease exceptions if space or equipment is leased under the contract.

- Federal Anti-Kickback Statute.
  - Attempt to fit within a safe harbor, but not mandatory.
Health Care Laws (cont'd)

- 1989 OIG Management Advisory Report: “Financial Arrangements Between Hospitals and Hospital-Based Physicians” (the “1989 MARs”).
  
  - Can be implicated by a hospital’s efforts to delegate/shift significant responsibilities/functionalities, or costs, to the exclusive physician group without corresponding commercially reasonable fair market value compensation to the group.
  
  - Also, can be implicated in the context of joint ventures between hospitals and exclusive physician groups.
Health Care Laws (cont’d)

- Analogous state self-referral, anti-kickback and fee-split laws.

- Recent state initiatives.
  - Attempts to limit the ability to grant exclusivity.
  - Anti-“balance billing” laws.
  - “Surprise billing” laws.
Health Care Laws (cont'd)

- HIPAA.
  - A business associate agreement might not be required.
  - However, if the physician group is providing any sorts of management and/or other administrative functionalities or infrastructure under the exclusive contract, then a business associate agreement probably is required.
Tax-Exemption Rules

- Private use and private benefit, and the heightened scrutiny from:
  - Congress and the IRS.
  - State legislatures and Attorneys General.
  - The (former) tobacco litigation tort bar and other plaintiffs’ lawyers.

- Excess benefit sanctions.
  - Context
  - The tax-exempt entity really drives the handling of any discovered excess benefits.
Tax-Exemption Rules (cont'd)

- HOWEVER, see IRS Notice 2014-67.
  - Five years probably became OK.
  - Query whether 30 years is now theoretically possible.
- Isn’t it just a business issue now?
  - Handle the exclusive contract just like any other longer term agreement?
Basic Provisions of Exclusive Contracts
Exclusivity

- The contract should contain an affirmative grant of exclusivity.
  - Need to make sure the grant is consistent with the medical staff bylaws, rules and regulations.

- The breadth of exclusivity will depend upon the extent to which the hospital and the physician group want to “partner” for services.
  - But also remember the commitments the hospital will be asking for and the physician group will be making under the contract.

- The extent of the exclusivity should be clearly defined.
  - Ideally specify by CPT codes or categories of services/procedures.
Exclusivity (cont'd)

- Need a process for addressing exclusivity involving new technologies or new uses of existing technologies.
  - Should the contract default to the physician group that has the exclusive?
- Any “carve-outs” or exceptions to the exclusivity should be clearly defined, and should not become “the exception that swallowed the rule.”
Exclusivity (cont'd)

- Hot button issues:
  - A process for modifying the exclusivity if the ultimate discretion is left in the hands of only one party (i.e., the hospital or the physician group).
  - Exclusivity that isn’t very exclusive.
    - Remember the *quid pro quo* for exclusivity.
  - Carve-outs based on *who* reads the procedure versus *what* procedure is performed.
Physician Group
Coverage and Services

- The contract should clearly articulate the coverage and professional service obligations of the physician group.

- On the other hand, the parties shouldn’t try to build too much into the exclusive contract.
  
  - As an example, the hospital may be developing some type of center of excellence, and may want the exclusive physician group to participate, including playing some type of management or other administrative role.

  - Under these circumstances, depending upon the extent of the role that the hospital is seeking, it may make more sense to memorialize the center of excellence participation (particularly any compensation) in a separate contract.
Physician Group Coverage and Services (cont’d)

- Common provisions:
  - Physical presence at the hospital.
    - Sub-specialization?
  - Supervision of the technical component (“TC”): who is responsible and when?
  - Off hours and call.
  - Use of *locum tenens*.
  - Charitable care.
  - Records and clinical service reports.
  - Participation in UM, QI, risk management and compliance programs.
  - Participation in GME.

- As an alternative, could default to requirements specified by the medical staff, but this entails its own set of risks for both parties.
Physician Group Coverage and Services (cont'd)

- Hot button issues:
  - Provisions that give either party almost a unilateral right to set the coverage and call requirements.
  - Coverage and call requirements with respect to services/procedures for which the physician group does not have the exclusives, especially if other physician specialties who have privileges to provide such services/procedures don’t have the same obligations imposed on them, either by contract or under the medical staff bylaws, rules and regulations.
Performance Standards

- Hospitals are increasingly incorporating into the exclusive contract detailed “performance standards.”
Performance Standards  (cont'd)

- Assess the need for and the content of performance standards:
  
  - If the hospital and physician group haven’t had problems in the past, consider whether standards are even necessary.
  
  - Hospitals shouldn’t just copy standards that they have heard about from other hospitals.
  
  - The standards should be unique to the exclusive relationship, should be based on sound clinical and operational principles, and should be tailored to address past problems as well as future problems that can be reasonably anticipated to arise.
  
  - Query whether it’s reasonable to impose standards on the physician group that depend heavily on effective and efficient operations by the hospital or that are outside the control of the physician group?
    - As an example, patient satisfaction scores (which hospital-based specialties often cannot materially affect).
Performance Standards  (cont'd)

- Evaluate whether failure to satisfy the performance standards will constitute a breach under the exclusive contract.
  - Consider making the standards “objectives” to be strived for, but not requirements that can lead to a breach (at least for some initial period of time, after which they could become requirements).

- Neither party should have the right to unilaterally modify the performance standards.

- Some hospitals will seek to incorporate numerous separate hospital policies, procedures and protocols, and, in effect, make them part of the contract.
  - At a minimum, the physician group will want to review all of these.
  - Because the exclusive relationship is a creature of contract, consider a provision that states that the exclusive contract will control with respect to any conflicts or inconsistencies.
Department Director

- If the physician group will be providing a department director (or similar leader) for the department, then the contract should clearly articulate the role and responsibilities of the position.

- The physician group should have the right to designate which physician from the group will fill the position, subject to the prior approval of the hospital, which approval may not be unreasonably withheld.
Department Director (cont'd)

- **Hot button issues:**
  - Position descriptions that shift too much responsibility to the department director.
    - Remember the 1989 MARs.
    - Also, the department director obligations of the physician group should not be used as a new source of recovery for the hospital when the department is poorly run.
  - Language that could have the effect of making the department director personally liable to the hospital for her or his actions (when acting as the department director).
    - The exclusive contract should include language that disclaims all such personal liability, and that affirmatively states that the physician group is solely responsible.
  - Delegations of responsibilities to the department director that are inconsistent with, and can be “trumped” by, the medical staff bylaws, rules and regulations.
  - Additional obligations in the exclusive contract that are unique, and only apply, to the department director.
Qualifications of Physicians

- Common provisions:
  - Licensure.
  - Medical staff membership and privileges.
  - Board certification or eligibility.
  - Medicare and other payor status.
  - Compliance with ethical and religious directives.
    - However, “ethical” and/or “conflict of interest” policies should not trump any negotiated restrictive covenants contained in the exclusive contract.
  - Relationship with the physician group.
Qualifications of physicians (cont’d)

- Additional requirements might be requested for certain key physicians such as the department director.

- Should address how *locum tenens* are treated under the contract.
  
  - Will the physician group even be allowed to utilize *locum tenens* physicians?
  
  - If so, what will be the approval process (if any) for the hospital?
Qualifications of physicians (cont'd)

- **Hot button issues:**
  - Mandatory written “acknowledgment” (by each physician) of the exclusive contract.
    - It’s reasonable for the hospital to demand that each physician acknowledge and agree to any clean sweep provisions and covenant(s) not to compete (more later on these provisions and covenants).
    - However, these acknowledgments should not be drafted in a way that makes each physician personally liable for all of the terms and conditions of the exclusive contract, or for any breach thereof.
Service Obligations of Hospital

- The contract should clearly articulate the obligations of the hospital.
- Any sources of past conflicts should be specifically addressed.
- Will the hospital be responsible for supervision as and to the extent required under Medicare and any other applicable payor requirements?
- If physician group is separately billing for its services, the hospital will need to provide requisite information to the group.
Compensation

- Any compensation to be paid to the physician group (e.g., for providing a department director) should be described in the contract.
  - The compensation needs to be fair market value and cannot be calculated in a manner that takes into account the volume or value of referrals or other business generated among the parties.
  - The compensation can be a fixed amount, although it is more common today for compensation to be calculated on an hourly basis.
Compensation (cont'd)

- Likewise, any compensation to be paid to the hospital for items and services it provides the physician group should be described in the contract, and is subject to the same rules.
Compensation (cont'd)

- If the hospital will be billing for any of the professional component ("PC"), then the contract must include or describe:
  - The proper steps and documentation for reassignment.
  - A methodology to calculate the PC compensation.

- Absent extenuating circumstances, it is common for the physician group to separately bill for the PC.

- On the other hand, if the contract is intended to be in the nature of a “coverage agreement,” then the hospital will likely be responsible for billing of the PC, and the compensation methodology and amount will be even more important.
Term and Termination

- **After Rev. Proc. 2017-13:** For tax-exempt hospitals, the term of the exclusive contract is probably a strictly business issue.
- For all other hospitals, the term has always been a strictly business issue.
- Neither party should be able to terminate the exclusive contract without cause, *i.e.*, merely upon notice (at least not until after some minimum period of time).
  - On the one hand, a contract with a longer “no cut” term takes more thought to construct, and creates more deal risks for both parties.
  - On the other hand, contracts that are terminable without cause on short notice can make it difficult for the physician group to recruit physicians.
Term and Termination (cont'd)

- For cause termination provisions should be mutual and should allow a reasonable period of time for a party to cure the breach.
  - Minimum is 30 days, and 60 to 90 days is better.
  - Could be shorter for breach of payment or other very important obligations.

- The hospital should not be able to terminate the entire exclusive contract because of the actions of a single physician, provided the physician group bars the physician from providing services at the hospital.
Term and Termination (cont'd)

- **Hot button issues:**
  - Vague, “bad citizen” termination rights.
  - Termination upon change in law.
    - Needs to require more than just the possibility of a potential risk that there might have been a change in law that could cause a party to theoretically be in violation of applicable law.
    - Should include a process for a party to provide some level of proof that there has indeed been a change in law, and then for the parties to evaluate alternatives for resolving the issue before the contract is terminated.
Term and Termination (cont'd)

- Hot button issues (cont'd):
  - “Transition rights” that allow the hospital to unilaterally require the physician group to continue providing services for a specific period of time after termination (even after a termination for cause).
    - Such a provision will make it easier for the hospital to terminate the contract and replace the group (and for this reason, this type of provision is not favored by physicians).
    - It could also have a mutual benefit by giving the parties some breathing room in negotiating a replacement exclusive contract.
  - Post-termination obligation on the physician group requiring it to release all of its physicians from their covenant(s) not to compete with the group.
    - Very few hospital-based physician groups will agree to this type of provision because they know it would give the hospital the de facto ability to cause a break-up of the group.
“Clean Sweep”

- If the exclusive contract is terminated for any reason, then the medical staff membership of each physician is automatically terminated without a hearing or other due process rights.

- Clean sweep is becoming, if it hasn’t already become, a standard *quid pro quo* when the hospital grants exclusive privileges to a physician group.

- Conversely, if the “exclusivity” isn’t very exclusive, query whether the exclusive contract should include a clean sweep (rather than defaulting to the usual medical staff process)?
Sidebar on HCQIA Reporting

- In order to access the immunity protections under the HCQIA, a hospital is generally required to report to the National Practitioner Data Bank:
  - A professional review action which terminates, suspends or restricts a physician’s clinical privileges based on actual or potential harm to patients, and . . .
  - Any resignation in lieu of corrective action or during an “investigation.”

- Medical staff termination pursuant to a typical clean sweep provision does not require reporting because no professional review action, i.e., a hearing, even takes place.
Sidebar on HCQIA Reporting  (cont’d)

- Sometimes the physician group and/or the hospital may want to build a mechanism into the exclusive contract for reviewing and addressing problems that might arise with respect to a specific physician (as distinguished from the group as a whole).
  
  - This mechanism is designed to assure that the physician group has had a chance to make its case before it is required to remove the physician from providing services under the exclusive contract.
  
  - Even though this is a mechanism based in contract (not on the medical staff bylaws, rules and regulations), it potentially could be deemed to be a professional review action.
  
  - Consideration should be given to specifying in the exclusive contract that the mechanism is not and will not be deemed to be a professional review action, and therefore is not reportable to the Data Bank.
Payor Contracting

- From the hospital’s perspective, it ideally would want the rights to:
  - Negotiate and enter into payor contracts for the physician group.
  - Approve the physician group’s fees.

- From the physician group’s perspective, it ideally would want the rights to:
  - Negotiate and enter into its own payor contracts.
  - Approve its own fees.
Payor Contracting (cont'd)

- How this issue should, and will, get resolved depends on local market conditions and recent payor contracting experiences.

- Examples of alternative, compromise resolutions:
  - Build a process for the hospital to request participation by the physician group, or . . .
  - The physician group has discretion in payor contracting, but cannot unreasonably refuse to participate with a payor, or . . .
  - Mandate that the physician group participates, but only if all the terms and conditions are reasonable, or . . .
  - Mandate that the physician group participates with a listed set of the largest payors, as well as with all other payors if the terms and conditions for these other payors are reasonable, or . . .
  - Mandate that the physician group participates if the group’s rates from a payor are greater than or equal to the rates the group receives from its “x” largest payors, or . . .
  - Mandate that the physician group participates if the group’s discounts are no greater than those of the hospital (usually measured against Medicare).
This is probably the most controversial issue these days in exclusive contracting.
Covenant Not to Compete

- The hospital will often want the physician group to agree to not compete with the hospital.
  - At a minimum, the hospital will likely want to bar TC competition.
  - But the hospital may also ask to bar PC work outside the hospital.
Covenant Not to Compete (cont'd)

- Whether the physician group will be willing to agree to a covenant not to compete for the TC will depend on local market dynamics and the history of the physician group’s relationship with the hospital.

- Existing TC facilities of the physician group will need to be carved out.

- But even if the physician group does not currently have TC facilities, it should ask itself how likely it is that the group would develop new TC facilities in light of any rights the hospital has to terminate the exclusive contract.

- Most physician groups believe it is almost never acceptable to limit a group’s ability to provide the PC.
  - This is particularly the case if the hospital has asked for, and the physician group has agreed to, relatively detailed performance standards: if the physician group doesn’t do a good job, the hospital can terminate it.
Covenant Not to Compete (cont'd)

- This is probably the second most controversial issue these days in exclusive contracting.
Indemnification

- Any indemnification should be mutual, *i.e.*, it should apply equally to the hospital and to the physician group.

- If presented with a draft contract that doesn’t include indemnification, then it’s a judgment call whether to ask for it.

- In any event, each party (particularly the physician group) needs to make sure it has insurance that covers the indemnification liability.
Dispute Resolution

- Consider the pros and cons of any dispute resolution mechanisms such as binding arbitration.

- A party may prefer to reserve its rights to litigate in the event it gets into a dispute with the other party.
  - A party’s threat of litigation (versus the obligation to pursue binding arbitration) may itself create leverage to the benefit of that party.
  - And these days, hospitals and physician groups (even hospital-based specialties) are more willing to sue each other.
Process to Get Deal Done

- First, be mindful of what is really happening.
- Have a realistic sense for how much leverage each party holds.
- And try to keep the discussions from becoming confrontational (they usually don’t have to be, but it will depend on your circumstances).
- Offer to prepare a first draft, but only if you are ready to present a moderate draft and you are reasonably confident the other party will not just ignore your efforts and respond with its own draft.
Occasionally a hospital will ask the physician group to sign a nondisclosure agreement before the hospital will begin negotiating the terms of a new exclusive contract.

- It might bar the group from speaking with other physicians on the medical staff to find out what terms the hospital has previously agreed to.
- It might preclude the group from speaking with members of the medical staff leadership (e.g., the MEC) and/or with the hospital’s board of directors/trustees in the event negotiations with the hospital’s management team take a turn for the worse.
- And it might preclude the group from taking it’s case to “the public” if the group needs to.
- In general, physician groups are very hesitant to sign these types of nondisclosure agreements.

In any event, there may be confidentiality obligations that are already set forth in any existing exclusive contract.
Process to Get Deal Done (cont'd)

- Each party shouldn’t just accept what the other party says (whether on legal or business issues).
  - Challenge positions and rationales that are based on extreme legal positions or that seem unreasonable or not supported by the clinical and operational realities.
Dialogues Heard During Negotiations

- **Hospital:**
  - “Everything must be at fair market value. For example, you must pay us fair market value for any of our infrastructure that you use to provide services within our facilities.”

- **Physician Group:**
  - “We agree, so if you want us to provide extensive medical director services, then we need to be paid fair market value. In other words, we can’t provide these services to you for free.”
Dialogues Heard During Negotiations (cont'd)

▪ **Hospital:**
  - “We have to be very protective of our tax-exempt status.”

▪ **Physician Group:**
  - “Although the law really hasn’t changed, we recognize the scrutiny may be higher.
  - We [the hospital and the physician group] have to find a way to balance your [the hospital’s] concerns against our [the physician group’s] need for a reasonable and workable contract.”
Dialogues Heard During Negotiations (cont'd)

- **Hospital:**
  - “We can’t grant you exclusives because we need to have an open staff.”

- **Physician Group:**
  - “A vast majority of hospitals don’t have ‘open staffs.’
  - But if that’s what you want, then there shouldn’t be a clean sweep provision, and we shouldn’t be expected to provide coverage and be on call by ourselves.”
Dialogues Heard During Negotiations (cont'd)

- **Hospital:**
  - “We need the right to modify the exclusivity.”

- **Physician Group:**
  - “Exclusivity is the *quid pro quo* for us making a strong commitment to you and for us agreeing to a clean sweep.
  - If you could unilaterally modify the exclusivity, then we really wouldn’t have an exclusive.
  - If there’s no exclusivity, then why should we make such a commitment, and why should there be a clean sweep?”
Dialogues Heard During Negotiations  (cont'd)

- **Hospital:**
  - “You must give us the right to sign any and all payor agreements that involve the physician group.
  - Or at least you must agree, without conditions, to participate with all payors that we participate with.”

- **Physician Group:**
  - “If we agree to what you’re asking for, we would have no leverage with the payors. The possibility of de-participation is the only real leverage that most physician groups have with payors.
  - We would be at the mercy of every payor who somehow figures out that once it gets its deal done with you [the hospital], then we [the physician group] must participate, regardless of the terms and conditions proposed by the payor.
  - The result is that our reimbursement will drop precipitously.”
Dialogues Heard During Negotiations (cont'd)

- **Hospital:**
  - “We want to partner with you, and we want to work with partners who are committed to us.
  - So, we don’t want you providing professional services for anyone who competes with us.”

- **Physician Group:**
  - “We will have a robust exclusive contract with you, including detailed performance standards.
  - The contract is full of specific requirements that we’ve agreed to because we are committed to you and want to partner with you.
  - If we don’t do what we’re supposed to, you [the hospital] can terminate the contract, and sue us for breach.
  - Also, providing professional services at other places allows us to be, and support ourselves as, a broad, subspecialized group that you alone could not support.”
THANK YOU!

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