

2017

MSN Educational Practice Management Seminar

Negotiating Hospital Contracts

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Disclosure

- NONE

Introduction

- Key legal considerations.
- Important provisions of exclusive provider agreements.
- Negotiating strategies.
- Responses to some things hospitals say these days.
- What should you do when all else fails?

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Key Legal Considerations

Health Care Regulations

- Stark Law.
 - Don't ignore Stark Law compliance just because you're a radiology group and you think the radiologists don't make "referrals" for designated health services.
 - Fit the agreement within a Stark Law exception, probably the exception for personal services arrangements.
- Federal Anti-Kickback Statute.
 - Attempt to fit within a safe harbor, but not mandatory.

Health Care Regulations (cont'd)

- 1989 OIG Management Advisory Report: “Financial Arrangements Between Hospitals and Hospital-Based Physicians”
 - With *de facto* efforts at cost-shifting by hospitals, this is becoming a bigger issue.
 - Also, can be implicated in the context of joint ventures between hospitals and radiology groups.
- State initiatives.
 - Limits on the ability to grant exclusivity.
 - Anti-“balance billing” laws.

Tax-Exemption Rules

- Private use and private benefit.
 - And the heightened scrutiny from:
 - Congress and the IRS.
 - State legislatures and Attorneys General.
 - The tobacco litigation tort bar and other plaintiffs' lawyers.
- Excess benefit sanctions.
- IRS Rev. Proc. 97-13.
- HOWEVER, now see IRS Notice 2014-67.
 - Five years is probably now OK.

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Important Provisions of Exclusive Provider Agreements

Exclusivity

- The agreement should contain an affirmative grant of exclusivity.
 - Need to make sure the grant is consistent with the medical staff bylaws, rules and regulation.
- The grant of exclusivity should be broad.
 - Does the hospital want you as their “partner” or not? And remember the concessions that are being made to the hospital.
- The extent of the exclusivity should be clearly defined.
 - Ideally would like to specify by CPT codes or categories of procedures.

Exclusivity (cont'd)

- Need a process for addressing exclusivity for new modalities or new uses of existing modalities.
 - The default should be that the radiology group has the exclusive.
- Any “carve-outs” or exceptions to the exclusivity should be narrow and clearly defined, and should not become “the exception that swallowed the rule.”

Exclusivity (cont'd)

- Insidious provisions:
 - A process for modifying the exclusivity if the ultimate discretion is left in the hands of the hospital.
 - Exclusivity that isn't very exclusive.
 - Remember that the agreement may contain a clean sweep provision.
 - Carve-outs based on *who* reads the procedure versus *what* procedure is performed.

Coverage and Services

- The agreement should clearly articulate the coverage and professional service obligations of the radiology group.

Coverage and Services (cont'd)

- Common provisions:
 - Physical presence at the hospital.
 - Sub-specialization?
 - Supervision of technical component (“TC”): who is responsible and when?
 - Off hours and call.
 - Report turnaround times.
 - Use of *locum tenens*.
 - Charitable care.
 - Records and clinical service reports.
 - Participation in UM, QI, risk management and compliance programs.
- As an alternative, could default to requirements specified by the medical staff, but this entails its own set of risks.

Coverage and Services (cont'd)

- Insidious provisions:
 - Provisions that give the hospital almost a unilateral right to set the coverage and call requirements.
 - Coverage and call requirements when the radiology group does not have the exclusives, especially if the other physician specialties who read films don't have the same obligations imposed on them, either by contract or under the medical staff bylaws, rules and regulations.

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Performance Standards

- Many hospitals are demanding detailed, and burdensome, “performance standards.”

Performance Standards (cont'd)

- How do you address performance standards?
 - Read them very carefully.
 - If you haven't had problems at the hospital, consider pushing the standards back completely.
 - Be wary of hospitals just copying standards that they have heard about other hospitals using.
 - The standards should be unique to your relationship, should be based on sound clinical principles, and should be tailored to address past problems as well as future problems that can be reasonably anticipated to arise.
 - Also be wary of standards that depend heavily on effective and efficient operations by the hospital or that are outside the control of the radiology group.
 - As an example, maximum report times when the hospital has a poor history of transcribing dictations.
 - As another example, patient satisfaction scores.

Performance Standards (cont'd)

- Evaluate whether failure to satisfy the performance standards will constitute a breach under the agreement.
 - Consider making the standards “objectives” to be strived for, but not requirements that can lead to a breach.
- The hospital should NEVER have the right to unilaterally modify the performance standards.
- Also be careful of efforts by hospitals to incorporate all sorts of separate hospital policies, procedures and protocols, and, in effect, make them part of the agreement.
 - At a minimum, obtain and review all of these.

Radiology Director

- If the radiology group will be providing a radiology director for the department, then the agreement should clearly articulate the role and responsibilities of the position.
- The radiology group should have the right to designate which radiologist will fill the position, subject to the prior approval of the hospital of the hospital, which approval may not be unreasonably withheld.

Radiology Director (cont'd)

- Insidious provisions:
 - Position descriptions that shift too much responsibility to the radiology director.
 - The radiology director obligations of the radiology group should not be allowed to become a new source of recovery to the hospital when the department is poorly run.
 - Language that could have the effect of making the radiology director personally liable to the hospital for her or his actions (when acting as the radiology director).
 - The agreement should include language that disclaims all such personal liability, and that affirmatively states that the radiology group is solely responsible.
 - Delegations of responsibilities to the radiology director that are inconsistent with, and can be “trumped” by, the medical staff bylaws, rules and regulations.
 - Additional obligations in the agreement that are unique, and only apply, to the radiology director.

Qualifications of Radiologists

- Common provisions:
 - Licensure.
 - Medical staff membership and privileges.
 - Board certification or eligibility.
 - Medicare and other payor status.
 - Compliance with ethical and religious directives.
 - Don't let “ethical” or “conflict of interest” policies trump any restrictive covenants that have been negotiated for the agreement.
 - Relationship with the radiology group.

Qualifications of Radiologists (cont'd)

- Additional requirements might be requested for certain key radiologists such as the radiology director or department chair.
 - But these should be narrow and appropriate.
- Be aware of how *locum tenens* are treated under the agreement.
 - The qualifications provisions can sometimes make it difficult to utilize *locum tenens*.

Qualifications of Radiologists (cont'd)

- Insidious provisions:
 - Mandatory written “acknowledgment” of the agreement by each radiologist.
 - It isn’t unreasonable for the hospital to demand that each radiologist acknowledge and agree to any clean sweep provisions and covenant(s) not to compete.
 - HOWEVER, these acknowledgements are sometimes drafted (perhaps unintentionally) in a way that makes each radiologist personally liable for ALL of the terms and conditions of the exclusive provider agreement, and for any breach thereof.
 - Random drug testing obligation imposed on each physician.

Service Obligations of Hospital

- The agreement should clearly articulate the obligations of the hospital.
- Any sources of past conflicts should be specifically addressed.
- If the hospital demands performance standards from the radiology, then it should be willing to agree to performance standards for itself.
- Will the hospital be responsible for supervision as and to the extent required under Medicare and any other applicable payor requirements?

Compensation

- Any compensation to be paid to the radiology group for providing a radiology director should be described in the agreement.
 - 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 radiology group should be described in the agreement, and is subject to the same rules.

Compensation (cont'd)

- If the hospital will be billing for any of the PC, then the agreement must include or describe:
 - The proper steps and documentation for reassignment.
 - A methodology to calculate the professional component (“PC”) compensation.
- Absent extenuating circumstances, it is generally recommended that the radiology group separately bill for the PC.
- On the other hand, if the agreement is intended to be more of a “*Coverage Agreement*,” then the compensation methodology and amount will be critical.

Term and Termination

- It's generally preferable to seek the longest possible term, and ask for an evergreen clause.
- Neither party should be able to terminate without cause, i.e., upon notice, until after a minimum period of time.
- As a result of IRS Notice 2014-67: If the radiology department is being used to secure tax-exempt financing, then the hospital can allow agreement to not be terminable without cause before 5 years.
 - And even this maximum term is not an absolute requirement.

Term and Termination (cont'd)

- For cause termination provisions should allow a reasonable period of time for a party to cure the breach.
 - Absolute minimum is 30 days, and 60 to 90 is better.
 - Could be shorter for breach of payment obligations.
- The hospital should not be able to terminate the entire agreement because of the actions of a single radiologist, provided the radiology group bars the radiologist from providing services at the hospital.

Term and Termination (cont'd)

- Insidious provisions:
 - Vague, “bad citizen” termination rights.
 - Termination upon change in law, e.g., the hospital can terminate the agreement if it merely perceives a potential risk to its tax-exempt status.
 - Could be very problematic in the future as hospitals become more and more nervous about their tax-exempt status.

Term and Termination (cont'd)

- Insidious provisions (cont'd):
 - “Transition rights” that allow the hospital to unilaterally require the radiology group to continue providing services for a specific period of time after termination (even after a termination for cause).
 - On the one hand, such a provision will make it easier for the hospital to terminate the agreement.
 - On the other hand, it could also give the parties some breathing room in negotiating a replacement agreement.
 - It’s a judgment call.
 - Post-termination obligation on the radiology group requiring it to release all of its radiologists from their covenant(s) not to compete with the radiology group.

“Clean Sweep”

- If the exclusive provider agreement is terminated for any reason, then the medical staff membership of each radiologist is automatically terminated without due process rights.
- Clean sweep is becoming, if it hasn't already become, the standard hospital *quid pro quo* when the hospital grants exclusive privileges to a radiology group.

“Clean Sweep” (cont'd)

- Be aware of efforts at the state level to limit the ability of hospitals to grant exclusives.
 - If you can't be granted exclusives, why agree to a clean sweep?
- Similarly, if your exclusivity isn't very exclusive, then why agree to a clean sweep?

Payor Contracting

- From the hospital's perspective, it ideally wants the rights to:
 - Negotiate and enter into payor contracts for the radiology group.
 - Approve the radiology group's fees.
- From the radiology group's perspective, it ideally wants 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:
 - Radiology group has discretion in payor contracting, but cannot unreasonably refuse to participate with a payor, or . . .
 - Build a process for hospital to request participation by the radiology group, or . . .
 - Mandate that the radiology group participates, but only if all the terms and conditions are reasonable, or . . .
 - Mandate that the radiology 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 radiology 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 radiology group participates if the group's discounts are equal to or greater than those of the hospital (usually measured against Medicare).

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Payor Contracting (cont'd)

- This is probably the most controversial issue these days in hospital contracting.

Covenant Not to Compete

- The hospital will often demand that the radiology group agree to not compete with the hospital.
 - At a minimum, the hospital will likely want to bar TC competition.
 - But the hospital may also attempt to bar PC work outside the hospital.

Covenant Not to Compete (cont'd)

- Whether the radiology group will have to agree to a covenant not to compete for TC will depend on the radiology group's leverage.
 - Existing TC facilities of the radiology group will need to be carved out.
 - But even if the radiology does not currently have TC facilities, it needs to ask itself how likely it is that the radiology group would develop new TC facilities given the hospital's right to terminate the exclusive provider agreement.
- It's almost never acceptable to limit the radiology group's ability to provide the PC.
 - This is particularly the case if you've agreed to relatively detailed performance standards: if you don't do a good job, they can terminate you.

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Covenant Not to Compete (cont'd)

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

Indemnification

- Any indemnification should be mutual, i.e., it should apply equally to the hospital and the radiology group.
- If the draft agreement does not include indemnification, then it's a judgment call whether to ask for it.
- In any event, make sure the radiology group has insurance that covers the indemnification liability.

Dispute Resolution

- Consider the pros and cons of any dispute resolution mechanisms such as binding arbitration.
- The radiology group may prefer to reserve its rights to litigate in the event it gets into a dispute with the hospital.
 - The radiology group's threat of litigation (versus the obligation to pursue binding arbitration) may itself create leverage to the benefit of the radiology group.

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Negotiating Strategies

Negotiating Strategies

- First, be mindful of what is really happening.
- Have a realistic sense for how much leverage the radiology group 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 hospital will not just ignore your efforts and respond with its own draft.

Negotiating Strategies (cont'd)

- Be wary of the hospital asking the radiology group to sign a confidentiality agreement before the hospital will begin negotiating the terms of the new agreement.
 - It might bar the radiologists from speaking with other physicians to find out what terms the hospital has previously agreed to.
 - It might preclude the radiologists 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 radiology group from taking it's case to "the public" if the group needs to.
- On the other hand, don't forget about any confidentiality obligations that are already set forth in your existing agreement.

Negotiating Strategies (cont'd)

- Don't just accept what the hospital 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.
- Be prepared to use past statements and positions of the hospital:
 - Hospital has said: "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 read films from other locations."
 - Radiology group should say: "Don't expect us to provide extensive medical director services for less than fair market value. In other words, we're not going to provide these services to you for free."

Responses to Some Things Hospitals Say These Days

- Hospital: “We have to be very protective of our tax-exempt status.”
- Response:
 - “The law really hasn’t changed, although we recognize the scrutiny is higher.
 - The hospital and the radiology group have to find a way to balance your [the hospital’s] concerns against our [the radiology group’s] need for a reasonable agreement.”

Responses to Some Things Hospitals Say These Days (cont'd)

- Hospital:
 - “We can’t grant you exclusives because we need to have an open staff.”
- Response:
 - “A vast majority of hospitals don’t have ‘open staffs.’
 - But if that’s what you want, then don’t expect a clean sweep right, and don’t expect us to provide coverage and be on call by ourselves.
 - By the way, who’s more qualified to read the films?”
- Hospital:
 - “We need the right to modify the exclusivity.”
- Response:
 - “Exclusivity is the *quid pro quo* for agreeing to a clean sweep.
 - If you can unilaterally modify the exclusivity, then we really wouldn’t have an exclusive, and there would be no reason to agree to a clean sweep.”

Responses to Some Things Hospitals Say These Days (cont'd)

- Hospital:
 - “You must give us the right to sign any and all payor agreements for the radiology group.
 - Or at least you must agree, without conditions, to participate with all payors that we participate with.”
- Response:
 - “If we agree to what you’re asking for, we would have no leverage with the payors.
 - We would be at the mercy of every payor who somehow figures out that once it gets its deal done with the hospital, then we [the radiology group] must participate, **REGARDLESS OF THE TERMS AND CONDITIONS PROPOSED BY THE PAYOR.**
 - The result is that our reimbursement will drop precipitously.
 - Oh, and by the way, how do you think the payors will learn about this? And they always do.”

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**What should you do
when all else fails?**

Be aggressive

- Prepare for asymmetrical, guerilla warfare.
- Conduct a multi-channel PR campaign.
 - Remember to comply with any existing confidentiality obligations.
- Engage in Kissinger-like shuttle diplomacy.
- NEVER underestimate the support of a medical staff that values and appreciates the quality and service of the radiology group.
- Always remember: it ain't over 'til it's over!
- But also: it ain't finished 'til it's finished!

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THANK YOU!

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