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# Professional Service Agreements

This session's main topic is professional service agreements (PSAs). With the growing complexity of oncology practice, collaborative arrangements between business entities to expand services, provide key supportive functions, or provide a single service are often undertaken. These agreements can vary widely in scope. The case studies presented in the video for this session are available in written format and can be found at the end of this document.

**Understanding the Regulatory Framework**

The sale of the group's assets and the subsequent contracts between the hospital and the group are all subject to the federal and state fraud and abuse statutes and will need to be carefully structured to ensure regulatory compliance. The federal statues—in particular, the Anti-Kickback Statute (AKS) (section 1128B(b) of the Social Security Act (42 U.S.C. 1320a-7b(b)) and the physician self-referral law, codified at 42 U.S.C. § 1395nn ("Stark" or the "Stark Law")—apply when services are paid under government healthcare programs (e.g., Medicare, Medicaid, and TriCare, including Medicare Advantage).[1]

The AKS prohibits the knowing and willful offer, solicitation, payment, or receipt of anything of value that is intended (1) to induce the referral of an individual for a service for which payment may be made by Medicare and Medicaid or certain other federal or state healthcare programs, or (2) to induce the ordering, purchasing, leasing or arranging for, or recommending the purchase, lease, or order of, any service or item for which payment may be made by such federal or state healthcare programs (collectively referred to as an illegal inducement). For purposes of the AKS, remuneration includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

[1] This overview is intentionally high-level and summary in nature. It is for informational purposes only and is not intended as legal advice or as a substitute for professional legal advice. It is recommended that readers consult a qualified legal professional licensed in their jurisdiction regarding the legal implications of these laws.

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The statute is broadly applicable to participants in the healthcare space (it would apply to all aspects of the vignette described above), and has been interpreted to cover any arrangement where one purpose of the remuneration is to induce improper referrals. The AKS is a criminal statue and can also lead to liability under the Civil Monetary Penalty (CMP) Statute and the False Claims Act. The Office of Inspector General has promulgated so-called "safe harbors," such that when all of the conditions of the applicable safe harbor are met, the arrangement will be deemed compliant. However, failure to meet all safe harbor requirements does not necessarily mean there is a violation of the law. In such cases, the particular arrangement would be reviewed on a facts-and-circumstances basis to determine whether the requisite intent to induce referrals is present.

The Stark Law prohibits a physician from referring a patient to an entity with which the physician (or an immediate family member) has a financial relationship for the furnishing of so-called designated health services (DHS) that are reimbursable by Medicare or Medicaid—unless an exception applies. A financial relationship, for purposes of the statute, can be both direct and indirect, and includes an ownership/investment interest as well as a compensation arrangement. DHS includes, among other things, all inpatient and outpatient hospital services, outpatient prescription drugs, clinical laboratory services, radiology and certain other imaging services, radiation therapy services and supplies, durable medical equipment and supplies, and home health services. Stark is a civil statute, and violations can lead to onerous financial penalties plus potential liability under the CMP and False Claims Act. Unlike AKS, Stark is strict liability, meaning that the government does not need to prove an intent to make an illegal inducement in order to establish a violation; if the Stark Law applies to an arrangement, the arrangement must be structured to comply with all of the requirements of an applicable Stark Law exception, or a violation will be deemed to occur.

While the AKS safe harbors and their correlating Stark exceptions are not entirely aligned, there are commonalities. Typical requirements include that the arrangement be in writing and have a minimum 1-year term, and that the remuneration under the arrangement be fair market value and commercially reasonable, without regard to the volume or value of any referrals between the parties. The parties would be well-advised to obtain a third-party valuation which takes into account the applicable regulatory framework in reaching a determination.

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**Getting Ready for the Negotiation**

Over the last 10 years, there has been tremendous consolidation within the oncology marketplace with more physicians entering into a spectrum of relationships with private equity, venture capital, and hospital-based systems. Over this same time frame, there has been growing discontent among physicians about the overall loss of autonomy, increasing work burdens, and downward pressures on earning potential. The loss of autonomy, declining reimbursement, and excessive workloads are cited as some of the major drivers for physician burnout. Determining whether these trends are correlative or coincidental will require more workforce research. When entering into any agreement, keep these factors in mind as you negotiate.

Affiliating with a hospital, private equity backed management services organization (MSO), or other third party can provide your practice several benefits including, but not limited to:

1) Income protection in an environment of declining Centers for Medicare & Medicaid Services (CMS) physician payments and challenging payer contracting
2) Succession planning—hospital may support income guarantees for new hires, relieving financial pressure on the practice during the new hire's ramp-up years
3) Market expansion faster than that organic growth would allow
4) Ability to develop integrated services across specialties and streamline patient care
5) Ensuring alignment with community providers
6) Relieve administrative burdens (payor contracting, electronic medical record maintenance, etc.)
7) Relieve overhead costs (for example, facilities care and oversight)

Affiliation transactions come in many flavors. In a typical private equity transaction, an MSO would typically acquire the group's non-clinical assets for a purchase price calculated as a multiple of earnings before income taxes, depreciation and amortization (EBITDA). The physician owners of the group receive cash and typically a portion of the purchase price in the form of so-called "rollover" equity in the MSO, and remain employees of the group with long term employment agreements. The group could be folded into a larger (regional, or sometimes national) platform practice or remain independent. In either case, due to corporate practice of medicine requirements, going forward the group would be managed by the MSO under a long-term contract.

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The purchase price in these transactions is generally expressed as a multiple of projected EBITDA, created by the physicians agreeing to take a “scrape” (or reduction) to their compensation going forward.

A hospital that is looking to expand its oncology services may similarly seek to buy the assets and operations from a group, thereby allowing it to convert the group’s clinic locations to hospital services. If the physicians do not want to be employed by the hospital, they may remain independent and continue to provide professional services at the clinics on behalf of the hospital through a professional services agreement. The hospital could also engage the group to provide administrative and management support for the sites under a separate management services agreement. Hospitals are generally seen as being subject to more regulatory scrutiny than private parties and, typically, the hospital’s proposed fair market value purchase price for the assets may not seem competitive with private equity-backed options. However, the group might see their aggregate compensation increase following the transaction, subject to fair market value considerations, as described below. The group should also be aware that following a transaction, the physicians would no longer be able to share in revenue from chemotherapy supervision (which is not reimbursed by Medicare under the OPPS), or participate in imaging or other ancillary service lines, although they may be eligible for fair market payments tied to their supervision or other services. If the group’s locations are assumed by the hospital, the costs to patients (e.g., co-pays) and insurers would also increase due to the hospital’s differing reimbursement structure.

Many hospitals’ short-term goals for such a transaction include:

1) Building an oncology service line with horizontal and vertically integrated services that can maximize patient outcomes.
2) Capturing upstream and downstream revenue (imaging, pathology, laboratory, surgical, and radiation oncology revenue streams).
3) Maximizing revenue via regulatory and legislated mechanisms providing enhanced payments to hospitals over private practice such as 340b, facility fees, and CMS hospital payment models.
4) Respond to potential competition on the oncology space (neighboring hospital developing an oncology program).

In the case-based scenario accompanying this session, a hospital deal is the route that the group will choose.

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Two key components when negotiating with hospital systems are:

1) What are your negotiation goals?
2) How do you negotiate?

There are many reasons why a practice would like to develop a professional service agreement with a hospital, and knowing your practice's strengths and weaknesses and what differentiating services your group brings to the table will be crucial to the agreement's mutual success. Once your practice's goals are defined, a good exercise is to try to determine why the hospital is interested in pursuing a professional services agreement with your group. In this instance, consider both the hospital's long- and short-term goals — perform some due diligence. If you are partnering with a large institution with a national and/or regional presence, see if they have pursued other PSAs with oncology (or other specialty) practices and reach out to these groups to gauge the pros and cons of their engagement.

When your practice embarks on the path of negotiations, you must first identify the key decision makers. This may be the hardest bit of information to gather and can lead to hours of frustrating work if the individuals you have been negotiating with do not have the authority to make an agreement. When this happens, prior points of negotiations could be null and void, and you may have to start over with the next tier of administrators. Such frustrations only are increased the larger and more complex the institution is, and academic institutions can be very difficult to deal with; you may negotiate with a 'division' (hematology/oncology or cancer center) only to have to go another round with a 'department'. The first principle is to name the key decision maker parties, and with large institutions, you may have to negotiate with more than one entity.

Once a hospital has started working with a practice within the structure of a PSA and the short-term goals have been achieved, many hospitals will begin to focus on maximizing revenue generation. These objectives may not be beneficial to the practicing physician's autonomy, time, or independence, and may include:

1) Maximizing revenue by increasing physician volumes, employing the practice's staff through the hospital, cutting physician reimbursement.
2) Mandating participation in hospital quality metrics.
3) Buying the practice's "bricks and mortar"—buildings and properties.
4) Moving towards a physician employment model.

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Although the short-term goals are typically advantageous to both parties, practices must be wary of the long-term implications of these arrangements and negotiate up front with the long-term strategy in mind.

Additionally, no relationship lasts forever. Hospital leadership changes and pivots depending on market forces, and there is no guarantee that the favorable terms you agree to today will continue in perpetuity. One important aspect to the contracting process is how can you protect yourself if you wish to terminate this relationship and how you can do it successfully.

A group's greatest assets are their reputation and their ability to exit a hospital partnership. If you manage these assets well, you can walk away from any partnership that is no longer mutually beneficial:

1) Your staff – A loyal, well-trained staff is a group's most valuable asset and the hardest for the hospital or practice to reconstitute. Imagine if a group who still oversees their staff wished to discontinue a relationship with a hospital. The hospital would have to hire and train new medical assistants, secretaries, infusion nurses, office managers, triage nurses, advanced practice providers, etc. This would be a tremendous headwind if a hospital elected to directly compete with a departing practice, and can give the practice the edge in the marketplace.
2) Real estate – An expensive asset to rapidly acquire and upfit in the case of ending a hospital relationship can be a financial barrier to extraction. Hospitals will pay a premium to purchase a practice's properties, but if the practice ever wishes to leave (especially a quick departure), they will have to pay a premium to rebuild.
3) Imaging equipment and certificates of need – Practices may be offered a premium for the transfer of these assets. Unfortunately, this would typically be a one-time payment, and does not continue indefinitely. Practices may assume that by transferring equipment to the hospital that those revenue streams would continue moving forward, but given the regulatory considerations described above, they will often expire.
4) Patient records – Hospitals will negotiate to control patient records in the event of a separation, which can restrict a practice's ability to communicate with patients that the practice is moving.

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Patients will often elect to remain with their doctors in this scenario; however, if the hospital controls the patient records, the practice loses the ability to communicate this change to patients. In this case, up-front negotiation for a mutually agreed upon letter informing the patients of the practice change and giving the patients the option of where they would like to continue their care is ethically sound and can benefit the patients and the practice.

5) Unwind (or, what happens after the PSA ends?) – To reconstitute after a separation from a hospital system, a practice would need a minimum of 6 months to secure payor contracts and upfit facilities. Many hospitals will not engage in serious negotiations until the final 1-2 months of the PSA. There have been multiple instances where "soft negotiations" occurred for months, but in the final weeks before an agreement was to expire, the hospital would backtrack from previously discussed terms and take a more aggressive stance. In such a scenario, a practice would have to either agree to the hospital terms or run the risk of having to shut down operations until the practice can be reconstituted. Agreeing to predefined timelines and negotiation processes for PSA renewal of 6 to 9 months prior to the expiration of the contract will give the practice time to formulate alternate practice plans.

As long as your group preserves those elements that are critical to reconstitute as an independent practice, you will be able to maintain the balance of power throughout these negotiations.

Once you grasp the value your practice brings to a negotiation as well as key bargaining positions, then there are a multitude of details that need to be sorted out. The governance of the agreement should be clear, and one or more formal working groups should be established to meet regularly to ensure ongoing communication. These groups would address both legal and administrative items such as who would oversee market expansion, call coverage, work hours, clinic staffing, research, decision-making (critical for preservation of physician autonomy), budgeting, dispute management, performance measures, and compensation. The parties would work carefully with counsel to define terms and ensure their business deal is accurately captured.

Although this process can become monotonous, all of these points need to be fleshed out and elaborated upon. These points should be very granular, particularly when it comes to technical, pharmacy, infusion, and radiation services in oncology.

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When dealing with hospitals, be aware of contracting terms and conditions of compliance with medical staff requirements. These are likely defined under separate documents and governed independently of the hospital executive, so be sure to understand any 'quality metrics' or credentialing requirements. In academic entities, this can include requirements for faculty (division or departmental regulations).

One final area that will require significant review and discussion with your legal team are the terms of the contract renewal, as well as how either party can exit the agreement. Due to the lucrative nature of oncology services for hospital systems, hospitals will likely wish to impose numerous restrictions in the case of a practice exit. Many of these restrictions create barriers for the physician practice to find a place where they can launch a successful competitive position in a market, and can include restrictions with whom a practice can partner. As part of the negotiations, a practice can request carve-outs for certain partnerships when the contract terminates. Many hospitals may want to prevent a group from partnering with the hospital across town, but may not have any specific grievance if the group wants to partner with a management service organization. An additional consideration for these exits is data management. If done well, critical patient records can be transferred seamlessly to the new practice if the patient agrees to transfer. This can be done in the form of a structured data dump and can save a practice hundreds of work hours regarding record transfers and chart updating (and tens of thousands of dollars). If done poorly, it will be a significant headache for the doctors and staff as they are trying to rebuild their practice.

Although the primary focus of this chapter is negotiating for practice financial success there is a crucial element that will always ensure the desired outcome: put patient care first. Case study after case study demonstrate that organizations which put excellent patient centered-care first and then work backwards to financial success will nearly always succeed compared with those putting financial success first and work backward to establish great care. Having an impeccable reputation for providing great care will ensure that patients will keep coming back, and your referral base stays strong and loyal.

PSAs are complex documents that cannot be successfully constructed without professional help. Practices may need both a consultant to help ascertain the practice's market value and hire a legal professional familiar with oncology PSA contracting. There are many more suitors entering the oncology space looking to purchase oncology practices including hospitals, venture capital, insurers, etc., and a consultant can help determine a practice's value on the open market.

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## Glossary of Terms

The authors have identified terms thought to be beneficial for this session.

**Administrative Support:** Services provided to manage the non-clinical aspects of a medical practice, including billing, scheduling, and human resources.

**Billing and Coding:** The process of submitting claims to insurance companies for reimbursement of medical services provided, including the use of specific codes for diagnoses and procedures.

**Clinical Autonomy:** The ability of healthcare providers to make independent clinical decisions based on their professional judgment and patient needs without external interference.

**Compliance:** Adherence to laws, regulations, and guidelines that govern medical practices, including HIPAA, Medicare, and Medicaid requirements.

**Confidentiality:** The obligation to protect patient information and proprietary information from unauthorized disclosure.

**Dispute Resolution:** Methods agreed upon by the parties to resolve any disagreements that arise, which may include negotiation, mediation, or arbitration.

**Electronic Health Records (EHR):** Digital versions of patients' paper charts that provide real-time access to patient data, facilitating coordinated and efficient care.

**Fee Structure:** The agreed-upon method of compensation for services provided, which can include fixed fees, percentage-based fees, or performance-based incentives.

**Human Resources Management:** The process of recruiting, hiring, training, and managing employees within a medical practice.

**Indemnification:** A contractual obligation to compensate another party for losses or damages incurred due to specific actions or omissions.

**Joint Committee:** A group formed by representatives from both parties to oversee the implementation and management of the agreement, ensuring compliance and quality standards.

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**Marketing and Business Development:** Strategies and activities aimed at promoting the practice and expanding its patient base.

**Oncology Practice Management Company:** A company that provides specialized administrative and operational support to oncology practices to enhance efficiency and profitability.

**Patient Outcomes:** Measures of the results of healthcare services provided to patients, including survival rates, quality of life, and patient satisfaction.

**Performance-Based Incentives:** Additional compensation linked to achieving specific performance metrics, such as patient outcomes, patient satisfaction, and adherence to clinical guidelines.

**Practice Management Software:** Software used to manage the day-to-day operations of a medical practice, including scheduling, billing, and patient records.

**Proprietary Information:** Confidential business information owned by a party, including trade secrets, business strategies, and financial data.

**Quality Assurance:** Processes and procedures used to ensure that services provided meet established standards and regulations, often involving regular audits and reviews.

**Regulatory Compliance:** Ensuring that the practice adheres to all relevant laws and regulations governing medical services and patient care.

**Revenue Sharing:** An agreement to distribute a portion of the revenues generated from services provided between the parties involved.

**Scope of Services:** A detailed description of the specific services to be provided under the agreement, outlining the roles and responsibilities of each party.

**Termination Clause:** Provisions outlining the conditions under which the agreement can be terminated by either party, including notice periods and grounds for immediate termination.

**Term of Agreement:** The duration for which the agreement is valid, including the initial term and any options for renewal.

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## Resources and References

The authors are sharing additional resources and references below that can be reviewed for further learning.


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## Case Scenarios

MetroHealth Hospital is a well-established healthcare facility that seeks to enhance its oncology services to provide comprehensive cancer care. They aim to collaborate with Courage Cancer Centers—a reputable medical oncology group with 101 employees, infusion room, and PET scanner—to deliver high-quality oncology services within the hospital. MetroHealth wishes to leverage the partnership with Courage Cancer Centers to expand its oncology services. Courage Cancer Centers wishes to be the provider of oncology services in MetroHealth but is concerned about the impacts of losing control of its practice to the hospital. Both MetroHealth and Courage Cancer Centers are aligned with the goal of improving patient outcomes.

The negotiation team from Courage Cancer Centers, led by Dr. Marty Krawb, meets with MetroHealth to discuss opportunities to partner. Options discussed include: (1) co-management service agreement, (2) joint venture, (3) professional services agreements (PSAs), and (4) employment model.

**What is the difference between these different relationships?**
In a clinical co-management relationship, the physicians and the hospital collaborate to jointly provide leadership and direction to a hospital-based service line. Co-management agreements can be especially helpful for providers that are participating in emerging payment models because compensation typically includes a fixed base fee plus a performance incentive intended to support enhanced quality, improved efficiency, or reduced cost of care. The agreements are more extensive than medical directorships, as they assign additional operational duties to physicians, who retain their autonomy.

Various joint venture and clinical integration opportunities are also available for hospitals that want to expand their footprint, improve inefficiencies, or reduce costs. These arrangements, like co-management, are subject to a variety of legal and regulatory considerations that would need to be carefully navigated; but, if appropriately structured, a joint venture or clinical affiliation can help to align the parties (through shared ownership and/or financial responsibility), support strategic objectives such as development of ambulatory surgery centers, and enhance the ability of physician practices and hospitals to collaborate to gain expertise.

PSAs are an alternative to an employment model under which the hospital would employ the individual physicians and other staff. In a PSA, the physicians continue to operate through their own legal entity and corporate structure, but contract with the hospital to provide professional medical services to hospital patients.

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The benefit of a PSA is that the physicians maintain some autonomy, both in governance over their own practice and with respect to the group's income distribution model and benefits. As the group remains independent, there may be an easier unwind should the relationship with the hospital fail.

Employment is the highest level of integration. In an employment model, the hospital may acquire the physician group's locations, assuming real estate leases and other contracts supporting the sites to run them as hospital locations. It would then hire the physicians and other clinical and non-clinical staff, winding down and eventually dissolving the physician group's operations.

After discussing the different potential relationships, Dr. Krawb and his team elect to move forward with a combined asset sale and professional services agreement. As the organizations discuss opportunities for integration, MetroHealth would like to take over the infusion and PET imaging services to bring Courage Cancer Centers under the hospital umbrella, buying the group's tangible assets (including the PET scanner) and assuming the real estate leases. However, MetroHealth would not employ the physicians and other Courage Cancer Center staff. After the transaction closes, Courage Cancer Center locations would operate under the hospital's license and billing numbers. Although it would no longer own or control the practice locations, Courage Cancer Center would remain independent, and the hospital and Courage Cancer Center would enter into a PSA under which Courage Cancer Center would be the exclusive physician group serving patients at those locations. MetroHealth also plans to build a new cancer center with the intentions of winding down former Courage Cancer Center locations to allow MetroHealth to see patients in this new space.

**Dr. Krawb and his team are very concerned about the degree of integration desired by the hospital. What are the pros and cons of giving up these different components of Dr. Krawb's practice?**

Oftentimes, the more services that the hospital can integrate under their corporate umbrella, the more profitable the endeavor. There would be greater flexibility to refer for ancillary and other services within the hospital, and the hospital would typically receive payment at a higher level under the Outpatient Prospective Payment System (OPPS). From the group's perspective, this may help support a comfortable fair market value (FMV) level of compensation; however, the more services that Courage Cancer Centers give up, the more difficult it will be for the practice to ever extract itself from the hospital in the future. Dr. Krawb and his team negotiate a purchase price for their assets and a rate for productivity— or work relative value unit (wRVU)-based compensation from the hospital—that is determined to be FMV through a third-party valuation.

Courage Cancer Centers has a dedicated and well-trained staff. The practice is concerned that turning over the staff to the hospital could be detrimental to the staff over time and result in a loss of committed employees.

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Additionally, maintaining a committed staff will make any transition out of MetroHealth easier and the practice more valuable to the institution, as it would be difficult for MetroHealth to replace 101 employees. As a result, the parties determine that Courage Cancer Centers will retain their staff and enter into a separate management agreement with the hospital. Under this policy, the hospital would separately engage Courage Cancer Centers to manage and oversee the cancer services including the infusion room for an acceptable FMV fee.

Regarding the PET scanner, MetroHealth offers Courage Cancer Centers an additional payment (which may be structured as a flat fee or a per-RVU enhancement, subject to FMV valuation); however, the physicians would not be eligible for any payments tied to their imaging referrals once the transaction is complete.

MetroHealth and Courage Cancer Centers partner to design the new cancer center, with the physicians having a joint venture opportunity to invest in the real estate.

**What are some value-added bargaining points for both parties?**
Both businesses put together a value-based care co-management proposal with target and stretch goals for the practice that would result in incentive payments and bonuses. These goals were mutually discussed, agreed upon, and subsequently supported through an independent third-party valuation process.

**What are other factors that need to be considered in this partnership?**
There are many subtleties in these negotiations, and working with an experienced law firm in hospital partnerships is critical to future practice success, long-term autonomy, and the ability to pivot or extract the group in the future.

Topics that need to be considered include:

1) Coverage of billing and coding support
2) Ways the physicians can have input into any proposed organizational or service changes
3) Terms for contract renegotiations
4) Term and termination provisions, including any potential for unwinding. This includes post-termination non-competition and other restrictive covenants, the ability to resume tenancy at the former practice locations, and an agreed approach to patient notice and disposition of patient records.

**Dr. Krawb and his team successfully finalize the PSA, and the relationship is mutually beneficial for both parties for the first 3 years. At 3 years, the contract is up for renegotiation which expires December 31st of 2022. How should Dr. Krawb proceed with negotiations?**

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Starting in June of 2022, Dr. Krawb and his team request that the hospital continue the current terms of the agreement for another 3-year term. Initial feedback from MetroHealth suggests that they are also on board with this plan. However, July, August, September, and October pass without a new contract being presented to Courage Cancer Centers. Dr. Krawb calls a formal meeting with Metro Health's negotiation team in November. MetroHealth notes that they would like to reduce the per wRVU reimbursement by $5, arguing that this amount reflected a one-time fair market payment for the PET. Additionally, due to challenges with payor contracting, the hospital feels that they need to reduce payment by an additional $6 per wRVU, consistent with a new FMV determined by the hospital's consultants. Finally, Courage Cancer Centers met their target and stretch goals every year, resulting in a substantial bonus for the practice. As a result, the hospital would like to increase the cutoffs for the target and stretch goals to make them more challenging.

Dr. Krawb is surprised by the last-minute changes to the contract, and his team deems them unacceptable. Negotiations fervently continue into December, with the hospital refusing to back down from their requested changes. Therefore, Courage Cancer Centers decides that they would like to terminate the contract. MetroHealth states that if Courage Cancer Centers terminates the contract, they will have to vacate the cancer center on January 1st, 2023, as there were no terms for continued occupancy in the case of termination.

**What options are on the table for Dr. Krawb and Courage Cancer Centers?**
In this situation, Courage Cancer Centers has very limited options. If Courage Cancer Centers wants to reconstitute themselves as a practice, they will need a new building, new payor contracts, new electronic medical record systems, and so on; this cannot be accomplished in less than 6 months. Courage Cancer Centers agrees to a 12-month extension with a clause that all negotiations are finalized by June 2023 to avoid last minute issues or surprises.

In the interim, MetroHealth is bought out by a larger regional health system, Gervald Health. Gervald Health meets with Courage Cancer Center in April of 2023 after the acquisition and insists on moving beyond the PSA to an employment-based model.

**What should Dr. Krawb and Courage Cancer Center do next?**
Negotiations have been challenging, and the hospital seems to be moving in a new direction. Dr. Krawb now recognizes that last minute negotiations put his team at an inherent disadvantage. If negotiations continue to stall, Dr. Krawb would need to establish back-up options. Dr. Krawb continues negotiations with Gervald Health in hopes of continuing the original contract but is actively pursuing alternative solutions.

Unfortunately, Gervald Health fails to reach a deal with Courage Cancer Centers by the agreed upon date and the contract is set to terminate December 31st, 2023.

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Dr. Krawb and his team are working diligently to reconstitute their practice. As December 31st approaches, Courage Cancer Centers wishes to send a letter to their patients alerting them of the change. Gervald Health notifies Courage Cancer Centers that according to the terms of their PSA, the hospital owns the patient's records, and that Courage Cancer Centers cannot reach out to the patients.

Courage Cancer Centers successfully transitions out of the hospital contract, but failure to adequately consider several aspects of the termination clause up front made the exit substantially more challenging.

**Key Questions**

When evaluating a PSA with a hospital (or other third party), a practice must address many potential iterations of the contract such as immediate goals, long term goals, market changes (like future acquisitions of the hospital partner), and the termination and unwind process. It is essential to ask detailed questions to ensure clarity, alignment of expectations, and protection of interests for both parties involved. A list of considerations in addition to the points made above include:

1. Scope of Service:
    a. What specific services are required from our practice?
    b. Are there any limitations or exclusions on the services we will provide?
    c. How is the scope of work defined in the agreement? Have we agreed upon each definition outlined in the agreement?
2. Compensation and Payment Terms:
    a. How will our organization be compensated for the services rendered?
    b. What is the payment schedule, frequency, and method of payment?
    c. How can the physicians audit billing, coding, and collections data for the group?
    d. Are there any performance-based incentives or penalties tied to compensation? What are the metrics and what process will be used to review them during the life of the contract?
3. Insurance and Liability:
    a. What insurance coverage is required for our organization? How is this paid?
    b. How do we ensure that the other party has adequate insurance coverage?
    c. Who is responsible for indemnifying against claims, damages, or liabilities arising from the services provided, and what limitations (e.g., floors and caps on indemnification exposure) apply?
    d. Are there any limitations of liability specified in the agreement?

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4. Compliance and Regulatory Requirements:
    a. What regulatory standards, certifications, or licenses must the organization maintain to comply with hospital/business/governmental policies and regulations?
    b. How does the agreement address compliance with healthcare laws, privacy regulations (such as HIPAA), and quality standards?
5. Confidentiality and Data Security:
    a. How will confidential information, patient records, and proprietary data be protected and managed?
    b. What measures are in place to ensure compliance with data security protocols and privacy laws?
    c. Will the group retain some access to records for audits, litigation, and other operational matters?
6. Dispute Resolution and Governing Law:
    a. What procedures are in place for resolving disputes or disagreements between the physician group and the hospital?
    b. Which jurisdiction's laws govern the interpretation and enforcement of the agreement?
7. Governance, Signatories and Contact Information:
    a. Who are the authorized signatories for the agreement on behalf of our organizations?
    b. What are the primary points of contact for communication and coordination between the parties?
    c. How do we govern the relationship? Do we set up a joint services committee? Who should be involved?
    d. Does the contract sufficiently protect against undue influences on physician judgment?
    e. What is the process for approving capital improvements or spending money on the service line? What input will the group have, if any?
8. Termination and Unwind:
    a. How will the agreement be terminated, and what are the procedures for transitioning services back to the entities?
    b. What obligations exist for the return of property, data, or records upon termination?
    c. Who controls the patients' medical records, especially in a termination event. Is there a pathway for a streamlined transfer of records in the setting of a dispute? Medical records can be very expensive to transfer manually; are there provisions to do this electronically which is more cost effective?

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