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Evergreen Clauses: Be Aware of the Pitfalls

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Introduction

One of the most basic, but important, elements of a contract is its term. Term indicates "the duration" for a contract or how long a contract remains in force. Terms of contracts, of course, vary widely in length and can be dictated by applicable law. Sometimes the parties to a contract sign the agreement, put the contract in a drawer, and go forward in the relationship not thinking about the consequences of the term until several years later when one party is looking to end the relationship even though neither party has breached the agreement. That party tells the other party that it is terminating the relationship immediately, but the latter directs the former back to the term clause in the contract and reminds the former that the term is still ongoing due to the inclusion of an evergreen clause. An evergreen clause, or automatic renewal provision, is a key term in many healthcare agreements.

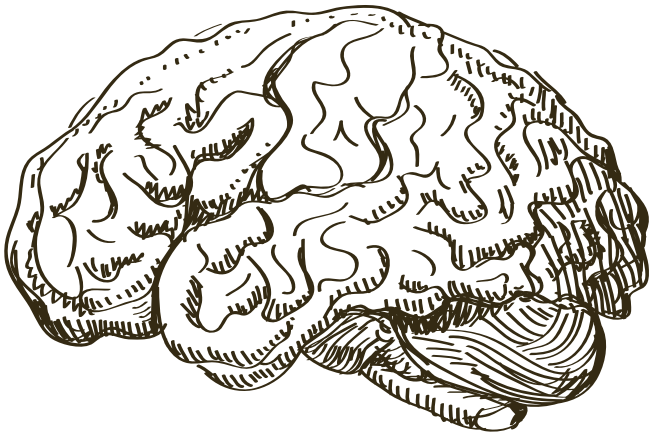
This article examines the intricacies of the evergreen clause, the possible benefits, the issues to be wary of, and its application in the healthcare world.

What Is an Evergreen Clause?

As a general concept, an evergreen clause provides that the term of an agreement will automatically renew for some period of time unless one party provides the other party with notice before the end of the current term that it does not wish to renew the term of the agreement. An example of such a clause is as follows:

> The initial term of this Agreement shall be one (1) year commencing as of the date hereof. Thereafter, the term of this Agreement shall automatically renew for successive one (1) year terms unless one party provides written notice to the other party at least ninety (90) days in advance of the end of the then existing term that it does not wish to renew the term of this Agreement.

Under the terms of the above clause, if neither party provides the appropriate advance notice, then the parties will be locked in for another year. Of course, all parties to an agreement can mutually agree in writing at any time to terminate the agreement, irrespective of the inclusion of an evergreen clause. There also may be additional termination clauses in the agreement that allow one party to terminate the agreement on the occurrence of certain triggers such as breach by the other party, subject to any applicable notice-and-cure periods.



The above is merely an example as evergreen clauses can take many shapes and forms. Further, automatic renewal periods can be longer than one year each and the advance notice required to terminate the agreement can be longer than 90 days.

Why May Evergreen Clauses be Useful?

Peace of Mind for Both Parties

The inclusion of an automatic renewal provision allows the parties to continue the relationship without having to renew the agreement in writing every time the term ends. While doing so would be a simple task, for those who are a party to countless agreements, the ability to affirmatively renew each and every agreement on time would likely be very difficult, resulting in relationships continuing with no agreement in force and possible litigation, among other consequences.

Advantage to the Provider

If the term of the agreement continues to renew and the party who is making payments under the agreement is not constantly required to agree to renew the agreement, it is possible that such party may not be reminded to end the relationship and therefore continue to regularly pay the performing party without second thought. An example of this is monthly payments for information technology services.

Key Issues for Evergreen Clauses

Notice Transmission

If a party desires to provide notice of non-renewal of an agreement, such party must make sure that the notice complies in full with the notice provision of an applicable agreement. This will include who, where, and how notice must be sent. Failure to strictly abide by the notice provision may result in the other party having a strong argument that the agreement has, in fact, not been terminated. Most notice provisions will require a method by which the sender will receive some indication that the recipient has actually received the notice, such as certified mail—return receipt requested. If the agreement does not require such a method, follow the notice provision in the agreement and send a duplicate copy of the notice via a method that does alert the sender to receipt.

Notice Timeline

There is no one-size-fits-all approach to determining how much advance notice should be required of a non-renewing party. Generally, the thought process is how much time the parties reasonably need to unwind their relationship to prepare for termination. Each party to the agreement may have a different opinion on the amount of time, which can make this a heavily negotiated point of the agreement. Additionally, parties should be careful when negotiating this issue as short notice is not always as advantageous as it would appear on the surface.

Termination for Special Circumstances

Certain parties may want to negotiate special circumstances under which they could terminate the agreement, other than for breach of the agreement, notwithstanding the inclusion of an evergreen clause. For example, managed care agreements, which often include evergreen clauses, also may permit payors to change reimbursement rates during the term of the agreement. With respect to a managed care agreement, providers should negotiate for both a period of advance notice pursuant to which the payor must disclose the new proposed rates to the provider well in advance of implementation and a period in which the provider has the ability to terminate the agreement due to such changes.

Termination for Breach of Contract

Each party to an agreement with an evergreen clause should, nevertheless, still have an opportunity to terminate the agreement for breach of contract by the other party immediately. Depending on the services and performance required under the agreement, a cure period may be applicable, but the cure period should not be the remainder of the applicable term. This is especially important when the breach in question is nonpayment of compensation.

Renegotiation

The inclusion of an evergreen clause in the agreement does not prohibit the parties from renegotiating the terms of the agreement. In fact, evergreen clauses can be helpful for renegotiation as the parties have set out for a long-term relationship, but have essentially designated periods along the way where they can revisit the terms of that relationship and determine if the terms continue to make sense in light of the relationship.

Change in Terms

In the context of a provider of services under the agreement, if an evergreen clause is included, but there is no escalation in the compensation under the agreement, the provider may find himself/herself neglecting to renegotiate the terms of the agreement prior to

the conclusion of the notice period and obligated to provide services during the renewal period with no increase in compensation.

Are Evergreen Clauses Enforceable?

Evergreen clauses are generally enforceable unless there is a statute in the state whose law governs the agreement prohibiting evergreen clauses or there is case law in such state that refuses to enforce it. It is important to research state law for the state whose law will govern the agreement before including and drafting an evergreen clause.

For example, New York has a statute that applies to contracts for services, maintenance, or repairs to real or personal property that have automatic renewal clauses for periods of greater than one month.[1] The statute provides that the provider of the service, maintenance, or repair must serve notice personally, or by certified mail, to the recipient at least 15 days, but not more than 30 days, prior to the notice period required by the automatic renewal clause in the contract calling the attention of the recipient to the existence of the automatic renewal clause.[2]

The failure to comply with statutes such as the foregoing New York statute may render an automatic renewal clause unenforceable and result in the contract being terminated at the end of the current term. Those doing business in states that have statutes regulating these clauses should be mindful of such statutes so as to ensure compliance with their provisions. On the other hand, parties who find themselves unwillingly bound to another contract term as a result of an evergreen clause should also be mindful of new legislation that may provide defenses to an automatic renewal claim.

Additionally, evergreen clauses should be carefully drafted, so as not to risk being unconscionable. For example, an agreement that contains a three-year initial term and then automatically renews for successive six-year renewal terms may not be enforceable.

Evergreen Clauses in the Healthcare Fraud and Abuse World

Evergreen clauses can be helpful for parties entering into arrangements that must comply with an exception to the Physician Self-Referral Act, commonly known as the Stark Law.[3] Many exceptions to the Stark Law, such as the exception for the rental of office space and equipment, require a written agreement to continue to be in effect for the duration of the relationship for the relationship to continue to fall within the exception.[4] The inclusion of an evergreen clause in the written agreement allows the parties to always have a written agreement in place during the term of the relationship. The Stark Law does not prohibit the inclusion of evergreen clauses in agreements.

Nonetheless, while an evergreen clause may allow an agreement that needs to comply with an exception to the Stark Law to continue to meet the written agreement requirement, the parties must constantly reevaluate the financial terms of the agreement to ensure that they continue to be fair market value (FMV), as FMV is a constantly evolving standard. The United States and the state of Delaware entered into a settlement agreement with Christiana Care Health System (CCHS) in 2010 to resolve allegations that CCHS violated federal and state false claims acts. The underlying complaint centered on agreements entered into between CCHS and neurologists pursuant to which CCHS paid the neurologists for services rendered to CCHS. The agreements dated back to 1989, but continued in place through 2003 due to the inclusion of evergreen clauses. However, the fees paid under the agreements were never adjusted and were alleged to be significantly above FMV. The settlement was for the amount of $3 million.[5]

Conclusion

Evergreen clauses are included in numerous agreements, including many healthcare agreements. While they can prove to be beneficial to both parties, each party should take care, when negotiating the agreement, to evaluate the merits of the automatic renewal provision on a long-term basis. Such clauses may appear benign at first glance, but after careful evaluation of the potential consequences of the relationship, a party may change its mind.

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1 N.Y. GOB. Law § 5-903(3).
2 *Id.* at (3).
3 *See* 42 U.S.C. § 1395nn.
4 *See e.g.* 42 C.F.R. § 411.357(a) and (b).
5 *See* www.justice.gov/usao/de/news/2010/Christiana%20Care%20PR.pdf.

The Rise of Hospital Outpatient Departments in the Era of Decreased Provider Reimbursement

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Introduction

Although physicians avoided the large 26.5% reduction in Medicare reimbursement that was scheduled to begin on January 1, 2013, they are still not in the clear. As the article addresses below, the provision of provider-based ancillary services, which were once extremely profitable, are slowly succumbing to the pressure of declining reimbursement. As a result, the healthcare market has seen an uptick in both the number of hospital outpatient departments (HOPDs) and the frequency in which they provide the services that were once rendered in freestanding facilities and physicians' offices. Unlike their non-hospital-based counterparts, the reimbursement rates for HOPDs are seen as an attractive alternative for both physicians and hospitals. However, before the physicians and hospitals can take (or continue to take) advantage of these hospital-based reimbursement rates, they should be aware of the legal issues associated with HOPDs, including the sale of ancillary departments and the federal and state restrictions surrounding involvement of the sellers in management of the HOPD.

Reimbursement

Reimbursement of imaging services is one illustration of this disparity in reimbursement. Since 2006, there has been a significant decline in reimbursement for imaging services.[1] Specifically, over a period of six years, Medicare reimbursement for imaging services has been reduced a total of eight times.[2] Current estimates put the amount of Medicare spending attributed to imaging services at 9.3% of the program's overall spending, which is a 28.4% decrease since 2006.[3] This decrease is attributed, in part, to the reimbursement deductions contained in the Deficit Reduction Act of 2005 (DRA).[4] Before 2005, Medicare actually reimbursed freestanding imaging facilities and physicians' offices at a higher rate via the Physician Fee Schedule (PFS) than it did for hospital outpatient facilities via the Hospital Outpatient Prospective Payment System (HOPPS).[5] The DRA required that, beginning in 2007, imaging studies could not be reimbursed at a higher rate than what was provided under the HOPPS.[6] Thus, many imaging centers were forced to shut their doors or look toward hospital acquisition as a means to remain viable.[7] In fact, by 2010, hospitals owned eight of the top 20 diagnostic imaging chains.[8] The table below shows the current differences in reimbursement rates for certain imaging services between the 2013 PFS and HOPPS. (See Table 1 below)

Another illustration of reimbursement disparity can be seen when comparing ambulatory surgery centers (ASCs) and HOPDs. Although ASCs have not seen the significant decrease in profits compared with imaging facilities,[10] there is a notable difference in their reimbursement rates. In 2012, Medicare reimbursement rates for HOPDs were 74% higher compared with those for ASCs.[11] The differing conversion factors used to determine the payment rates for surgical procedures performed in ASCs and HOPDs is, in part, to blame for this difference.[12] In 2012, the conversion factor applicable to most surgical procedures was $42.63, but for HOPPS, which is applicable for HOPDs, it was $70.12.[13] The reason for the difference in conversion factors is the product of both how the Centers for Medicare & Medicaid Services (CMS) set the original conversion factors and the methods utilized to adjust them to account for inflation.[14] Not surprisingly, studies suggest that the proliferation of ASCs is slowing, as is the volume of services that they provide.[15] Instead, hospital acquisition of freestanding ASCs and their conversion into HOPDs is on the rise.[16] The outlook for ASCs reimbursement compared to HOPDs does not look much brighter. The 2013 Medicare payment final rule provided only a 0.6% increase in reimbursement for ASCs, while HOPDs, through the HOPPS, received a 1.8% increase.[17] The table below shows the current differences in reimbursement rates for certain procedures. (See Table 2 on page 5)

HOPDs

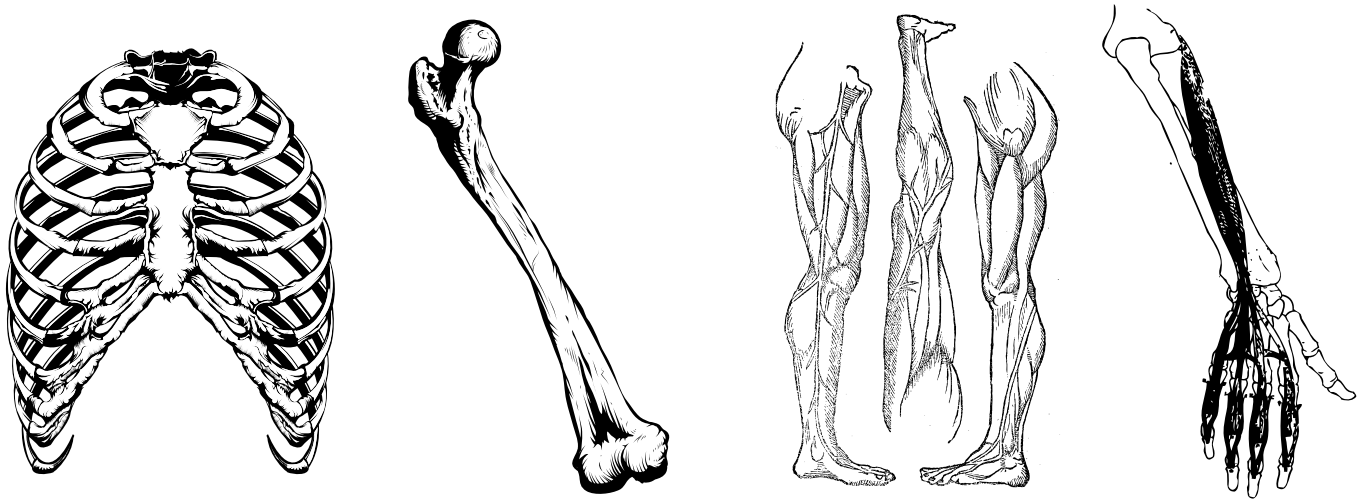
Given the differing reimbursement rates noted above, hospitals, in some sense, have come to the rescue by offering to acquire the ancillary services while providing physicians opportunities to manage the facilities through co-management agreements. As a result, hospitals, through HOPDs, are beginning to regain the

Table 1

Procedure	2013 HOPPS	2013 PFS[9]
Chest X-ray	$45.95	$30.96
Computed tomography (CT) head/brain without dye	$173.58	$167.39
CT pelvis with dye	$297.15	$277.97

Table 2

Procedure	2013 HOPPS	2013 ASC
Treatment of humerus fracture	$1,908.84	$1,071.11
Removal of wrist bone	$2,306.77	$1,294.39
Application of long leg cast	$189.14	$61.50



control they once had over the ancillary services through the growth and/or acquisition of these ancillary departments.[18] As with many transactions in healthcare, however, there is a host of federal and state regulatory concerns that must be considered before freestanding departments are converted into HOPDs.

Medicare's Provider-Based Regulations

Although the attestation process is voluntary,[19] before a hospital considers acquiring and/or converting a freestanding facility into an HOPD and billing services provided in it as such, it should take great care in ensuring that it will be able to adhere to and maintain the requirements Medicare places on provider-based entities.[20] Generally speaking, these regulations impose a requirement on the HOPD to be financially, clinically, and operationally integrated with the hospital. The regulations provide the following requirements for all provider based facilities:[21]

- Licensure—the facility must be operated under the hospital's license, unless state law requires otherwise;
- Clinical Services—the clinical services rendered by the facility seeking to be provider based must be integrated with the hospital and can be demonstrated by the following:
  - Staff privileges at the hospital for those providing services at the facility;
  - Hospital must exert oversight over the facility as it does for other departments;
  - The medical director of the facility must maintain a reporting relationship with the hospital chief medical officer or other official that is of the same intensity as the relationships between department medical directors and is subject to the same type of supervision and accountability;
  - The hospital's committees are also responsible for the activities at the facility;
  - Medical records belonging to patients of the facility are integrated into the hospital's retrieval system; and
  - Integration of the facility's inpatient and outpatient services with the hospital such that patients at the facility requiring additional care have full access to the hospital's inpatient and outpatient services.
- Financial Integration—the facility's financial operations are completely integrated with those of the hospital, as evidenced by: shared income and expenses; the facility's costs being reported in the hospital's cost center; and the facility's financial status is incorporated and easily identifiable within the hospital's trial balance.
- Public Awareness—the facility is held out to the public and other payors as being part of the hospital.

There are additional requirements imposed on facilities that are considered to be off campus.[22] HOPDs also have additional requirements imposed on them, as follows:[23]

- HOPDs must comply with anti-dumping rules if located on the main hospital campus or if off campus and considered a hospital department and dedicated emergency department;[24]
- HOPDs must bill the correct site-of-service code;
- HOPDs must comply with the Medicare provider agreement of the hospital;

Table 3

State	Geographic Restriction of Hospital License	CON
Texas	Thirty-mile radius of the main address of the applicant's address	Not Applicable
Illinois	Based on county and number of inhabitants	Permit likely required

- Physicians that work in the HOPD must comply with anti-discrimination provisions (42 C.F.R. § 489.10(b));
- For the purposes of billing, HOPDs must treat all Medicare patients as outpatients;
- If a patient receives care in the HOPD and then is admitted as a hospital inpatient, the HOPD payments are subject to the three-day payment window provisions;
- For HOPDs not located on the hospital's campus, Medicare beneficiaries are to be given written notice of their potential financial liability before services are rendered; and
- HOPDs must comply with the health and safety rules for hospitals participating in Medicare.

Compliance with these requirements is crucial. Therefore, hospitals should consider going through the attestation process. Not only can formal determination of provider-based status provide a hospital with peace of mind, but participation in the attestation process provides other benefits as well.[25] For example, if an attestation is made and CMS determines that the HOPD fails to satisfy the requirements, it will only recover the difference between the actual amounts paid since the submission of attestation and the amount it estimates that should have been paid as a non-provider-based facility.[26] Additionally, if an attestation is made and approved, but later a material change occurs that brings the facility out of compliance with the provider-based requirements and CMS is notified of this change, then the provider-based status would only end as of the date CMS makes the determination that it no longer applies.[27] It is important, however, to note that a facility that is located off campus and is used as a site where physician services that would ordinarily be rendered in a physician's office are provided will be presumed to be a free-standing facility unless CMS determines it qualifies for provider-based status.[28]

State Licensure/Certificate of Need

As noted above, one of the provider-based requirements pertains to licensure. Therefore, hospitals need to be mindful of their state's hospital licensing and applicable certificate of need (CON) requirements before acquiring a facility with the intent to convert it to an HOPD as state licensure requirements may be more restrictive than the provider-based attestation requirements.[29] For example, 42 C.F.R. § 413.65(e)(3)(i) allows for outpatient departments that are located within 35 miles of the hospital's main campus, while Section 241.023 of Texas Health & Safety Code imposes a 30-mile requirement, in addition to other state requirements.[30] Similarly, the Illinois Hospital Licensing Act, 210 ILCS 85/*et seq.*, contains certain restrictions with respect to the ability of a hospital to conduct their operations through more than one location in a county under a single license. Hospitals should consider contacting their state's licensing agency to determine how the potential HOPD will need to be licensed, whether it be under or separate from the license of the hospital. In addition to the hospital licensing requirements, hospitals in Illinois (a CON state) seeking to acquire a facility for the purposes of its conversion to a HOPD will likely need to apply for a permit from the Health Facilities and Services Review Board, as the acquisition itself may exceed capital expenditure minimum.[31] (See Table 3 above)

Seller Considerations

Another consideration for providers as they weigh the option of converting a department into an HOPD is the ability to participate in the revenue from the new HOPD. The hospital must wholly own the department. Generally speaking, this leaves other providers with more-limited options as to participation in an HOPD, e.g., leasing space to the hospital or entering into a co-management agreement with the hospital, in which all major decisions must be made by the hospital. In both options, the parties must be cognizant of potential violations of federal and state fraud and abuse regulations and the increased scrutiny such agreements may bring to the transaction.[32,33]

With respect to co-management agreements, on December 31, 2012, the U.S. Department of Health & Human Services, Office of Inspector General (OIG) issued a favorable advisory opinion[34] with respect to a proposed co-management agreement involving performance bonuses for patient service, quality, and cost-savings measures for a hospital's cardiac catheterization laboratories. OIG indicated that the co-management arrangement aligned incentives and that the arrangement included sufficient safeguards to avoid sanctions. Safeguards included monitoring for potential inappropriate reductions in care, access to clinically appropriate devices and supplies, calculation of the performance bonus in the aggregate, and the implementation of an annual cap on the performance bonus. Any structuring of co-management agreements should be done with consideration of OIG's comments and concerns regarding co-management agreements both as outlined in the advisory opinion as well as the OIG Work Plan.

Conclusion

As reimbursement declines, the number of HOPDs and volume of services they provide will seemingly continue to increase. With this increase, however, hospitals need to be sure that they are complying with the provider-based requirements, as well as the applicable state laws relating to licensure and CON. Failing to address and satisfy any of the state or federal requirements discussed above may significantly hinder ability of the hospital to convert a facility to an HOPD.

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1 *Imaging Today: Medical Imaging Trends in Medicare*, Medical Imaging & Technology Alliance 3 (2012), *available at* www.medicalimaging.org/wp-content/uploads/2012/09/Medicare-2011-Data-MITA-Report-Final-9.20.2012.pdf.

2 *Id.* at 1.

3 *Id.*

4 Public Law 109-171; *see* David W. Lee and Frank Levy, *The Sharp Slowdown In Growth of Medical Imaging: An Early Analysis Suggests Combination of Policies Was The Cause*, 31 Health Affairs 1, 5 (2012), *available at* http://content.healthaffairs.org/content/early/2012/07/24/hlthaff.2011.1034.full.pdf+html.

5 *Id.*

6 *Id.*

7 Regents Health Resources, *Hospital-based Versus Freestanding Outpatient Imaging Services*, Radiology Business Journal (2011), *available at:* www.imagingbiz.com/articles/rbj/hospital-based-versus-freestanding-outpatient-imaging-services.

8 *Id.*

9 National payment amount (i.e. carrier locality 0000000).

10 Leigh Paige, *Though Similar to ASCs, Imaging Centers Experiencing Harder Times,* Becker's ASC Review (Sept. 15, 2011), available at www.beckersasc.com/news-analysis/though-similar-to-ascs-imaging-centers-experiencing-harder-times.html.

11 *Ambulatory surgery center services: Assessing payment adequacy and updating payments*, MEDPAC 116 (March 2012), *available at* www.medpac.gov/chapters/Mar12_Ch05.pdf.

12 *Id.* at 119.

13 *Id.*

14 *Id.*

15 *Id.* at 115; *ASC to HOPD Conversion: Costly Consequences,* Ambulatory Surgery Ctr Ass'n, *available at* www.wasca.net/wp-content/uploads/2007/03/ASC-to-HOPD-Conversion-Costly-Consequences.pdf.

16 Laura Miller, *Best Ideas & Biggest Threats to Ambulatory Surgery Centers Today*, Becker's AS Review (Oct. 26, 2012), *available at* www.beckersasc.com/asc-turnarounds-ideas-to-improve-performance/best-ideas-a-biggest-threats-to-ambulatory-surgery-centers-today.html; Laura Miller, *Ambulatory Surgery Center Partnerships With Hospitals: Possibilities & Opportunities*, Becker's ASC Review (Oct. 28, 2012), *available at* www.beckersasc.com/asc-transactions-and-valuation-issues/ambulatory-surgery-center-partnerships-with-hospitals-possibilities-a-opportunities.html.

17 2013 Final Rule, Ambulatory Surgery Ctr Ass'n, *available at* www.ascassociation.org/ASCA/FederalRegulations/Medicare/.

18 Paige, *supra* note 10.

19 *Program Memorandum Intermediaries*, Ctrs. for Medicare & Medicaid Srvs. 2 (Apr. 18, 2003), *available at* www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/a03030.pdf; *See* 42 C.F.R. § 413.65(b)(3).

20 *See* 42 C.F.R. § 413.65.

21 *Id.*

22 *See* 42 C.F.R. § 413.65(e).

23 42 C.F.R. § 413.65(g).

24 *See* 42 C.F.R. §489.20(l), (m), (q) and (r).

25 *See* Ctrs. for Medicare & Medicaid Srvs., *supra* note 19 at 2-3.

26 42 C.F.R. § 413.65(k).

27 42 C.F.R. § 413.65(l)(1).

28 42 C.F.R. § 413.65(b)(4).

29 Texas Health & Safety Code § 241.023.

30 Texas Health & Safety Code § 241.023(c-1)(2).

31 20 ILCS 3960/3; 77 Ill. Admin. Code § 1130.310.

32 Hospital acquisition of ASCs and their conversion into HOPDs was noted as an area of interest in the 2013 OIG Work Plan. *See Office of Inspector General Work Plan for Fiscal Year 2013*, U.S. Dept. of Health & Human Servs. 7 (2012), *available at* https://oig.hhs.gov/reports-and-publications/archives/work-plan/2013/Work-Plan-2013.pdf.

33 Parties should consider the implications under their state's anti-remuneration and self-referral laws, as applicable, as well as the Anti-Kickback Statute, Stark, False Claims Act, and Civil Monetary Penalties Law. The applicable notice and accreditation requirements should be addressed as well.

34 *See* Advisory Opinion 12-22, Office of Inspector General (2012), *available at* www.healthlawyers.org/News/Health%20Lawyers%20Weekly/Documents/0101113/AdvOpn12-22.pdf.

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Basics of Negotiating HIT Agreements

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Health information technology (HIT) contracts, including software license and services agreements, must include adequate protections, safeguards, and other rights reserved for the healthcare provider, in the event that the vendor defaults or otherwise fails to perform in accordance with the contract documents. This is especially important in situations where a small provider is entering into an agreement with a vendor that is a much larger organization, and the balance of power strongly favors the vendor. This article provides a sampling of, though by no measure all, such protections and safeguards.

Key Provisions in HIT Contracts

Getting Started

It is important to remember that *everything* is negotiable in a contract, including license scope, payment terms, limitations of liability, and warranties. This fact is too often ignored. Of course, vendors encourage this by supplying standard form contracts with small print, multiple columns, often in portable document format or locked format, which makes it difficult to modify. An easy way to avoid falling into this trap is to require the vendor to provide a copy of the contract in a modifiable electronic format (e.g., Microsoft Word), which can then be easily transformed into a readable document showing proposed changes in redline, prior to commencement of negotiations.

Providers should also consider starting contract negotiations with more than one "finalist" in the vendor selection process. There is nothing wrong with letting one of the vendors know that it is your "vendor of choice," and if the negotiations don't go well, you have no hesitation about using your second choice. By doing so, the provider increases its bargaining position, because the vendor knows that there is someone else in the running. In some cases, it may also be worthwhile actually engaging in a dual-track negotiation process. These methods tend to keep pressure on the preferred vendor and may generate additional concessions for the provider. Similarly, it is never wise to disclose to the vendor the exact amount of money budgeted for the project. Invariably when this is done, the contract price will come in very close to the budget price.

The final negotiating tip may seem inconsistent with the above, but it is essential: strike a fair deal, aim for a win/win situation, and keep in mind the concept of partnering. This is important because, unlike other contract negotiations, when acquiring a healthcare

information system, the provider and vendor will have to work together in the future for an extended period of time. If the negotiations have been too contentious or mean spirited, there may be at least two unpleasant outcomes: (1) at some point in the future, when the provider needs a new product or service from the vendor that is not explicitly covered by the contract (which will invariably occur), the vendor will either be uncooperative or impose an excessive charge in an attempt to make up for perceived losses at the outset; or (2) the provider has squeezed so much out of the initial pricing of the contract that the vendor will not devote sufficient resources to the project, potentially causing the provider to experience poor service and frequent errors or malfunctions.

Definitions

The "Definitions" section of HIT contracts is frequently overlooked by the parties and often by counsel, yet it is a linchpin of the entire agreement. Definitions of such key terms as "software," "system," "acceptance," "documentation," "affiliate," and "permitted users" may make the difference between a successful project and a failure. For example, if the "documentation" does not include the vendor's response to the request for proposals (RFP) and listing of functional and performance specifications, a warranty that "the system will operate in accordance with the documentation" will not be particularly helpful.

License

It is essential to determine the correct type of license for the provider's particular needs and proposed use.

There is no such thing as a "standard" license. For example, there are:

- Shrink-wrap licenses, typically used for off-the-shelf software;
- Site licenses, covering a specific geographical location; enterprise-wide licenses, encompassing an entire business or institution; network licenses, for all users of a specified local area network or wide area network;
- Named user or concurrent user licenses; and

- Application service provider (ASP) or software as a service (SaaS) licenses, governing the right to use software on a subscription-type basis.

Each of these and other types of licenses has its own inherent set of unique issues, which must be carefully dealt with and analyzed. For example, the authors were recently involved with a dispute arising from a "routine" software audit by a vendor. The provider's IT department had inadvertently imaged the vendor's software on every personal computer in the organization, even though only a handful of employees actually used the software. Unfortunately, the license agreement required a license for each user who could simply access the software, whether or not they ever did. As a result, the vendor submitted a multi-million dollar claim for copyright infringement, license, and support fees to the provider. Following the provider's filing of a preemptive complaint for declaratory judgment, extensive settlement negotiations led to an out-of-court resolution that amounted to an expensive lesson for the provider.

Other license issues include consideration of whether a perpetual or term license is appropriate; limitations on the number of users; agreeing in advance on the costs of adding additional users and/or facilities; inclusion of any third-party software in the license; and many others. Providers should also consider adding provisions permitting expansion of the scope of the license to include use of the software or services in connection with a regional or internal health information exchange, as well as advance approval in connection with e-discovery matters. Failure to address these issues may lead to significant problems during the term of the agreement.

Confidentiality, Privacy, and Security

Most boilerplate contract provisions protect the vendor's trade secrets and restrict access to the software. However, it is rare to find similar protections for the healthcare provider. Insist on mutual confidentiality obligations with strict limitations on the vendor's use of the provider's patient data, including protected health information (PHI), as well as the provider's financial, marketing, or other business information.

Privacy and confidentiality are especially important in light of the substantial changes to the existing Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security regime, mandated by the Health Information Technology for Economic and Clinical Health Act (HITECH)[1] and the recently issued omnibus HIPAA final regulations.[2] Obtaining privacy and security rights are crucial to the provider's ability to amend and/or terminate the contract; achieve fair allocation of compliance costs (if the vendor is a much larger entity, it may be fair to ask them to bear at least part of the burden for adapting to new regulations); and remain compliant with the extensive and ever-evolving regulatory obligations of covered entities. Any vendor in the healthcare business should be willing to agree to considerable obligations regarding safeguarding the provider's patient data. If the vendor pushes back on such obligations, it should raise a red flag for the provider's organization.

Warranties

The warranties are usually one of the areas most in need of revision, since many vendors provide minimal to non-existent warranties. Examples of recommended warranties include those dealing with: system compliance with the documentation and functional and performance specifications; compatibility of system components; viruses, time bombs, bugs, and disabling devices; prevention of unauthorized access to or usage of the system; compliance with federal and state laws (e.g., HIPAA or HITECH Act provisions) and nationally recognized industry standards; interoperability and interfaces; sunset issues; ownership of software; availability of support/maintenance; and system uptime, availability, and service response time issues. In addition, depending upon the type of deal, it may be appropriate to insist on detailed service level agreements (SLAs), to ensure that the vendor's ongoing performance meets minimum specifications.

Assuming that the vendor's product is essential to achieving "meaningful use" under the HITECH Act regulations, the vendor also needs to warrant that it will fully cooperate with the healthcare provider to enable it to achieve meaningful use within the time frames set forth under the applicable regulations, so as to allow the provider to receive the maximum incentive payments for which it is eligible. In addition, use of "certified EHR technology" is a component of the meaningful use requirement under the American Recovery and Reinvestment Act of 2009. Therefore, vendors must warrant that the electronic health record (EHR) product licensed under the applicable contract is certified by the Certification Commission for Health Information Technology, or comparable U.S. Department of Health & Human Services-approved certification body, as of the effective date of the agreement and shall retain such certification throughout the term of the agreement. The vendor also needs to warrant that if its EHR product fails to meet certain certification criteria, the vendor will correct such failure at its expense.

Vendors also need to warrant that they will comply with, and, more importantly, make the necessary modifications to, their products, systems, documents, and practices in order to comply with the fast-changing legal requirements surrounding HIT. This is particularly important not only in the area of meaningful use, as discussed above, but also for the ever-evolving privacy and security regulations. A vendor's failure to comply with or adapt to new requirements may result in the disqualification of the healthcare entity from EHR incentive payments or cause it to incur significant HIPAA violation penalties.

The agreement should also be specific about the customer's remedy for the vendor's breach of these warranties. Be wary to accept typical boiler-plate warranty disclaimers or other limitations of liability (more on this later) in the agreement, and try to create or expand the provider's rights to terminate the agreement and seek appropriate refunds and damages for a vendor's material breach of warranty.

Testing and Acceptance

HIT agreements should contain comprehensive acceptance testing procedures, methodology, and remedies for failure to achieve successful acceptance testing, including but not limited to a refund of all monies paid. At the least, a significant portion of the license, implementation, and other payments due to the vendor under an agreement should be tied to the vendor's achievement of acceptance. The entire acceptance testing procedure should be spelled out in detail, including testing procedures and protocols, re-tests, and options if the tests are not successful. Be prepared, however, for significant push-back by vendors in this area, who will invariably cite "revenue recognition" as their talisman against any meaningful acceptance testing provisions. Be careful not to accept that and remain firm.

Pricing and Payment Terms

In reference to payment terms, it is best to negotiate objectively measurable performance milestones that the vendor must achieve before payment is required. These milestones should be coordinated with detailed acceptance testing criteria. For example, 10% of the contract price may be paid upon execution, 20% upon delivery, 30% upon completion of installation, and the remaining 40% upon final acceptance. Be aware, however, that vendors citing revenue recognition rules are increasingly resisting the use of objective milestones, instead preferring date-driven payments. Nevertheless, the use of carefully drafted performance milestones is highly recommended. Otherwise, the form contract may require the majority of the purchase price to be paid before the purchaser is satisfied that the software performs as warranted.

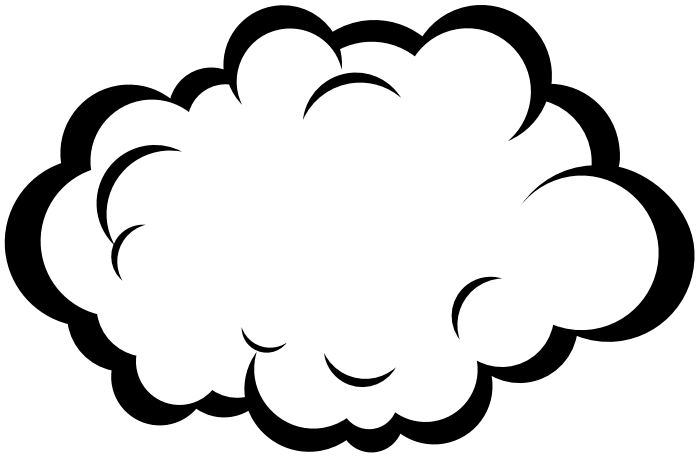
In most financing or leasing scenarios, the contracts contain what are commonly referred to as "hell or high water" clauses, meaning that, no matter what happens, the customer must make the payments required under the contract. Under no circumstances should a vendor-financed deal contain such a clause, since it is essential for the buyer to have the right to withhold payments if the vendor is not performing or if the product is defective, either of which events may jeopardize the customer achieving meaningful use or a successful implementation.

Financing may be difficult for providers to obtain, and customers may be entering into vendor-financed transactions simply because they do not have another choice. Healthcare organizations may still want, however, to leave some flexibility in their loan agreements in order to: increase the loan amount if a customer's needs expand dramatically (e.g., due to a merger or a significant acquisition of another healthcare provider); pay off the amount of the loan at the present-day value; or even to refinance the loan with another entity (possibly compromising to grant the original vendor/lender a right of first refusal on the more favorable loan terms).

At the same time, a customer may want to prevent the vendor/lender from assigning the note or the loan agreement to a third party (including via derivatives or other financial instruments), because such third parties tend to be removed from the substance and purpose of the underlying agreements. In fact, customers in vendor-financed deals should insist on tying the license and services agreement with the loan agreement, even if such agreements are between different corporate entities (e.g., GE Healthcare and GE Capital). For example, a hospital's payment obligations to GE Capital, pursuant to the applicable loan agreement, should be subject to GE Healthcare's performance under the related services and license agreement.

Limitation of Liability and Indemnification

The limitation of liability clause is often one of the most contentious areas of negotiation in HIT contracts. Failure to adequately address this issue may result in the inability to recover or even claim damages for actual losses suffered as a result of breach of contract or negligence by the vendor. It is essential to "carve out" a number of areas, including breach of confidentiality and privacy; personal injury, death, and property damage; intellectual property infringement; and vendor's breach resulting in the provider's failure to achieve meaningful use in a timely manner. Without such carve outs, the provider may find itself barred from



recovering any significant damages relating to its actual losses, including its lost HITECH incentive payments.

A good contract should also contain strong indemnification provisions. The indemnification should protect the purchaser from HIPAA and privacy/confidentiality violations, as well as claims that the software infringes on third-party patents, trademarks, or copyrights, or misappropriates trade secrets. In the event that the vendor has to replace software or a component thereof due to an intellectual property infringement claim, the vendor should also reimburse the provider for all costs and expenses related to such replacement, including the cost of implementation of a new software component or system.

Another area of concern is the increasing tendency of vendors to require providers to indemnify them for any third-party claims brought against the vendor (e.g., by patients), even if due to defects or errors in the software. Even more egregious are provisions that require such indemnification for the vendor's own negligence. An extensive discussion of this issue is beyond the scope of this article.

Breach and Termination Rights

The agreement should contain an explicit and clear provision regarding what constitutes a breach. The agreement should also contain termination-for-cause rights for the provider, including breaches of warranty, confidentiality, and data privacy, failure of testing or certification, and other significant obligations under the contract. Breaches for cause should ideally trigger some form of refund obligations (depending on the circumstances of the breach) in addition to the provider's rights to pursue other remedies. Providers also should be wary of signing very long-term (seven to ten years) contracts. While such agreements may be attractive for financial reasons, they are often especially difficult to terminate. Considering the ever-changing technology landscape, when entering into a long term agreement, insist on some termination for convenience rights after five years from the contract effective date and upon the occurrence of specified events.

ASP, SaaS Models, and the "Cloud"

The subscription-type models pose significant additional risks to healthcare providers. One of the biggest disadvantages for providers using these models for their EHR systems is that they have no actual access to, or possession of, their data, independent of the vendor. Thus, there is a real concern about a vendor's ability to hold its customer's data hostage (e.g., because of a payment dispute), or concerns arising if the vendor loses certification or ceases business operations, which is particularly relevant for small IT vendors. Therefore, customers need to negotiate broad protections and rights to access their data in such deals, including: barring vendors from ever holding customer information, including PHI, hostage (i.e., denying customer access to such data); mandating regular backups of data; and explicit provisions regarding return of any customer data, including PHI, to customer upon termination of the agreement, especially if the agreement is terminated due to the vendor going out of business.

Dispute Resolution

The inclusion of contract provisions for alternative dispute resolution may help avoid expensive and time-consuming litigation. An escalation provision defines the specific hierarchy of employees who are to be involved in resolving any problems that arise. If first-level managers are unable to successfully reach an agreement, the problem is escalated to the next level of management within a specified amount of time. If this informal process is unsuccessful, the contract may require binding or non-binding mediation and/or arbitration, or permit the parties to institute old-fashioned litigation.

Conclusion

There are a significant number of other issues that should not be overlooked, including support and maintenance agreements, third-party access to the software in an enterprise environment, assignment of contract obligations, survival of terms and software customization, limitations on price increases, and a slew of others. If all of these matters are dealt with in a professional, straightforward, and equitable manner, providers and vendors will have a solid foundation for a long-term relationship.

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1 The HITECH Act is part of the American Recovery and Reinvestment Act of 2009, Pub. L. 111-5, Sec. 13001 ***et seq.***, Sec. 4001 ***et seq.***

2 45 C.F.R. pts. 160 and 164 (issued in the *Federal Register* on January 25, 2013, 78 Fed. Reg. No. 17, 5566).

The Fiduciary Out Clause in a Nonprofit Change-of-Control Transaction

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The fiduciary out, or similar exception to the traditional no shop clause, is a contractual provision that may add protection to governing boards in certain change-of-control transactions involving nonprofit hospitals and health systems. Consideration of fiduciary out-type clauses, however, requires a broader understanding of the parameters that nonprofit law may place on the process by which nonprofit boards evaluate potential change-of-control partners. Further, the utility of a fiduciary out clause will be highly dependent upon specific market conditions and the circumstances confronting the nonprofit seller. The health lawyer can play a valuable role in advising client leadership on whether a fiduciary out clause is appropriate for a specific transaction.

This is especially the case given the current wave of merger/acquisition transactions, in which many nonprofits are simultaneously conducting collaborative discussions with multiple different parties. Many markets are fluid in nature and have experienced substantial horizontal and vertical integration involving hospitals. Those situations resemble a game of musical (merger) chairs, with the remaining unaffiliated hospitals seeking a partner, and the growing systems seeking additional affiliations in order to grow. In these situations, all parties have a heightened sense of strategic interest in the other collaborative discussions of its prospective partner(s). They want to understand, for example, who they will ultimately be dealing with; what are the component parts of the system they ultimately would be collaborating with; and whether collaboration with that new system would present antitrust or other feasibility barriers. Thus, negotiation premiums may be placed on exclusivity and disclosure/confidentiality provisions, as parties seek some degree of strategic certainty to their discussions.

It is in that context that inclusion of a fiduciary out clause needs to be evaluated on a cost-benefit basis. The fiduciary out clause is typically used in companion with the traditional exclusive dealing or no shop condition.[1] In traditional form, the fiduciary out is intended to allow a seller (in the context of an asset disposition) to consider one or more subsequently received, superior offers, to the extent necessary to assist the seller's board of directors in exercising its fiduciary duty to shareholders or other constituents with respect to the sale.[2]

According to the authoritative published commentaries, the fiduciary out clause traditionally can take one of three different approaches:

First: The ability of the seller's governing board to accept and evaluate subsequently received superior third-party offers and to accept one such offer in replacement for a currently existing, fully executed definitive-sale agreement.[3] This is a frequently utilized form of fiduciary out clause; it presents challenging drafting/negotiation issues with respect to such key business terms as notification to the current purchaser (usually appropriate); the right (if any) to actually solicit a potentially superior offer (doubtful); and evaluating the cost of including such in terms of a break-up fee and/or potential loss of a deal for a less certain, but potentially more advantageous one (a challenge).

Second: What is sometimes referred to as the gold-in-the-backyard scenario: where the seller's board is given the ability to revoke its initial decision on change of control, and to cancel the executed definitive agreement, in the situation where a previously unanticipated, intervening event has the effect of substantially increasing the value of the seller's assets beyond the amount determined in the valuation conducted prior to closing.[4] Such unanticipated intervening development must usually be truly unique, highly material, and totally unanticipated by the seller's board at the execution of the sales agreement in order for it to be sustainable. Examples might include receipt of an enormous, unrestricted charitable donation that provides immediate long-term financial stability and flexibility, or the integration with a very large physician group that has the promise for dramatically increasing the seller system's market presence.

Third: The board's ability to cancel the seller's obligations under an executed sales agreement, based upon a determination made in good faith, and in reliance on the advice of qualified legal counsel, that the board would breach its fiduciary duties if it did not cancel.[5] This often creates significant concerns on the part of the potential buyer and, as such, may be dependent on the standard of certainty with respect to fiduciary duty exposure required to trigger the provision.

Note that in some circumstances the scope of the fiduciary out may be limited by certain purchaser-requested clauses, such as: (1) a requirement that the seller provides advance notice to the purchaser before exercising the right; and (2) a right of the purchaser to match the other offer.[6]

The health lawyer will note that under the corporate laws of most states, there is no inherent right of a seller to a fiduciary out; if that is the expectation of the seller it must be specifically negotiated and memorialized in the definitive transaction agreement.[7]

In most circumstances, the exercise of a fiduciary out by a seller will trigger an associated break up or similar pre-arranged fee to be paid to the proposed purchaser in compensation for the time, effort, expense, and opportunity cost associated with the failed transaction.[8] Simply put, "Party A agrees to negotiate exclusively with Party B towards the execution and closing of a definitive agreement for the sale of Party A's assets—except if Party A

receives a better offer which its board is obligated to review. In such case, the exclusivity obligation is waived and should Party A abandon the transaction with Party B to pursue the other offer, it shall pay to Party B a break-up fee in the amount of $X." Note that a nonprofit seller should receive expert advice on the reasonableness of any negotiated break-up fee.

The utility of the fiduciary out clause is premised generally upon core concepts of fiduciary duty that apply to the board of a company considering a change of control. Delaware courts have traditionally held a board to a higher incidence of care when presented with complex or challenging transactions outside of the ordinary course of business. Specifically, these courts have held that special obligations are imposed on directors in situations involving the sale or transfer of control of a company and that they [the courts] will "apply enhanced scrutiny" to ensure that directors have acted reasonably in such circumstances.[9] Attorneys general (AGs) and other state charity officials are likely to take the same position in the context of a proposed change of control involving a nonprofit, charitable healthcare company. Experience suggests that these officials will likely contend that a change-of-control proposal is such an extraordinary circumstance and so outside the ordinary course of business as to require exercise by the board of a higher level of care in connection with transaction evaluation.

The particular duty that the fiduciary out is intended to address is the obligation to generate the highest value reasonably available through a sale or other change-of-control to corporate shareholders. That is the so-called *Revlon* duty—that when negotiating change-of-control transactions, the board must conduct a market check and accept the change-of-control proposal that offers the highest value.[10] In such a situation, the board's obligation is to allow "market forces . . . to operate freely to bring the target's shareholders the best price available."[11] The board is thus responsible for "the maximization of the company's value at a sale for the stockholders' benefit."[12] The application of the *Revlon* duty to a particular transaction typically serves as the justification for the inclusion of a fiduciary out provision; i.e., despite the inclusion of transaction protection mechanisms running to the purchaser (e.g., a no-shop or exclusivity clause), the seller must have the right to accept a superior transaction should one be presented.[13]

The complicating factor in the nonprofit context is the absence of any clearly relevant judicial decision (of which the authors are aware) applying *Revlon* to a nonprofit corporation.[14] The circumstances of the proposed change-of-control transaction, and certainly the laws of the particular jurisdiction, will dictate the approach to whether a fiduciary out provision is necessary or even appropriate given the parties and the relevant terms and conditions.

In this regard, it should be noted that many (if not all) state healthcare change-of-control regulations—including specific nonprofit conversion statutes and regulations—speak in terms of recovering fair value for the transfer of control or all or substantially all of a charity's assets to a for-profit acquirer/controlling party.[15] The state's great concern is that decisions that will result in transferring control of nonprofit assets to for-profit control are made with informed, heightened business judgment by the nonprofit board and generate consideration that is fair and reasonable under the applicable circumstances.[16] The Internal Revenue Service has similarly adopted standards requiring nonprofit, tax-exempt organizations to obtain fair market value (FMV) in exchange for the sale of assets to a for-profit organization.[17]

That notwithstanding, many nonprofit change-of-control transactions involve other nonprofit organizations. Indeed, a significant feature of the current M&A wave is the renewed popularity of the nonprofit collaboration option. In markets throughout the country, nonprofit health systems are responding to competitive pressures through partnerships with other nonprofits, in addition to transactions with proprietary firms. For many provider systems, there is a sense that Affordable Care Act challenges, and the larger shift in healthcare financing, can effectively be addressed in the nonprofit model—albeit one that offers more programmatic diversity, geographic scope, and economic strength.

In the context of the nonprofit-to-nonprofit transaction model, the fiduciary out may have reduced relevance. The nonprofit laws and regulations of most states allow a nonprofit corporation to transfer control of its assets (whether by merger, sale, or change of membership) to another nonprofit corporation, for less than FMV. The justification for this can be found in state nonprofit laws that specifically authorize a nonprofit corporation to gift its assets to another nonprofit corporation with similar charitable purposes.[18] In this regard, no charitable assets go out of the charitable trust—there is just a change of stewardship of such assets. Along the same lines, these laws do not prevent a nonprofit from limiting its change-of-control search to strictly nonprofit organizations because of a desire to keep the underlying assets within the charitable sector and under continued nonprofit, charitable control. Similarly, the law will usually permit a nonprofit to restrict the universe of potential change-of-control partners to a specific subset of the nonprofit sector (e.g., only charitable healthcare system with similar religious sponsorship).

This flexibility may even extend to circumstances where a nonprofit chooses a purchase offer from another nonprofit on terms and conditions that are below FMV, even in the presence of a competing FMV offer from a for-profit purchaser. In most jurisdictions, the board may choose to accept certain forms of non-cash consideration (e.g., capital improvement commitments; capital finance commitments; access to acute care-based commitments; preservation of workforce; and preservation of employee benefits) that are consistent with the nonprofit's charitable mission yet may serve to reduce the ultimate purchase price/value of consideration.

In such circumstances—where there is no fiduciary obligation of the board to maximize the nonprofit's assets by sale—it may be difficult to justify the inclusion of a fiduciary out clause in the definitive agreement to protect the interests of the transferor nonprofit's board. The proposed purchaser is likely to object on the grounds that such a clause would be prejudicial to its interests in the absence of a clear fiduciary obligation. There may be exceptions under applicable state law or the enforcement

discretion of the state charity officials where the proposed transaction would serve to transfer control of charitable assets to an out-of-state nonprofit, at a significant loss or subject to insubstantial consideration. In that circumstance, charity officials might oppose such a transfer absent significant demonstration that no suitable alternative (e.g., in-state) transferee was found (i.e., the presence of a fiduciary out may help mollify their concerns).

There is little question that the nonprofit board must assure satisfaction of FMV/reasonable consideration requirements for transactions involving change of control to a for-profit transferor. Furthermore, in those transactions the board should be committed to a process that allows market forces to work freely, not to favor one proposal over another, and to render an informed, disinterested decision. Indeed, the common practice in the nonprofit healthcare sector is for the board to engage a qualified investment banker or similar type of advisor well qualified to measure the value of the nonprofit assets, and capable of soliciting offers from the universe of likely purchasers. Also, an important part of the engagement is to provide the nonprofit board with written comfort on value (e.g., a fairness opinion or a reasonableness letter). If a full market test/bid process has been conducted, and the advisor provides some form of certification that it sought expressions of interest from all likely buyers (based on its experience), a fiduciary out clause may be unnecessary. It would be more difficult for a regulatory agency to fault the transferor for not including a fiduciary out provision where a market clear process has been followed—and is certified by the advisor. In other words, the transferor board's interests have already been protected by the advisor's thorough canvassing of the market.

The value of the fiduciary out provision to the nonprofit organization arises more specifically in the context of a proposed sale to a for-profit purchaser in the absence of such a market clear-type approach. This would be where the seller dealt with less than the likely universe of purchasers in arranging a potential sale—either because it did not engage an outside advisor, or the advisor did not (or was not authorized to) contact the likely universe of purchasers. When confronted with a superior unsolicited offer, it becomes much harder for the seller/transferor to demonstrate that the negotiated sale price constitutes FMV. In such a circumstance, a consultant's fairness opinion is a poor substitute for a full market check. This is especially the case should board members and the advisors be subjected to deposition questions from the AG with respect to the depth and sufficiency of the purchaser selection process and their related review and involvement.

The benefits of a fiduciary out clause may be most apparent in the following scenarios:

- *Timing factors*, such as a rapidly shrinking base of potential acquirors, prompt the nonprofit board to move quickly and accept the proverbial "bird in the hand"/purchase offer. In this way, the nonprofit assumes the business risk that, instead, by waiting and pursuing a more formal bid process, a superior offer may actually appear. In this situation, the board determines the most prudent approach is to accept the first offer (the only offer on the table) while hedging its position with the fiduciary out clause.
- *Pre-emptive offers*, such as a specific purchase offer made by a for-profit purchaser seeking a strategic niche in the market, that is for a price that the nonprofit itself determines to be at or above what it believes (on its own determination) constitutes FMV. In this situation—where the offer may be available for only a limited period of time—both parties may be more amenable to a fiduciary out provision; the nonprofit to protect itself from regulatory scrutiny and the for-profit to provide the nonprofit with the comfort necessary to induce it to complete the transaction.
- *Controversial cross-border transactions*, in which control of a nonprofit hospital or health system is transferred to a nonprofit system domiciled in another state, for terms and conditions far below market value. In this situation—in which there may be public/regulatory concern with control of charitable assets moving out of state—a fiduciary out provision might be styled to address the possibility of a more competitive (if still below market value) bid from a nonprofit located within the state.

Of course, a nonprofit intending to sell assets to a for-profit will assume significant regulatory risks by declining—for whatever reason (e.g., cost, timing, bias against advisors) a market check process or including a fiduciary out clause in the binding transaction agreement. Such a clause should not, however, be perceived by the nonprofit as a reliable substitute for a thoughtful board change-of-control process. Indeed, relying on a fiduciary out clause without additional market evaluation could in certain circumstances serve to expose weaknesses in the underlying board review process.

The fiduciary out clause is a recognized substantive business term frequently used in change-of-control transactions involving for-profit companies. Its utility in the context of nonprofit hospital mergers and acquisitions has attracted attention of late given the highly fluid nature of many individual hospital markets and the interest of some potential nonprofit sellers to move rapidly to find a partner before their strategic options are closed. These timing issues are prompting some nonprofit hospitals to expedite the transaction review process, in some situations by limiting the extent to which potential universe of purchasers is vetted. In those and similar, limited circumstances, there may be significant merit for the health lawyer to consider proposing a fiduciary out provision in the definitive agreement.

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1 Robert A. Eible and Matthew G. Oliver: "'Fiduciary Out' Provision Can Benefit Both Parties to a Transaction and Should be Included in Most Sale Agreements," *BNA's Corporate Counsel Weekly*, June 15, 2011 (Vol. 26, No. 23) (Weible and Oliver). *See also*, Law of Corp. Offs. & Dirs.: Rts., Duties & Liabs. § 6:12 (2012), citing *Omnicare, Inc. v. NCS Healthcare, Inc*. 818 A.2d 914 (Del. 2003).

2 *Id; Practice Note, What's Market: Fiduciary Out, available at* http://us.practicallaw.com/5-386-5737 (last visited March 19, 2013), (What's Market).

3 Eible and Oliver, *supra*; What's Market, *supra. Glossary Item, Fiduciary Out, available at* http://us.practicallaw.com/5-382-3460 (last visited March 19, 2013) (Glossary Item).

4 *Id.*

5 *Id.*

6 What's Market, *supra*; Weible and Oliver, *supra.*

7 Glossary Item, *supra*; Weible and Oliver, *supra.*

8 What's Market, *supra. See, e.g., Global Asset Capital LLC v. Rubicon US Reit, Inc.* C.A. No. 5071-VCL (Del. Ch. Nov. 16, 2009).

9 *See, e.g., Paramount Communications v. QVC Network*, 637 A.2d 34 (Del. 1994); *Omnicare, Inc. v. NCS Healthcare, Inc.*, 818 A.2d 914 (Del. 2005); *See also*, Peregrine and Schwartz, "The Nonprofit Board's Duties When Considering a Change of Control"; *Health Lawyers News*, April, 2008 at 26 (American Health Lawyers Association).

10 *Revlon, Inc. v. MacAndrews & Forbes Holdings, Inc.*, 506 A.2d 173 (Del. 1986).

11 506 A.2d at 184.

12 506 A.2d at 182.

13 *See, e.g.,* Weible and Oliver, *supra.*

14 *But see, e.g.*, Colin T. Moran, *Why Revlon Applies to Nonprofit Corporations*, 53 Bus. Law 373, 375 (1998); Md.Ins.Admin., "Report of the Maryland Insurance Administration, Steven B. Larsen, Commissioner, Regarding the Proposed Conversion of CareFirst, Inc. to For-Profit Status and Acquisition by WellPoint Health Networks, Inc. (Mar. 5, 2003) at 76.

15 *See, e.g.,* Cal. Corp. Code §§ 5914 to 5925; California Attorney General Review of Proposals to Transfer Health Facilities Under Corporations Code Sections 5914 *et. seq.* and 5920 *et. seq.*; Connecticut (CGS §§ 19a-486 to 486h); Pennsylvania Attorney General Review Protocol For Fundamental Change Transactions Affecting Health Care Nonprofits, *available at* www.attorneygeneral.gov.

16 *Id.; see also*, Peregrine and Schwartz, "Revisiting the Duty of Care of the Nonprofit Director," *Journal of Health Law*, Spring 2003 Volume 36, No. 2 at 196 *et. seq.*

17 Charles F. Kaiser & T.J. Sullivan, "Integrated Delivery Systems and Health Care Update," in IRS, Continuing Professional Education Textbook for Fiscal Year 1996 Ch. P, Sec. 6 (1996).

18 *See, e.g.*, 805 ILCS 105/103.10 (e), (m).
- Application of the fiduciary out clause can be highly dependent upon specific facts and circumstances, and upon application of relevant law in the jurisdiction. This article is not intended to be a comprehensive discussion of case law interpreting fiduciary out clauses.
- For a broad-based overview of the concept of the fiduciary out clause, without specific reference to the nonprofit sector, the authors commend Robert A. Eible and Matthew G. Oliver: "'Fiduciary Out' Provision Can Benefit Both Parties to a Transaction and Should be Included in Most Sale Agreements," *BNA's Corporate Counsel Weekly*, June 15, 2011 (Vol. 26, No. 23), and the Practical Law resources cited above.

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Part I: Current State of Health Systems M&A, Strategic Partnerships, and Other Innovative Transactions
Friday, February 22, 2013

Part II: Transactional Counsel Perspective on Executing Innovative Healthcare Transactions
Thursday, March 7, 2013

Part III: Antitrust Implications for Innovative Transactions
Tuesday, March 19, 2013

Part IV: Impact on Physician Network Development and Medical Staff
Wednesday, April 3, 2013

Part V: Financing an Innovative Transaction
Friday, April 12, 2013

Part VI: Integration and Implementation Issues in Healthcare Transactions
Friday, April 19, 2013

Note: MP3s are available for purchase three days following the live webinar.

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