AMA
AMERICAN MEDICAL ASSOCIATION

Unwinding existing arrangements

How to evaluate contractual agreements

Table of contents

Introduction **3**

Key provisions **4**

Billing practices 5

Limitations on patient relationships 6

Professional liability coverage 8

Non-compete provisions 9

Non-solicitation of personnel 11

Exclusivity 12

Practice infrastructure 12

Ownership, use and creation of materials 14

Governmental or payer reporting obligations and other timing considerations 16

Related agreements **17**

Conclusion **17**

Introduction

In the past decade, there has been an unprecedented integration of physicians into settings outside traditional physician practices, including entities such as hospitals, health systems, large group practices, private equity-backed managed practices, insurance companies and retailers. For simplicity, we refer to these entities as "Health Organizations" in this document. These relationships are often highly negotiated to balance physician autonomy and the business interests of the Health Organization while complying with the law. But, like any commercial arrangement, the parties may wish to exit the arrangement over time. Because of the high degree of integration in these relationships, it can be challenging for physicians to unwind them. Physicians can put themselves in the best situation by understanding common unwinding pitfalls and evaluating their agreements with the Health Organization to address these.

Physicians may wish to unwind relationships with Health Organizations for many reasons, including disputes over compensation, disagreements about practice style, or a desire for more clinical autonomy. Such unwinding may mean the departure of one physician or the departure of a whole physician practice (we refer to "physicians" in this document to cover both situations).

The decision to unwind a relationship with a Health Organization often requires significant strategic planning. In general, physicians' goals are straightforward: regain the ability to practice independently as soon as possible, with minimal practice and business restrictions, and as much access as possible to the benefits of their investment in the Health Organization (for example, physicians may want to retain access to patient relationships, service lines they developed, non-physician staff they trained, etc.). However, the strategy needed to achieve this result will vary based on the type of Health Organization, the physician's contractual relationships, and applicable law. Therefore, it is important to carefully evaluate contractual relationships with an eye to potential unwinding, ideally both at the beginning and end of a relationship with a Health Organization.

Although it is important to understand the terms of a physician's relationship with the Health Organization, physicians should remember these obligations are not necessarily set in stone. With a well-planned unwinding strategy, physicians may be able to negotiate terms more favorable than those contained in their agreements with a Health Organization. For example, many legacy physician arrangements contain noncompete provisions that may face challenges under changing federal and state law; physicians may be able to negotiate more flexible terms. Similarly, physicians may want to enter "quasi-unwinding" relationships in which they restructure arrangements to get greater independence while continuing to access practice infrastructure owned by the Health Organization.

This resource describes certain key contractual provisions that physicians should consider prior to unwinding their relationships with Health Organizations. The decision to unwind an arrangement can significantly impact access to patients, infrastructure, services, and compensation. Physicians may need to evaluate complex legal terms across multiple different agreements to fully understand the implications of an unwinding strategy, including a purchase agreement, employment agreement, management agreement, and operating or shareholder agreement, among others. This document presents this information at a high level of detail. However, the American Medical Association has also produced a high-level "Unwinding existing arrangements: Model checklist" resource that covers key issues to consider when negotiating an unwinding of

an existing contractual arrangement. You can also access the corresponding "Unwinding existing agreements: Snapshot" resource for a topline view of issues to consider when unwinding an arrangement.

Understanding these key contractual provisions and potential implications can help physicians navigate the process strategically to limit financial impact and disruption to their practice. For purposes of providing model language, this resource assumes direct employment of physicians by a Health Organization; however, language provided below can be tailored to other employment and professional service models involving Health Organizations.

Key provisions

Commonly found provisions in physician employment and professional services agreements that significantly affect physicians' ability to unwind the arrangement are discussed below, including sample contract language. Although the specific terminology covering these concepts may differ in a given contract, the requirements/restrictions in these types of provisions represent frequent restrictions on physicians who are seeking to unwind an employment or services relationship.

Suggestions are also provided to help physicians address these restrictions and (potentially) negotiate alternatives. Depending on the relationship between the parties and the physicians' negotiating power, the parties may be able to negotiate new relationships that help physicians achieve economic and practice independence while allowing them to continue to practice in the region and gain access to needed resources.

Examples of these negotiated relationships include the following:

Personal services agreements
Changing from a physician employment agreement to a personal services agreement in which the physician becomes an independent contractor and provides services to the Health Organization for a fair market value fee, usually a per-shift fee or a fee based on the physician's professional productivity. Personal service agreements can include everything from straightforward staffing or medical director agreements to highly complex service line management or hospital efficiency arrangements.

Managed practice structures
A managed practice structure in which a physician practice is independent, but the Health Organization manages its business elements (e.g., billing, collections, information technology, administration) in exchange for a fair market value fee reflecting the value of all of the items and services the hospital is providing. Managed practice structures can vary from tightly defined outsourcing of business functions to comprehensive delegation of control over virtually all non-clinical practice functions.

Ownership models
In many states, entities practicing medicine must be wholly owned by physicians. However, affiliation models between a Health Organization and physicians sometimes involve joint ownership of a separate legal entity (such as an ambulatory surgical center, management services organization, technology company or managed care organization). These can range from a simple equity investment in a surgical facility to sophisticated structured affiliations like joint operating

companies, with defined areas of responsibility for both the physicians and Hospital Organization over multiple clinical functions. In these models, the parties invest in a third entity, which performs certain operational or clinical functions and may bill payers separately for these services. These arrangements may also involve various management fees, professional service fees and profit distributions paid to the owners of this new legal entity.

Joint negotiating entities, including accountable care organizations, clinically integrated networks and independent practice associations
Formal models, including accountable care organizations (ACOs), clinically integrated networks (CINs), or independent practice associations (IPAs) in which the physician is in an entity independent from a Health Organization, but they work together (often with other practices) to negotiate favorable arrangements with payers by demonstrating greater coordination of care, improved cost management, and better quality outcomes. ACOs, CINs and IPAs usually involve joint contracting with payers to earn incentives for managing a patient population, including quality bonuses, bundled payments for defined sets of services, capitated or global budget arrangements, and payment of shared savings.

Other arrangements
A variety of other ad hoc contractual agreements in which the physician and Health Organization agree to share the costs and responsibility for operating certain elements of practice infrastructure (e.g., leasing space, jointly investing in equipment, sharing personnel, etc.) that may include payments based on a variety of fees including lease payments, management and service fees, quality incentives and compensation based on a physician's productivity performance.

Billing practices

When an arrangement unwinds, physicians are faced with the task of obtaining payment for their services independent of their former employer/counterparty. In some cases (such as employment by a hospital or a large multispecialty practice), physicians had previously assigned their right to bill third-party payers to this Health Organization as part of their relationship. The Health Organization is then usually responsible for negotiating and entering into contracts with third-party payers, including commercial insurers, managed care organizations and employer-sponsored health plans. It may have also assumed billing and coding responsibilities for the physician and employed the staff who performs these functions. Therefore, upon leaving the relationship, physicians may need to negotiate new third-party payer agreements, become re-credentialed with commercial insurers and hire or contract with new staff to accomplish these goals. The AMA has resources on negotiating payment options with private payers available here.

Sample language: Physician obligations

Physicians shall:

(i) Participate in and be credentialed under Medicare, Medicaid, commercial and third party payer contracts or health delivery plan(s) in which Hospital participates (collectively the "Designated Contracts"); provided, however, that individual Physicians

(ii) May elect whether to accept new or additional Medicare or Medicaid patients into their practice consistent with the standards of Hospital for its employed primary care physicians; and shall

(iii) Reassign right to payment under the Designated Contracts to the Hospital's Tax ID;

(iv) Abide by all applicable requirements and guidelines of the Designated Contracts in which the Physicians participate; and

(v) Continue to maintain current levels of effort to achieve pay-for-performance revenue efforts and other revenue uplift and quality metrics efforts that impact revenue. The Parties agree that the Physicians shall be credentialed on all Designated Contracts prior to the Effective Date, or the Effective Date shall be moved to such date as all Physicians are credentialed under the Designated Contracts.

Physicians may be able to address this concern at the outset of the relationship by negotiating specific contractual language addressing third-party payer issues in the event of unwinding. The language below is one example of contractual language establishing this right.

Sample language: Obligations with third-party payers

In the event that Physician elects to exercise the "unwind" provisions herein, the Parties will take all steps necessary to secure the maintenance, orderly transition and/or assignment of Physician Contracts to permit Physician to continue providing services under the Physician Contracts effective as of the Termination Date. To the extent requested by Physician, Hospital shall use its best efforts to assign the Physician Contracts back to the Physician Practice as of the Termination Date. In addition, Physician will be permitted to begin good faith, commercially reasonable negotiations with the payers in the Designated Contracts to secure new agreements with such third-party payers, and to undertake all necessary credentialing and other actions to permit Physician to furnish services under such payer agreements commencing on or after the Termination Date.

If a relationship between the physicians and Health Organization is positive, the physicians may continue to provide services to the Health Organization on an independent contractor basis. Depending on the relationship between the physicians, Health Organization, and applicable third-party payers, the Health Organization may be able to continue to bill payers for the physicians' services as a "reassignment" under its existing payer agreements.

Billing and collection issues have become more pressing with the proliferation of "narrow" networks based on tightly integrated groups of providers. If a Health Organization is in a narrow network or is party to an exclusive relationship with an employer, physicians may find it difficult to re-establish new relationships with that payer after unwinding. On the other hand, narrow networks are often vulnerable to shifts in provider services. For example, if a Health Organization such as a hospital is engaged in payer negotiations (or even leaves a payer's network), or the physician is providing unusual or highly prized services, the payer may be willing to negotiate improved terms with the physician organization as part of an unwinding process.

Limitations on patient relationships

Many Health Organization agreements limit physicians from conducting certain kinds of activities after the relationship ends. While these "restrictive covenants" are increasingly regulated by federal and state policymakers, Health Organizations may still limit physicians in many ways, including by limiting ongoing relationships with patients. Physicians should understand these restrictions and may wish to negotiate limitations to such provisions as part of structured unwinding.

First, relevant agreements may include "patient non-solicitation" provisions that prohibit physicians from approaching patients to provide services on an independent basis. Patient non-solicitation clauses will also often prevent physicians from contacting or marketing their services to patients after their employment (or other affiliation) terminates. These non-solicitation provisions were explicitly left out of federal regulations banning non-compete provisions.

Sample language: Patient non-solicitation

During Physician's employment with Hospital and for a period of two (2) years after the termination of Physician's employment with Hospital, Physician will not solicit or attempt to solicit (either directly or by assisting others) any business from Hospital's patients or prospective patients which are actively being sought by Hospital at the time of Physician's termination for the purpose of providing services that are competitive with the type of services provided by Hospital at the time of Physician's termination. This restriction shall apply only to patients and prospective patients who: (a) Physician treated in a Hospital location within two years prior to Physician's termination; (b) were treated by an individual supervised by Physician in a Hospital location within two years prior to Physician's termination; or (c) about whom Physician obtained confidential information in the ordinary course of business as a result of Physician's association with Hospital within two years prior to the date of Hospital's termination.

Notwithstanding the foregoing, nothing in this Agreement shall prohibit Physician from engaging in general marketing campaigns associated with the formation of a new practice following Physician's termination of employment for any reason. In the event of an unwind event, all patients who were previously seen by Physician with the three-year period prior to the unwind date, will receive a notice setting forth information on the location of Physician's practice.

Under state law, non-solicitation clauses pertaining to patients must be narrowly tailored to be enforceable. For example, they should not contain blanket prohibitions on ever contacting or providing care to all patients previously treated by the physician or group. To be enforceable, non-solicitation clauses should be limited, for example, to a certain geographic area and time period depending on the specialty and type of services. This also means that services provided outside the agreement should not be subject to the non-solicitation clause.

Additionally, most states mandate that patients must be free to choose the physicians who will treat them, and physicians are free to treat patients who have sought them out. Most non-solicitation clauses do not restrict normal advertising directed to a wider geographic region. Rather, these provisions normally prohibit "solicitation" in the form of contacting or attempting to contact patients to encourage them to transfer their practices to the physicians' new, independent practice. One way to ensure a smoother transition in case of an unwinding of a relationship is to negotiate how patients would be informed when physicians leave, such as explicitly including a right and obligation to inform patients that the physicians are departing from Health Organization's employment.

Second, affiliation agreements often say that the Health Organization will own the medical records and other treatment-related information for any patients treated by the physician during the term of the relationship. This may stop physicians from continuing their effective treatment of certain patients following an unwinding, at least without recreating these records. However, certain state laws may limit Health Organization's ability to own these materials, or require them to share these records with physicians for purposes of patient care. Physicians should understand any restrictions contained in their relevant agreements and seek to craft language to permit continued care of their patients (and avoid patient abandonment) following termination of the relationship.

Sample language: Continued patient care

Physician shall document in a timely and appropriate manner all consultations for services provided at Hospital and shall prepare such records and reports related to the Services in accordance with Hospital's electronic health record protocols and in such format and upon such intervals as Hospital shall reasonably require. All records shall be and remain the property of Hospital.

Following termination of this Agreement for any reason, Physician shall have reasonable access to those records created by Physician as may be necessary for the continuing care of the patient and as otherwise permitted by law, subject to any Physician-patient confidentiality limitations and compliance with any statutory or regulatory requirements or limitations. In the event of the termination or expiration of this Agreement, Physician shall complete all medical records, cooperate with Hospital with respect to any action filed against Hospital and otherwise satisfy all responsibilities and obligations assumed herein.

Either the provision will be waived or modified as part of the unwinding strategy, or the Health Organization and physicians will continue to work closely such that the physicians' ongoing treatment of patients does not violate these provisions.

Professional liability coverage

As part of the affiliation, physicians may have agreed to obtain professional liability coverage through the Health Organization or other entity. In these cases, physicians will need to obtain new ongoing coverage. However, physicians should also understand their coverage for any liability that arises after the termination of the employment (or other affiliation).

In some cases, the Health Organization may have agreed to pay for "tail coverage" covering the physicians for this post-termination period, as indicated in the sample provisions below.

Sample language: Tail coverage

In the event Hospital procures Insurance Coverage which is not on an "occurrence basis," Hospital shall, throughout the Term hereof and thereafter until the expiration of any statute of limitations applicable to claims reasonably arising from the Services furnished hereunder, maintain Insurance Coverage for any liability directly or indirectly resulting from acts or omissions in the provision of services pursuant to this Agreement, or by the Physicians' Private Practice by Hospital, any of the Physicians, or any of Hospital's employees or agents, occurring in whole or in part during the Term of this Agreement. Hospital may procure such Continuing Coverage by obtaining subsequent policies which have a retroactive date of coverage equal to the retroactive date of the insurance policy in effect as of the Effective Date of this Agreement, by obtaining an extended reporting endorsement ("tail" coverage), applicable to the Insurance Coverage maintained by the Hospital during the Term of this Agreement, or by such other method reasonably acceptable to Hospital. Following termination of this Agreement for any reason, Hospital shall be responsible for obtaining and paying for the cost of "tail" coverage providing coverage for acts or omissions of Physician during the term of this Agreement.

In other cases, the physicians may be required to provide tail coverage to protect against the Health Organization's liability associated with the physicians' service.

Sample language: Provision of tail coverage

In the event this agreement is terminated or not renewed, Hospital shall purchase or otherwise acquire professional liability ("tail") insurance coverage to cover all of Physician's professional services rendered during the Term of this Agreement. Physician shall deliver promptly to Hospital, upon receipt, a copy of any notice of claims against Physician involving Physician's liability insurance or any adverse action, change or modification to the terms and conditions of Physician's insurance coverage. Physician shall cooperate in filling out applications or other documents to obtain insurance.

In most cases, physicians will retain insurance coverage for their newly formed practice as part of the unwinding process.

Non-compete provisions

Non-compete provisions are a common issue (coupled with non-solicitation, discussed above) that may affect whether physicians may practice in the same location once the practice is unwound or whether physicians must move their practice outside of a geographical area. A non-compete provision is a contractual prohibition on physicians providing certain clinical and/or administrative services within a defined region. Certain non-compete clauses can limit physicians from accepting employment with competing Health Organizations or opening up practice locations in a given region. If physicians violate an enforceable non-compete, a court can stop the physicians from performing those competing services. In some regions, non-compete restrictions also may include "liquidated damages" clauses that specify financial penalties if physicians violate the non-compete restriction.

Non-compete restrictions have been the subject of significant policymaking and litigation. In 2024, the Federal Trade Commission (FTC) passed a regulation prohibiting most non-compete requirements (defined as "a term or condition of employment that prohibits a worker from, penalizes a worker for, or functions to prevent a worker from (A) seeking or accepting work in the United States with a different person where such work would begin after the conclusion of the employment that includes the term or condition; or (B) operating a business in the United States after the conclusion of the employment that includes the term or condition," including any contractual term or workplace policy.)[1] However, this provision continued to permit non-compete agreements in certain situations, including non-compete clauses predating the effective date of the FTC's rule, contracts with non-profit organizations, and agreements related to the sale of a business. Shortly after the rule was finalized, it faced multiple legal challenges, most of which are still pending at the time of this writing.[2]

1. See 16 C.F.R. § 910.1.
2. See e.g., Polsinelli, PC, Lawsuits Filed Challenging the FTC's Final Rule Banning Non-Competes (April 30, 2024), https://www.polsinelli.com/polsinelli-at-work/lawsuits-filed-challenging-the-ftcs-final-rule-banning-non-competes. See also Polsinelli, PC, Impact of the Texas Federal Judge Partially Blocking FTC Ban on Non-Competes for Franchisors and Franchisees (July 5, 2024), https://www.polsinelli.com/publications/impact-of-the-texas-federal-judge-partially-blocking-ftc-ban-on-non-competes-for-franchisors-and-franchisees

Many states have also passed or considered laws limiting the use of non-competes, which may be broader than the federal requirement. For example, under California law, contracts restraining a person from engaging in a profession are void, such that California courts have invalidated agreements, including provisions that restrict competition.

The extent to which non-compete provisions are enforceable generally depends on whether they are "reasonable," typically defined by state law. Non-compete provisions must be reasonably limited in subject, duration and scope. Practically, that usually means these restrictions can only apply to services consistent with those the physician actually provided, can only last a small number of years after the agreement terminates (usually 1–3 years) and must cover a reasonably limited radius around locations where the physician actually provided services.

Furthermore, the American Medical Association Code of Medical Ethics advises physicians not to enter into covenants that restrict competition among physicians for a specified period of time or in a specified geographic area on termination of a contractual relationship and that prevent a reasonable accommodation for patients' choice of physicians. (Code of Medical Ethics Opinion 11.2.3.1). Non-compete provisions can disrupt continuity of care and may limit access to care. In short, non-compete provisions are generally discouraged and may be unenforceable. Sample language of a non-compete provision is provided below.

Sample language: Non-compete provision

Except as otherwise agreed to by the Parties, Physician will be restricted from practicing medicine outside of the provision of services under the Agreement, through contract, employment, or in any other capacity, within the Restricted Area, during the term of the Agreement and for a period of one (1) year following termination of the Agreement. Notwithstanding the foregoing, Physician will not be considered to be in violation of the non-compete if Physician returns to the private practice of medicine and does not enter into employment or professional services agreements with any other hospital, health system and/or hospital or health system affiliate, or other institutional provider in direct competition with Hospital's Physicians. For purposes of this arrangement, "health system" will mean any entity that owns and operates both hospitals and physician practices and "institutional provider" will mean non-physician-owned group practice providers that employ or contract with physicians to provide primary care services. The foregoing prohibition shall not apply to Physician's participation in contracting networks with which Physician may be affiliated or involved prior to or during the term of this Agreement.

In many cases, a Health Organization will seek non-competes that are as broad as possible under applicable state law, especially as part of a practice purchase. Broad non-compete provisions can make it difficult to restart an independent practice if they are enforceable. As a result, physicians should evaluate the breadth of any non-compete provisions as part of their unwinding strategy. If a physician is party to a broad non-compete provision that is likely to be enforced, it may be advisable to seek a negotiated unwinding process. However, physicians should take a fresh look at any non-compete provisions they previously entered in light of the rapid changes in this area of law. Rules around enforceability may have changed between the start of the agreement and the time of unwinding. If the non-compete provision is not enforceable at the time of termination, the physician may have greater flexibility to restart a new practice or greater leverage to negotiate unwinding.

Under a negotiated unwinding strategy, the parties may agree to modify the non-compete provision to allow physicians to continue to practice in the same geographic region with certain limitations. For example, the non-compete might still apply to locations or kinds of services that are relevant to the type of Health Organization or affiliation created by the parties to facilitate the partial unwinding. Even if the parties do not enter into a new formal arrangement, Health Organizations may be willing to negotiate a waiver or limitation of a non-compete clause in exchange for financial compensation or an offset/reduction to any outstanding compensation the Health Organization owes the physician. If the non-compete calls for liquidated damages, the Health Organization may agree to waive or reduce these as part of a negotiated unwinding as well.

Finally, even if non-compete provisions are unenforceable, other contractual provisions can still limit a physician's ability to set up a new independent practice. For example, after terminating an agreement with a Health Organization, physicians may be required to resign medical staff privileges in an affiliated hospital. Termination on this basis is usually separate and apart from any peer review or credentialing process associated with the hospital's medical staff bylaws. This is often a significant strategic consideration in negotiating a partial unwinding arrangement. By voluntarily revising their arrangement with the Health Organization, physicians may continue to practice as part of the hospital's medical staff despite terminating the relevant employment or services agreement. An example of medical staff membership and clinical privileges being limited to the term of an employment agreement is provided below.

Sample language: Limitation of medical staff membership and clinical privileges

Upon the termination of the Agreement for any reason, the Medical Staff appointment and clinical privileges of Practice's Physicians shall automatically expire. Upon termination of the affiliation between Practice and a Physician, the Medical Staff appointment and clinical privileges of such Physician shall automatically expire. No action occurring as a result of this Section shall constitute a professional review action and no person shall be entitled to any hearing or appeal rights as a result of any such action. Hospital's rights pursuant to this Section shall supersede any contrary terms as may be established in the Medical Staff Bylaws. Practice shall ensure that, prior to performing services pursuant to this Agreement, each Physician shall deliver to Hospital a written statement acknowledging and agreeing to the terms of the Agreement and this Section.

Non-solicitation of personnel

Non-solicitation provisions prohibit physicians from recruiting Health Organization's clinical and non-clinical staff to join their new practices after unwinding from the Health Organization. This means that, as part of an unwinding, physicians must consider the type and number of support personnel needed to perform practice functions like billing, non-physician clinical services, payer contracting and technological needs. Moreover, Health Organizations often hire any staff employed by the physician practice at the time the relationship was formed. Non-solicitation provisions may prevent the physicians from rehiring these staff upon unwinding of the arrangement.

In most cases, the disposition of key personnel is a significant part of any negotiation between a Health Organization and physicians around unwinding. For example, in a structured unwinding, the key personnel may be moved back to the physicians or a new collaboratively operated entity (such as a joint operating company). In other examples, the Health Organization may lease back the personnel or provide the use of these personnel subject to a larger management services

agreement. Finally, the Health Organization may be willing to negotiate the waiver of a non-solicitation clause for certain key personnel (e.g., advance practice practitioners, billing and coding staff, executive administrators) to allow physicians to hire these individuals back. This strategy is most likely to be effective when the parties include language allowing re-hiring at the inception of the arrangement (e.g., in the purchase agreement or physicians' employment agreement).

Sample language: Disposition of key personnel during an unwinding

During the Term and for one (1) year thereafter, neither Party shall solicit, or assist anyone else in the solicitation of, any of the other Parties' then-current employees for the purpose of terminating such person's employment and/or the employment of such person by any business enterprise with which the Party may then be associated, affiliated, or connected; provided however, that in the event of a practice unwind, Physician may offer employment to those individual clinical and non-clinical staff persons who had an employment relationship with Physician prior to Physician's establishment of an employment or service relationship with Hospital. In addition, nothing herein shall prohibit Physician from offering and hiring personnel who respond to general advertisements for position openings.

Exclusivity

An "exclusivity" provision is an agreement to designate a practice as the only physicians that a Health Organization (often a hospital) will retain to provide certain services. These provisions are most often found in professional services agreements for hospital-based services like emergency services, anesthesia and radiology. Unwinding this arrangement can be difficult for both the physicians and the Health Organization. The physicians may lose multiple revenue streams, while the Health Organization is usually faced with a challenge to find replacement staff for rounding, call coverage and, potentially, staffing outpatient clinic locations. Because both parties have certain elements of leverage, unwinding this kind of relationship may be particularly suited to renegotiation rather than simple termination.

Sample language: Exclusivity provision

Hospital concludes that an exclusive relationship with Physician will best facilitate the delivery of efficient, effective and quality patient care. Such a relationship is expected to enhance the quality of patient care by improving the relationships between the Medical Staff and other services of Hospital; affording effective utilization of Hospital's equipment; providing consistent service and quality control; providing prompt availability of professional services; simplifying scheduling of patients and Physician coverage; and enhancing the efficient and effective administration of the Hospital Program. In furtherance of these purposes, Hospital hereby establishes Physician as its exclusive provider upon and subject to the following terms. Any esoteric, unusual or other procedures that cannot reasonably be performed through the Hospital Program may be sent to an outside provider selected by Hospital.

Practice infrastructure

As part of a typical physician practice acquisition or similar affiliation, a physician sells or transfers rights in all or more of the assets used in their practice. This may include office space, licenses for electronic health records (EHR) and other information technology systems (sometimes including a formal practice management system integrating medical records, billing, and scheduling

functions), specialty medical equipment (e.g., imaging technology such as an MRI), non-clinical assets (e.g., office equipment, computers, furniture, etc.) and medical supplies. As part of an unwinding, physicians will need to understand which of these assets will remain with the Health Organization since physicians will need to replace them in order to practice independently. As part of the transition, physicians (and the Health Organization) may consider relationships that permit the physicians to continue to use assets required for the operation of their practice (i.e., by lease or purchase).

In addition, the ongoing service agreements with the physicians will often require the physicians to use practice infrastructure provided by the Health Organization. An example mandating use of a hospital's EHR and information technology system is below.

Sample language: Asset purchase agreement—use of EHR and IT system

Note: This language would be in an Asset Purchase Agreement, in which a hospital purchases most of a physician's practice infrastructure. In this example, "Seller" is the physician practice and "Purchaser" is the hospital.

Purchased Assets. The Seller shall sell, assign, convey, transfer and deliver to the Purchaser, and the Purchaser shall purchase, acquire and accept delivery from the Seller, all assets owned or used by the Seller in connection with the Practice (except for those assets identified as Excluded Assets [note: non-transferable assets like Medicare/Medicaid provider numbers]), including, but not limited to:

(a) All business records, inventories of medical and business supplies relating to the Seller

(b) All equipment, devices, machinery, furniture, furnishings, fixtures, leasehold improvements and other tangible property, and disposable medical and office supplies used in connection with the Seller;

(c) All right, title and interest in and to the Contracts [note: certain contracts with vendors, suppliers, or payers, to be included in a list called a "Schedule"] (the "Assumed Contracts");

(d) All right, title and interest of the Seller in and to the leases listed on [a Schedule] (the "Assumed Leases");

(e) All transferable permits, licenses, telephone and facsimile numbers of the Seller;

(f) All Medicare Advantage and Medicaid HMO memberships of the Seller;

(g) All patient records, patient lists, personnel records and payroll records associated with the Practice, excluding those records relating to transferred patients, terminated patients (as evidenced in such patient's medical record) or deceased patients (collectively, the "Excluded Medical Records");

(h) All intellectual property, proprietary data and confidential information of the Seller concerning the plans, systems, methods, designs, procedures, books and records relating to operations, personnel and practices, as well as records, documents and information, concerning the business activities, practices, procedures and other confidential information of the Practice (all of the foregoing, collectively, the "Trade Secrets"), including the methodology of running the Practice, trade names, trademarks and/or logos; and

(i) All computer hardware and software located at the Premises or elsewhere related to Practice's operations and/or patients (collectively "Purchased Assets").

Practice infrastructure will be a major part of the negotiation of any structured unwinding arrangement. If a Health Organization is a management entity, these are the core services that the Health Organization usually supplies to the physicians in exchange for compensation. If the Health Organization is a hospital or similar provider, the practice infrastructure may be transferred to the Health Organization or may be moved to a collaborative entity like a joint operating company. In this case, the Health Organization and physicians may each contribute (or contractually provide) different kinds of infrastructure. In practice, this structure may be quite complex, and physicians should take time to identify all of their necessary practice infrastructure and understand the termination and unwinding terms of necessary agreements. In any structured unwinding arrangement involving the apportionment and redistribution of practice infrastructure, it will be important that any ongoing shared infrastructure is provided in exchange for a fair market value fee.

Sample language: Apportionment and redistribution of practice infrastructure

In fulfilling Physician's duties and responsibilities under this Agreement, Physician shall exclusively utilize Hospitals' information technology systems. The Parties agree to negotiate in good faith regarding a timeline for Physician to transition Physician's existing medical records to Hospitals' electronic medical record, with Hospital to provide EHR transition stabilization and support in accordance with the terms of a separate, written agreement between the Parties.

Following termination of this Agreement for any reason, the parties shall cooperate in connection with the transition, provision and/or use of EHR technology in order to permit Physician to practice and provide patient care, and Hospital shall offer physician the opportunity to lease or purchase the EHR at fair market value, under commercially reasonable terms, for continued use in Physician's practice following termination.

Ownership, use and creation of materials

Physicians should also consider who owns any confidential material or new intellectual property created over the course of the affiliation. This is particularly true for physicians engaging in innovative health care models or specialties in which the physicians may develop new patentable devices. The terms of the affiliation may prevent or limit the physicians' ability to use these new assets or confidential material.

Sample language: Work product

Work Product. Physician acknowledges and agrees that whatever Physician and/or any Physician Representative creates in the performance of duties in the course of rendering Services to Hospital hereunder, including, without limitation, ideas, inventions, discoveries, developments, writings, improvements, designs, drawings, models, graphic, and other works (the "Work Product") is the property of Hospital.

All Intellectual Property which Physician created prior to the Term of this Agreement or which may be created subsequent to the Term of this Agreement, with the exception of Intellectual Property created: (i) during Physician's scheduled working hours; or (ii) using any of Hospital's resources,

including confidential information or premises, shall be and remains the property of Physician. For purposes hereof, "Intellectual Property" shall mean all intellectual property, including, but not limited to, discoveries, developments, technologies, designs, devices, improvements, modifications, inventions, work of authorship, formulae, processes, software programs, techniques, data, computer-related knowledge, patents, copyrights, trademarks and trade secrets, and other rights and protections in connection therewith (whether or not patentable or able to be registered under copyright, trademark or similar statutes or subject to analogous protection), and all documentation with respect thereto, however recorded, which documents the design and details of any of the foregoing, contains a description thereof, or explains the utilization thereof.

Sample language: Copyright

Copyright. To the extent that any of the Work Product is capable of protection by copyright, the following applies:

(a) If the Work Product falls within the scope of the definition of a work made for hire under the United States Copyright Act, Physician acknowledges that it is a work made for hire.

(b) To the extent that the Work Product may not be a work made for hire, Physician hereby assigns to Hospital all rights in such material and all copyrights therein in all media throughout the world.

(c) To the extent that any of the Work Product is an invention, Physician hereby assigns to Hospital all right, title, and interest worldwide in and to all inventions, improvements, discoveries or ideas conceived or invented by Physician and/or any Physician Representative during the Term hereof.

(d) Physician agrees to execute any documents at any time reasonably required by Care Site in connection with the registration of copyright, assignment or securing of patent protection for any invention, or other perfection of Hospital's ownership of the Work Product.

(e) All Work Product shall be considered Proprietary Information for purposes of this Agreement.

Physician represents and warrants, on behalf of Physician and any Physician Representatives, that Physician and/or any applicable Physician Representatives are the sole authors of the Work Product; that it is their original work of authorship; that the Work Product has not been published previously in any form; that reproduction, publication or other use of the Work Product as contemplated in this Agreement will not infringe the property rights of any other person or entity; and that the Work Product is factually accurate, is not libelous, does not invade anyone's right of privacy or publicity, and does not otherwise violate or infringe the rights of any person or entity.

Parties may address this issue by either negotiating for the applicable intellectual property rights upon unwinding or by contributing these rights to a new legal entity as part of a joint operating company model or other shared practice model.

Governmental or payer reporting obligations and other timing considerations

Payers, including the Medicare program, require physicians to report certain information regarding their quality and the services they provide. For example, a physician's Medicare reimbursement may be reduced if he or she does not report data under the Merit-based Incentive Payment System (MIPS). These reporting obligations are often assumed by an employer and/or Health Organization and occur early in the year following the performance year. As a result, the need to report on this information may impact the timing of any unwinding. For example, if a physician's practice leaves an accountable care organization prior to certain dates in the year, the practice may not be eligible for shared savings payments. Similarly, if a physician leaves the employment of a large group practice late in the year, they may not be able to collect information and develop reporting capabilities in time for the MIPS reporting deadline. Physicians should understand the schedule of any such reporting obligations and the impact of any unwinding.

Similarly, employment and contractor agreements may also include quality and productivity incentive payments that are assessed at specific periods of the contract term. Physicians should understand when or how any quality incentive payments are calculated and the impact of unwinding on paying any such payments.

Sample language: Quality and productivity incentive payments

During each Contract Year of the Term, Employer will allocate the following amounts to be distributed through the Internal Distribution Plan, which aggregate amount shall be used to pay annual compensation to Physician and all other Employed Physicians, subject to withholds, deductions, expenses, or other provisions of this Agreement: ... Pass Through Amounts; "Pass Through Amounts" shall mean any of the following amounts received by Employer during a given Contract Year:

i. Amounts which are attributed to Physician's performance of activities and services required to obtain physician-specific incentive payments from Medicare, Medicaid or other payers for e-prescribing, payments made under the Merit-based Incentive Payment System, Electronic Health Record "meaningful use" incentives and any other physician-specific incentive payments as designated by Employer (with the approval of the Board);

ii. Amounts received by Employer for investigator or other research services performed by Health System or Employer under research study or similar agreements administered by Employer under which Physician serves as the investigator, net of direct costs incurred by Employer in performing the duties and obligations of Employer under all such Research Agreement(s) or otherwise in connection with the operations of the research department;

iii. Amounts received by Employer for investigator or other research services that are attributable directly to Physician's personally performed services under research study or similar agreements not administered by Employer; and

iv. Any additional payments for services which are outside of Physician's duties under this Agreement which are approved in advance by Employer and following the completion of any third-party valuation or other review deemed necessary by Employer.

Related agreements

Physicians should also consider all other agreements which they have entered into with a Health Organization that are related to the employment or services agreement. As part of a physician practice acquisition, the Health Organization often acquires most of the physician's practice infrastructure, including office space, equipment and personnel. The Health Organization will then often create new agreements that cover the physician's access to these services through one or more additional agreements (including a management agreement, lease of office space and/or equipment, or a license to access software).

In the event that the Health Organization and physicians unwind their overall agreement, these other agreements may have their own unwinding requirements or may be implicated through the unwinding process. For example, the physicians' employment agreement may explicitly terminate if another overall "affiliation" agreement terminates, as described below:

Sample language: Termination of agreements

This Employment Agreement shall automatically terminate upon the "Unwind Purchase Date" as defined in the Asset Purchase and Lease Agreement by and among the Employer and the Group.

Conclusion

Understanding contractual provisions and implications can help physicians navigate the unwinding process strategically to limit financial impact and disruption to their practice. Physicians would be well served to actively review their agreements with Health Organizations so they are able to make the best decision about the manner and timing of the unwinding process.

Disclaimer
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