PREPARED BY HOGAN LOVELLS; NOT REVIEWED OR ENDORSED BY ANY PARTY
4/4/13 UNOFFICIAL DISCUSSION DRAFT
PRIVILEGED/CONFIDENTIAL/TRADE SECRET/COMPETITIVELY SENSITIVE[1]

Possible Terms for St. Vincent/UAMS Network Collaboration Agreement

1. Common Vision, Goals and Value Proposition

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St. Vincent Infirmary Medical Center, d/b/a St. Vincent Health System ("SVHS") is the Little Rock component of Catholic Health Initiatives ("CHI"), a non-profit health care organization that operates in several regions of the United States. The University of Arkansas for Medical Sciences ("UAMS") is the academic health center ("AHC") component of the University of Arkansas (the "University"), a leading public institution of higher education. Despite their different organizational forms, SVHS and UAMS share several important values and goals. Both are non-profit and seek to provide health care to the community at large, regardless of ability to pay. Both seek excellence by providing high-quality hospital and ambulatory care facilities and by attracting talented and dedicated physicians, nurses and other professionals and support staff. Both seek to provide services cost-effectively, and to increase the accessibility and responsiveness of their healthcare services to the public.

UAMS and SVHS (the "Parties") operate hospitals and related facilities in close proximity to one another. SVHS and UAMS recognize that hospitals and academic health centers will face increased financial pressures in the coming years due to stresses in the economy, the continued rise in health care costs, reforms of the health system resulting from the Affordable Care Act, pending regulatory changes, pressure on payer fees, and other factors. It is increasingly costly for any hospital, and especially for an AHC, to maintain all the specialized and "safety net" services that may be needed by the community, and to finance new and more expensive technologies, information systems, equipment, facilities and improvements. The AHC also bears substantial unreimbursed costs of medical education and research. All these factors suggest that it may not be consistent with the community's interests, or the fiduciary duty of non-profit trustees, for SVHS and UAMS to operate redundant or in some cases under-utilized services next door to one another -- if by collaborating they could increase both their quality and cost-effectiveness.

In addition, it is apparent that high-acuity tertiary/quaternary hospitals such as SVHS and UAMS can be financially successful in the future only if they perform their special roles as part of larger networks. It is increasingly difficult for a "stand-alone" hospital to prosper. AHCs such as UAMS face another imperative as well: for UAMS to maintain the world-class super-specialist faculty, and to engage in clinical and translational research on specialized or rare disorders, UAMS must draw patients from a large geographic area and referral base of physicians. This requires a growing hospital/health network. An appropriate "Model of Care" for such a network can help assure that care remains local when that is most convenient and best for the patient, while referrals are made to "hub" tertiary/quaternary facilities such as SVHS and UAMS when that is best for the patient.

1" This is a preliminary draft intended to assist in further discussions among the Parties. It has not been endorsed by anyone. Its terms are subject to ongoing analysis as to legal and operational feasibility and desirability.

Finally, the Affordable Care Act contemplates the development of Accountable Care Organizations that are able to manage large populations, improve their preventive and acute care, and accept some financial risk of the costs of care. Once again, organizations such as SVHS and UAMS can only take on such roles if they are part of a financially strong, larger network to be created under the terms described here (the "Network Collaboration").

For these and other reasons, the Parties have determined that their respective missions can best be secured in the coming decades by working together, by sharing certain administrative and management services, by collaborating in the joint development of a regional network and in certain collaborative clinical programs.

At the same time, the Parties will insist on preserving (a) the statutory authorities and vested powers of the UAMS Board of Trustees, and (b) the prevailing governance authorities of the CHI Board within its system.

Hence, each existing organization will continue to be autonomously governed. However, each governance body is expected to seek the benefits of efficiency through collaborations which are developed by the Network Collaboration and then are approved separately by each Board, consistent with the statutory or system requirements that apply.

The Parties' common vision is that the Network Collaboration will enable the Parties to achieve their missions and very substantial value because they can:

- Share certain operational, support, and administrative services and thereby save costs.
- Reduce unnecessary redundancy and underutilization of specialized services, and improve the cost-effectiveness of services.
- Attract hospital and physician group affiliates in additional Arkansas communities.
- Enhance the capacity of local physicians and hospitals to provide sophisticated care through network arrangements, availability of telemedicine consults, and continuing education offerings.
- Expand the scope of UAMS' undergraduate student clinical experiences and the range of graduate medical education rotations.
- Preserve the separate values of UAMS (public) and SVHS (Catholic) while enabling them to collaborate on specific programs.
- Provide world-class care to communities throughout Arkansas, and do so in a manner that is accessible, responsive, and respectful of the dignity of the individual human being.
- Enhance the standing of the combined Network Collaboration enterprise as a nationally recognized, academic medical center system.

2. **Scope of Network Collaboration**

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The Network Collaboration will have at least six components (which will be implemented subject to applicable law, appropriations and other conditions):

2.1 Shared Support Services

. The Parties will explore opportunities to share support services if that can improve cost-effectiveness. An initial list of potential services includes:

- Materials and services management (group purchasing)
- Environmental services
- Clinical resource management
- Revenue cycle/administrative services
- Planning, marketing
- Patient information services
- [Shared services are detailed on Exhibit 2.1]

2.2 Collaborative Clinical Support Services

. The Parties also intend to explore opportunities to improve service delivery and reduce the costs of care by means of coordinating, collaborating or combining parts of programs. Possible examples include:

- Ambulatory clinics
- Imaging
- Laboratory
- Pharmacy
- Rehabilitation

2.3 Consolidated Clinical Services

. The Parties also will explore potential improvements in patient care quality and cost-effectiveness that might be achieved through consolidation in certain services, such as:

- Cardiovascular
- Cancer
- [Other?]

2.4 New Off-Campus Services

. The Parties may also decide to collaborate in the development of ambulatory care facilities, diagnostic facilities or other new off-campus services.

2.5 Network Affiliations and Network Contracting

. The Parties expect to develop clinical and related affiliations with hospitals across Arkansas, and to achieve a level of financial alignment and clinical integration such that they will be able lawfully to jointly contract with payers for certain services. They will jointly propose a Network Development Plan.

2.6 Academic Affiliation Agreement

. The Parties will have an Academic Affiliation Agreement, under which UAMS will make certain academic and research programs available to CHI, and CHI will provide (a) financial support for academic and research enhancements at UAMS, as is customary in such academic medical center agreements, and (b) a substantial commitment of future capital for expansion of facilities and services of the Network Collaboration.

The Network Collaboration is intended to encompass these six features, and any others that the Parties may by agreement add ("Network Services").

2.7 Separate Services

. Both Parties may retain or develop separate programs and activities that are not part of the Network Collaboration (e.g., the UAMS School of Medicine's basic science research enterprise, and the provision of certain services that may be restricted or prohibited in Catholic organizations). UAMS will continue to provide services needed by Arkansas communities, as determined under the leadership of the University of Arkansas Board of Trustees and UAMS executives and medical staff. The Parties acknowledge that SVHS, as a Catholic organization, shall not be involved in any way in certain services or activities in any way. UAMS shall not impose unacceptable requirements on SVHS, and SVHS conversely shall not restrict the services that UAMS can provide outside of and apart from the Network Collaboration. In this way, each organization will continue to be faithful to its mission, values, and the needs of its respective community.

3. **Governance**

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3.1 Network Collaboration: Joint Management Services Company

. The Network Collaboration will be created via a Collaboration Agreement, which is essentially a contract that will set forth the purposes, structure and general principles governing the collaboration.

The Parties also will create a non-profit Management Services Organization ("MSO") to provide services to the Parties and to coordinate their Network Collaboration activities.

They may create additional arrangements for particular ventures; this will depend on further program planning, and regulatory and legal issues to be analyzed.

3.2 Collaboration Council

. The MSO will be governed by a Collaboration Council comprised of five Councilors appointed by SVHS/CHI; and five Councilors appointed by UAMS.

The UAMS Councilors shall include the University President, Chancellor for Health, Medical School Dean, the CEO of University Hospital and one member of the University of Arkansas Board of Trustees. The SVHS/CHI Councilors shall include [TBD].

3.3 Councilors' Terms

. Councilors appointed by UAMS ex officio shall serve during their terms of office or until removed or replaced as Councilors by UAMS. Councilors appointed by CHI may serve until removed or replaced by CHI. Any vacancies appointed may be filled by the entity that appointed the predecessor Councilor.

3.4 Executive Committee

. The MSO Collaboration Council will appoint an Executive Committee comprised of three SVHS appointees and three UAMS appointees.

3.5 Member Powers

. The MSO Collaboration Council will possess specific powers delegated to it in the Collaboration Agreement. The Parties separately will retain (a) those powers that they, respectively, are required to possess by law and/or the constitutive documents establishing them, and (b) all powers not delegated to the MSO Collaboration Council.

3.6 MSO Collaboration Council Powers

. Subject to the reserved powers (and in the case of UAMS, vested University Powers) noted in Section 3.7, the MSO Collaboration Council will have the authority to:

- Propose capital and operating budgets for Network Collaboration activities
- Propose a strategic plan for Network Collaboration Activities
- Propose a business plan for Network Collaboration, subject to approval of each Member (see Section 4.6)
- Propose guidelines for payer contracting
- Adopt internal governance policies and procedures for the Network Collaboration
- Approve Network services contracts

- Approve joint activities, subject to the capital budget and other policies adopted by each Member's own Board

- Approve acquisition or disposition of MSO assets

- Approve new affiliations within the Network Collaboration

3.7 Member Reserved Powers

. Each of the following Network Collaboration actions shall require the separate approval of the Board of each independent Member:

- Capital and operating budgets

- Strategic plans

- Business plans

- Major contracts

- Creating joint programs or other commitments in excess of a value of [$TBD]

- Maximum capital commitment under the Collaboration Agreement

- Material affiliation with any other academic institution

- As to UAMS, other matters which by law require University of Arkansas Board approval or are subject to limitations warranting such review/approval

- As to SVHS, other matters which require CHI Board approval under CHI's policies applied nationally

- "Major" MSO initiatives

- Other major matters [TBD]

3.8 Dispute Resolution

. If a Party believes that a proposed action by the Network Collaboration violates the Agreement or is inconsistent with its reserved powers, or any other material dispute arises thereunder (a "Dispute"), it will be resolved by the following Dispute Resolution process:

(8.1.a) First, by submission to the MSO Collaboration Council;

(8.1.b) Then, if it is still not resolved after a reasonable period of time, by referral to a jointly selected mediator, who will work with representatives of the Parties and the MSO Collaboration Council, and will try to develop a mutually acceptable solution within a reasonable period of time; and

(8.1.c) [Alternative A: Then, if the Dispute is not resolved within such time, for definitive and binding resolution by a Special Master, who shall be a health care consulting firm or individual with expertise in the operation of hospitals, academic medical centers and related networks, and shall be appointed in advance by agreement of the Parties, to be "on tap" as needed.]

(8.1.d) [Alternative B: Then, if the Dispute is not resolved within such time, the Dispute shall be submitted to a Special Committee comprised of two Trustees of SVHS, two Trustees of University of Arkansas, and a jointly-chosen neutral independent expert having no material connection to either Party, and if the Parties cannot promptly agree on such person, then the expert shall be chosen by coin toss among the two most favored candidates proposed by the Parties. Majority vote of the Special Committee shall finally determine the issue, and its decision shall be binding on both Parties.]

4. **Economic Model**

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4.1 MSO and Collaboration: Financial Model

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(1.1.a) Each Party will continue to own its medical center and associated assets, and maintain its own financial statements, debt, and so on.

(1.1.b) The MSO will be a [501c3] [LLC] and will operate as customary for such an enterprise. It will provide administrative and support services to each Party; will be reimbursed for its costs and overhead; and will be managed on a financially prudent basis but is not expected to be a separate profit center. If the MSO needs capital to obtain infrastructure such as IT systems, the Parties will approve capital budgets and will contribute capital in equal amounts. The MSO will have its own financial statements. It is not expected that the MSO will be a separate issuer of debt. But if that ever makes sense, an appropriate issuer will be selected, and a debt allocation agreement will assign separate (not joint and several) liability for portions of the debt to each Party. Thus UAMS and SVHS capital debt will always be separately calculated.

(1.1.c) As the Parties build out the anticipated larger network of affiliations in Arkansas, they may determine that there is a need for particular joint efforts. Each "major" initiative would need to be approved by each Party's board, and well as by the MSO Collaboration Council, and the agreements would include capital and operating commitments.

(1.1.d) Beyond the MSO entity, the Parties' financial relationship under the Network Collaboration will be under a "virtual" financial model. Each Party will earn and receive revenues from its own separate services. But contractually, the Parties will seek to achieve a "virtual" financial collaboration model that is fair to both Parties,

that aligns their conduct, and therefore provides a stable basis for an ongoing relationship. This is described in more detail ion Section 4.2.

(1.1.e) Each Party will contribute initial capital in equal amounts to support the MSO services it will receive. The Collaboration Agreement will provide that neither Party is required to contribute more than [$TBD] in capital in total during the first five years of the Term, and thereafter only such amounts as are agreed to by the MSO Collaboration Council and by the independent vote of the Board of each of the Parties.

(1.1.f) If due to unexpected events, the Network Collaboration's operations require more funds than have been agreed to by the Parties, the MSO Collaboration Council may determine to take one or more of the following actions:

(1.1.f.1) Obtaining funds from one willing and if legally permissible Party, or from both Parties in differing amounts, as loans and not as capital contributions. Such loans will bear interest at a rate equal to the Network Collaboration's cost of funds plus [X%].

(1.1.f.2) Borrowing from commercial banks or other commercial sources, on an unsecured or secured basis; and /or

(1.1.f.3) Scaling back operations so they can be operated profitably within the available resources.

(1.1.g) Since the Parties will be contributing initial capital equally to the Network for operation of the MSO (see Section 4.1(b)), their initial Capital Account balances should be equivalent. Capital Account balances will be increased to reflect further capital contributions and decreased for capital distributions to Members, all as may be approved by the Collaboration Council. Any arrearage in payment of required capital shall bear interest at the Network Collaboration's cost of funds plus [X%].

4.2 Network Revenues

. All revenues for a Party's services under the Network Collaboration will be credited to the "virtual financial statement" of the Network Collaboration. Such Network Collaboration revenues include:

(2.1.a) Payer contract revenue realized from the technical component of those services that are coordinated by the Parties within the Network. An initial list of Network Services is attached as Exhibit 4.2.

(2.1.b) Physician and other professionals' fee revenue, plus "incident to" ancillary service revenue of physicians employed by a Party within the Network Services.

(2.1.c) All other net patient service revenue realized for Network Services.

(2.1.d) DSH, UPL/IGT, HRSA, Medicaid special pools or other governmental special payments, to the extent they arise from the Network Services. Unless the Parties otherwise agree, this allocation shall be based on a ratio of costs to charges methodology.

(2.1.e) Direct and indirect medical education payments, also based on an agreed allocation methodology by service.

(2.1.f) Reimbursement by life sciences companies for clinical trials.

(2.1.g) Interest on Network Collaboration restricted funds or working capital.

(2.1.h) Other sources may be agreed.

4.3 Exclusions

. Network Collaboration revenues exclude the following:

(3.1.a) Research revenue other than per Section 4.2(f).

(3.1.b) Tuition.

(3.1.c) State support for medical education.

(3.1.d) Philanthropy (but see Section 7).

(3.1.e) Other revenue received separately by a Party and not described in Section 4.2 or which by law is restricted to that Party.

4.4 Network Expenses

. Network expenses shall include:

(4.1.a) Operating expenses for the Network Services, including corporate allocations from the respective Parties, and Medical School and institutional taxes, provided that such allocations and taxes (1) are based on the same methodology that is used consistently to allocate costs to other comparable components of such Party's enterprise, and (2) are approved as part of the Network Collaboration Budget.

(4.1.b) Capital costs for replacement of depreciated capital assets, or acquisition of new capital assets necessary for operation of the Network Services, provided that such costs are approved as part of the Network Budget.

(4.1.c) Personnel expenses for staffing of the Network Services.

(4.1.d) Costs of administrative or other services that are provided by a Party to the Network Collaboration, which shall be at mutually agreed FMV rates.

(4.1.e) "Enterprise level" costs such as administrative services, marketing, contract negotiation, etc. as per the approved Network Collaboration Budget.

(4.1.f) Cost of conducting Network Collaboration relations with additional hospitals and physicians, including IT support, contract administration, credentialing, and so on.

(4.1.g) Contractually agreed "Academic Support" for AHC functions.

4.5 Non-Network Expenses

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As described in Section 2, the Network Collaboration includes Network Services and other relationships. The Parties will likely continue to operate separately certain non-Network Services, and to operate academic and research programs that are not within the administrative and financial structure of the Network Collaboration. Initially these excluded activities will include:

(5.1.a) SVHS Separate (Non-Network) Services: [TBD]

(5.1.b) UAMS Separate (Non-Network) Services: [TBD]

5. **Non-Undercutting and Fair "Rules of the Road"**

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5.1 Obtaining Services Via the MSO

. In order to achieve economies of scale, each Party will be obligated (to the extent legally permissible) to obtain from the MSO the agreed services described on Exhibit 2.1.

5.2 Principle of Non-Undercutting

. Both UAMS and SVHS will be devoting substantial resources to the Network Collaboration and to making its programs successful. Therefore, they agree during the Term of the agreement to refrain from actions that would materially undercut the success of the MSO and the Joint Programs. They continue to be free to compete energetically and take any other actions warranted by their missions in the non-joint programs outside the Network Collaboration, subject to the Right of First Offer described in Section 5.3 below. The currently planned Joint Programs are described on Exhibit 5.2.

5.3 Right of First Offer

. During the Term, if either Party desires to commence a new program or establish a new ambulatory care site for the provision of services that are within the scope of Joint Programs as described in Exhibit 5.2, they shall afford the other Party a right to participate in such program and for such program to be a Joint Program via the Collaboration Agreement, on commercially reasonable fair market terms generally consistent with the conduct of existing Joint Programs hereunder. If the other Party via the MSO declines or is unable to accept the opportunity within a reasonable period of time not to exceed 60 days, then the proposing Party may pursue the activity on its own or with others, provided that it shall not under any circumstances pursue any activity, whether or not previously offered to the MSO, that would materially undercut or have an material adverse effect on the Network venture as a whole.

5.4 Non-Solicitation

. With regard to the Joint Programs, the Parties will engage in a joint and coordinated recruitment process for needed physicians and other employees. They will refrain from separately soliciting (except through media directed to the professions or the public generally) or seeking to attract to employment or contractual relationships any person who is then employed by the other Party.

5.5 [Do the Parties Need Additional Rules?]

6. Academic Affiliation and Branding

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(1.1.a) The Network Collaboration's exclusive academic affiliation will be with the University of Arkansas, unless otherwise consented to by the University.

(1.1.b) The Parties will agree on an overall "Brand Architecture" document under a Reciprocal Trademark License Agreement for branding and marketing the Network Collaboration and joint programs. It will define permitted uses, including either (i) use of both Parties' names or abbreviations in parity, and/or (ii) use of a mutually-agreed new name.

7. Network Collaboration Development

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The Network Collaboration will seek to develop a statewide network for effective payer contracting, and that is clinically and financially integrated to an appropriate extent so that it can achieve efficiencies. This will include hospitals, ambulatory care facilities, physician groups and other providers. To that end, the Parties, through the MSO Collaboration Council and after any required Member approvals, shall as soon as feasible after the effective date, seek to develop (a) best practices, (b) clinical pathways and guidelines, (c) cost of care targets, (d) hospital/physician alignment mechanisms and (e) data measures "dashboards" and compliance mechanisms to improve physician use of resources and adherence to quality protocols.

8. Term and Termination

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The Parties recognize that they are not likely to be successful unless they are committed to the long-run success of the Network Collaboration. Therefore, they agree that:

8.1 The term of the Collaboration Agreement shall be ten years, and it may be renewed by prior written agreement of the Parties.

8.2 The Collaboration Agreement may be terminated only:

(2.1.a) By mutual written agreement of the Parties;

(2.1.b) Due to a ruling by a court of competent jurisdiction, which ruling is not then under appeal, that the operation of the Network Collaboration as provided herein is materially unlawful, and the Parties have been unable after a period of at least 60 days of good faith negotiation, to reform the Collaboration Agreement so as to overcome such illegality;

(2.1.c) By a Party due to failure of the other Party to contribute capital to the MSO as required by the Collaboration Agreement and vote of the MSO Collaboration Council, and such arrearage exceeds [$2 million] for more than 90 days;

(2.1.d) For material breach by a Party which is not cured for [60] days after written notice, but only if such breach exposes the non-breaching Party to material liability or impairment of reputation and such matter has not been resolved by the Dispute Resolution process set forth herein; or

(2.1.e) By a Party for loss of Joint Commission accreditation of Medicare or Medicaid participation by the other Party, which remains uncured for more than [90 days].

In the event of termination, the Parties will agree on a formal and effective transition process of not less than 180 days, to resolve prior liabilities, and transfer operations in a manner that avoids harm to each Party and its missions and constituencies (including students and residents).

9. **Legal Provisions**

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Customary legal provisions will be included in the Collaboration Agreement on such matters as mutual access to information, coordination in defense of claims, responsibilities for liability, amendment of the Agreement, etc.

Related Documents To Be Developed:

Exhibit 2.1	-	Shared Support Services
Section 2.6	-	Academic Affiliation Agreement
Exhibit 4.2	-	Network Services
Exhibit 5.2	-	Planned Joint Programs
Section 6	-	Brand Architecture and Reciprocal Trademark License Agreement