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Medical-Legal Partnerships in Smaller Communities- Symposium Panel

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THE LEGAL ROLE IN BUILDING SUSTAINABLE PUBLIC HEALTH

MEDICAL-LEGAL PARTNERSHIPS IN SMALLER COMMUNITIES

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Moderated by Hailey Janeway, Associate, Waller, Lansden, Dortch, & Davis

[edited for reading]

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Lauren Caverly-Pratt: Time for our first attorney panel of the day. On this panel, we have Doug Mefford, who is Managing Counsel of Healthcare Transactions at Vanderbilt University Medical Center; Charleyn Reviere, who is the Chief Legal Counsel at West Tennessee Healthcare; and David Clay, who is at Waller, Lansden, Dortch & Davis.

This panel will be moderated by Hailey Janeway, a proud alumnus of Belmont University College of Law. Hailey was on Law Review here, and she was also a member of the Health Law Transactional Moot Court team. She is an associate also at Waller, Lansden, Dortch & Davis in the corporate group where she focuses on mergers and acquisitions and other transactional work in the healthcare space.

With that, Hailey, it is good to see you. I am going to hand the reins over to you.

Hailey Janeway: Thank you. Alrighty. I think we will start with just letting each panelist introduce themselves and share a little bit about their background. So, if Doug Mefford wants to start.

Doug Mefford: Sure, I'd be glad to. Good morning, everybody. Thanks for the opportunity to be with you today. I am managing counsel at Vanderbilt University Medical Center. I've been at Vanderbilt since late 2013. My work is focused primarily on the transactional work that Vanderbilt is engaged in pretty much constantly. Prior to that, I was general counsel at a hospitalist provider company in Brentwood, and part of that I was with community health systems representing community hospitals in the western United States for several years. I started my career with a law firm here in Nashville, Bass, Berry, and Sims where I did corporate securities work for them. Most of my career has been in the healthcare sector from the transactional perspective. I tell folks I'm a corporate lawyer in a healthcare environment.

Hailey Janeway: Alright, Charleyn if you want to go next.

Charleyn Reviere: Good morning. First of all, I would like to say there is some construction going on behind me, so if you hear … and banging, that is what that is. I am general counsel for West Tennessee Healthcare. We are a large multisystem facility here in West Tennessee and have an 18-county service area. We are a nonprofit health system, so we take everyone regardless of their ability to pay. We have seven hospitals, a mental health facility, multiple physician clinics, you name it we do it in this area.

My background - I've been here for 17 years. Before that, I was in private practice. Between there I took twelve years off to raise my kids. I'm not sure which of those three has been the most challenging, but right now, I'm going to say it's been working in the hospital setting. I will say that for any of you who are in or are considering an in house career, do not make the naïve mistake that I did when I came here 17 years ago. I thought, this will be a narrow specialty, I will be able to just do healthcare, not really knowing what that meant, but I will be able to specialize. Then you come to work for a hospital, and it is like running a small town. You have, we have 7,200 employees, we have vehicles that go out and run into awning at the bank, we have ambulances that run off in ditches, we have malpractice cases, we have patients that fight in the hallway, and people who slip and fall, and then of course we have a multitude of compliance regulatory concerns that any healthcare institution has.

It is an interesting job; it is never dull. I am happy to be here throughout the day to talk about rural healthcare because that is vitally important in our area.

Hailey Janeway: Thank you. David, if you want to share.

David Clay: Yeah, David Clay here. Started my career at Waller in 2004 and have been here the whole time. I've been involved in healthcare transactions and healthcare securities work the entire time. Primarily I represent for-profit healthcare systems that are making investments in rural communities or smaller communities, whether through acquisitions, in and out of the market, partnerships, maybe a little bit about that and come at this more solely from an outside counsel perspective. I have not been in house in the healthcare system. When the time is right, I can talk about what I've seen from some of the for-profit players and look at those investments in communities.

I am happy to be here and enjoy working with Hailey, too. We get to work on some things together, and I am glad I get to be on this panel with her today.

Hailey Janeway: Thank you. Alright, so I don't think this has to be extremely structured. I know we have a list of questions that we can bounce around or go off the script if any of you have anything that you really want to talk about. I think I will just get started with the top of our list if that's alright with everyone. These questions are focused on the urban versus rural idea here. Number one, how does

merging with other healthcare providers contribute to a more sustainable public health system generally?
Anyone can jump in.

Doug Mefford: Okay, I'll jump in first. Let me say a bit of legalese, I am counsel for Vanderbilt University Medical Center, but I don't represent them in this context. My opinions and views are not attributable to them.

One thing I would point out initially is that consolidation, for consolidation sake, is not necessarily something that is going to make public healthcare more sustainable. I mean, there is a place for competition and diversification. But in the right combinations, there are a number of benefits to be achieved. You've got potentially, and hopefully, some kind of scale of cost reduction. In days past, that might have also included staffing reductions, but I don't think there are many hospitals out there anymore who would say they'd look at merger opportunities as a staff reduction opportunity. We are all desperately seeking additional staff for all of our facilities.

Certainly better bargaining positions with commercial payers, better access to capital for larger institutions for a number of the initiatives that hospitals just have to make these days in order to keep up.

Theoretically, you get better and more successful clinical recruitment. If you have a better and larger, more stable organization, that's attractive clinicians who are looking to move into a particular market or consider an offer from a healthcare provider.

Lastly, and probably most importantly, hopefully the transaction will translate into better quality of care for the patients and for that organization. That ultimately is the bottom line. All of the things that those of us in administration do are really worthless except to the extent that they translate into better bedside care for the patient. That's where the real work gets done. That should ultimately be the high objective in mergers and acquisitions that we do in the healthcare sector.

Hailey Janeway: Great. Anyone else have anything else to add?

David Clay: Yeah, I think all that Doug had said is exactly right. Of course, you're seeing a lot of government oversight in this area from an antitrust perspective. The government is not very keen on mergers and acquisitions in the healthcare space right now, maybe

not taking such a favorable view that they're going to improve access or healthcare, they have a very, maybe, skeptical view of the mergers and acquisitions that are occurring. That's one of the reasons why you're seeing fewer mergers right now that I think are what we'd call horizontal or system-to-system kind of things. I think you're seeing more acquisitions that are vertical in nature, and systems are trying to improve their continuum of care in the healthcare spectrum.

At the end of the day, I think it's access to capital that's a critical component. When I see our for-profit systems trying to get involved in local communities, usually the community is in the position that they don't have the capital or the operating revenue to keep the services that they want in the community. The for-profit system is able to provide something a little different in that regard.

Hailey Janeway: Makes sense. The next question we have is very much related to the first, but that is, what qualities in the mergers and acquisitions setting are very distinct in the rural setting versus the urban setting?

And then, follow up on that, are there any defining characteristics of the partnership between the two on paper on legal practice as opposed to other types of mergers?

Charleyn Reviere: I'd be happy to talk about that one. We've found that rural communities each have their own personalities. When you come into one, you need to be aware of that and use an individualized approach when working with those people.

I'll tell you a funny story. We have a small hospital in a county around here, and we were looking to consolidate three hospitals in a small county so that we could provide better service through one hospital. The people in the community were unhappy about one being closed, not because they utilized it, but because we were closing the cafeteria. No one cared about the hospital, but they were very, very upset about the cafeteria. So, once we figured that out, we offered to extend/expand the cafeteria services at the consolidated facility, and everyone was happy.

But, you do have to go in there and talk about what their community needs are and match those to the services that they will use. We use local advisory boards and retain those local advisory boards for those hospitals, because those are the people that live in that community area and are in touch with it.

We do have the ability to provide obviously some streamlined operations, policies, and compliance programs. We do find that in a smaller hospital, like in our main flagship hospital, we have a risk manager. But in our smaller hospital, we might have one person who wears that hat along with they are also HR Director and also managing all of the insurance and several other things. So we can bring that expertise to them and allow that person to continue to function in that role.

We want the rural community to have a sense of ownership of their facility while recognizing the benefits of the bigger operations.

Doug Mefford: Yeah, I would second the comments about the unique nature of rural hospitals and communities in which they operate. There is just a significant political overlay when you're doing a transaction with a rural community hospital.

Hospitals, community hospitals, rural hospitals, they represent a real sense of community pride for the locale. It's often one of the largest employers. It often is sort of a symbol of the strength and vitality of the community. Business leaders are often on their boards. It becomes a real, much more emotional and political issue for rural hospitals than you might find in some urban settings.

I think also the influence of the medical staff in keeping community hospital transactions is quite significant, probably more so than in urban hospital transactions just because they do have much more sway and control over how that hospital operates. They are very protective, rightly so, of their medical staff, and the providers that are given privileges at those hospitals… you really have to deal with all of those contingencies in a way that, maybe not quite so much in an urban environment.

I think one thing that has changed over time though, in those transactions, is that years and years ago, it might be much more common for a rural hospital to have much less sophisticated legal representation in their transaction than I think exists today. Even rural hospitals now have gotten much more sophisticated in how they approach these transactions and the representation that they secure to represent them in the transactions. It's not at all more so of the David and Goliath transaction that it maybe once was.

David Clay: I agree with Doug and Charleyn on that, and I was looking and thinking, all of the things that were mentioned are items

that get rattled off when you start the conversation with a local community hospital that is looking to acquire. It has questions about what investments are we going to make in the community, and what continuing over – you know there are covenants in your agreement about hospital operations that you're going to continue because the community wants to know you're not going to step in and just change everything, unless that's the deal.

You mention that local boards of trustees get set up, and so local community leaders' promises are made about how those are going to be structured and set up.

Indigent care policies – that you're going to keep the same indigent care policies in place or that you're going to convince them that your existing policies are strong, good. Those are all things that I think are very unique to rural areas, maybe a little bit different than the urban setting. Maybe there's not as much of a community affiliation to the hospital because of the urban nature.

But, the parallel I think between the two, and this is maybe only if you're dealing with your, maybe a county owned kind of hospital, or maybe a single not-for-profit that owns a facility route than something that's system based. All of those, whether in a rural or urban setting, you really get into interesting compliance issues when you start doing the due diligence because the compliance function for a single facility is just a little bit different than something that is within a system.

So even when they get sophisticated counsel, I agree with Doug on that, you're seeing that the due diligence ends up being kind of interesting, and there's a parallel I think even between rural and urban when you're looking at just a single facility where the compliance, as you get into diligence, may result in some voluntary self-disclosures and other things that a buyer is going to want to do. That's a parallel I see between urban and rural when you're talking about your smaller hospital settings rather than something that is a system and has a lot of support.

Hailey Janeway: Moving on to the next one, maybe we've touched on this a bit. Have you seen the urban and rural hospital groups doing anything to initiate a system in smaller communities, or what does that look like in your experience?

Doug Mefford: I'm happy to lead off on that one. In Vanderbilt's case, and I think in the case of many large urban hospital systems, there are a number of things that we are trying to do, and systems

are trying to do generally to bolster the care provided in regional and smaller community hospitals.

The real thrust of that is sometimes misunderstood in ways. Assistance provided from a large academic medical center, in Vanderbilt's case, for example, can sometimes be viewed with a bit of skepticism when we start to initiate activities in local communities because it's viewed sometimes as, oh here they come, trying to pull all the patients out of the community and drag them back to the mothership in Nashville. Frankly, that couldn't be further from the truth. We enjoy the benefit of being overcrowded all the time, so our objective really is to try to ensure that the right patient's in the right location, and that we are doing what we can to bolster the services in smaller communities so that patients will be comfortable staying there and so that we can provide additional resources there that perhaps the hospital hadn't had before.

A couple of the ways we do that specifically are, we developed I think ten years ago this year, the Vanderbilt Health Affiliated Network,[1] which is a clinically and financially integrated network of providers around not just Tennessee but surrounding states that help bring best practices to the network members. They are able to do some joint contracting together, and provide [group purchasing organization] services to some of the smaller hospitals to bolster their supply chain operations and reduce their cost… we try to have some alignment on clinic establishment in local communities where we could form clinics that would be complementary to the services that the local hospital has in place. In the prior presentation, telemedicine was a big topic. I think telemedicine is one of the most prolific and fastest growing service lines that larger systems can implement in smaller communities, and that's here to stay. I think early on there were some questions about if it would be long term accepted by payers, and clearly now I think the answer to that is yes. It has proven its effectiveness through the pandemic.

Lastly, there are the traditional professional services agreements, where larger hospitals may contract with smaller facilities that provide specialists or physician coverage in various respects. So, all of those are just some examples of the way that I think larger systems try to invest and partner with smaller community hospitals.

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[1] VANDERBILT HEALTH AFFILIATED NETWORK, https://www.vhan.com/ (last visited March 20, 2023).

Charleyn Reviere: Everything you said is the same thing we're experiencing. We, at one point during the pandemic, had the dubious honor of the most COVID patients in the state in our hospital. We had hospitals calling us from other states trying to transfer patients here, so I think everyone was in that same boat. But as part of that, and as an overall practice, we've established a regional transfer center, so that patients, so that we can see the beds that are available in facilities all around the west Tennessee area. The goal would be that if the patient lives in a county two counties away, if we can find a bed for them and provide the appropriate level of care in that community hospital, we want to do that for them. It's better for the patient, better for the family… And we're like you - we had the honor of being packed to the gills every day. So, to the extent that we can make quality care at the appropriate acuity level available to people in their own communities, that's what we want to be able to do.

We have established hospital call programs at all of our community hospitals so that the days when the physician came to the hospital to see the patient, we've seen a lot of that go away. Most family practices don't take calls at the hospital anymore. The hospital is practiced in the hospital, and that relationship exists where the family practice doctor refers the patient to the hospitals, and the hospitals take care of them during their acute stay, and then refers them back out to their family care provider.

Some of the things we've done to help that and facilitate that is that we are making sure that every patient, when they leave the facility, they have a follow up appointment with their primary care provider. If they don't have a primary care provider, we help them establish a relationship with someone.

Because we are nonprofit, we see a huge number of indigents, Medicare, Medicaid, TennCare patients here. We do run into some issues with private clinics not necessarily wanting to take those patients and have them be part of their practice. We have built up our own primary care practices so that we would have the ability to provide care.

Hailey Janeway: Thank you. I think just moving along, if anybody has anything they want to highlight, let me know. I'll kind of move into the more rural issues after this one. It would be interesting to know how large-scale mergers and acquisitions with other providers have impacted the urban providers of patient care and the rural providers of patient care.

Charleyn Reviere: It has increased the referrals back and forth, they have improved. Having those primary care rural providers aware of the specialists that are available at the flagship hospital, where often the rural community doesn't usually have the sub-specialists present. So being able to bounce those patients back and forth has been a good thing I think for both.

Doug Mefford: Yeah, I think when we talk about patient care you really have it sort of break that down to say what do you mean when you say patient care, and sort of in my mind, that's really at least three elements: it's certainly the quality of care, but it's also access, and it's also cost. All of those are impacted particularly through large scale system mergers.

David can probably speak better to some of the large system merger transactions that he's worked on. I think you may get different answers to that question depending on what contingency you're talking to. Physicians versus patients versus payers may have different perspectives on how mergers impacted patient care.

For large mergers, physicians may feel they have more autonomy perhaps than they may used to have in decision making. They may be feeling like they're more subject to corporate policy and directives than they were before. Patients might feel like there are more restrictions on their access to care. You hope, and we can talk about cost later, I think that's on the list, but the hope was that consolidation would bring lower patient cost. That was part of the Affordable Care Act, one of its objectives. I'm not sure that's proven to be the case.

But the success of the merger can have a big impact on a number of areas: systems integration, human integration, leadership alignment… All of those things play into whether or not a merger is successful and how that merger is then going to play out in terms of the patient care that is provided.

David Clay: Yeah, I don't know if I have much more to add to what Doug said there. Partly because, one of the interesting things you all will discover too, is that outside counsel – we help get a transaction done, and what it looks like operationally after that, I'm not going to get to see how it plays out.

Certainly, every one of my clients will expect that they're doing this transaction because they think it is going to be beneficial to the community and that it will improve patient care better, but doing the transaction and completing the merger is one thing.

Integrating it, getting the operations folks on board, and actually implementing your transaction is a different thing once the deal is closed.

Doug Mefford: Yeah, so I'll take that opening to just say one more thing about integration because I'm sort of passionate about that. Integration is just huge in terms of whether or not a transaction and a merger or an acquisition was successful across the metrics that you might use to ascribe success. Integration of these transactions really starts way before closing. It starts in the evaluation of whether or not you're going to do a transaction. There's so many things you have to think about in terms of philosophy toward patient care, philosophy toward indigent care, philosophy toward physician leadership, philosophy towards staffing. All of those things really have to be aligned on the front end between the two organizations particularly more in a merger of more equals.

Even on a true sort of winner – loser type acquisition where one system is getting consumed by another, for example, the winner or the buyer in that case has really got to be prepared to take the steps necessary to achieve that post-closing integration. If that doesn't happen, it ends up being worse for both organizations than if you had not done the merger or the acquisition at all.

Hailey Janeway: I think we have an audience question. This is coming from an attorney nurse who wants to know, how does the lack of Medicaid expansion in TN play into the issues we are discussing? Multiple rural hospitals are closing due to the lack of Medicaid coverage.

Doug Mefford: Well, I think there's probably not much question that the fact that there has not been Medicaid expansion in Tennessee has negatively impacted particularly smaller, rural providers in this state. The opportunity to provide them with more resources that would naturally occur because the reality is many of those hospitals do have a higher degree and a reliance on government beneficiary patients for their operations. The simple answer from my view of the world is, yeah, it has negatively impacted community providers to not have Medicaid expansion.

Charleyn Reviere: Yes, we've seen that play out in our system. We still provide them provide services; we just don't receive the reimbursement.

Hailey Janeway: Alright I think we can move into more specific rural issues. The first question would be, how can we attract a higher

volume of quality providers to smaller communities? And what do these kinds of partnerships and systems look like?

Charleyn Reviere: I can take that. We, in our hospital, we have a very active physician recruiting department. Part of what they focus on with physicians coming out of training today, is we find that they are very focused on the quality of life and work life balance.

In a smaller community, a smaller community can offer that in a way that larger communities can't sometimes. More time with family versus commuting in traffic, more opportunity to be involved in schools and also lower cost of living for a med student coming out with a lot of debt can be attractive. We have added with that some things that our keynote speaker mentioned. Our physicians can get public service loan forgiveness when working for us because of our status. So that's potentially a factor, too.

We don't find that any providers these days really want to come out of school and take on the risk of setting up their own practice. Employment does seem to be the model right now. We are also working toward establishing a rural track program through some expansion and residency funding. So, [University of Tennessee at] Martin ("UT Martin") is in our service area, and we have a family practice residency, a UT family practice residency that's centered here in Jackson. What we are looking at doing is having those residents come to Jackson for year one of that three year residency, and moving to UT Martin to complete years 2 and 3. Those years, we find, are generally the years in which they are getting married, starting a family, starting to put down roots, and the thought is if they can complete those 2 years of residency in that rural area, they might decide to remain there. So we're in the process of working with … to get that approved. We hope that will be something that will help providers move towards those areas.

Of course, we offer traditional recruiting incentives too, like loan repayment, sign on bonuses, we try to be competitive with those in those areas.

Hailey Janeway: Alright, something else that's interesting to think about is what kind of compliance issues do rural hospitals face the most? How are those different from urban hospital compliance issues?

Doug Mefford: David, do you want to jump in on that one?

David Clay: Yeah, I can. I don't know how you would characterize what they face the most, and some of that is for every transaction you look at - and I'm coming at this from more of a diligence standpoint, and I'm not a healthcare regulatory specialist, I've got colleagues that do sort of the fraud and kickback and Stark analysis,[2] but - that is what I think we would typically see, is that you've got a lot of things going on within smaller community hospitals that maybe don't have, and we mentioned before that, they're hiring more sophisticated counsel: a lot of times that's for the transaction that they maybe have not have sophisticated counsel day to day.

You're typically seeing Stark law compliance issues when it comes to, are agreements in writing? And how is compensation set up with the physicians? Things like that that are not intentional, they're just missteps and unfortunately Stark is a strict liability issue and is not intent-based, and so it results in a lot of items that get flagged.

Often you can come up with ways to build a, take a holistically, say oh yes this is compliant, maybe with pay stubs and other things. In other cases, you're going to end up having self-disclosure. Sometimes that is certainly going to be scary to a local system, but it's also very, very common.

Since the Affordable Care Act,[3] and sort of the CMS voluntary self-disclosure regimen, the settlements on those are very reasonable and it's really a way for a buyer to get a clean start on a facility, rather than having ongoing compliance issues.

I don't know if Doug or Charleyn have different thoughts on that. I don't know that I see different compliance issues between a rural or urban facility either.

Doug Mefford: Yeah, I agree with that. And to your point on Stark issues, I think that Stark issues, physician relationships, generally between physicians and hospitals, I think tend to crop up more just because you might have a much lower percentage of your medical staff as being employed by the hospital in a rural community and so anytime you're dealing with independent physician groups you've got a heightened Stark risk, and even for employee positions, the whole commercial reasonableness focus on compensation that didn't use to be as much in the limelight has certainly taken on a higher focus than it has in the past. Then you've just got the issues of fair

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[2] Stark Act, 42 U.S.C. § 1395nn (1989).

[3] The Patient Protection and Affordable Care Act, Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

market value and payment of subsidies in some cases that small community hospitals have to pay in order to obtain fundamental services that they need to operate which don't exist as frequently in an urban environment.

Hailey Janeway: What do you perceive as the biggest problems facing rural communities in terms of healthcare outcomes?

Charleyn Reviere: I would say a lot of the things that Mary, the keynote speaker, mentioned and what we see here: access to care. One of the things that we've done that has been somewhat effective is, we used, since we are the destination hospital for all of these counties around us, we have used deidentified data from our patients' demographic data to determine if we have pockets of particular health issues in communities. For example, we had a community two counties over where we noticed we were getting a lot of patients who had uncontrolled diabetes that wasn't being controlled in any way. We were able to reach out to the providers there in that area and provide resources, education, put on a few clinics with the community, just to talk about how to manage diabetes and what supplies were available and make those available where we could. A couple of pharmacies partnered with us in that, so trying to do some targeted outreach like that for specific health conditions has had some positive effect. But that's one of the ways that we kind of impact that.

Doug Mefford: Yeah, I think recently now that Vanderbilt has gotten into acquiring a couple of smaller hospitals, one of the things we're seeing and we're hearing, certainly anecdotally, is as I mentioned earlier: staffing. It's just an issue for most all hospitals these days, and the ability to have adequate, particularly nursing, staff to provide the kind of care that you really want to provide for patients is a challenge. I have to think that's more acute even in smaller environments. The opioid crisis for small rural communities is a huge issue that just the degree of the number of patients that come through with drug related issues oftentimes perhaps uninsured patients it's just a real problem that small community hospitals struggle with I know on a day-to-day basis. Then last, I would just offer the lack of behavioral health services and psychiatric beds can be a real big challenge for smaller community hospitals, particularly, and that's largely in connection with the opioid crisis and drug issues and so forth. But just not having enough places to send patients who need that specialized care, I think it's going to, it continues to be a real challenge.

Hailey Janeway: And speaking to the staffing issues that people addressed, one of the issues addressed in Belmont's healthcare business and finance class is the necessity to maintain fair market value salaries and compensation for health care providers to maintain a tax-exempt status. How is this impacted your operations in a rural setting where there tend to be less providers?

Charleyn Reviere: From our standpoint, obviously, it's what David touched on earlier, it's Stark and Anti-Kickback.[4] It's not just the tax exempt, its Stark and anti-kickback rules as well that require us to pay fair market value to physicians that we obviously have to stay within that and sometimes we've found that to be a challenge. A market, you might not have anything comparable in the market to pay a specialist a certain number of dollars to go there, and yet we need that specialist to be there to provide care, so we have some other ways of looking at that to justify it. And given the need, we have a good community needs assessment that tells us the age of the physician population in the area, the number of patients they're carrying, the wait times for appointments and all those things help us justify rates that help us attract physicians to those communities, but sometimes even with all that we can't, we're not successful. With those limitations, I wish there was some more flexibility on those would be great.

Hailey Janeway: We have time for one last question, but you can wrap this up…

David Clay: Well, I was going to say when I saw that, when I saw that question my first thought was, I don't know if there was a difference between for profit and not for profit when it came to fair market value and other things, but I think that's a key issue for anybody. And then one thing I did think about from that nonprofit standpoint, it's not exactly on point for that question, but maybe along the lines; when you are doing an acquisition, for instance, maybe a for profit is acquiring a local hospital that has been a not-for-profit facility it's often going to implicate conversion statutes within the state. So, you're going to have to be able to show, that facility has to show as a not for profit to the attorney general, the state attorney general, hey this transaction is fair, the price being paid is fair market value, there's a reason why we're doing this deal and you're going to actually have to get approval from the state [attorney general] in order for the transaction to go through. That is something that is different when you're doing a transaction with a not for profit versus a for profit to for profit transaction, and in fact

[4] Anti-Kickback Statute (Anti-Kickback Statute), 42 U.S.C. § 1320a-7b (1994).

that gets implicated even when you're doing a long-term lease arrangement or something else that's not a pure acquisition.

Doug Mefford: So, I'll just offer it on the compensation fair market value front. Fair market value as an issue generally has spawned, not even a cottage industry, but an entire stable industry I think, of fair market value consultants who are working diligently to help facilities justify and validate prices they're paying, comp. they're paying, and so forth. It's evolved way beyond just saying well where do we follow the [Medical Group Management Association] scale[5] or the SullivanCotter scale,[6] right, I mean that's Charleyn's point, there are a lot of other factors that have to get factored into it these days.

Hailey Janeway: Alright Lauren, do we want to ask one more question or is that time for us?

Lauren Caverly-Pratt: I think we have time for one more question.

Hailey Janeway: OK, I have one for Charleyn, specifically, if she wants to close us out. As the leader of an entirely nonprofit hospital system, has the shift to value-based care driven the need to merge with other providers in your localities?

Charleyn Reviere: It has, it has led to the need to expand our primary care base and to create partnerships with [inaudible]. Value based care obviously goes beyond the walls of the hospital, so you're looking at the continuing care to that patient to reduce the admission rates and make sure that they have a positive health outcome, and so we've had to expand primary care significantly over the past several years to work towards that. Where sometimes our private clinics are not able to take on some of these patients, we also have a [federally qualified health center ("FQHC")] here in this community that we supported to help facilitate some of that that continuation of care. Telehealth has been a great help with that as it expands. I think telehealth will help us stay more in touch with patients and monitor them. We did a lot of remote monitoring during COVID which is great. We could send patients home, monitor them remotely so they didn't have to stay in the hospital, but yes, it's definitely going to lead to the need to not necessarily merge with other providers but at the very least establish partnerships and relationships with them that allow us to share data and work together to achieve positive outcomes.

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[5] MEDICAL GROUP MANAGEMENT ASSOCIATION (MGMA), https://www.mgma.com/ (last visited March 20, 2023).

[6] SULLIVANCOTTER, https://sullivancotter.com/ (last visited March 20, 2023).

Hailey Janeway: Thank you and I think that's time if Lauren wants to close us out.

Lauren Caverly-Pratt: Yes, thank you, thank you, thank you. Thank you so much David, Charleyn, Doug, and Hailey, it's been so great to have you here and all of your insights and thank you for sharing everything from your personal experiences.