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After the Handshake: Physician Integration in Academic Medical Center Mergers

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Becca Waltuch, Holland & Knight LLP | **Rudd Kierstead**, VMG Health |
Jeanna Gunville, Morgan Lewis & Bockius LLP | **Robert Hess**, Husch Blackwell LLP |
Jon DeBardeleben, University of Florida Health Corporation |
Allison Cohen, Baker Donelson Bearman Caldwell & Berkowitz PC | **Nili Yolin**, Holland & Knight LLP |
McKenna Cloud, Baker Donelson Bearman Caldwell & Berkowitz PC



It is often said that after a merger, the merger has only just begun. The concerns, opportunities, and priorities identified during due diligence do not go away once the transaction closes. Rather, as the parties begin building the envisioned academic medical center (AMC) together, the issues identified

come back to the table with a need for meaningful action, often revealing new challenges and opportunities. A companion article in this series [1] addressed the legal and regulatory considerations that arise during the negotiation and structuring of AMC-community hospital affiliations, including antitrust compliance, fraud and abuse structuring, and governance design. This article picks up where that analysis leaves off, focusing on the practical work of post-closing physician integration. Successful integration requires aligning physicians' clinical and operational priorities while establishing the governance, infrastructure, and incentives necessary to support long-term success. This article focuses on three priority areas for physician integration: governance, credentialing, and system revenue and compensation.

Part I: Who's in Charge

Structural Divergence: Who Employs the Physicians?

Perhaps the most fundamental challenge in an AMC merger is reconciling different physician organizational structures under a unified governance framework. One legacy system may have employed physicians directly through the hospital, while the other housed them in an independent faculty practice plan, a tax-exempt medical foundation, or a physician-owned professional corporation. These structures reflect distinct philosophies about the physician-hospital relationship. Direct employment potentially maximizes institutional control but may dampen entrepreneurial incentives and the sense of independence that many physicians value. Indeed, bringing together legacy structures can sometimes trigger a defensive or retrenchment mindset among physicians who may prefer the familiarity of the status quo over the uncertainty of change. Thoughtfully establishing leadership to align interests and engage stakeholders is often a critical early priority.

Foundation and practice plan models preserve greater physician autonomy and often tie compensation more directly to practice performance, but they create governance complexity when the physicians who generate clinical revenue sit in a legally separate entity from the hospital that depends on that revenue. The structural question facing the parties is whether to absorb one model into the other, create an entirely new unified structure, or maintain parallel arrangements under coordinated oversight. Each path carries significant implications for physician tax treatment, benefit eligibility, malpractice coverage, and the degree of physician voice. However, the preferred outcome for institutional decision making depends heavily on the existing clinical and administrative cultures, clinical gaps and opportunities, and financial imperatives—there is no one–size-fits-all checklist.

Decision-Making Authority: Whose Voice Counts?

Beyond organizational structure lies the question of governance voice: who participates in strategic and operational decisions, and through what mechanisms? A faculty practice plan may have granted physicians board control with reserved powers over compensation methodology and clinical program decisions. A hospital, by contrast, may operate under traditional hierarchical governance, with employed physicians executing policy rather than setting it. AMCs add further complexity, as faculty governance traditions, departmental structures, and the authority of chairs and division chiefs must be woven into any unified governance framework. These differences can create friction during integration. Physicians from one legacy entity may perceive themselves as having been demoted or as having lost

certain authority and voice they previously exercised. Others may be unaccustomed to the more collaborative, and sometimes slower, decision-making that shared governance requires. For example, physicians in a smaller community setting may be accustomed to direct access to the CEO. In other circumstances, physicians integrated into provider-based departments or remote locations may have to accept changes to reporting relationships to satisfy clinical integration requirements set forth in regulation. Depending on the reorganization, access to department leaders and reporting relationships may change significantly. A thoughtful rebalancing of physician voice, leadership roles, and the skills needed to ensure physicians remain engaged is often essential.

Practical solutions include establishing a physician advisory council with defined escalation rights, creating a reserved powers matrix that specifies which decisions require physician supermajority approval, and appointing representative leadership from both legacy systems to key committees. Addressing the cultural dimension of governance—not merely the legal structure—early in the process can prevent friction that otherwise surfaces months after closing.

Reconciling Governance Documents: Whose Bylaws, Rules, and Regulations Survive?

The merger also requires reconciling the legal documents that formalize governance authority. Corporate bylaws, medical staff bylaws, and rules and regulations from each legacy system may reflect different approaches to board composition, quorum requirements, voting thresholds, officer roles, and the scope of reserved powers. This harmonization process demands substantive decisions about which governance protections survive and which are abandoned. For example, if one legacy entity granted physicians supermajority protection over compensation changes while the other vested that authority entirely in hospital leadership, the parties must decide whether to preserve, modify, or eliminate that protection—and communicate the rationale clearly to affected physicians.

Some mergers adopt transition governance provisions that preserve legacy protections for a defined period (often two to three years) before sunsetting into a unified structure, which can ease the perception that the transaction was an acquisition rather than a true merger of equals. This approach may also aid the transition of authority and the development of skills necessary to make new structures effective. Particular attention is needed where governance documents intersect with academic structures: faculty bylaws, departmental and residency program policies and procedures, and the role of chairs and deans may not map neatly onto corporate governance frameworks. Failure to address these intersections risks ambiguity about who holds authority over physician affairs, which can paralyze decision making precisely when the merged institution most needs to move decisively. A thoughtful transition plan—one that honors legacy commitments while charting a clear path toward unified governance—can make a significant difference in securing physician buy-in during the critical post-closing period.

Part II: Who Can Practice Where

Physician Qualifications: What Standards Apply?

With governance structures established, the next critical integration workstream is ensuring that physicians can practice across the combined system. This requires navigating credentialing standards, peer review protections, payer enrollment, and—for AMCs—residency program expansion. Each of these areas involves distinct regulatory and operational considerations.

While AMCs and community hospitals operate under common regulatory and accreditation frameworks for credentialing, each hospital develops its own standards for determining whether a physician is qualified for appointment to its medical staff and granting clinical privileges. These standards are embodied in medical staff governing documents, such as bylaws, rules, regulations, and policies, which are developed by the hospital and medical staff and evolve over time based upon the needs of the hospital and medical staff.

AMCs and community hospitals that come together through a merger or other transaction may discover significant differences in credentialing and privileging requirements set forth in their respective medical staff governing documents. For example, one hospital may require 50 completed cases of a particular procedure for privileges while the other requires 100, meaning a physician credentialed at one facility may not meet the threshold at the other. Prior to the transaction, medical staff governing documents of both hospitals should be carefully reviewed to identify any eligibility issues.

The parties should also review whether the medical staff is open or closed. An AMC's medical staff may be closed to non-faculty physicians, meaning community physicians may not be eligible to join and provide services at the AMC. Similarly, the parties should review hospital contracts with physician groups to determine if the community hospital has contracted with a physician group to be the exclusive provider of a service offered at the hospital. Hospitals commonly contract exclusively with a single group for hospital-based services such as emergency medicine, radiology, pathology, and anesthesiology, but they can have exclusive arrangements for additional specialty areas as well. If a hospital has a closed medical staff or exclusive agreements, physicians from the other system may not be able to obtain or exercise privileges at the hospital.

Creating uniform credentialing and privileging standards across multiple hospitals requires collaboration among chief medical officers, department service chiefs, credentials committees, and medical executive committees. The participating hospitals may consider creating a committee of medical staff leaders from each campus to develop uniform standards. If proposed changes require revisions to the medical staff bylaws' membership eligibility criteria, the bylaws often require approval by the full medical staff and governing board.

Uniform standards can create consistency in quality, safety, and operational efficiency, and facilitate the ability of physicians to obtain privileges at various system hospitals. However, hospitals should consider whether maintaining differences in criteria remains appropriate based on the communities served and the scope of services offered. Newly merged parties could consider developing a single application form for the various system hospitals and establishing a centralized credentialing office to serve as the hub for processing applications. The centralized office could receive and verify primary-source

information such as medical school graduation, dates and location of training, state licensure, and claims history for all applicants and then send the verified information on to the department chiefs and credentials committees at the individual hospitals, who would then review the applications and make recommendations to the hospital's medical executive committee. If permitted by applicable law and accreditation standards, hospitals could also consider delegating some credentialing review to a system-level committee, while maintaining confidentiality and peer review protections. The application should clearly disclose that information will be shared and obtain the physician's consent, and hospitals should confirm whether any laws restrict sharing particular information (e.g., National Practitioner Data Bank query responses may not be shared unless specific criteria are met).

Peer Review: How to Preserve Ongoing Protections?

If permitted by law and the medical staff governing documents, the hospitals could enter into an agreement that delineates the process for sharing information, sets forth limitations on how the information can be used and disclosed, and emphasizes the parties' intent to maintain confidentiality and applicable peer review protections. A medical staff application that obtains consent from physicians to share the information, and includes a waiver and release, can ease this process.

With respect to corrective actions, hospitals should consider whether a corrective action taken with respect to a physician's privileges at one hospital in a system should automatically apply to the physician's privileges at affiliated hospitals. If so, they will need to consider what due process, if any, should be made available at the affiliated hospitals and how that process would be reflected in the medical staff governing documents and applications.

Payer Enrollment: Must Physicians Be Re-Verified?

Whether physicians will need to be re-verified with payers depends on the payers and the structure of the merger transaction. For commercial payers, re-verification requirements will vary by payer, and each contract must be examined. Generally, if physicians will bill under a different tax identification number, some level of re-verification with commercial payers will likely be required. Even in situations where comprehensive re-verification is not required, the payers will likely require updates regarding contact information, new ownership, service locations, and other matters. With respect to Medicare, if physicians will bill under a different tax identification number, each physician will typically need to reassign the right to bill to the new entity, terminate the old reassignment, and update certain enrollment information. Even if the tax identification number and entity stay the same, updates to enrollment information may still be required. Hospitals should engage with the applicable Medicare Administrative Contractor early in the process to confirm requirements.

Beyond re-verification of individual physicians, the parties must analyze their respective commercial payer contracts to determine how each contract defines the entities and individuals authorized to bill for services. Payer contracts vary significantly in how they characterize participating entities—some contracts distinguish between "practitioners" (individual licensed providers) and "providers" (institutional entities such as group practices, facilities, or health systems), while others use terms such as "group providers," "contracted providers," or "represented providers" with contract-specific definitions that control who may render and bill for covered services. The distinction matters because

whether a newly acquired practice location, joint venture facility, or affiliated physician can bill under an existing payer contract often turns on whether the contract's participation definitions are broad enough to encompass the new arrangement or whether the contract limits participation to providers who are employed by, or owners of, the contracting entity. Because this analysis is contract-specific and fact-intensive, the parties should begin the payer contract review early in the integration planning process and ideally during due diligence. Any required amendments, credentialing applications, or enrollment updates can be initiated well in advance of the operational go-live date for newly integrated practice sites.

Residency Programs: How to Expand and Add New Training Sites?

A merger that brings community hospitals and affiliated practices into an AMC system frequently creates opportunities to expand residency training by establishing new clinical rotation sites at the acquired facilities. However, expanding residency programs and establishing new training sites raises important credentialing, supervisory, and regulatory considerations that the parties should address during integration planning. There should also be a comprehensive review of whether the proposed new sites have established a Medicare Graduate Medical Education (GME) Per Resident Amount (PRA) and caps for GME payment purposes. Careful planning is needed for any resident rotations to GME-naïve sites to ensure the AMC considers and protects those facilities' future eligibility for GME payments, including accounting for the costs that will establish the PRA and determining when to send residents in new residency programs to trigger the cap-building period. The parties should also ensure that pro formas accurately calculate anticipated Medicare GME payments from merged facilities, as misunderstandings often arise regarding the effects of caps, when residency rotations can count toward building new caps, and the implications of the community support and redistribution principle on training at affiliated ambulatory clinics and other non-hospital sites.

When community hospitals become new training sites, resident supervision requirements must be diligently addressed. Accreditation Council for Graduate Medical Education (ACGME) accreditation standards require residents to be supervised at all training sites by qualified faculty, with the level of supervision—direct, indirect, or oversight—appropriate to the resident's level of training and the complexity of the service. Community physicians who will supervise residents at new training sites must hold appropriate medical staff appointments and clinical privileges at those sites. The credentialing process for these supervising physicians should be coordinated with the residency program's requirements to ensure that supervisors meet both institutional privileging criteria and ACGME program-specific standards. Additionally, the general rule for teaching physicians billing Medicare for services performed with a resident is that the teaching physician must be present for key and critical portions of the service, making documentation of supervisory time essential for both accreditation and billing compliance. Community physicians who will work with residents should also be educated on supervision requirements and teaching physician billing rules.

Additional Credentialing Considerations; What Else Belongs on the Checklist?

Delegated credentialing arrangements, where one hospital in the system credentials physicians on behalf of affiliated hospitals, must comply with applicable state law, accreditation requirements, and payer conditions. The parties should verify that existing delegated credentialing agreements extend to the newly merged entities and that the scope of delegation is consistent with the standards of each accrediting body.

Transition planning should also address temporary privileges. Because the credentialing and privileging process can take several months, hospitals should consider whether their medical staff bylaws permit the grant of temporary privileges to physicians from the merging system during the integration period, subject to applicable accreditation and regulatory requirements. Ensuring continuity of patient access while credentialing processes are completed is particularly important for specialties where physician availability is limited. Finally, the parties should develop a realistic integration timeline that sequences credentialing, payer enrollment, peer review harmonization, and any needed residency program changes. Each of these workstreams has different lead times and interdependencies, and a coordinated project plan will help avoid gaps in physician coverage or billing capability during the transition.

Part III: Money Matters—Revenue and Pay

Funds Flow: Who Is Paid What, and When?

Beyond governance and credentialing, integrating community physicians into an AMC also requires careful attention to funds flow arrangements: the structured pathways through which revenue moves among legally distinct AMC components to sustain the combined enterprise. These arrangements define financial expectations among the integrated organizations, shape governance relationships, and create the legal structures that regulators will scrutinize. Funds flow mechanisms are also critical to realizing the programming and financial efficiencies that the pre-merger discussions envisioned. Whether the goal is to optimize sites of service, expand hospital or trainee sites, or build integrated service lines across business units, funds flow is both the glue and the grease that makes those visions possible.

Three streams of funds flow typically require attention:

General overhead and shared services. The community physicians will rely on AMC infrastructure—billing, compliance, IT, human resources, malpractice coverage, and facilities. The AMC must establish a defensible methodology for allocating those shared overhead costs to the community physicians.

Mission support. Strategic transfers of funds are likely to support services that are important to the overall mission of the AMC but are not self-funding—for example, support for primary care or underserved-community settings, or hospital-based programs and outreach that goes beyond the interests of the physician network. These transfers can represent remuneration flowing among entities that are in a referral relationship with one another, which requires diligent planning and attention to regulatory compliance.

Academic and teaching activities. Integration often brings community physicians into teaching roles such as supervising residents, expanding GME training sites, and supporting clinical education. The AMC must fund those activities through appropriate mechanisms that can include direct compensation adjustments, reduced productivity expectations, or financial transfers from the teaching hospital or medical school to the faculty practice plan.

A common point of discussion is the so-called "dean's tax" (or "mission support assessment" or "academic enrichment fund"). This is a formulaic withhold from physician clinical collections that is dedicated to supporting research, GME, and other academic mission components. When applied to a newly integrated group of community physicians, however, the dean's tax requires thoughtful calibration. Community physicians acquired to increase patient access and build scale may carry little or no academic obligation and subjecting them to the same assessment rate as research or teaching faculty physicians may be difficult to justify. AMCs should consider tiered assessment structures that reflect actual academic commitment.

Without effective funds flow, organizations may be forced to approve internal transactions on a case-by-case basis, often requiring general counsel intervention. Addressing these issues upfront with clear, prospective parameters can provide the organization with significant efficiency in managing internal financial arrangements. Any organizational framework for evaluating funds transfers should address legal compliance and consider the degree of legal and financial integration that the community physicians will retain.

Generally applicable health care laws still apply to the financial and compensation relationships that are created via an AMC merger transaction, but with some recognition that interrelated finances are necessary to achieve AMC objectives in ways that are different from other health care providers. Of particular note are four advisory opinions issued by the Department of Health and Human Services Office of Inspector General that have approved inter-component transfers in the AMC context, subject to safeguards. These opinions provide constructive guidance regarding the application of the federal Anti-Kickback Statute to financial relationships within an AMC. Furthermore, a Stark Law exception must also be identified for any financial relationship with a referring physician. The AMC exception and the employment, personal services, and fair market value exceptions are the most commonly relied-upon options in the integration context.

Compensation: How Do We Preserve Talent and Ensure Compliance?

Physician compensation can be among the most legally and politically sensitive areas in any merger. All physician pay—whether for clinical work, teaching, research, or administrative duties—must reflect fair market value (FMV) principles. Parties should consider whether new referral patterns will emerge post-merger and ensure that all physician compensation is within FMV to avoid regulatory scrutiny under the Anti-Kickback Statute and Stark Law. Based on this assessment, organizations may need to obtain fresh FMV opinions where pay structures are being harmonized or physicians will begin referring to previously unaffiliated facilities.

Merging different compensation methodologies presents its own challenges. The scope of services in employment agreements will also vary with respect to call coverage, administrative duties, and non-compete provisions, warranting systematic review to identify inconsistencies that could create

exposure or operational friction. For example, one legacy system may pay primarily based on productivity (work relative value units (wRVUs)) while another emphasizes base salary with quality incentives. Reconciling these models requires careful benchmarking, as maintaining unjustified or undocumented pay disparities for physicians doing similar work not only raises regulatory concern but will likely raise operational issues as physicians begin comparing notes. Geographic differences, such as rural community hospital versus urban AMC settings, may support different compensation levels, but the rationale should be developed and documented.

Transitioning compensation plans, depending on operational culture in the physician networks, can take many months, and sometimes years. New compensation plans typically result in some compensation winners and losers, and perceived distinctions between legacy physician groups—particularly between faculty and community physicians—can take time to iron out. Changing compensation plans is much more than a mathematical exercise; it requires clear guiding principles and an overall strategy. Compensation structures should be designed to translate strategic and operational priorities into meaningful incentives, with proposed approaches evaluated and tested before implementation. Physician input is important, but it is sometimes difficult to obtain consensus on "how much" and "when" in the compensation design process to engage physicians. A detailed plan to implement the new compensation model should consider not only changes at the group level but a plan to address changes to individual physician arrangements, which can create contracting challenges as terms are revised, and in many cases, negotiations renewed.

Academic missions add another layer of complexity. Physicians in AMCs typically split their time between clinical care, teaching, and research, and compensation for each component must independently satisfy FMV requirements. Unlike clinical productivity, which can be benchmarked against national wRVU data, teaching and research activities lack robust measures and market comparables—making compensation levels harder to defend if challenged and even harder to implement. Time documentation and a shared understanding of effort expectations are critical.

The need for effective funds flow and rationalized compensation across a diverse physician network should lead organizations to broadly and consistently capture how physicians allocate their effort across mission activities. Such tracking provides both a better foundation for compensation and funds flow compliance efforts and a shared language for day-to-day transactions and program shifts without the constant intervention and attributed delays from the general counsel's office. Paying above-market rates for nominal teaching duties, or failing to adjust compensation when academic responsibilities decrease, can create regulatory compliance exposure. Community physicians who supervise residents at new training sites present a particular challenge: they must be fairly compensated for their teaching time, but payments must be structured in a manner that does not tie compensation to referrals to the academic system, and the same timekeeping issues come into play where both the supervising physicians and residents need to track time for regulatory compliance. Written agreements specifying teaching responsibilities, hourly rates tied to supportable benchmarks, and consistent documentation of program and individual effort spent are essential to defending these arrangements. Consistent payment among business units (funds flow) and individuals (compensation) are also critical to ensuring consistent and fair payments for services across the system. While this does not mean all payments must be the same, it does mean that there must be a rationale that aligns with AMC system priorities and maintains shared rules of the road.

Conclusion

While closing is an important milestone that completes the transaction, it is only the beginning of the physician integration process. Successful integration in AMC mergers requires early planning, clear communication, and strong operational infrastructure. Rather than addressing governance, credentialing, and revenue and compensation issues one at a time as they arise, AMCs should develop clear frameworks and systems that anticipate these needs and provide consistent pathways for addressing them. Doing so can help preserve the strengths of legacy organizations while creating a more integrated system positioned to achieve the clinical, operational, and financial goals that drove the transaction in the first place.

Becca Waltuch, a Partner at Holland & Knight LLP, advises academic medical centers, hospitals, and health systems on complex transactional and regulatory matters, including physician practice acquisitions, joint ventures, and strategic affiliations. She brings in-house experience from a clinically integrated network and hospital system, offering practical insight into operational and contracting challenges. Ms. Waltuch is also the Vice Chair of the AHLA AMC and Teaching Hospital Practice Group, bringing her clients the most current resources available. Her work supports the integration and expansion of clinical and specialty service lines across a range of academic and research-driven programs.

Rudd Kierstead, based in New York City, is a Director for the Compensation Valuation division at VMG Health. Rudd brings 25 years of diverse experience in health care provider settings, with a particular focus on physician initiatives. His expertise includes enterprise performance improvement, medical staff planning, financial analysis, physician alignment, compensation planning, and fair market valuation projects. Rudd works extensively with academic medical centers, health systems, and community hospitals, advising on physician enterprise formation, unique arrangements with physicians, and the design and management of partnering ventures.

Jeanna Gunville is a Partner in the Chicago office of Morgan Lewis. Jeanna advises health systems, hospitals, academic medical centers, ambulatory surgery centers, post-acute care providers, physician and other provider organizations, and investors in healthcare companies on mergers and acquisitions, strategic partnerships and affiliations, joint ventures, provider alignment and clinical integration, cost-saving initiatives, governance, and a broad range of corporate and regulatory matters. Her experience across the health care industry enables her to provide practical, business-focused counsel tailored to her clients' objectives.

Robert Hess, Senior Counsel at Husch Blackwell LLP, advises academic medical centers, universities, and health care providers on transactional, regulatory, and strategic matters. Prior to rejoining Husch Blackwell, he was in-house counsel and health care practice group leader for a university's health

system and health schools for 12 years. Robert currently serves as a vice chair of the Academic Medical Centers and Teaching Hospitals practice group of the American Health Law Association. He is also a member of American College of Healthcare Executives, the Missouri Society of Health Care Attorneys, and the St. Louis Area Health Lawyers Association.

Jon DeBardeleben is a Vice President and Regional Chief Legal Officer with University of Florida Health Corporation where he focuses on regulatory, transactional, and operational health care matters.

Allison Cohen is a Shareholder in Baker Donelson's Washington, DC office. Her practice focuses on advising health care providers and suppliers with respect to Medicare reimbursement and regulatory issues, including those relating to graduate medical education payments, billing for inpatient and outpatient services, cost reporting issues, complying with provider-based rules, the 60-day Overpayment Rule, and the False Claims Act. Prior to joining Baker Donelson in 2020, Ms. Cohen practiced at another national law firm for five years. Before entering private practice Ms. Cohen served as a senior policy and regulatory specialist for the Association of American Medical Colleges (AAMC). Ms. Cohen received a B.A. in Public Policy from Duke University and a J.D. from University of Maryland School of Law.

Nili Yolin, a Partner in Holland & Knight's New York office, advises health care providers, including hospitals, home health agencies, assisted living facilities, community-based providers of behavioral health and social services, large and small physician practices, and emerging companies in connection with various health care transactional matters, including joint ventures, mergers and acquisitions, divestitures, and affiliations, primarily within New York's heavily regulated environment. With a deep understanding of the health care industry, Ms. Yolin oversees comprehensive diligence of target companies and offers practical, creative solutions that lead to successfully closed deals for her clients.

McKenna Cloud is an Associate in Baker Donelson's Jackson, MS, office and a member of the firm's Health Law Group, where she concentrates her practice on health care transactional and regulatory matters, including mergers and acquisitions, physician compensation and alignment structures, joint ventures, and federal and state health care regulatory compliance. She has represented academic medical centers, nonprofit health systems, hospitals, ambulatory surgery centers, organ procurement organizations, and physician-owned practices across all phases of complex transactions and regulatory compliance.

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*This Feature Article is brought to you by the **Academic Medical Centers and Teaching Hospitals Practice Group: Allison Cohen**, Baker Donelson Bearman Caldwell & Berkowitz PC (Chair); **Jon DeBardeleben**, University of Florida Health Corporation (Vice Chair); **Jeanna Gunville**, Morgan*

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1 *See Key Legal Issues in Academic Medical Center and Community Hospital Tie-Ups*, HEALTH L. CONNECTIONS (AM. H. L. ASS'N, Nov./Dec. 2025), https://www.americanhealthlaw.org/content-library/connections-magazine/2025/november-december-2025/key-legal-issues-in-academic-medical-center-and-co.

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1099 14th Street NW, Suite 925, Washington, DC 20005 | P. 202-833-1100
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