Northern Inyo Healthcare District

Board Meeting

Special Meeting - September 10, 2026

2025 Press Ganey Guardian of Excellence Award Winner

SOUTHERN MONO HEALTHCARE DISTRICT
JOINT MEETING WITH NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS SPECIAL MEETING AGENDA

NOTICE IS HEREBY GIVEN that the Board of Directors of Southern Mono Healthcare District and the Board of Directors of Northern Inyo Healthcare District will convene a special board meeting at the location and on the date and time set forth below.

In compliance with the Americans with Disabilities Act (ADA), if you need special assistance to attend this meeting via telephone, please contact the District Board Administrative Assistant at Mammoth Hospital by telephoning 760.924.4114. Prompt notification prior to the meeting will enable the district to make reasonable arrangements to assist with accessibility to this meeting.

TO CONNECT VIA ZOOM: (A link is also available on the NIHD Website)
https://us06web.zoom.us/s/86114057527
Webinar ID: 861 1405 7527
Passcode: 898843

PHONE CONNECTION:
(669) 444-9171
(719) 359-4580
Webinar ID: 861 1405 7527

Date: September 10, 2026

Time: 12:15 pm

Place: Northern Inyo Healthcare District Annex and Zoom
2957 Birch Street
Bishop, CA 93514

I. CALL TO ORDER

II. PLEDGE ALLEGIANCE TO THE FLAG
A. READING OF THE NIHD MISSION, VISION, AND VALUES
B. READING OF THE SMHD MISSION, VISION, AND VALUES

III. PUBLIC COMMENTS

IV. NEW BUSINESS – Information Items
a. Legal overview and antitrust education session

b. Welcome, introductions, and ground rules
c. Review discussions to date
d. Facilitated Small-Group Discussions Regarding Potential Collaboration
    i. Board members and executives will participate in facilitated small-group discussions. Each small group will include no more than two Board members from each district. Members of the public attending in person may observe and listen to the small-group discussions but will not participate.
    ii. During the small-group discussion period, approximately 1:25 p.m. to 2:10 p.m., multiple discussions will occur simultaneously and the virtual meeting audio and camera will be unavailable.
e. Reconvene and Review of Small-Group Discussions
    i. At approximately 2:25 p.m., participants will reconvene as a full group and the virtual meeting audio and camera will resume. Each small group will summarize its discussion and respond to the facilitated discussion questions for review by the full Boards and the public.
f. Identify areas of consensus and open questions
g. Prioritize potential collaborations for further investigation
h. Discuss how the Boards will continue this work together and keep their communities informed
i. Closing reflections: key takeaways from each participant
j. Confirm next steps and evaluation

V. PUBLIC COMMENT

ADJOURN

Antitrust for Board Members

September 10, 2026

Jim Wiehl
Partner, BakerHostetler

Mary Waller
Partner, BakerHostetler

Roadmap

- Intro to Antitrust
- Antitrust and the Healthcare Marketplace
- Red and Yellow Flags: Anticompetitive Conduct
- M&A and other Collaborations
- Document Creation, Dos and Don’ts

Intro to Antitrust

Fair competition in an open marketplace

- No agreements that restrain trade (Section 1 of the Sherman Act).
- No monopolization (Section 2 of the Sherman Act).
- No unfair methods of competition (Section 5 of the FTC Act).
- No acquisitions that restrain competition (Clayton Act Section 7).

Enforced by

- The Department of Justice (DOJ).
- The Federal Trade Commission (FTC).
- State attorneys general.
- Private plaintiffs.

Penalties can be severe

- Treble damages (x3).
- Criminal liability.

Intro to Antitrust: Sherman Act § 1

"Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade … is declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding $100,000,000 if a corporation, or, if any other person, $1,000,000, or by imprisonment not exceeding 10 years, or by both said punishments, in the discretion of the court."

15 USC § 1

Intro to Antitrust: Sherman Act § 1

- Prohibits agreements to restrain trade unreasonably in any product or service
    - Agreements to fix prices or allocate customers/markets
    - Agreements that facilitate group boycotts or refusals to deal
- Unreasonably Restrains Trade
    - Analytical Frameworks:
        - ***Per Se Rule***. Conclusive presumption that the activity restrains trade
        - ***Rule-of-Reason***. Weighs an agreement's procompetitive and anticompetitive effects in context of the competitive market

Intro to Antitrust: Sherman Act § 2

"Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding $100,000,000 if a corporation, or, if any other person, $1,000,000, or by imprisonment not exceeding 10 years, or by both said punishments, in the discretion of the court."

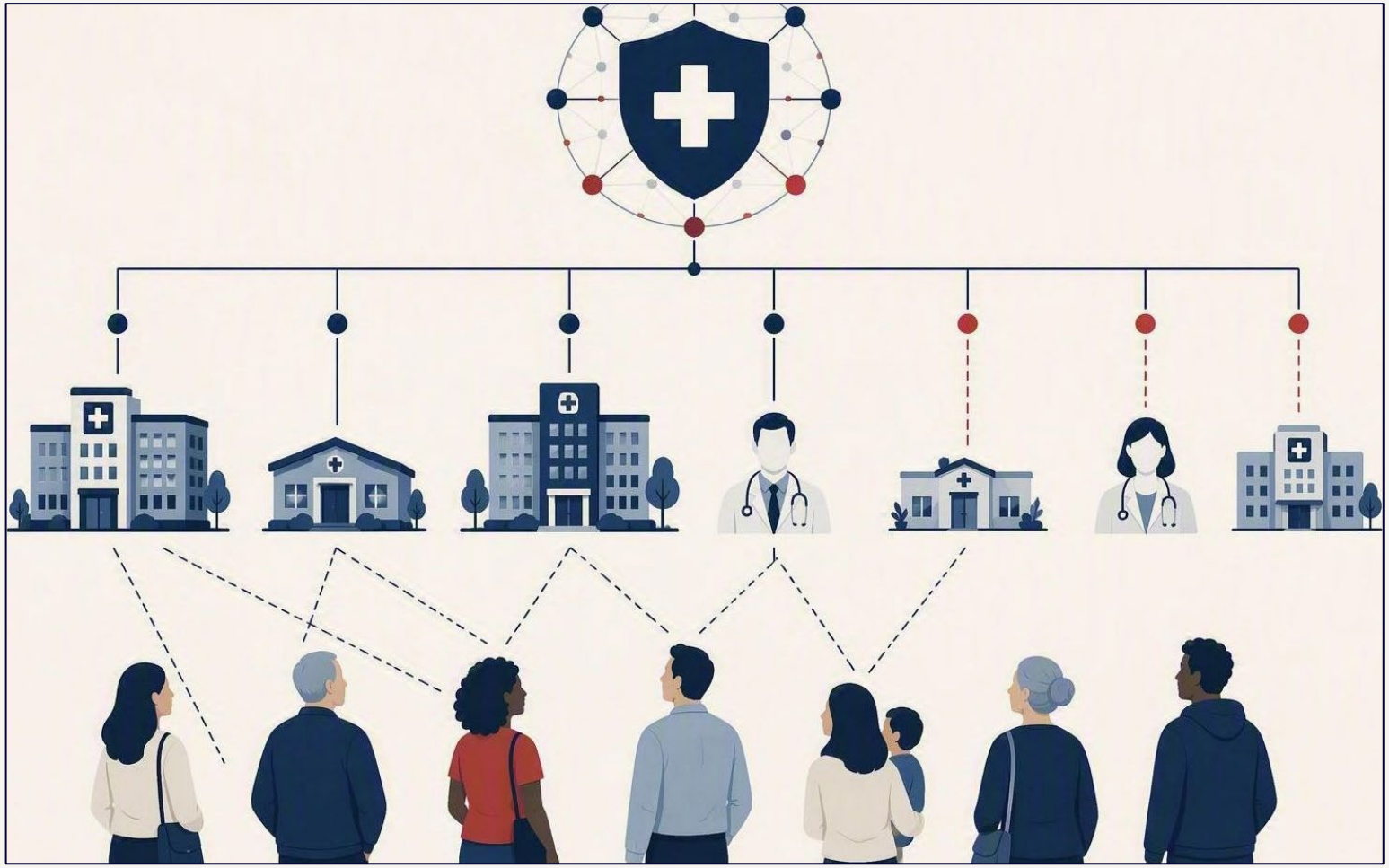
15 USC § 2

Antitrust and the Healthcare Marketplace

Antitrust authorities view health care providers as **competing with insurers**, **and also as competing with each** other at two levels:

(1) Compete to be included in provider networks

(2) Compete for patients/enrollees



Red & Yellow Flags: Anticompetitive Conduct

HIGH RISK

- Agreements not to compete, including price-fixing.
- May be written or unwritten, formal or informal agreements.

For example, agreements with other companies:

– Not to market in each other's territories.
– About wages, salaries, or other benefits.
– Not to hire or solicit their employees.
– Not to provide health care services in each other's territories.

Can lead to civil or criminal liability.

RISK AREAS (STRUCTURE CAREFULLY)

- Exclusive arrangements.
- Tying and bundling of health care services.
- Anti-steering, non-discrimination, and all-or-nothing contractual provisions.
- Refusals to deal.

Information Exchanges

- Sharing sensitive information with other companies can be illegal or create the appearance of illegality.
- Benchmarking initiatives and other information exchanges must be supervised by counsel.
- Safeguards can mitigate antitrust risk and allow companies to exchange certain information.

What is sensitive information?

- Pricing, costs, or discounts.
- Current wage, salary, or benefit information.
- Growth or contraction plans.
- Product offerings and innovation.

DO

Seek the advice of counsel in advance when considering joint rate-setting or other competitor collaborations.

DON'T

Never discuss prices, reimbursement rates, employee wages or other sensitive information with competitors.

Exclusive Agreements

- Certain exclusive dealing agreements can violate Sections 1 and 2 of the Sherman Act, including between providers.
    - **For example**: a hospital contracts with a physician group to provide cardiovascular services exclusively at the hospital (to the detriment of other competing hospital programs).
- Contracts with exclusivity provisions should be reviewed by counsel, particularly for entities with high market shares.

Refusals to Deal

- Health care providers have been the subject of refusal-to-deal claims that relate to staffing and patient referrals and insurer contracting decisions.
- The FTC has settled charges against providers for collectively refusing to deal with health insurers.
  - **For example:** The FTC settled with a group of nephrologists that refused to treat patients with a particular insurance when that insurer did not agree to the doctors' demand for higher reimbursement rates.
- Private plaintiffs have also brought refusal to deal claims against providers, including, for example:
  - Hospitals for denying staff privileges.
  - Competing groups of physicians who refused to refer patients to another provider.

Clayton Act § 7

"No person … shall acquire the whole or any part of the assets of another person engaged also in commerce or in any activity affecting commerce, where … the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly…"

15 USC § 18

M&A and Other Collaborations

Horizontal mergers, such as between two hospitals.

Vertical mergers, such as between hospitals and physicians, hospitals and health insurers, and health care providers and ancillary service providers like laboratories.

Joint ventures.

Clinically Integrated Networks (CINs), such as ACOs and IPAs.

Information exchanges

Risk Factors in Collaborations:

- Joint negotiation of reimbursement rates.
- Joint marketing.
- Other terms that may limit competition among the participants.

DO

Promptly consult with legal counsel if you receive another company's competitively sensitive information, such as pricing, cost, or discount information.

DON'T

Do not discuss any of the following with executives or other employees of competitors:

- Current or future prices, discounts, or costs.
- Current benefits, compensation terms and policies.
- Any other competitively sensitive or nonpublic information.

DO

Do be prudent when describing the competitive landscape in written communications.

DON'T

Do not agree with another company to take common actions with antitrust risk, e.g., fixing prices or allocating territories.

Document Creation

- Enforcement agencies review internal written communications, even those that pre-date a proposed transaction.
- Be judicious about creating and distributing deal-related written communications.

Avoid suggesting:

- Eliminating a competitor or neutralizing a threat
- Raising prices / pricing leverage
- That the transacting parties intend to reduce output, quality, services or innovation.
- The transacting parties are close competitors or lack meaningful competition.
- High market shares, lack of competition in the market, or high barriers to entry.

For Further Information or Questions Contact:

Jim Wiehl
Partner, Dallas
T +1.214.231.2402
jwiehl@bakerlaw.com

Mary R. Waller
Partner, Chicago
T +1.312.416.6210
mwaller@bakerlaw.com

Southern Mono Healthcare District and Northern Inyo Healthcare District

Joint Board Meeting: Pre-Meeting Interview Themes

August 2026

In August 2026, Karma Bass of Via Healthcare Consulting held confidential telephone interviews with members of both Boards of Directors and both chief executive officers. No comment is attributed to any individual.

Overall Impression from the Interviews

The conversations were candid and constructive. People on both sides described the two districts talking, cooperating, and enjoying it, and welcomed the change. Interviewees consistently supported closer collaboration and want the progress of the past few years to continue. At the same time, many expressed concern that this opening could be lost, whether through slow follow-through, old disagreements resurfacing, or meetings that do not lead to action. The interviews show broad agreement on direction, with differences centered on pace and on the role the Boards themselves should play.

The Relationship Today

Nearly every interviewee described the relationship as significantly better than it was a few years ago, and most credited the two chief executives for the change. Interviewees spoke with appreciation about the cooperation already underway, including the orthopedic contract and providers working at both hospitals. At the same time, the history is still present. Several interviewees noted that the years of litigation left caution on both sides, and a few acknowledged wariness about moving too fast. At least one interviewee noted that the Boards themselves have had little contact over the years, and described a long-standing rivalry between the two communities that will likely persist in some form even as more residents have friends in both towns. The May joint meeting was widely described as a good first step, with some difference in what people took from it: many found it the right gentle beginning, and at least one interviewee had hoped it would accomplish more. Several want additional time for the members of the two Boards to get to know one another before the Boards take on harder questions together.

Why Closer Collaboration Matters

Interviewees across both Boards gave similar reasons for wanting closer collaboration. Rural healthcare is under national pressure, both communities are aging, and winter travel puts distant care out of reach for many residents. At least one interviewee added that anything beyond emergency care means a trip not every resident can make, and that, given the region's remoteness and size, a number of specialties could be made available if the two districts work together. Many interviewees observed that competing for patients and physicians serves neither district, and that duplicating services stretches limited dollars. Personal motivations were consistent: keeping both hospitals open, keeping care close to home, and strengthening healthcare for the region's communities.

Complementary Services

A regional approach to women's health and obstetrics, anchored at Northern Inyo, was the most frequently named opportunity. At least one interviewee called obstetrics an essential service, the most logical place to start, and a bridge to other shared services, given the gap left when Mammoth's labor and delivery program closed and Northern Inyo's financial incentive to build a strong one. Many interviewees also pointed to services suited to Bishop's lower elevation, such as cardiology and pulmonology; to Mammoth's strength in orthopedics; and to shared challenges in radiology coverage, urology, neurology, and services for an aging population. A few raised longer-range ideas, including a regional cancer program and lower-altitude recovery for selected patients. Interviewees on both sides

spoke candidly about current friction over how patients are guided between the two organizations, and several expressed confidence that the chief executives are addressing it. Some on the Mammoth side asked whether the exchange of services could become one-sided, and some on the Northern Inyo side raised the long-standing concern about revenue moving up the hill. Both concerns were offered as considerations for the work ahead.

Shared Infrastructure and Workforce

A common electronic health record was named in a majority of interviews, most often Epic through the rural health transformation grant, so that patients who move between Bishop and Mammoth carry one record. Interviewees also saw promise in coordinated physician recruitment, credentialing providers at both hospitals, staff able to work in either facility, and group purchasing. A smaller number raised the possibility of sharing administrative capacity over time. Several noted that some of this is already happening, and pointed to the general surgeons working across both campuses as a model.

Boundaries and Guardrails

Interviewees were nearly unanimous that each district's independence and local identity should stay intact, and most consider a merger off the table. A smaller number would leave the long-range question open. At least one would rule nothing out in advance, reasoning that anything that does not benefit both districts will fall away on its own. Several emphasized careful attention to antitrust boundaries and the Brown Act, and welcomed having legal guidance available to the Boards. Transparency came up throughout the interviews: people want candor between the organizations about finances, needs, and intentions, and several said that anything perceived as hidden would set the relationship back.

Hopes for September 10

The most common hope was that the meeting produce something concrete. Interviewees want agreed priorities; a high-level framework for how the Boards will work together, with operational details left to management; at least one visible early win; and a plan for communicating with the communities about the work. Several asked that the ground rules from the May meeting carry forward, and that the day include time for personal connection. The most repeated concern was a good meeting with no follow-through, and a few interviewees said they want to understand their counterparts' motivations and commitment. At least one interviewee said the day would be well spent simply because the two Boards are meeting, since the harder questions will take longer than an afternoon and the conversation itself has been missing for years.

Follow-Through After the Meeting

Interviewees agreed that some structure after the meeting matters, and differed on its form. Ideas included a small joint committee meeting bi-monthly with the full Boards convening semiannually; the full Boards meeting together quarterly without a subcommittee at first; a lighter task force meeting every six months; and relying mainly on the two management teams with periodic board check-ins. At least one interviewee described the Boards' part as oversight: setting a clear expectation that the executives and providers of both districts work together, including on smooth transitions for patients moving between the hospitals, and otherwise staying out of the details. Underneath the structural question is a difference about pace: some interviewees want visible progress within months, and others cautioned against rushing a relationship that is still recovering. Several suggested that management analyze options between meetings so the Boards can decide from shared facts.