2025

written by the professionals of

Providing Solutions in an Era of Healthcare Reform

314-994-7641
1807 Park 270 Drive, Suite 110, St. Louis, MO 63146

Disclaimer

This work includes information regarding the basic characteristics of various regulatory, reimbursement, competition, and technology aspects of the healthcare industry. It is intended to provide only a general overview of these topics. The author and publisher have made every attempt to verify the completeness and accuracy of the information. However, neither the author nor the publisher can guarantee, in any way whatsoever, the applicability of the information found herein. Further, this work is not intended as legal advice or a substitute for appropriate legal counsel. This information herein is provided with the understanding that the author and publisher are not rendering either legal advice or services.

Dedication

As we celebrate another year of service, the entire team at **Health Capital Consultants** dedicates this 14th edition of Health Capital Topics to the many clients nationwide whom we have had the privilege to serve; to their attorneys, accountants, consultants, and vendors with whom HCC has worked to serve the needs of the projects we undertake on their behalf; and, to our professional colleagues nationwide, who both inform and inspire us toward excellence.

Preface

Health Capital Topics is a monthly e-journal, which has been published by **Health Capital Consultants** since 2007, featuring timely topics related to the regulatory, reimbursement, competition, and technology aspects of the U.S. healthcare delivery environment. It is sent monthly to over 20,000 healthcare executives, physicians, attorneys, accountants, and other professionals in the healthcare industry. Past issues of the Health Capital Topics e-journal, as well as special alert issues, may be found at www.healthcapital.com.

Acknowledgements

The assistance and support of a number of colleagues on the **Health Capital Consultants** team were instrumental in the development of the Health Capital Topics articles, from which the writings in this book were excerpted. Health Capital Topics is a monthly e-journal published under the direction of HCC's President Todd A. Zigrang, MBA, MHA, FACHE, CVA, ASA, ABV.

Jessica L. Bailey-Wheaton, Esq., Senior Vice President & General Counsel, serves as editor and directed the development of this book.

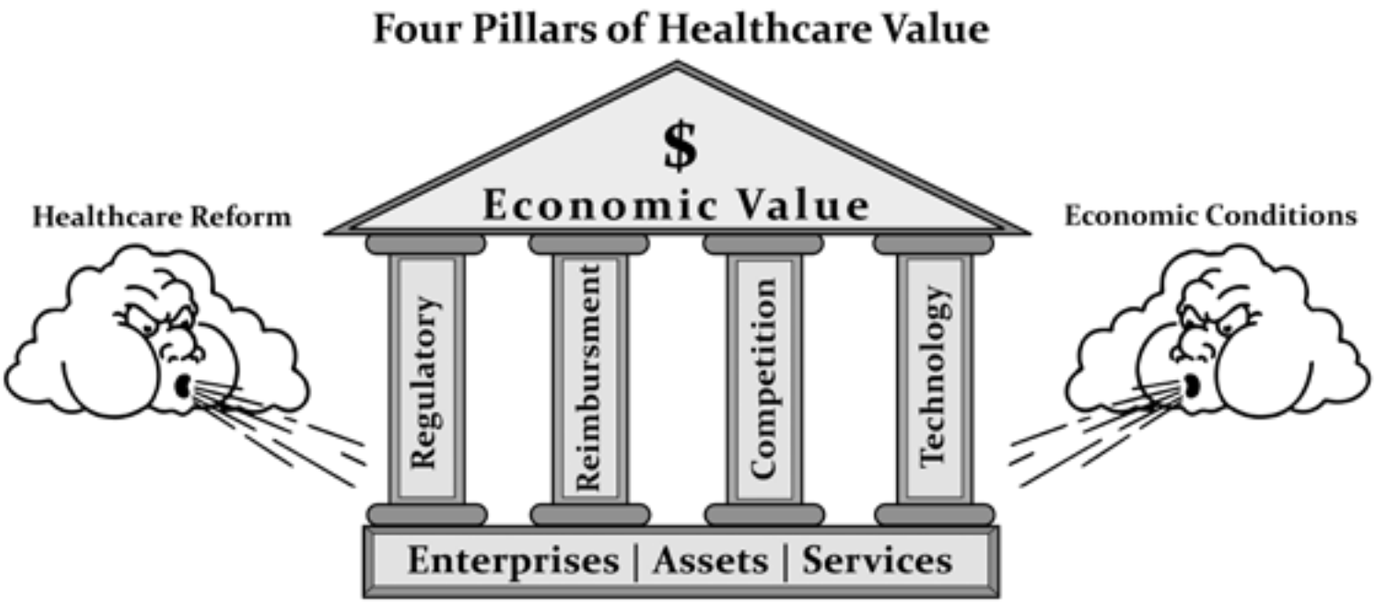
Janvi R. Shah, MBA, MSF, CVA, Senior Financial Analyst, has excelled in representing HCC throughout numerous healthcare client engagements, assisted with research, writing, review, and comments.

Sean J. Wallace, Director of Operations, was instrumental in the e-publishing, web archiving, and design of this book.

HCC's research and library support staff, as well as, members of HCC's consulting and administrative support team, were of great help.

Introduction

In 2025, we at **Health Capital Consultants** (HCC) have witnessed, and our clients have experienced, industry changes in each of the Four Pillars i.e., regulatory, reimbursement, competition, and technology. See figure below.



While the healthcare industry expected 2025 to be uncertain, the year has surpassed expectations. Many questions and uncertainties emerged heading into 2025, few (if any) of which have been answered. U.S. healthcare providers continue to grapple with industry volatility, driven by federal agency actions, repeated congressional stalemates, and the One Big Beautiful Bill. Reimbursement reductions persist across numerous medical specialties. Although these cuts are often justified as cost-containment measures, they fail to reflect sustained inflationary pressures and escalating operating expenses, straining provider resources and challenging long-term sustainability. The 2025 healthcare regulatory landscape was marked by increased state activity in response to reduced federal enforcement. While federal authorities have maintained that competition oversight remains a top priority, enforcement actions have not matched this rhetoric. Many states have responded by strengthening their own regulatory frameworks and legislative initiatives. Technology further solidified its role in care delivery during 2025, with accelerated adoption of AI-powered clinical support tools expanding diagnostic capabilities and operational efficiency. This compilation highlights key developments from 2025 and their influence on healthcare operations, as well as the considerations we apply when valuing healthcare enterprises, assets, and services in today's evolving market.

At HCC, we strongly believe that in developing an understanding of the forces and stakeholders that have the potential to drive healthcare markets, especially during a time of such uncertainty, it is useful to examine what value may be attributable to healthcare enterprises, assets, and services as they relate to the Four Pillars of the healthcare industry, i.e., regulatory, reimbursement, competition, and technology.

This book is a compilation of excerpts from articles originally published in the e-journal, Health Capital Topics, which have been loosely organized by topic in relation to each of the Four Pillars.

The included articles represent a retrospective look at a topic, as noted by the date of original publication that appears following the article title.

The intent of this book is to serve as an (admittedly abridged) brief annual primer and reference source for these topics. In the months and years ahead, we will strive to continue staying on top of key issues in the healthcare industry and publishing them in the monthly e-journal issues of Health Capital Topics and special alerts.

We appreciate the many comments and expressions of support for this research endeavor. HCC's research is the foundation for all of our client engagements and firm as a whole. As always, we solicit your continued input and recommendation of topics or subject matter that you may find useful.

Sincerely,

Valuation Topics

Valuation of Hospitals (Five-Part Series) 7-18
Valuation of Cardiovascular Services (Five-Part Series) 19-28
Valuation of Anesthesiology Services (Three-Part Series) 29-35
Valuation Standards in Healthcare 36

Reimbursement Topics

MPFS Final Rule Cuts Physician Payments: Will It Last? 41
Congressional Spending Bill Excludes Physician Payment Increase 44
MedPAC Recommends Hospital & Physician Payment Updates 46
Continuing Resolution Excludes Physician Payment Increase Again 48
2026 Proposed Physician Fee Schedule Increases Payments 50
OPPS Final Rule Issued by CMS 52
CMS Proposes Updates to the OPPS 54
CMS Proposes Increasing Inpatient & Long Term Care Payments 56
CMS Releases 2026 IPPS Final Rule 58
Record-Breaking Savings for ACOs in 2023 60
Four Medicare Payment Models Ended Early 62
The Shift to Value-Based Care: Evidence of Progress 64
Healthcare Spending Surged in 2023 65
Healthcare Spending Projected to Exceed $8.5 Trillion by 2033 66
Hospital Finances Held Steady in First Month of 2025 67
MA Plan Rates Substantially Increased for 2026 68

Regulatory Topics

Recent Court Actions Provide Insight into Future of Fraud & Abuse Laws 72
OIG Recommends Higher Scrutiny of RPM 75
Where the Candidates Stand on Healthcare 77
Looking into the Crystal Ball: 2025 Healthcare Industry Outlook 79
Trump Administration's Day-One Healthcare Moves 82
Fast & Furious: Healthcare Policy Edition 83
2 Fast 2 Furious: HHS Cuts on the Horizon 86
CON Laws: Current Landscape and Future Outlook 88
CMMI's Evolving Strategy: Initial Indications from Recent Actions 91
"Big Beautiful Bill" Not so Beautiful for Healthcare 93
DOJ-HHS FCA Working Group Revived 95
New HHS-CMS Committee Announced 96
Healthcare Policy Disputes Threaten Government Shutdown 97

Competition Topics

Leadership on the Brink: Healthcare Executives Eyeing the Exits 99
Oregon Bans Corporate Control of Physicians 100
Hospital Acquisitions of Physician Practices Increase Prices 103
FTC Walks Away From Noncompete Ban 104
GAO Report: Rising Physician Consolidation Increases Prices 106

Technology Topics

Amazon's Healthcare Pivot 109

About HCC

HCC Firm Profile 112
HCC Firm Leadership 113

Valuation Topics

Valuation of Hospitals: Introduction

[This is the first article in a five-part series regarding Valuing Hospitals. This installment was published in July 2024.]

Hospitals are one of the key elements in the market for healthcare services in the U.S.,[1] both as a clinical provider and as an economic actor. Clinically, hospitals operate as one of the fundamental elements of the continuum of care, providing intensive services to patients with severe conditions, whose treatment requires a significant investment of time and resources. Economically, hospitals control a dominant portion of U.S. healthcare expenditures, with healthcare expenditures for hospital care expected to overtake healthcare expenditures for physician clinical services.[2]

Hospitals face multiple challenges, due to conditions in the competitive, reimbursement, regulatory, and technological environments in which these providers operate. Chief among these challenges is the rise in demand for healthcare services resulting from the aging of the Baby Boomer generation.[3] Additionally, hospitals must continue to navigate increasing regulatory scrutiny in the realm of healthcare fraud and abuse. Further, the current state of the reimbursement environment for hospitals is marked by stagnant payments for inpatient services as well as the implementation of a number of programs that punish poor quality healthcare services with reduced payments (even in the wake of the COVID-19 pandemic, which decimated hospital finances), creating a setting in which hospitals must simultaneously provide high quality healthcare and control the costs associated with providing that healthcare in order to survive. Lastly, hospitals must find ways to compete with less traditional outpatient care settings (e.g., ambulatory surgery centers and urgent clinics), which patients find to be more convenient and payors find to be more cost efficient. To meet these challenges, hospitals may be able to leverage certain technological advancements in order to provide the high quality, efficient healthcare that is demanded by the modern healthcare industry.

There are various types of hospitals in the U.S.:

(1) Short-term acute care hospitals, which represent over half the nation's hospitals, specialize in the general, short-term treatment of patients;
(2) Academic medical centers (AMCs) are short-term acute care hospitals that educate healthcare providers in partnership with medical schools, with some AMCs conducting medical, academic, and human subject research, in addition to delivering a wide breadth of healthcare services;
(3) Specialty hospitals focus on certain medical conditions or patient population and offer a specialized subset of technology and skills. Examples of specialty hospitals include children's hospitals and psychiatric hospitals;
(4) Critical access hospitals (CAHs) provide healthcare services to underserved and rural communities. CAHs typically have fewer than 25 inpatient beds, a 24-hour emergency department (ED), and are located more than 35 miles away from the closest hospital;
(5) Rural emergency hospitals are small rural hospitals that maintain emergency outpatient hospital services in communities that may not have a CAH or other rural hospital;
(6) Federal hospitals are operated by government agencies, such as the Veteran's Administration (VA), Department of Defense (DOD), or the Department of Health and Human Services (HHS).[4]

Hospitals provide a variety of healthcare services, which can generally be categorized as either (1) inpatient care or (2) outpatient care. Inpatient care refers to those services that are furnished to patients who have been admitted by a physician's order to stay in the hospital, while outpatient care refers to observation services, ED services, many diagnostic services, and any other hospital services furnished to patients who have not been admitted to the hospital.[5] In recent years, improvements in technology and medical practices have allowed many procedures that formerly required inpatient care to be performed on an outpatient basis, thus drawing attention to the distinction between inpatient and outpatient services.[6] This distinction between inpatient and outpatient care may have a significant impact on a hospital's revenue, as hospitals typically receive higher reimbursement for inpatient care than outpatient care, even for patients with similar clinical needs.[7]

Inpatient hospital stays in the U.S. typically span 4.5 days, with average costs of over $3,000 per day.[8] Common services furnished during inpatient hospital stays include: (1) procedures associated with pregnancy, childbirth, and newborns; (2) orthopedic procedures; and (3) cardiovascular procedures.[9]

Outpatient hospital care is often provided in either a hospital outpatient department (HOPD) or hospital ED. In 2021, the five most common primary outpatient diagnoses were:

(1) Essential (primary) hypertension (3% of diagnoses);
(2) Contact with and (suspected) exposure to COVID-19 (2.5% of diagnoses);
(3) Other long term (current) drug therapy (1.4 % of diagnoses);
(4) Hyperlipidemia, unspecified (1.1% of diagnoses); and
(5) Type 2 diabetes mellitus without complications (1.0% of diagnoses).[10]

Comparatively, the reasons for visits (as defined by patients' own words) to hospital EDs are more varied, with the five most common reasons for ED visits accounting for less than one quarter of all visits to hospital EDs.[11] The top five most common reasons for visits to hospital EDs are:

(1) Stomach and abdominal pain, cramps, and spasms (8.7% of visits);
(2) Chest pain and related symptoms (5.3% of visits);
(3) Fever (4.3% of visits);
(4) Cough (3.6% of visits); and
(5) Shortness of breath (2.9% of visits).[12]

Across all settings, elderly patients are the most frequent users of hospital services. Despite comprising approximately 18.64% of the total population,[13] individuals age 65+ represent approximately: (1) 35.5% of inpatient stays; (2) 18% of visits to HOPDs; and, (3) 18% of visits to hospital EDs.[14] For inpatient hospital stays, individuals age 65+ have the highest utilization per capita of all age groups.[15] For HOPDs (as compared to ambulatory surgical centers), Medicare beneficiaries were more likely to be under age 65 or over age 85 and have higher medical acuity.[16] Due to their relatively frequent use of inpatient hospital services, combined with the high cost of inpatient hospital stays, patients age 65+ may have a disproportionate impact on a hospital's revenue. As such, the aging of the Baby Boomer generation will likely have significant consequences for the hospital industry, although the ultimate impact on hospital revenue may depend on inpatient or outpatient classification trends.

In light of the current conditions of the U.S. healthcare delivery system, demand for hospital services may be driven by: (1) the number of individuals with private health insurance; (2) disposable income per capita; (3) funding for Medicare and Medicaid; and (4) the number of adults aged 65+.[17] While there is significant demand for hospital services, competition from other facilities, such as ASCs, urgent care centers, and freestanding emergency departments (FSEDs), may lessen the role of hospitals going forward.[18] The next installment of this five-part series will review the competitive environment in which hospitals operate.

Valuation of Hospitals: Competitive Environment

[This is the second article in a five-part series regarding Valuing Hospitals. This installment was published in August 2024.]

Demand for a variety of healthcare services – including those provided by hospitals – is likely to increase significantly in the near future, primarily as a result of the changing demographics of the U.S. population, most notably the growth in the number of Americans over the age of 65.[19] Indeed, a *Health Affairs* study found that population aging alone will create approximately 0.74% annual growth in the demand for inpatient hospital services.[20] While hospital consolidation is leading to operational efficiency for hospitals in providing services to an increasing number of patients, the federal government's intensifying focus on anticompetitive behaviors in healthcare may hinder traditional consolidation efforts going forward. This second installment in a five-part series on the valuation of hospitals reviews the competitive environment in which hospitals operate.

Demand for hospital services is driven by the number of people with health insurance, per capita disposable income, federal funding for Medicare and Medicaid, and the aging population.[21] The number of Americans who are employed and/or have private health insurance typically drives demand for increased healthcare services, including those provided by hospitals. Individuals with higher incomes typically have higher healthcare utilization, and simultaneously reduces the likelihood of bad debt for hospitals since patients can afford to pay hospital bills.[22] The elderly population also utilizes a greater proportion of (and expenditures related to) medical services relative to the rest of the general population, and as such will comprise a growing part of the patient population in future years. In addition to those with the means to purchase healthcare services (through insurance or out-of-pocket spending), hospital services are also typically utilized by those who are less healthy. The prevalence of chronic diseases has been on the rise nationwide, with 60% of adults having one chronic disease and 40% having two or more chronic diseases.[23] In fact, 90% of U.S. annual healthcare expenditures (totaling nearly $4.5 trillion), are for patients with chronic diseases.[24] Healthcare utilization is almost twice as high for chronic disease patients than those without any chronic diseases, with hospital inpatient utilization being as much as four-fold higher.[25]

The total number of non-federal, short-term hospitals in the U.S. is 6,120.[26] The number of beds in these hospitals (and, consequently, the number of available beds per capita) has been falling since the 1980s.[27] The national reduction of available hospital beds likely represents a shift in the type of services rendered in these hospitals, rather than a shortage of available hospital services. Over the past couple decades, the utilization of outpatient visits in hospitals has risen steadily, from 1,848 per 1,000 persons in 2000 to 2,399 per 1,000 persons in 2022.[28]

Although the total number of hospitals in the U.S. has remained relatively stable since the late 1990s, these organizations have not been idle. Since the 2010 passage of the *Patient Protection & Affordable Care Act* (ACA), the number of hospital mergers and acquisitions (M&A) has increased dramatically.[29] Between 2005 and 2009, there were approximately 50-60 hospital transactions in the U.S. each year;[30] in 2019 alone, there were 92 hospital deals.[31] Likely due to the COVID-19 pandemic, this activity has slowed back down – in 2021, only 49 hospital transactions were announced (although several of those transactions were "mega mergers").[32] In 2023, 65 deals were announced,

representing the highest M&A activity since 2020.[33] This uptick in transactional activity may be due to the fact that hospitals are battling financial issues that were exacerbated by the pandemic; to combat such issues, hospitals are looking for partnerships to stay afloat and diversify.[34]

Industry stakeholders are divided on the potential effects of this consolidation trend, with some claiming that integration will bring operational efficiency, as well as improved coordination and quality of care, while others warn that concentration of market share among fewer providers may result in rising prices for healthcare services.[35] While consolidation allows providers to operate efficiently, and could potentially help providers keep their doors open in underserved areas, it often has the effect of reducing competition.[36] Evidence has found that consolidation has led to higher prices (without any increase in the quality of care).[37]

Perhaps as a result of recent studies highlighting the potential ill effects of hospital concentration, the federal government has turned its regulatory focus in recent years toward competition in healthcare, which may serve to further cool hospital M&A. In 2018, the U.S. Department of Health & Human Services (HHS), the Department of the Treasury, and the Department of Labor issued a report comprising over 50 recommendations to increase quality, decrease cost, and promote competition in healthcare.[38] Three years later, President Biden issued an executive order to promote competition in the American economy.[39] The executive order was designed to address issues the administration identified as contributing to harmful trends associated with decreased competition and corporate consolidation, which are ultimately harming American consumers.[40] While the executive order did not immediately establish requirements, it directed federal agencies to review issues and implement policies to reflect the administration's goals.[41] Pursuant to the executive order, federal agencies have subsequently taken action to increase competition in hospitals, among other priorities.[42] Specifically, the Federal Trade Commission (FTC) has filed a number of lawsuits over the past couple years to halt hospital transactions, including suing to block:

(1) A merger of two New Jersey-based health systems, RWJ Barnabas Health and Saint Peter's Healthcare System, which caused the systems to scrap their merger plans;[43]
(2) HCA Healthcare's acquisition of five Utah hospitals from Steward Health, which caused HCA to abandon the acquisition;[44]
(3) A merger of two Rhode Island health systems, Lifespan and Care New England, which caused the systems to abandon their merger plans;[45]
(4) New Jersey's biggest hospital system, Hackensack Meridian Health, from acquiring competitor Englewood Healthcare, which caused Hackensack to scrap the acquisition;[46] and
(5) Novant Health, a non-profit health system, from acquiring two North Carolina hospitals from Community Health Systems, a publicly-traded mega-system. Ultimately, Novant Health decided to call off the acquisition.[47]

As a result of increased regulatory scrutiny, hospitals are changing integration strategies, and merging across markets. Cross-market mergers can involve health systems and hospitals thousands of miles apart, or simply those in neighboring markets.[48] These mergers are more attractive to hospitals, as they have received little resistance from government agencies compared to mergers occurring within the same market.[49] For example, BJC Healthcare in Saint Louis, Missouri, merged with St. Luke's Health System in Kansas City, Missouri, to create a combined statewide system with a revenue of nearly $8.7 billion.[50] Similarly, Risant Health, a nonprofit established by California-based integrated health system Kaiser Permanente, announced acquisitions of Geisinger, a Pennsylvania-based integrated health system, and Cone Health, a nonprofit integrated health system in North Carolina, in the past year.[51] Together, the three systems have combined revenues of over $105 billion.[52]

In addition to the overall number of hospitals and hospital beds, the supply of hospital services is also dictated by the number of physicians and non-physician practitioners (NPPs) who can provide those services.[53] Over 945,000 physicians actively practiced in the U.S. in 2021,[54] approximately 52% of which were employed by hospitals and health systems.[55] Over 46% of these physicians are over the age of 55,[56] which indicates that over the next 10 to 15 years, nearly half of all physicians will either retire or significantly reduce the number of hours worked per week, resulting in a shortage of physician services.

Although the U.S. may face a shortage of physicians in the near future, the supply of NPPs may actually double over the fifteen years.[57] The Association of American Medical Colleges (AAMC) has projected that by 2034, the supply of advance practice registered nurses, including nurse practitioners, in the U.S. will grow by 309,000 full-time equivalents (FTEs); and the supply of physician assistants in the U.S. will grow by nearly 129,000 FTEs.[58] This growth exceeds the growth in patient demand for healthcare services, which may serve to ameliorate the physician manpower shortage.

Hospitals are increasingly operating in a highly competitive environment with other, freestanding facilities, such as urgent care centers, free standing emergency departments (FSEDs), and ambulatory surgery centers (ASCs).[59] While hospitals typically have competitive advantages over ASCs, such as established managed care contracts and community position, ASCs have been able to treat a more profitable pool of patients (relative to hospitals) by: (1) concentrating only on specific diagnosis-related groups (DRGs); (2) treating far fewer Medicaid patients, which often involves reduced reimbursement rates; and, (3) opting out of emergency room facilities and services so as to forego the related regulatory requirements under laws such as the Emergency Medical Treatment and Active Labor Act (EMTALA) related to the provision of care regardless of a patient's ability to pay.[60] With fluctuations in reimbursement and other operating pressures, hospitals are attempting to combat this competition by similarly shifting procedures from the inpatient setting to lower-cost outpatient settings.[61]

Over the next few years, hospitals may benefit from: (1) the number of individuals with private health insurance; (2) disposable income per capita; (3) funding for Medicare and Medicaid; and (4) the number of adults aged 65+.[62] However, hospitals are still hampered by the increasingly intense, complex, and overlapping regulatory scrutiny from federal, state, and local regulators. The next installment in this five-part series will review the regulatory environment in which hospitals operate.

Valuation of Hospitals: Regulatory Environment

[This is the third article in a five-part series regarding Valuing Hospitals. This installment was published in September 2024.]

Hospitals face a range of complex, overlapping federal and state legal and regulatory constraints, which affect their formation, operation, procedural coding and billing, and transactions. Fraud and abuse laws, specifically those related to the federal Anti-Kickback Statute (AKS) and physician self-referral laws (the "Stark Law"), may have the greatest impact on the operations of hospitals. The third installment in this five-part series on the valuation of hospitals highlights some of the newer and more pressing statutes and regulations that comprise the regulatory environment in which hospitals operate.

Federal Fraud & Abuse Laws

The AKS and Stark Law are generally concerned with the same issue – the financial motivation behind patient referrals. However, while the AKS is broadly applied to payments between providers or suppliers in the healthcare industry and relates to any item or service that may be paid for under any federal healthcare program, the Stark Law specifically addresses the referrals from physicians to entities with which the physician has a financial relationship for the provision of defined services that are paid for by the Medicare program.[63] Additionally, while violation of the Stark Law carries only civil penalties, violation of the AKS carries both criminal and civil penalties.[64]

Anti-Kickback Statute

Enacted in 1972, the federal AKS makes it a felony for any person to "*knowingly and willfully*" solicit or receive, or to offer or pay, any "*remuneration*", directly or indirectly, in exchange for the referral of a patient for a healthcare service paid for by a federal healthcare program,[65] even if only one purpose of the arrangement in question is to offer remuneration deemed illegal under the AKS.[66] Notably, a person need not have actual knowledge of the AKS or specific intent to commit a violation of the AKS for the government to prove a kickback violation,[67] only an awareness that the conduct in question is "generally unlawful."[68] Further, a violation of the AKS is sufficient to state a claim under the *False Claims Act* (FCA).[69]

Criminal violations of the AKS are punishable by up to ten years in prison, criminal fines up to $100,000, or both, and civil violations can result in administrative penalties, including exclusion from federal healthcare programs, and civil monetary penalties plus treble damages (or three times the illegal remuneration).[70] In addition to the civil monetary penalties paid under the AKS, if the AKS violation triggers liability under the FCA, defendants can incur additional civil monetary penalties of $13,508 to $27,018 per violation, plus treble damages.[71]

Due to the broad nature of the AKS, legitimate business arrangements may appear to be prohibited.[72] In response to these concerns, Congress created a number of statutory exceptions and delegated authority to HHS to protect certain business arrangements by means of promulgating several *safe harbors*.[73] These *safe harbors* set out regulatory criteria that, if met, shield an arrangement from regulatory liability, and are meant to protect transactional arrangements unlikely to result in fraud or abuse.[74] Failure to meet all of the requirements of a *safe harbor* does not necessarily render an arrangement illegal.[75] It should be noted that, in order for a payment to meet the requirements of many AKS safe harbors, the compensation must not exceed the range of fair market value.

The AKS was revised in December 2020, many of which revisions are similar to those made to the Stark Law, as discussed more fully below.[76] Among the more notable revisions are newly-established safe harbors for value-based arrangements (the safe harbor requirements for which arrangements lessen as the participants take on more financial risk) and revisions to existing safe harbors.[77]

Stark Law

The Stark Law prohibits physicians from referring Medicare patients to entities (such as hospitals) with which the physicians or their family members have a financial relationship for the provision of designated health services (DHS).[78] DHS include, but are not limited to, the following:

(1) Inpatient and outpatient hospital services;
(2) Radiology and certain other imaging services;
(3) Radiation therapy services and supplies;
(4) Certain therapy services, such as physical therapy;
(5) Durable medical equipment; and,
(6) Outpatient prescription drugs.[79]

Under the Stark Law, financial relationships include ownership interests through equity, debt, other means, and ownership interests in entities also have an ownership interest in the entity that provides DHS.[80] Additionally, financial relationships include compensation arrangements, which are defined as arrangements between physicians and entities involving any remuneration, directly or indirectly, in cash or in kind.[81]

Civil penalties under the Stark Law include overpayment or refund obligations, a potential civil monetary penalty of $15,000 for each service, plus treble damages, and exclusion from Medicare and Medicaid programs.[82] Further, similar to the AKS, violation of the Stark Law can also trigger a violation of the FCA.[83]

Notably, the Stark Law contains a large number of exceptions, which describe ownership interests, compensation arrangements, and forms of remuneration to which the Stark Law does not apply.[84] Similar to the AKS safe harbors, without these exceptions, the Stark Law may prohibit legitimate business arrangements. It must be noted that in order to meet the requirements of many exceptions related to compensation between physicians and other entities, compensation must: (1) not exceed the range of fair market value; (2) not take into account the volume or value of referrals generated by the compensated physician; and, (3) be commercially reasonable. Unlike the AKS safe harbors, an arrangement must fully fall within one of the exceptions in order to be shielded from enforcement of the Stark Law.[85]

As noted above, the Centers for Medicare & Medicaid Services (CMS) released a number of revisions to the Stark Law in December 2020, including:

(1) Revised definitions for Fair Market Value, General Market Value, and Commercial Reasonableness; and,
(2) New permanent exceptions for value-based arrangements.[86]

Importantly, the new value-based arrangements exceptions protect the following arrangements:

(1) Full Financial Risk Arrangements: Includes capitated payments and predetermined rates or a global budget;
(2) Value-Based Arrangements with Meaningful Downside Financial Risk: Where a physician pays no less than 25% of the value of the remuneration the physician receives when he or she does not meet pre-determined benchmarks; and,
(3) Value-Based Arrangements: Applies regardless of risk level to encourage physicians to enter value-based arrangements, even if they only assume upside risk.[87]

It is important to note that, the regulatory scrutiny of healthcare entities (especially with regard to fraud and abuse violations) has generally increased over the past decade. The Department of Justice (DOJ) recovered over $1.8 billion from healthcare fraud and abuse enforcement in 2023 alone.[88] These recoveries reflect the DOJ's focus on its current enforcement priorities, including violations of cybersecurity requirements in government-funded grants and contracts and fraud in pandemic relief programs.[89]

The Emergency Medical Treatment and Labor Act (EMTALA)

In April 1986, Congress passed the *Consolidated Omnibus Budget Reconciliation Act of 1985*, which included an amendment to the *Social Security Act* that created new requirements for hospitals that participate in the Medicare program.[90] Known today as EMTALA, this law requires Medicare-participating hospitals that operate an emergency department (ED) to provide "an appropriate medical screening examination" to any patients who present themselves to the ED.[91] Further, if the hospital determines that a patient is in active labor or is suffering from some other emergency condition, the hospital is required to provide treatment for the patient, regardless of the patient's ability to pay or insurance status.[92] If the hospital cannot provide appropriate treatment, or if the patient requests, the hospital must transfer the patient to a more suitable site.[93] Medicare-participating hospitals that fail to comply with EMTALA regulations may: (1) lose their status as a Medicare-participating hospital; (2) incur civil monetary penalties of up to $50,000; and/or (3) be liable for damages in civil actions brought by patients or other medical facilities that were harmed as a result of the violation of EMTALA.[94]

Price Transparency Act

One of the newer regulations that has targeted hospitals is price transparency. Beginning January 1, 2021, group and individual health plans and insurers were required by CMS to disclose cost-sharing information for certain covered items and services.[95] This information must be available online and in paper form, and aims to allow patients to estimate their own out-of-pocket expenses.[96] The Price Transparency Act requires the disclosure of negotiated rates, historically allowed amounts for out-of-network providers, and drug prices.[97] The goal of this final rule is to create better-informed consumers who can shop for services more efficiently and ultimately slow the rise of healthcare spending.[98] On November 2, 2023, CMS finalized changes to the hospital price transparency regulations; the updated rule requires hospitals to provide the pricing information in a standardized template and include a completeness and accuracy affirmation statement.[99] The updates, most of which took effect in 2024, are intended to expand transparency and streamline the enforcement process.[100]

Conclusion

Hospitals face many obstacles within the regulatory environment that can prohibit their formation, growth, and development. For example, fraud and abuse scrutiny has increased over the past two decades and continues to be a significant risk factor for hospitals. Moreover, new regulations, such as the Price Transparency Act, adds to a hospital's administrative burden, and can result in large fines if not complied with. Consequently, having a robust compliance program, to ensure a hospital stays within regulatory bounds, is integral to a hospital's success.[101] Another factor integral to the success of a hospital is the reimbursement environment. Consequently, the next installment in this series will discuss the reimbursement environment in which hospitals operate.

Valuation of Hospitals: Reimbursement Environment

[This is the fourth article in a five-part series regarding Valuing Hospitals.
This installment was published in October 2024.]

The U.S. government is the largest payor of medical costs, through Medicare and Medicaid, and has a strong influence on reimbursement to hospitals. In 2022, Medicare and Medicaid accounted for an estimated $944.3 billion and $805.7 billion in healthcare spending, respectively.[102] The prevalence of these public payors in the healthcare marketplace often results in their acting as a price setter, and being used as a benchmark for private reimbursement rates.[103]

The Centers for Medicare & Medicaid Services (CMS) reimburses hospitals for inpatient stays under the Inpatient Prospective Payment System (IPPS) via two different payments: the operating payment and the capital payment.[104] The operating payment covers labor and supplies costs, while the capital payment covers costs for depreciation, interest, rent, and property-related insurance and taxes.[105] Further, the operating payment is split into labor-related and non-labor-related portions.[106] The labor-related portion of the operating payment is multiplied by a wage index, which is calculated as the ratio of the average hourly wage of hospital workers in a given market to the national average wage for hospital workers.[107] If the wage index is greater than 1.0, then the labor-related portion represents 67.6% of the operating payment; if the wage index is equal to or less than 1.0, the labor-related portion represents only 62% of the operating payment.[108]

Both operating and capital base payment rates have grown minimally each fiscal year for the past decade, although operating base payment rates were higher for 2020 through 2023, due to the COVID-19 pandemic.

In addition to the wage adjustment for the labor-related portion of the operating payment, the IPPS makes several other payment adjustments to account for factors specific to individual patients and hospitals. Chief among these adjustments is a modification based on the patient's condition and the associated treatment plan, wherein Medicare assigns the patient to one of 766 Medicare Severity Diagnosis Related Group (MS-DRG) classifications.[109] This adjustment occurs when clinically similar conditions within the same DRG use differing amounts of resources, in which CMS may choose to reassign them to a different DRG.[110] In order to calculate the operating payment, each MS-DRG is assigned a specific DRG weight, which is then multiplied by the base payment rate.[111] Similarly, to calculate the capital payment, the DRG weight is multiplied by the capital base rate.[112] The capital base rate is adjusted by the capital wage index and the capital cost-of-living-adjustment, if applicable, before being multiplied by the DRG weight.[113]

After adjusting the base payment rates for regional wage variations and the patient's MS-DRG classification, the IPPS payment may be further modified by several factors that account for a hospital's specific characteristics. These modifications include, but are not limited to:

(1) Direct graduate medical education (DGME), i.e., add-on payments for hospitals that incur costs associated with training residents in approved residency programs;
(2) Indirect medical education (IME) payments, i.e., add-on payments for hospitals that provide medical education for incurring higher patient care costs, given that they typically treat more complex patient cases;
(3) Disproportionate share hospital (DSH) and uncompensated care payments, i.e., add-on payments for hospitals that provide services to a disproportionately large share of low income patients and patients with no insurance;
(4) Reductions to IPPS payments due to excessive numbers of readmissions for certain procedures; and,
(5) Outlier payments for extraordinarily costly cases.[114]

The calculation of the IPPS payment methodology is illustrated in Exhibit 1, below.

Generally, hospital outpatient costs are reimbursed under the Hospital Outpatient Prospective Payment System (OPPS),[115] under which Medicare assigns certain procedures, organized into the Healthcare Common Procedure Coding System (HCPCS), to Ambulatory Payment Classifications (APCs) based upon their clinical and cost similarities.[116] Each APC is assigned a relative weight determined by resource requirements and mean cost of the service, which is converted into a dollar amount using a conversion factor (CF).[117]

The CF is broken down into two components: the labor and non-labor components.[118] The labor component, which comprises 60% of the CF, is multiplied by a hospital wage index to represent local economic conditions, while the non-labor component, which comprises 40% of the CF, undergoes no alterations.[119] To calculate a monetary payment for outpatient services, the geographically-adjusted CF is multiplied by the APC relative weight to produce a base APC payment rate.[120] In addition to this base APC payment rate, hospitals may receive additional payments under the OPPS, which include: (1) pass-through payments for certain drugs, biologicals, and devices; (2) outlier payments for extraordinarily costly cases; (3) bonus payments for certain specialized hospitals (e.g., cancer hospitals); and, (4) bonus payments for most rural hospitals.[121] The calculation of OPPS payment rates is illustrated in Exhibit 2, below.

Although most hospital outpatient services are billed under the OPPS, some outpatient services billed to Medicare do not use the OPPS, even if administered in an outpatient setting.[122] These services include, but are not limited to:

(1) Certain physician services, which are designated to be paid on a physician fee schedule;
(2) Services rendered by various non-physician practitioners (e.g., nurse practitioner, physician assistants, certified midwives, psychologists);
(3) Services rendered by an anesthetist or a clinical social worker;
(4) Physical therapy, occupational therapy, or speech language pathology services;
(5) Ambulance services;
(6) Certain prosthetics, orthotic devices, and durable medical equipment;
(7) Clinical laboratory tests; and,
(8) Services that the Secretary of the Department of Health & Human Services (HHS) designates as requiring inpatient care.[123]

The OPPS bundles procedures performed in outpatient hospital settings such as operating rooms and recovery rooms, as well as for anesthesia services. Bundling not only encourages efficiencies and cost reductions for the hospital, but it may also stabilize payments for procedures received.

In general, inpatient admissions tend to be more profitable than outpatient services. As such, the shift from inpatient care to outpatient care may present a significant threat to hospital revenues. However, shifts in the reimbursement environment may help to offset this risk, by providing hospitals with opportunities for increased reimbursement as a reward for improved operational performance. Examples include Medicare's Hospital Readmissions Reduction Program (HRRP), which rewards hospitals for eliminating unnecessary readmissions, and accountable care payment methodologies, which encourage providers to reduce the number and duration of inpatient stays.[124]

This inpatient-to-outpatient shift over the past decade can largely be attributed to technological advancements that have allowed a broader scope of care to be delivered in an outpatient setting. In the final installment of this five-part series, the current state of the technology environment in which hospitals operate will be discussed.

Exhibit 1: Calculation of the IPPS Payment[125]

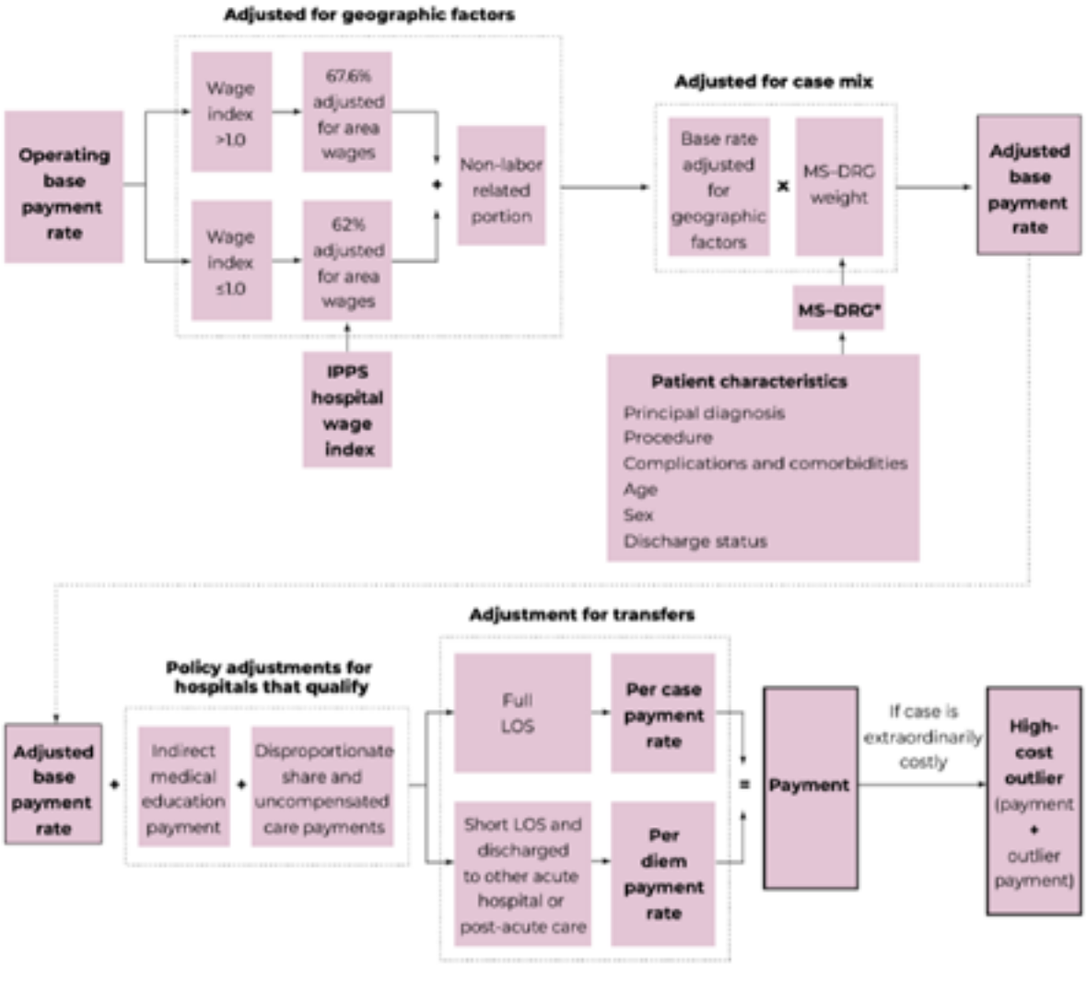
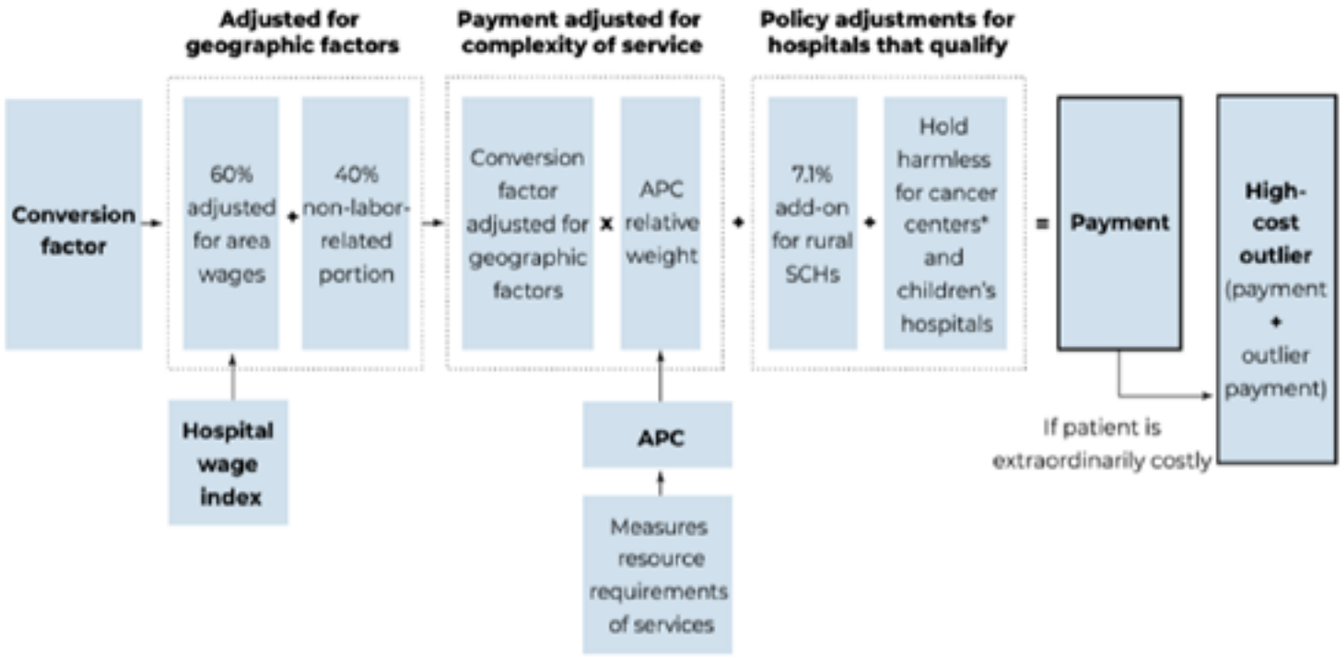


Exhibit 2: Calculation of OPPS Payment Rates[126]



Valuation of Hospitals: Technological Environment

[This is the final article in a five-part series regarding Valuing Hospitals. This installment was published in November 2024.]

Technological advancements have accelerated the shift of healthcare services from inpatient to outpatient settings,[127] creating both opportunities and challenges for hospitals. For instance, minimally invasive procedures often serve as alternatives to traditional, more invasive surgeries. Additionally, the integration of telehealth and artificial intelligence (AI) has the potential to enhance access to and quality of care while reducing expenditures and administrative burdens. This final installment of a five-part series on the valuation of hospitals examines the technological advancements transforming the industry.

Health Information Technology (HIT)

The rapid adoption of technological innovations has fundamentally reshaped the U.S. healthcare delivery system.[128] A prime example is healthcare information technology (HIT), encompassing applications such as billing software, staffing models, and electronic health records (EHR).[129] Studies show that HIT implementation can lead to greater efficiency and improved quality management.[130] For example, EHRs have driven cost savings, enhanced care quality, and improved care coordination.[131] Hospitals in particular many benefit from EHRs, which have demonstrated efficiency gains, financial savings, and clinical improvements, ultimately supporting hospital operations.[132]

Minimally Invasive Procedures

Minimally invasive surgical techniques enable physicians to perform procedures with less disruption to patients than traditional surgical methods. These techniques require smaller incisions, reducing pain and recovery time.[133] For high-risk patients, such as those with comorbidities, minimally invasive procedures may offer safer alternatives to traditional surgeries.[134] As technology and training have advanced, minimally invasive methods are now used for complex procedures, including knee arthroscopy, spine surgery.[135]

There are two main categories of minimally invasive surgery:

- Non-robotic, endoscopic (laparoscopic) surgery, wherein the physician performs the specified procedure through one or more incisions using small surgical instruments and video cameras; and,
- Robotic surgery, which utilizes small robotic arms equipped with surgical instruments, which the physician controls via console controllers and viewing a high-definition, 3D image on the console.[136]

For certain high-risk (e.g., elderly) patients, minimally invasive procedures may be a safer option than traditional surgery.[137] As the technology and training associated with minimally invasive surgery has advanced, it has been utilized to perform more advanced procedures (e.g., valve repair and coronary artery bypass surgery).[138] Ultimately, the broadening scope of procedures that may be performed using minimally invasive methods may result in nearly all procedures being able to be performed in the outpatient setting,[139] serving as a threat to hospitals that fail to adapt and integrate these advancements into their service offerings.

Artificial Intelligence (AI)

AI holds immense promise for revolutionizing the healthcare industry, particularly in hospitals where it can enhance patient care and streamline administrative tasks.[140] Notable applications of AI include:

(1) Clinical Decision Support: AI can process large datasets to improve diagnostic accuracy and treatment planning.[141]

(2) Diagnostic Imaging: AI has been instrumental in detecting and diagnosing conditions such as lung nodules and breast cancer through advanced data analysis.[142]

(3) Patient safety: AI can improve error detection, manage drug delivery, and identify potential complications earlier.[143]

Approximately 97% of the data captured from the 3.6 billion imaging procedures performed by hospitals every year is unused, presenting an opportunity for AI to review and synthesize what humans, with real-world time constraints, cannot.[144]

Despite its potential, AI adoption has been slowed by a lack of regulatory guidelines and the ethical challenges faced by providers. Nevertheless, nearly 50% of hospital CEOs and strategy leaders predict that by 2028, hospitals will have the infrastructure necessary to fully implement AI systems.[145]

Telehealth

Telehealth, defined as the "delivery of health care, health education, and health information services via remote technologies,"[146] has become nearly ubiquitous due to the shift from volume-based to value-based care. While adoption was initially limited, its use surged during the COVID-19 pandemic[147] as technology became more accessible and affordable to providers, and payors, including Medicare, expanded telehealth coverage. The use of telehealth has become increasingly popular among providers as well, with approximately 72% of all U.S. hospitals utilizing some form of telehealth in 2021.[148] Telehealth encompasses three main modalities:

(1) *Store-and-Forward* or "*asynchronous*" telehealth, where information such as medical histories, reports, or other data are sent to a specialist for diagnosis and treatment;

(2) *Remote patient monitoring*, where a patient's clinical status is evaluated continuously through video monitoring, images, or remotely reviewing tests; and,

(3) *Real-time* or "*synchronous*" telehealth, which consists of a live conversation between the patient and provider.[149]

Telehealth has proven especially valuable in rural areas, where 20% of Americans live but only 11% of physicians practice.[150] Telehealth may be particularly useful for patients and providers in these locations, as it may provide access to various medical specialists without having to travel great distances.[151] Beyond addressing geographic disparities, telehealth offers benefits such as convenience, improved patient engagement, and increased provider efficiency by reducing unnecessary in-person visits.[152]

In the past, the common refusal of payors to reimburse providers for telemedicine services limited the adoption of telemedicine technology.[153] However, as the market for this technology has grown, the availability of health insurance that reimburses providers for telemedicine services has also increased. As of October 2024, 43 states and the District of Columbia have enacted private payor laws.[154] Further, all states have Medicaid programs that include some level of telehealth coverage.[155] Prior to the COVID-19 pandemic, Medicare covered certain telehealth services (e.g., remote radiology, pathology and some cardiology) as physician services, and covers physician services via video conferencing for fee-for-service Medicare beneficiaries living in rural areas.[156] During the public health emergency, Medicare coverage was vastly expanded; however, these expansions are set to end on December 31, 2024 barring congressional intervention.[157] As reimbursement and regulatory frameworks evolve, hospitals are poised to leverage telehealth to improve accessibility, quality, and efficiency in healthcare delivery.

1 "IBISWorld Industry Report 62211: Hospitals in the US" By Marley Brocker, IBISWorld, February 2024, p. 10.
2 "CMS Releases 2023-2032 National Health Expenditure Projections" Centers for Medicare and Medicaid Services, June 12, 2024, https://www.cms.gov/newsroom/press-releases/cms-releases-2023-2032-national-health-expenditure-projections (Accessed 7/11/24).
3 Brocker, IBISWorld, February 2024, p. 12.
4 "Academic Medical Center (AMC)" Definitive Healthcare, https://www.definitivehc.com/resources/glossary/academic-medical-center#:~:text=Academic%20medical%20centers%20(AMCs)%20are,American%20Osteopathic%20Association%20(AOA). (Accessed 7/11/24); "Critical Access Hospitals (CAHs)" Definitive Healthcare, https://www.definitivehc.com/resources/glossary/critical-access-hospital#:~:text=A%20critical%20access%20hospital%20(CAH)%20is%20a%20medical%20center%20that,1%2C353%20CAHs%20in%20the%20U.S. (Accessed 7/18/24); "Specialty Hospitals" American Association of Orthopedic Surgeons, June 2016, https://www.aaos.org/globalassets/about/position-statements/1167-specialty-hospitals.pdf (Accessed 7/11/24); "Rural Emergency Hospitals" Rural Health Information Hub, https://www.ruralhealthinfo.org/topics/rural-emergency-hospitals (Accessed 7/11/24); "Short-Term Acute Care Hospital (STAC)" Definitive Healthcare, https://www.definitivehc.com/resources/glossary/short-term-acute-care-hospital#:~:text=What%20is%20a%20short%2Dterm,around%20half%20of%20the%20hospitals. (Accessed 7/18/24)
5 "Inpatient or outpatient hospital status affects your costs" Centers for Medicare & Medicaid Services, https://www.medicare.gov/what-medicare-covers/what-part-a-covers/inpatient-or-outpatient-hospital-status (Accessed 6/18/24).
6 Brocker, IBISWorld, February 2024, p. 31.
7 *Ibid*.
8 "Hospital Adjusted Expenses per Inpatient Day: 2022" Kaiser Family Foundation, State Health Facts, https://www.kff.org/health-costs/state-indicator/expenses-per-inpatient-day/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (Accessed 7/22/24); "Hospital average length of stay by state" Definitive Healthcare, June 21, 2023, https://www.definitivehc.com/resources/healthcare-insights/average-length-of-stay-by-state (Accessed 7/22/24).
9 "HCUP Fast Stats - Most Common Operations During Inpatient Stays: 2018" Healthcare Cost and Utilization Project, April 21, 2021, https://www.hcup-us.ahrq.gov/faststats/NationalProceduresServlet (Accessed 6/18/24).
10 "Top outpatient diagnoses by ICD-10 code" Definitive Healthcare, https://www.definitivehc.com/blog/top-outpatient-diagnoses-by-icd-10-code#:~:text=What%20were%20the%20most%20common,were%20frequently%20given%20in%202021. (Accessed 6/18/24).
11 "National Hospital Ambulatory Medical Care Survey: 2019 Emergency Department Summary Tables" Centers for Disease Control and Prevention, https://www.cdc.gov/nchs/data/nhamcs/web_tables/2019-nhamcs-ed-web-tables-508.pdf (Accessed 6/18/24).
12 *Ibid*
13 "Pop-Facts by Age, Race, Sex" Environics Analytics, 2022.
14 "Overview of U.S. Hospital Stays in 2016: Variation by Geographic Region" Healthcare Cost & Utilization Project, https://www.hcup-us.ahrq.gov/reports/statbriefs/sb246-Geographic-Variation-Hospital-Stays.jsp (Accessed 7/18/24); "Visits to physician offices, hospital outpatient departments, and hospital emergency departments, by age, sex, and race: United States" Centers for Disease Control and Prevention, https://data.cdc.gov/NCHS/Visits-to-physician-offices-hospital-outpatient-de/xt86-xqxz/data (Accessed 7/18/24).
15 "Health Care Utilization" By A.S. Watts and E.M. Crimmins, ScienceDirect, 2020, https://www.sciencedirect.com/topics/nursing-and-health-professions/health-care-utilization#:~:text=Older%20people%20have%20higher%20per,and%20long%2Dterm%20care%20services. (Accessed 7/11/24).
16 "Comparison of Medicare Fee-for-Service Beneficiaries Treated in Ambulatory Surgical Centers and Hospital Outpatient Departments" KNG Health Consulting, Prepared for American Hospital Association, April 4, 2019, https://www.aha.org/system/files/media/file/2019/04/kng-health-aha-analysis-of-hopd-vs-asc-report.pdf (Accessed 6/18/24), p. 7.
17 Brocker, IBISWorld, February 2024, p. 12.
18 *Ibid*, p. 48.
19 *Ibid*, p. 12.
20 "The Effect of Population Aging on Future Hospital Demand" By Bradley C. Strunk et al., Health Affairs, Vol. 25, No. 3 (March 28, 2006), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.25.w141 (Accessed 6/18/24), p. w141.
21 Brocker, IBISWorld, February 2024, p. 67-69.
22 *Ibid*.
23 "Chronic Diseases" Centers for Disease Control and Prevention, https://www.cdc.gov/chronic-disease/?CDC_AAref_Val=https://www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm (Accessed 7/29/24).
24 *Ibid*.
25 "Chronic disease excellence: "Service line 2.0" for health systems?" By Noam Bauman, Alex Harris, Amit Kunte, and Saum Sutaria, McKinsey April 19, 2018, https://www.mckinsey.com/industries/healthcare/our-insights/chronic-disease-excellence-service-line-20-for-health-systems (Accessed 7/29/24).
26 "Fast Facts on U.S. Hospitals, 2024" American Hospital Association, 2024, https://www.aha.org/statistics/fast-facts-us-hospitals (Accessed 6/18/24).
27 "Table 43. Community hospital beds and average annual percent change, by state: United States, selected years 1980–2018" Centers for Disease Control & Prevention, https://www.cdc.gov/nchs/data/hus/2019/043-508.pdf (Accessed 6/18/24).
28 "Hospital Outpatient Visits per 1,000 Population by Ownership Type" Kaiser Family Foundation, https://www.kff.org/other/state-indicator/outpatient-visits-by-ownership/?activeTab=graph&currentTimeframe=0&startTimeframe=23&selectedDistributions=total&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (Accessed 8/9/24).
29 "Hospital Industry Consolidation – Still More to Come?" By Leemore Dafny, Ph.D., New England Journal of Medicine, Vol. 370, No. 3 (January 16, 2014), http://www.nejm.org/doi/pdf/10.1056/NEJMp1313948 (Accessed 11/30/20), p. 198.
30 "A Wave of Hospital Mergers" New York Times, August 12, 2013, http://www.nytimes.com/interactive/2013/08/13/business/A-Wave-of-Hospital-Mergers.html (Accessed 6/18/24). New York Times analysis of data from Irving Levin Associates.
31 "2019 M&A in Review: In Pursuit of the New Bases of Competition" KaufmanHall, January 2020, available at: https://www.kaufmanhall.com/sites/default/files/documents/2020-01/2019_mergers_and_acquisitions_report_kaufmanhall.pdf (Accessed 8/9/24), p. 5.
32 "2021 M&A in Review: A New Phase in Healthcare Partnerships" By Anu Singh, KaufmanHall, January 10, 2022, https://www.kaufmanhall.com/insights/research-report/2021-ma-review-new-phase-healthcare-partnerships (Accessed 8/9/24).
33 "Hospital and Health System M&A in Review: Financial Pressures Emerge as Key Driver in 2023" KaufmanHall, January 18, 2024, https://www.kaufmanhall.com/insights/research-report/2023-hospital-and-health-system-ma-review (Accessed 8/9/24).
34 *Ibid*.
35 "Hospital Industry Consolidation – Still More to Come?" By Leemore Dafny, Ph.D., New England Journal of Medicine, Vol. 370, No. 3 (January 16, 2014), http://www.nejm.org/doi/pdf/10.1056/NEJMp1313948 (Accessed 6/18/24), p. 198; "Hospital Mergers Can Lower Costs and Improve Medical Care" By Kenneth L. Davis, Wall Street Journal, September 15, 2014, http://www.wsj.com/articles/kenneth-l-davis-hospital-mergers-can-lower-costs-and-improve-medical-care-1410823048?cb=logged0.5056344021577388 (Accessed 6/18/24).
36 "Ten Things to Know About Consolidation in Health Care Provider Markets" By Zachary Levinson, Jamie Godwin, Scott Hulver, and Tricia Neuman, Kaiser Family Foundation, April 19, 2024, https://www.kff.org/health-costs/issue-brief/ten-things-to-know-about-consolidation-in-health-care-provider-markets/#:~:text=Consolidation%20may%20allow%20providers%20to,evidence%20on%20quality%20is%20unclear. (Accessed 7/29/24).
37 *Ibid*.
38 "HHS Unveils Plans to Increase Healthcare Competition, Choice" By Jacqueline LaPointe, RevCycle Intelligence, December 5, 2018, https://revcycleintelligence.com/news/hhs-unveils-plans-to-increase-healthcare-competition-choice (Accessed 3/12/23).
39 "Executive Order on Promoting Competition in the American Economy" White House Press Release, July 9, 2021, https://www.whitehouse.gov/briefing-room/presidential-actions/2021/07/09/executive-order-on-promoting-competition-in-the-american-economy/ (Accessed 3/13/24).
40 "Unprecedented Executive Order 14036 "Promoting Competition in the American Economy" – a call to action" By Christopher Brennan, Selina Coleman, Brad Funari, and Michelle Mantine, July 15, 2021, https://www.reedsmith.com/en/perspectives/2021/07/unprecedented-executive-order-14036 (Accessed 3/13/24).
41 *Ibid*.
42 "White House Competition Council" White House, 2024, https://www.whitehouse.gov/competition/ (Accessed 3/14/24).
43 "2 N.J. health systems call off merger after federal lawsuit" By Spencer Kent, NewJersey.com, June 15, 2022, https://www.nj.com/healthfit/2022/06/2-nj-health-systems-call-off-merger-after-federal-lawsuit.html (Accessed 6/7/24).
44 "Following FTC Action, HCA, Steward Call Off Utah Deal" By David Raths, Healthcare Innovation, June 17, 2022, https://www.hcinnovationgroup.com/finance-revenue-cycle/mergers-acquisitions/news/21271444/following-ftc-action-hca-steward-call-off-utah-deal (Accessed 6/7/24).
45 "Lifespan and Care New England officially pull the plug on merger" By Patrick Anderson, The Providence Journal, February 23, 2022, https://www.providencejournal.com/story/news/politics/2022/02/23/ri-lifespan-and-care-new-england-pull-plug-on-merger/6914674001/ (Accessed 6/7/24).
46 "FTC's lawsuit can put the brakes on N.J. hospital merger - 3rd Circ" By Barbara Grzincic, Reuters, March 23, 2022, https://www.reuters.com/legal/litigation/ftcs-lawsuit-can-put-brakes-nj-hospital-merger-3rd-circ-2022-03-23/ (Accessed 6/7/24).
47 "Novant Health calls off North Carolina hospital deal, giving a win to the FTC" By Bob Herman, Stat News, June 19, 2024, https://www.statnews.com/2024/06/19/Novant Health-health-ends-north-carolina-hospital-deal-chs-ftc/ (Accessed 6/19/24).
48 "Understanding Mergers Between Hospitals and Health Systems in Different Markets" By Jamie Godwin, Zachary Levinson, and Scott Hulver, Kaiser Family Foundation, August 23, 2023, https://www.kff.org/health-costs/issue-brief/understanding-mergers-between-hospitals-and-health-systems-in-different-markets/ (Accessed 7/29/24).
49 *Ibid*.
50 *Ibid*.
51 *Ibid*; "Kaiser-owned Risant to buy North Carolina system Cone Health" By Susanna Vogel, HealthcareDive, June 24, 2024, https://www.healthcaredive.com/news/kaiser-permanente-owned-risant-health-buy-cone-health/719626/ (Accessed 8/9/24).
52 Kaiser Family Foundation, August 23, 2023; "Kaiser-owned Risant to buy North Carolina system Cone Health" By Susanna Vogel, HealthcareDive, June 24, 2024, https://www.healthcaredive.com/news/kaiser-permanente-owned-risant-health-buy-cone-health/719626/ (Accessed 8/9/24).
53 Brocker, IBISWorld, July 2022, p. 20, 30.
54 "Active Physician by Age and Specialty, 2021" American Association of Medical Colleges, https://www.aamc.org/data-reports/workforce/data/active-physicians-age-specialty-2021 (Accessed 6/18/24).
55 "Updated Report: Hospital and Corporate Acquisition of Physician Practices and Physician Employment 2019-2023" Prepared by Avalere Health for Physicians Advocacy Institute, April 2024, available at: (Accessed 8/9/24),
56 "Active Physician by Age and Specialty, 2021" American Association of Medical Colleges, https://www.aamc.org/data-reports/workforce/data/active-physicians-age-specialty-2021 (Accessed 6/18/24).
57 "The Complexities of Physician Supply and Demand: Projections from 2019 to 2034" By Tim Dall et al., IHS Markit, Report for Association of American Medical Colleges, June 2021, https://www.aamc.org/media/54681/download (Accessed 6/18/24), p. 35.
58 *Ibid*.
59 Brocker, IBISWorld, February 2024, p. 48.
60 "Could U.S. Hospitals Go The Way Of U.S. Airlines?" By Stuart H. Altman, David Shactman, and Efrat Eilat, Health Affairs, Vol. 25, No. 1, (Jan/Feb 2006), p. 19.
61 Brocker, IBISWorld, February 2024, p. 9.
62 *Ibid*, p. 12.
63 "Comparison of the Anti-Kickback Statute and Stark Law" Health Care Fraud Prevention and Enforcement Action Team (HEAT) Office of Inspector General (OIG), https://oig.hhs.gov/documents/provider-compliance-training/939/StarkandAKSChartHandout508.pdf (Accessed 6/13/24).
64 *Ibid*.
65 "Criminal Penalties for Acts Involving Federal Health Care Programs" 42 USC §

1320a-7b(b)(1).

66 "Re: OIG Advisory Opinion No. 15-10" By Gregory E. Demske, Chief Counsel to the Inspector General, Letter to [Name Redacted], July 28, 2015, https://oig.hhs.gov/fraud/docs/advisoryopinions/2015/AdvOpn15-10.pdf (Accessed 9/27/23), p. 4-5; "U.S. v. Greber" 760 F.2d 68, 69 (3d. Cir. 1985).

67 "Patient Protection and Affordable Care Act" Pub. L. No. 111-148, §§ 6402, 10606, 124 Stat. 119, 759, 1008 (March 23, 2010).

68 "Health Care Fraud and Abuse Laws Affecting Medicare and Medicaid: An Overview" By Jennifer A. Staman, Congressional Research Service, September 8, 2014, https://www.fas.org/sgp/crs/misc/RS22743.pdf (Accessed 6/13/24), p. 5.

69 "Health Care Reform: Substantial Fraud and Abuse and Program Integrity Measures Enacted" McDermott Will & Emery, April 12, 2010, p. 3; "Patient Protection and Affordable Care Act" Pub. L. No. 111-148, § 6402, 124 Stat. 119, 759 (March 23, 2010).

70 "Criminal Penalties for Acts Involving Federal Health Care Programs" 42 USC § 1320a-7b(b)(1); "Civil Monetary Penalties" 42 USC § 1320a-7a(a).

71 "False claims" 31 USC § 3729(a)(1)(G); "Civil Monetary Penalties Inflation Adjustments for 2023" Federal Register, Vol. 88, No. 19 (January 30, 2023), p. 5777.

72 Demske, Chief Counsel to the Inspector General, Letter to [Name Redacted], July 28, 2015, p. 5.

73 *Ibid*.

74 "Medicare and State Health Care Programs: Fraud and Abuse; Clarification of the Initial OIG Safe Harbor Provisions and Establishment of Additional Safe Harbor Provisions Under the Anti-Kickback Statute; Final Rule" Federal Register Vol. 64, No. 223 (November 19, 1999), p. 63518, 63520.

75 "Re: Malpractice Insurance Assistance" By Lewis Morris, Chief Counsel to the Inspector General, United States Department of Health and Human Services, Letter to [Name redacted], January 15, 2003, https://oig.hhs.gov/fraud/docs/alertsandbulletins/malpracticeprogram.pdf (Accessed 6/13/24), p. 1.

76 "Medicare and State Health Care Programs: Fraud and Abuse; Revisions to Safe Harbors Under the Anti-Kickback Statute, and Civil Monetary Penalty Rules Regarding Beneficiary Inducements" Federal Register, December 2, 2020, Vol. 85, No. 232, p. 77814-77815.

77 *Ibid*.

78 "CRS Report for Congress: Medicare: Physician Self-Referral ("Stark I and II")" By Jennifer O'Sullivan, Congressional Research Service, The Library of Congress, July 27, 2004, available at: http://www.policyarchive.org/handle/10207/bitstreams/2137.pdf (Accessed 6/13/24); "Limitation on certain physician referrals" 42 USC § 1395nn.

79 42 USC § 1395nn(a)(1)(B); "Definitions" 42 CFR § 411.351.

80 42 USC § 1395nn (a)(2).

81 42 USC § 1395nn (h)(1).

82 42 USC § 1395nn (g).

83 "Comparison of the Anti-Kickback Statute and Stark Law" Health Care Fraud Prevention and Enforcement Action Team (HEAT) Office of Inspector General (OIG), https://oig.hhs.gov/documents/provider-compliance-training/939/StarkandAKSChartHandout508.pdf (Accessed 6/13/24).

84 42 USC § 1395nn.

85 "Comparison of the Anti-Kickback Statute and Stark Law" Health Care Fraud Prevention and Enforcement Action Team (HEAT) Office of Inspector General (OIG), https://oig.hhs.gov/documents/provider-compliance-training/939/StarkandAKSChartHandout508.pdf (Accessed 6/13/24).

86 "Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations" Federal Register, Vol. 85, No. 232 (December 2, 2020), p. 77492.

87 *Ibid*, p. 77510-77528.

88 "False Claims Act Settlements and Judgments Exceed $2.68 Billion in Fiscal Year 2023" Office of Public Affairs, Department of Justice, February 22, 2024, https://www.justice.gov/opa/pr/false-claims-act-settlements-and-judgments-exceed-268-billion-fiscal-year-2023#:~:text=Settlements%20and%20judgments%20under%20the,Associate%20Attorney%20General%20Benjamin%20C (Accessed 9/11/24).

89 *Ibid*.

90 "Consolidated Omnibus Budget Reconciliation Act of 1985" Pub. L. No. 99-272, § 9121, 100 Stat. 82, 164 et seq. (April 7, 1986); "Understanding EMTALA" American College of Emergency Physicians, https://www.acep.org/life-as-a-physician/ethics--legal/emtala/emtala-fact-sheet/ (Accessed 6/13/24).

91 *Ibid*; "Examination and treatment for emergency medical conditions and women in labor" 42 U.S.C. § 1395dd(a).

92 Pub. L. No. 99-272, § 9121, 100 Stat. 82, 164 (April 7, 1986); "Emergency Medical Treatment & Labor Act (EMTALA)" Centers for Medicare & Medicaid Services, August 25, 2022, https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/ (Accessed 6/13/24); 42 U.S.C. § 1395dd(b).

93 Centers for Medicare & Medicaid Services, August 25, 2022; 42 U.S.C. § 1395dd(b).

94 42 U.S.C. § 1395dd(d).

95 "Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; etc." Federal Register Vol. 84, No. 218 (November 12, 2019), p. 61142-61146

96 "Transparency in Coverage" Centers for Medicaid & Medicare Services, October 30, 2020, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-Transparency-in-Coverage-9915F.pdf (Accessed 6/18/24).

97 *Ibid*.

98 *Ibid*.

99 "Hospital Price Transparency Fact Sheet" Centers for Medicare and Medicaid Services, November 2, 2023, https://www.cms.gov/newsroom/fact-sheets/hospital-price-transparency-fact-sheet (Accessed 6/18/24).

100 *Ibid*; "In OPPS rule, CMS increases payment rates by 3.1%, modifies price transparency rules" American Hospital Association, November 2, 2023, https://www.aha.org/news/headline/2023-11-02-opps-rule-cms-increases-payment-rates-31-modifies-price-transparency-rules (Accessed 6/18/24).

101 "What is a Healthcare Compliance Program?" By Steve Alder, The HIPAA Journal, January 12, 2024, https://www.hipaajournal.com/healthcare-compliance-program/#:~:text=The%20benefits%20of%20a%20healthcare%20compliance%20program%20are%20that%20the,and%20safety%20of%20patient%20care. (Accessed 9/11/24).

102 "NHE Fact Sheet" Centers for Medicare & Medicaid Services, September 10, 2024, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet (Accessed 9/25/24).

103 "Medicare's Role in Determining Prices Throughout the Health Care System: Mercatus Working Paper" By Roger Feldman et al., Mercatus Center, George Mason University, October 2015, https://www.mercatus.org/research/working-papers/medicares-role-determining-prices-throughout-health-care-system (Accessed 6/13/24), p. 3-5; "Physician Panel Prescribes the Fees Paid by Medicare" By Anna Wilde Mathews and Tom McGinty, The Wall Street Journal, October 26, 2010, https://www.wsj.com/articles/SB10001424052748704657305575540440173772102 (Accessed 6/13/24)

104 "Hospital Acute Inpatient Services Payment System" Medicare Payment Advisory Commission, Payment Basics, October 2023, https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_hospital_FINAL_SEC.pdf (Accessed 9/25/24), p. 1.

105 *Ibid*.

106 *Ibid*, p. 1-2.

107 *Ibid*.

108 *Ibid*.

109 *Ibid*, p. 3.

110 *Ibid*.

111 *Ibid*.

112 *Ibid*, p. 2-3.

113 *Ibid*, p. 3.

114 *Ibid*, p. 4-5.

115 "Hospital Outpatient PPS" Centers for Medicare & Medicaid Services, November 2, 2022, https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps (Accessed 6/13/24).

116 "Hospital Outpatient Hospital Services Payment System" Medicare Payment Advisory Commission, October 2023, https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_OPD_FINAL_SEC.pdf (Accessed 9/25/24), p. 1.

117 *Ibid*, p. 2.

118 "Hospital Outpatient Hospital Services Payment System" Medicare Payment Advisory Commission, January 2016, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf (Accessed 6/13/24), p. 6.

119 *Ibid*, p. 5, 6.

120 "Hospital Outpatient Hospital Services Payment System" Medicare Payment Advisory Commission, October 2023, p. 2.

121 *Ibid*, p. 3-4.

122 "Hospital Services Excluded from Payment under the Hospital Outpatient Prospective Payment System" 42 C.F.R. § 419.22.

123 *Ibid*.

124 "Hospital Readmissions Reduction Program (HRRP)" Centers for Medicare & Medicaid Services, August 5, 2022, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program (Accessed 10/15/24).

125 *Ibid*, p. 2.

126 *Ibid*, p. 2.

127 "Chapter 5: Ambulatory Surgical Center Services" in "Report to the Congress" Medicare Payment Advisory Commission, March 2022, https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch5_SEC.pdf (Accessed 6/18/24), p. 172.

128 "The Impact of Technology on Healthcare" American Institute of Medical Sciences and Education, June 2, 2019, https://www.aimseducation.edu/blog/the-impact-of-technology-on-healthcare/ (Accessed 3/28/24).

129 "Understanding the Costs and Benefits of Health Information Technology in Nursing Homes and Home Health Agencies: Case Study Findings" By Andrew Kramer MD, et al., U.S. Department of Health and Human Services, June 2009, https://aspe.hhs.gov/system/files/pdf/75876/HITcsf.pdf (Accessed 3/28/24), p. 1.

130 *Ibid*, p. iv-v.

131 American Institute of Medical Sciences and Education, June 2, 2019.

132 "Improved Diagnostics and Patient Outcomes" HealthIT, June 4, 2019, https://www.healthit.gov/providers-professionals/improved-diagnostics-patient-outcomes (Accessed 3/28/24); "Medical Practice Efficiencies and Cost Savings" HealthIT, August 13, 2018, https://www.healthit.gov/providers-professionals/medical-practice-efficiencies-cost-savings (Accessed 3/28/24).

133 "Minimally invasive surgery" Mayo Clinic, December 30, 2017, https://www.mayoclinic.org/tests-procedures/minimally-invasive-surgery/about/pac-20384771 (Accessed 10/23/24).

134 *Ibid*.

135 "Latest Minimally Invasive Surgery Options In Orthopedics" NY Orthopedics, https://www.newyorkorthopedics.com/2015/12/16/latest-minimally-invasive-surgery-options-in-orthopedics-ny/ (Accessed 10/23/24).

136 "Minimally Invasive Surgery" Johns Hopkins Medicine, https://www.hopkinsmedicine.org/surgery/specialty-areas/minimally-invasive (Accessed 10/23/24).

137 "Minimally invasive procedures offer hope for elderly patients with heart-valve problems" By Cathy Frisinger, UTSouthwestern Medical Center Newsroom, October 8, 2014, https://www.sciencedaily.com/releases/2014/10/141008140935.htm (Accessed 6/18/24).

138 "Cardiac (heart) conditions" da Vinci Surgery, https://www.davincisurgery.com/procedures/cardiac-surgery (Accessed 6/18/24).

139 See "Ambulatory Surgery Centers – A Positive Trend in Health Care" Ambulatory Surgery Center Association, https://higherlogicdownload.s3.amazonaws.com/ASCACONNECT/fd1693e2-e4a8-43d3-816d-17ecfc7d55c1/UploadedImages/About%20Us/ASCs%20-%20A%20Positive%20Trend%20in%20Health%20Care.pdf (Accessed 6/18/24).

140 "How AI Is Improving Diagnostics, Decision-Making and Care" American Hospital Association, https://www.aha.org/aha-center-health-innovation-market-scan/2023-05-09-how-ai-improving-diagnostics-decision-making-and-care#:~:text=Artificial%20intelligence%20(AI)%20holds%20great,survey%20of%20health%20care%20leaders. (Accessed 11/12/24).

141 "The Role of AI in Hospitals and Clinics: Transforming Healthcare in the 21st Century" By Shiva Maleki Varnosfaderani and Mohamad Forouzanfar, Bioengineering, Vol. 11, NO. 4 (March 2024), https://pmc.ncbi.nlm.nih.gov/articles/PMC11047988/ (Accessed 11/12/24).

142 "How AI Is Improving Diagnostics, Decision-Making and Care" American Hospital Association.

143 *Ibid*.

144 Shiva Maleki Varnosfaderani and Mohamad Forouzanfar, Bioengineering, Vol. 11, NO. 4, March 2024.

145 "How AI Is Improving Diagnostics, Decision-Making and Care" American Hospital Association.

146 Note that "The terms telehealth and telemedicine are often used interchangeably, but telehealth has evolved to encapsulate a broader array of digital healthcare activities and services." "What Is Telehealth?" NEJM Catalyst, https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0268 (Accessed 6/18/24).

147 "New HHS Study Shows 63-Fold Increase in Medicare Telehealth Utilization During the Pandemic" U.S. Department of Health and Human Services, December 3, 2021, https://www.hhs.gov/about/news/2021/12/03/new-hhs-study-shows-63-fold-increase-in-medicare-telehealth-utilization-during-pandemic.html (Accessed 6/18/24).
148 "Study Finds Rapid Rise Of Telehealth Use In U.S. Hospitals" By Victoria Forster, Forbes, July 12, 2024, https://www.forbes.com/sites/victoriaforster/2024/07/12/rapid-rise-of-telehealth-use-in-us-hospitals/ (Accessed 11/12/24).
149 "Telehealth Systems" By Oren Mechanic, Yudy Persaud, and Alexa Kimball, StatPearls, September 12, 2022, https://www.ncbi.nlm.nih.gov/books/NBK459384/ (Accessed 6/18/24).
150 "Attracting the next generation of physicians to rural medicine" By Peter Jaret, Association of American Medical Colleges, February 3, 2020, https://www.aamc.org/news-insights/attracting-next-generation-physicians-rural-medicine (Accessed 6/18/24).
151 "Telehealth Use in Rural Healthcare" Rural Health Information Hub, July 1, 2021, https://www.ruralhealthinfo.org/topics/telehealth (Accessed 6/18/24).
152 "Why Telemedicine's Time Has Finally Come" By Zina Moukheiber, Forbes, January 13, 2015, http://www.forbes.com/sites/zinamoukheiber/2015/01/13/why-telemedicines-time-has-finally-come/ (Accessed 6/18/24).
153 "Virtual reality: More Insurers are Embracing Telehealth" By Bob Herman, Modern Healthcare, February 20, 2016, https://www.modernhealthcare.com/article/20160220/MAGAZINE/302209980/virtual-reality-more-insurers-are-embracing-telehealth (Accessed 6/18/24).
154 "Telehealth Private Insurance Laws" National Conference of State Legislatures, October 24, 2024, https://www.ncsl.org/health/the-telehealth-explainer-series/telehealth-private-insurance-laws#:~:text=Forty%2Dthree%20states%20and%20the,to%20as%20%E2%80%9Cpayment%20parity.%E2%80%9D (Accessed 11/12/24).
155 "State Medicaid Telehealth Policies Before and During the COVID-19 Public Health Emergency" Assistant Secretary for Planning and Evaluation, Office of Health Policy, Issue Brief HP-2021-17, National Conference of State Legislatures, July 2021, https://aspe.hhs.gov/sites/default/files/2021-07/medicaid-telehealth-brief.pdf (Accessed 6/18/24).
156 "Telehealth Services" Centers for Medicare & Medicaid Services, Medicare Learning Network, MLN Fact Sheet MLN901705, June 2021, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf (Accessed 6/18/24).
157 "Additional Background: Sweeping Regulatory Changes to Help U.S. Healthcare System Address COVID-19 Patient Surge" Centers for Medicare and Medicaid Services, March 30, 2020, https://www.cms.gov/newsroom/fact-sheets/additional-backgroundsweeping-regulatory-changes-help-us-healthcare-system-address-covid-19-patient (Accessed 6/18/24).

Valuation of Cardiovascular Services: Introduction

[This is the first article in a five-part series regarding Valuing Cardiovascular Services. This installment was published in December 2024.]

Cardiovascular disease (CVD) is the leading cause of death in the U.S., accounting for approximately one out of every five deaths.[1] Approximately 48.6% of American adults have at least one form of CVD, and the prevalence increases with age in both male and females.[2] It is estimated that the average annual direct and indirect costs of CVD in the U.S. totaled $422.3 billion from 2019 to 2020,[3] and by 2035, costs associated with CVD are expected to be in the trillions.[4] Treatment of CVD and the heart is performed by a number of physician specialties, including internal medicine physicians specializing in cardiology, cardiovascular surgeons, and vascular surgeons. This first installment in a five-part series on the valuation of cardiovascular services provides a brief overview of the myriad cardiovascular specialties.

Surgical treatment of cardiovascular disorders, including minimally invasive surgeries, typically fall under the domain of thoracic surgeons, while cardiologists primarily treat cardiovascular conditions through medication.[5] However, the cardiothoracic surgeon is a part of a more holistic heart health team, which includes a patient's primary care physician, cardiologist, and cardiac rehabilitation team working to help the patient to recover from heart surgery.[6] Additionally, cardiothoracic surgeons and cardiologists may collaborate with physicians in other, related specialties, such as vascular surgeons, in order to provide comprehensive cardiac care to a patient.[7]

Cardiologists

Cardiologists typically focus on diagnosis, medical management (including the use of medications), and prevention of cardiovascular disease (CVD), rather than on surgical operations on the heart.[8] Additionally, a cardiologist may play a major role in a patient's cardiac rehabilitation program, which can help a patient to recover from heart surgery and prevent future heart problems.[9]

To become board certified in the treatment of CVD, a physician must first receive certification in internal medicine from the American Board of Internal Medicine (ABIM).[10] To earn this certification, the applicant must first complete a three-year internal medicine residency, which requires residents to master a broad range of clinical disorders, treatments, and preventive measures in a variety of clinical settings, including inpatient, critical, and ambulatory care.[11] Once certified as an internist, the physician must then complete a three-year graduate medical education fellowship in CVD.[12] These programs require fellows to demonstrate an ability to prevent, evaluate, and manage various cardiovascular conditions, as well as display competence in the performance of various cardiovascular procedures.[13]

The ABIM offers four subspecialties to those physicians who are already certified in CVD: (1) Advanced Heart Failure and Transplant Cardiology; (2) Clinical Cardiac Electrophysiology; (3) Interventional Cardiology; and, (4) Adult Congenital Heart Disease.[14] According to the *Accreditation Council for Graduate Medical Education* (ACGME), fellowships in these subspecialties of CVD provide further training in the following areas:

(1) Advanced Heart Failure and Transplant Cardiology – Focuses on its titular subjects of heart failure and heart transplants;[15]

(2) Clinical Cardiac Electrophysiology – Focuses on the diagnosis and treatment of arrhythmias, including the use of implantable electronic devices;[16]

(3) Interventional Cardiology – Focuses on techniques which improve coronary circulation and treat structural heart diseases;[17] and

(4) Adult Congenital Heart Disease – Focuses on the treatment of adult patients with congenital defects in the structures of the heart or blood vessels, often providing care over a long period of time.[18]

Among other requirements, each of these four certifications requires the successful completion of an accredited fellowship in their respective fields.[19]

Cardiovascular Surgeons

The Society of Thoracic Surgeons (STS) defines a cardiovascular surgeon (also known as a cardiothoracic surgeon, cardiac surgeon, or thoracic surgeon) as "*...a medical doctor who specializes in surgical procedures of the heart, lungs, esophagus, and other organs in the chest.*"[20] The STS notes that cardiovascular surgeons who focus on certain areas within thoracic surgery may be referred to by other names. For example, a surgeon who focuses on the heart and major blood vessels is typically referred to as a *cardiac* or *cardiovascular surgeon*, but the STS has stated that the terms *thoracic surgeon* and *cardiothoracic surgeon* are interchangeable.[21]

Procedures provided by cardiovascular surgeons include:

(1) Coronary artery bypass grafting (CABG), also called heart bypass, surgery;
(2) Valve repair or replacement;
(3) Repair of thoracic aneurysms;
(4) Minimal access cardiac surgery;
(5) Ventricular remodeling; and,
(6) Heart transplant.[22]

In order to be certified as a cardiovascular surgeon by the American Board of Thoracic Surgery (ABTS), a candidate for certification must complete a residency in thoracic surgery.[23] Completion of a residency in thoracic surgery requires residents to demonstrate competence in several areas, e.g.: (1) critical care of both trauma patients and patients with thoracic and cardiovascular surgical disorders (with or without operative intervention); (2) management of thoracic and cardiovascular patients before and after operation; and (3) utilization and interpretation of diagnostic procedures.[24]

Notably, traditional certification in thoracic surgery requires prior certification in either general surgery or vascular surgery, for a total of seven years in residency training (i.e., two years of thoracic surgery and five years of either general or vascular surgery).[25] If the candidate for thoracic surgery certification does not have prior certification in general surgery or vascular surgery, the candidate may enter a seven-year joint program in order to simultaneously complete residencies in both general surgery and thoracic surgery.[26] As a third alternative, some programs offer integrated programs that require only six years of training (two to three of which focus on core surgical education), but only offer certification in thoracic surgery (i.e., candidates would not be qualified for additional certification in general surgery).[27]

Upon completion of their thoracic surgery certification, physicians may elect to pursue subspecialty certification in congenital cardiac surgery (i.e., surgical treatment of heart problems that are present at birth), which requires an additional fellowship year focusing on congenital defects of the heart and major blood vessels, such as septal defects (holes in the heart).[28] Although thoracic surgeons may focus on various specific areas within the specialty, such sub-specialization may not be accompanied by additional ABTS certifications.

Vascular Surgeons

While *cardiologists* and *cardiovascular surgeons* provide treatment for the heart itself, *vascular surgeons* treat disorders of the arteries, veins, and lymphatic system.[29] These physicians often perform balloon angioplasties, stenting, and bypass surgeries.[30] Some of the more common services that vascular surgeons furnish include stroke prevention, revascularization in order to treat poor circulation, and management of aneurysms.[31] In some cases, vascular surgeons may work in collaboration with interventional cardiologists,[32] which may lead to improved patient outcomes.

Vascular surgeons may follow three different educational paths to become eligible for board certification in vascular surgery. Traditionally, physicians complete a five-year residency in general surgery, with an additional two years of training specifically tailored to vascular surgery techniques independent of the general surgery residency program.[33] Physicians embarking on this training pathway become eligible to earn certification in both general surgery and vascular surgery.[34] In addition to this traditional pathway, physicians may complete two alternative pathways to become eligible for board certification in vascular surgery. First, physicians may complete four years of residency in an early specialization program in general surgery, with two years of vascular surgery training proceeding the initial residency at the same institution.[35] Similar to the traditional pathway, physicians embarking on this training pathway become eligible to earn certification in both general surgery and vascular surgery.[36] Second, physicians may participate in a five-year integrated program starting upon medical school graduation, with some of that time devoted to general surgery training and the rest devoted to vascular surgery training.[37] Unlike the other pathways to vascular surgery board certification eligibility, the integrated pathway only allows residents to achieve board certification in vascular surgery.[38]

Conclusion

The market for cardiovascular services may experience increasing demand in the coming years, due to an aging U.S. population, which may increase the number of people seeking these services. As demand increases, the supply of cardiovascular providers will likely decrease, due to an imbalance between the number of these physicians who are moving toward retirement and the number of residents that are entering these fields. The next installment in this five-part series will explore the competitive environment in which cardiovascular providers operate.

Valuation of Cardiovascular Services: Competitive Environment

[This is the second article in a five-part series regarding Valuing Cardiovascular Services. This installment was published in January 2025.]

Demand for a variety of healthcare services, including cardiovascular services, is likely to increase significantly in the near future, primarily as a result of the increasing proportion of Americans over the age of 65. As noted in the first installment in this series, cardiovascular disease (CVD) is the leading cause of death in the U.S., rendering cardiovascular services in particularly high demand. However, at the same time that need for these services is increasing, the supply of these services, measured by the number of actively practicing physicians in cardiac specialties, is decreasing, leading to a potential tipping point in the foreseeable future. This second installment in a five-part series on the valuation of cardiovascular services reviews the competitive environment in which these providers operate.

Demand for Cardiovascular Services

Demand for cardiovascular services is likely to increase in the near future, primarily as a result of changing demographic and regulatory trends in the U.S. Population growth, most notably growth in the U.S. aging population, is increasing demand for a variety of cardiovascular services, as the prevalence of CVD is growing.[39] In addition to demand generated by population growth and aging, the incidence and prevalence of many of the risk factors for CVD are also increasing, which means that not only will more elderly people require cardiovascular surgical procedures, but younger, less healthy adults may also require earlier cardiovascular interventions.

As noted above, CVD is the leading cause of death in the U.S., accounting for approximately one out of every five deaths.[40] Approximately 127.9 million adults in the U.S. (48.6% of the population) have at least one form of CVD.[41] It is estimated that the average annual direct and indirect costs of CVD in the U.S. totaled $422.3 billion from 2019 to 2020.[42] By 2050, costs associated with CVD are expected to be in the trillions, with the total cost across all conditions expected to triple for those age 80 and older, and double for those between the ages of 20 and 44.[43]

The significant prevalence of CVD among adults over age 60 reflects one of the biggest non-modifiable risk factors for CVD – increasing age.[44] Equally important perhaps are social determinants of health; these modifiable risk factors account for 80% of cardiovascular health outcomes.[45] A study published in the *Journal of Gerontology* cited evidence that multi-morbidity is increasing in the age groups that are just beginning to enter the older stages of adulthood.[46] With the number of U.S. adults age 65+ projected to grow more than 50% by 2050, the increase in multi-morbidities will place a strain on the healthcare system.[47] With this increase in multi-morbidities in older age groups, it is likely that the demand for healthcare services, including for cardiovascular surgery, will likely increase as well. However, population cohorts other than the elderly are also responsible for the increased utilization of cardiovascular surgical services, as leading risk factors for CVD include tobacco smoking, diet, physical activity, and high weight.[48]

Smoking increases the risk of developing CVD by: (1) increasing blood pressure; (2) narrowing and stiffening the arteries due to the buildup of plaque; (3) thickening blood, making clotting more likely; and (4) depriving the blood stream of essential oxygen.[49] Studies have shown that smoking increases the risk of CVD and all its subtypes, with risk doubling for acute myocardial infarctions (AMI), heart failure, and cerebrovascular disease.[50] Further, smoking negatively affects physical endurance, reducing overall physical fitness; smokers also can have poor physical performance and increased risk of injuries.[51]

Obesity (i.e., body mass index over 30.0) increases the risk of developing CVD by: (1) increasing blood pressure and (2) increasing blood cholesterol, which may lead to increased plaque buildup in the circulatory system.[52] The U.S. obesity prevalence from 2017 through March 2020 was 41.9%, and the estimated annual medical cost of obesity is $173 billion.[53] By 2030, estimates suggest that nearly half of all American adults will be obese, and nearly 1 in 4 will be severely obese;[54] by 2050, approximately 20% of children, 33% of adolescents, and 66% of adults, are expected to be obese.[55]

Supply of Cardiovascular Services

According to data from the Association of American Medical Colleges (AAMC), in 2023 there were 22,843 active physicians specializing in CVD, 4,693 specializing in thoracic surgery, and 4,464 in vascular surgery.[56] Approximately 70% of these providers are employed by hospitals or health systems, and less than 20% are employed by an independent practice.[57] Cardiac specialists tend to be older than other specialists; as of 2023, 38.2% of CVD physicians, 33.5% of thoracic surgeons, and 20.3% of vascular surgeons were age 65+.[58] Among all physicians, approximately 23.4% are age 65+.[59] According to an AAMC physician workforce analysis, physicians typically retire around age 67.[60] Further, the hours worked per week remained consistent for men (specifically) through age 59, but started to decrease beyond age 60.[61] This progressive decline in physician productivity associated with aging indicates that the supply of cardiovascular providers will be restricted not only by the decline in the absolute number of surgeons, but also by the reduction in services offered by the aging CVD physician workforce. Even though cardiologists tend to work longer than other specialists,[62] these figures still indicate that the cardiovascular workforce will be significantly reduced in the next few years, and even more will likely reduce their hours work, further reducing the cardiovascular workforce.

Compounding the workforce reductions brought on by retirement (and reduced working hours leading up to retirement) is that fewer cardiovascular providers are entering the workforce than are leaving it,[63] resulting in a declining supply of cardiovascular providers even while demand for their services is increasing.

Conclusion

The market for cardiovascular services is expected to experience increasing demand in the coming years, due to an aging U.S. population and the growing prevalence of risk factors for cardiac conditions. As demand increases, the supply of cardiovascular providers is anticipated to simultaneously decrease, as the population of physicians continue to move toward retirement while the number of residents entering these fields remains insufficient to replace older physicians. Despite growing demand, cardiovascular providers may face challenges in the reimbursement for their services, where stagnating Medicare reimbursement rates may serve as one of the most significant challenges currently faced by these specialists. The third installment in this series will review the reimbursement environment in which cardiovascular providers operate.

Valuation of Cardiovascular Services: Reimbursement Environment

[This is the third article in a five-part series regarding Valuing Cardiovascular Services. This installment was published in February 2025.]

The U.S. government is the largest payor of medical costs, through Medicare and Medicaid, and has a strong influence on reimbursement to hospitals. In 2023, Medicare and Medicaid accounted for an estimated $1.03 trillion and $871.8 billion in healthcare spending, respectively.[64] The prevalence of these public payors in the healthcare marketplace often results in their acting as a price setter, and being used as a benchmark for private reimbursement rates.[65]

Medicare pays for physician services, including cardiovascular services, through the Physician Fee Schedule (MPFS), which calculates payments according to Medicare's Resource Based Relative Value Scales (RBRVS) system, which assigns relative value units (RVUs) to individual procedures based on the resources required to perform each procedure. Under this system, each procedure in the MPFS is assigned RVUs for three categories of resources: (1) physician work (wRVUs); (2) practice expense (PE RVUs); and, (3) malpractice expense (MP RVUs). Further, each procedure's RVUs are adjusted for local geographic differences using Geographic Practice Cost Indexes (GPCIs) for each RVU component. Once the procedure's RVUs have been modified for geographic variance, they are summed, and the total is then multiplied by a conversion factor (CF) to obtain the dollar amount of governmental reimbursement.

The methodology for calculating the Medicare physician reimbursement amount for a specific procedure and location is illustrated below in Exhibit 1.

The wRVU component represents the physician's contribution of time and effort to the completion of a procedure. The higher the value of the code, the more skill, time, and work it takes to complete.

The PE RVU is based on direct and indirect physician practice expenses involved in providing healthcare services. Direct expense categories include: clinical labor, medical supplies, and medical equipment. Indirect expenses include: administrative labor, office expenses, and all other expenses.

MP RVUs correspond to the relative malpractice practice expenses for medical procedures.[66] These values are updated at least every five years and typically comprise the smallest component of the RVU.[67] Due to the variation in malpractice costs among states and specialties, the malpractice component must be weighted geographically and across specialties.[68]

The GPCI accounts for the geographic differences in the costs of maintaining a practice. Every Medicare payment locality has a GPCI for the work, practice, and malpractice component.[69] A locality's GPCI is determined by taking into consideration median hourly earnings of workers in the area, office rents, medical equipment and supplies, and other miscellaneous expenses.[70] There are currently 109 GPCI payment localities.[71]

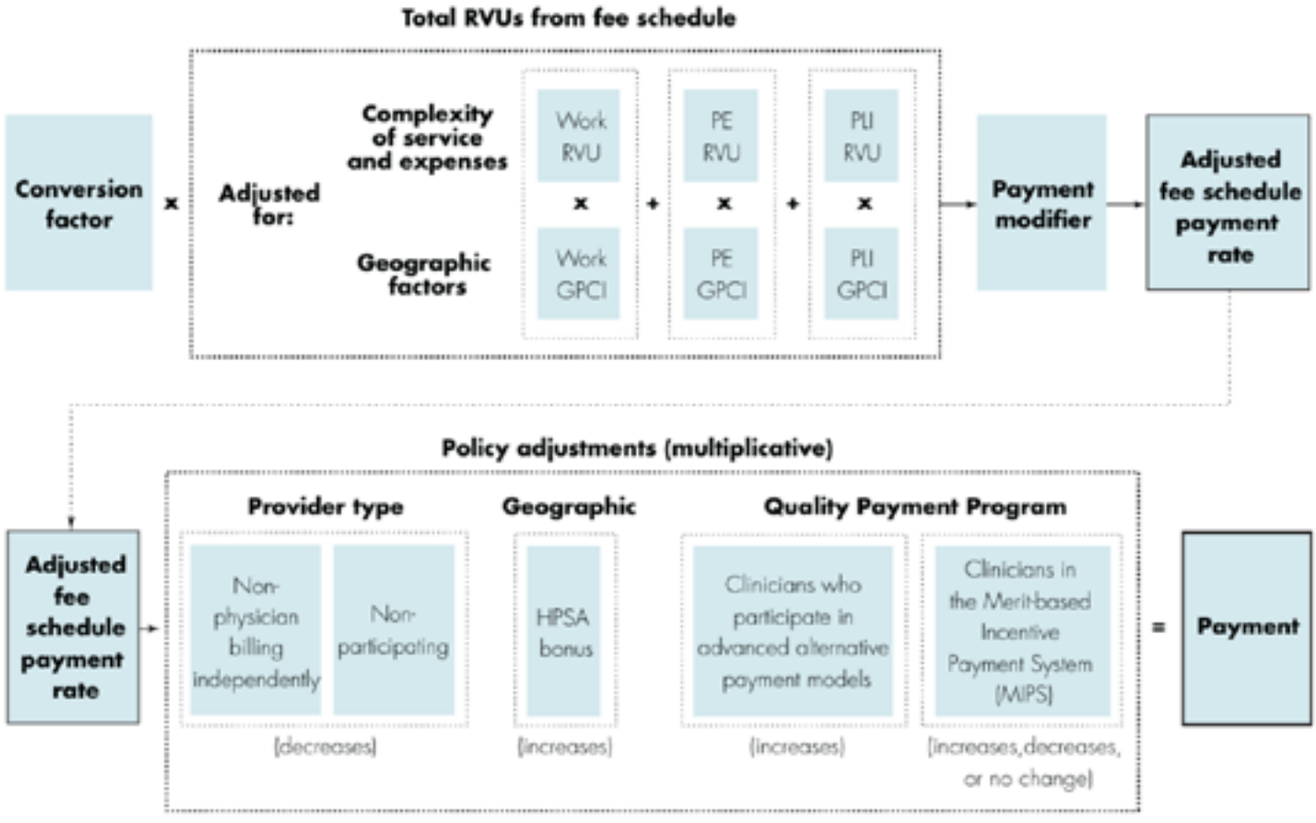
The CF is a monetary amount that is multiplied by the RVU from a locality to determine the payment amount for a given service.[72] This CF is updated yearly by a formula that takes into account: (1) the previous year's CF; (2) the estimated percentage increase in the Medicare Economic Index (MEI) for the year (which accounts for inflationary changes in office expenses and physician earnings); and (3) an update adjustment factor.[73] All physician services, except anesthesia services, use a single CF.[74]

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) contains a predetermined schedule of updates to the CF. However, these annual updates have been 0% since 2020, and will continue through 2025.[75] It should be noted that, although the annual updates to the MPFS will be stagnant for at least the next couple of years, MACRA includes several provisions related to financial rewards for providers who furnish efficient, high quality healthcare services.

For 2025, payment amounts were cut for the fifth straight year, with the MPFS conversion factor decreasing by 2.83%.[76] For cardiovascular providers specifically, the American College of Cardiology (ACC) stated that "Overall reimbursement for cardiovascular services is projected to remain flat compared to 2024, with changes to policies and individual services roughly balancing out. However, individuals and groups will see different impacts depending on patient populations and services offered."[77] Reimbursement may be ameliorated for 2025 if the *Medicare Patient Access and Practice Stabilization Act* (H.R. 879) is passed. The bipartisan bill, which is supported by the ACC, would increase Medicare physician payments by 6.62% from April through December 2025, which increase would also serve to offset the pay cut physicians experienced between January and March.[78]

As alluded to above, the reimbursement environment is strongly driven by the complex regulatory environment, with both the executive and legislative branches at the mercy of shifting political tides. Accordingly, the current state of the regulatory environment in which cardiovascular providers operate will be addressed in the next installment of this five-part series.

Exhibit 1: Calculation of the MPFS Payment[79]



Valuation of Cardiovascular Services: Regulatory Environment

[This is the fourth article in a five-part series regarding Valuing Cardiovascular Services. This installment was published in March 2025.]

Cardiovascular service providers face a range of federal and state legal and regulatory constraints, which affect their formation, operation, procedural coding and billing, and transactions. Fraud and abuse laws, specifically those related to the federal Anti-Kickback Statute (AKS) and physician self-referral laws (the "Stark Law"), may have the greatest impact on the operations of healthcare providers.

The AKS and Stark Law are generally concerned with the same issue – the financial motivation behind patient referrals. However, while the AKS is broadly applied to payments between providers or suppliers in the healthcare industry and relates to any item or service that may be paid for under any federal healthcare program, the Stark Law specifically addresses the referrals from physicians to entities with which the physician has a financial relationship for the provision of defined services that are paid for by the Medicare program.[80] Additionally, while violation of the Stark Law carries only civil penalties, violation of the AKS carries both criminal and civil penalties.[81]

Anti-Kickback Statute

The federal AKS makes it a felony for any person to "*knowingly and willfully*" solicit or receive, or to offer or pay, any "*remuneration*", directly or indirectly, in exchange for the referral of a patient for a healthcare service paid for by a federal healthcare program,[82] even if only one purpose of the arrangement in question is to offer remuneration deemed illegal under the AKS.[83] Notably, a person need not have actual knowledge of the AKS or specific intent to commit a violation of the AKS for the government to prove a kickback violation,[84] only an awareness that the conduct in question is "generally unlawful."[85] Further, a violation of the AKS is sufficient to state a claim under the *False Claims Act* (FCA).[86]

Criminal violations of the AKS are punishable by up to ten years in prison, criminal fines up to $100,000, or both, and civil violations can result in administrative penalties, including exclusion from federal healthcare programs, and civil monetary penalties plus treble damages (or three times the illegal remuneration).[87] In addition to the civil monetary penalties paid under the AKS, if the AKS violation triggers liability under the FCA, defendants can incur additional civil monetary penalties of $13,508 to $27,018 per violation, plus treble damages.[88]

Due to the broad nature of the AKS, legitimate business arrangements may appear to be prohibited.[89] In response to these concerns, Congress created a number of statutory exceptions and delegated authority to HHS to protect certain business arrangements by means of promulgating several *safe harbors*.[90] These *safe harbors* set out regulatory criteria that, if met, shield an arrangement from regulatory liability, and are meant to protect transactional arrangements

unlikely to result in fraud or abuse.[91] Failure to meet all of the requirements of a *safe harbor* does not necessarily render an arrangement illegal.[92] It should be noted that, in order for a payment to meet the requirements of many AKS safe harbors, the compensation must not exceed the range of fair market value.

The HHS Office of Inspector General (OIG) made several revisions to the AKS in 2020, many of which are similar to those revisions to the Stark Law made by CMS, as discussed below.[93] Among the more notable revisions are new safe harbors for value-based arrangements (the safe harbor requirements for which arrangements lessen as the participants take on more financial risk) and revisions to existing safe harbors.[94]

Stark Law

The Stark Law prohibits physicians from referring Medicare patients to entities with which the physicians or their family members have a financial relationship for the provision of designated health services (DHS).[95] Further, when a prohibited referral occurs, entities may not bill for services resulting from the prohibited referral.[96] Under the Stark Law, DHS include, but are not limited to, the following:

(1) Inpatient and outpatient hospital services;
(2) Radiology and certain other imaging services;
(3) Radiation therapy services and supplies;
(4) Certain therapy services, e.g. physical therapy;
(5) Durable medical equipment; and,
(6) Outpatient prescription drugs.[97]

Under the Stark Law, financial relationships include ownership interests through equity, debt, other means, and ownership interests in entities that also have an ownership interest in the entity providing DHS.[98] Additionally, financial relationships include compensation arrangements, which are defined as arrangements between physicians and entities involving any remuneration, directly or indirectly, in cash or in kind.[99]

Civil penalties under the Stark Law include overpayment or refund obligations, a potential civil monetary penalty of $15,000 for each service, plus treble damages, and exclusion from Medicare and Medicaid programs.[100] Further, similar to the AKS, violation of the Stark Law can also trigger a violation of the FCA.[101]

Notably, the Stark Law contains a large number of exceptions, which describe ownership interests, compensation arrangements, and forms of remuneration to which the Stark Law does not apply.[102] Similar to the AKS safe harbors, without these exceptions, the Stark Law may prohibit legitimate business arrangements. It must be noted that in order to meet the requirements of many exceptions related to compensation between physicians and other entities, compensation must: (1) not exceed the range of fair market value; (2) not take into account the volume or value of referrals generated by the compensated physician; and, (3) be commercially reasonable. Unlike the AKS safe harbors, an arrangement must fully fall within one of the exceptions in order to be shielded from enforcement of the Stark Law.[103]

As noted above, CMS made a number of revisions to the Stark Law in December 2020, including:

(1) Revised definitions for Fair Market Value, General Market Value, and Commercial Reasonableness; and,
(2) New permanent exceptions for value-based arrangements.[104]

Importantly, the new value-based arrangements exceptions protect the following arrangements:

(1) Full Financial Risk Arrangements: Includes capitated payments and predetermined rates or a global budget;
(2) Value-Based Arrangements with Meaningful Downside Financial Risk: Where a physician pays no less than 25% of the value of the remuneration the physician receives when he or she does not meet pre-determined benchmarks; and,
(3) Value-Based Arrangements: Applies regardless of risk level to encourage physicians to enter value-based arrangements, even if they only assume upside risk.[105]

It is important to note that, the regulatory scrutiny of healthcare entities (especially with regard to fraud and abuse violations) has generally increased over the past decade. Therefore, under current regulation, the severe penalties that may be levied against healthcare providers under the AKS, the Stark Law, and/or the FCA will likely raise a hypothetical employer's estimate of the risk related to the value of the subject cardiovascular services.

Valuation of Cardiovascular Services: Technological Advancements

[This is the final article in a five-part series regarding Valuing Cardiovascular Services. This installment was published in April 2025.]

Cardiac technologies have continually evolved over the years, changing the practice and purview of cardiology providers, as well as the demand for cardiac services. By 2035, the overall prevalence of cardiovascular disease (CVD) is expected to increase from 102.7 million in 2015 to 131.2 million cases, affecting 45% of the total U.S. population, with the highest prevalence in those 65 years and older.[106] As the cardiovascular market grows, providers can expect the types of technologies used to diagnose and treat CVD, particularly minimally invasive devices and procedures, to expand as well. This final installment of a five-part series on the valuation of cardiovascular services examines the technological advancements transforming the industry.

Minimally Invasive Procedures

Minimally invasive surgical procedures allow physicians to provide services in a manner that causes less disruption to the patient than a traditional surgical method, thus causing fewer complications, less pain, and reduced recovery time.[107] For certain high-risk patients (e.g., elderly patients), minimally invasive procedures may be a safer option than traditional surgery.[108] As the technology and training associated with minimally invasive surgery has advanced, it has been utilized to perform an array of cardiac procedures, including Transcatheter Aortic Valve Replacement (TAVR), Percutaneous Coronary Interventions (PCI), and Electrophysiology Procedures.[109] In particular, TAVR is one of the fastest growing minimally invasive procedures, as it is used to treat high-risk patients with severe aortic stenosis who are ineligible for traditional open heart surgery.[110]

There are two primary types of minimally invasive surgery:

(1) *Endoscopy* (also referred to as *laparoscopy*), wherein the physician performs the specified procedure through one or more incisions using small surgical instruments and video cameras;[111] and,

(2) *Robotic Surgery*, which utilizes small robotic arms equipped with surgical instruments, which the physician controls via computer.[112]

These advancements in minimally invasive cardiovascular procedures may trigger shifts in the volume of services rendered by cardiologists versus cardiovascular surgeons, as well as the shifts in the skills necessary to remain relevant in the cardiovascular industry.

Advanced Imaging Technologies

A number of advanced imaging technologies can be used to diagnose and treat heart conditions, including cardiac MRIs, echocardiography, nuclear imaging, and positron emission tomography (PET) scans.

Cardiac MRI is a non-invasive medical imaging technique that uses a powerful magnetic field and radio waves to create detailed pictures of the heart and blood vessels. This imaging offers superior image quality for diagnosing heart conditions, including heart muscle damage, blood flow issues, and congenital heart defects.[113]

Echocardiography (also known as an echocardiogram or echo) uses ultrasound to provide real-time 3D images of the beating heart, offering more detailed insights into cardiac function.[114] The imaging may be used to help diagnose heart problems, such as abnormal valves and rhythms, heart murmurs, and damage from a heart attack, as well as to check for an infection on or around the heart valves, blood clots or tumors inside the heart, and fluid buildup in the sac around the heart.[115]

Cardiac nuclear medicine imaging evaluates the heart for coronary artery disease and cardiomyopathy (diseases of the heart muscle) and can help determine whether the heart has been damaged by chemotherapy or radiotherapy.[116] This type of imaging can provide unique information that often cannot be obtained using other imaging technologies.[117]

PET scans can help detect and track the spread of cardiac diseases. A unique advantage to PET imaging is the ability to measure myocardial blood flow, which further enhances diagnostic accuracy and allows for the identification of other diseases, such as small-vessel disease, a common ailment in diabetic patients.[118] PET imaging has also proven to be an economically viable option for healthcare organizations, as it is more versatile in diagnosing multiple diseases in a shorter period of time, leading to higher utilization rates and greater operational efficiencies.[119]

Artificial Intelligence (AI)

AI is being used by cardiovascular providers to improve the diagnosis and treatment of CVD. AI is being increasingly used in healthcare to augment providers, who have mortal limitations. One such use is through processing and analyzing large data sets that humans cannot, due to the sheer number of data points. For example, providers receive thousands of data points from patients who use wearables (e.g., smart watches) and other monitoring devices designed to remotely observe a condition.[120] The goal of such data analysis is earlier detection of cardiac conditions and better treatment outcomes.[121] Specific AI applications in cardiology include detecting heart disease, treating strokes more quickly, and enhancing diagnostic radiology capabilities.[122]

A 2024 science statement on AI from the American Heart Association (AHA) confirmed that the AHA:

"supports the creation of tools and services that would further the science and practice of precision medicine by enabling more precise approaches to cardiovascular and stroke research, prevention, and care of individuals and populations. Nevertheless, several challenges exist, and few [AI] tools have been shown to improve cardiovascular and stroke care sufficiently to be widely adopted."[123]

This statement indicates that while AI will likely continue to evolve rapidly in the cardiovascular space, providers may require empirical evidence of its clinical benefit before widely adopting the technology.

Conclusion

Given the current conditions of the cardiovascular services industry, providers may experience significant opportunities and challenges in the coming years. As noted in previous installments, the market for cardiovascular services is expected to experience increasing demand in the coming years, due to an aging U.S. population and the growing prevalence of risk factors for cardiac conditions, especially obesity. As demand increases, the supply of cardiovascular providers is anticipated to simultaneously decrease, as the population of physicians continue to move toward retirement while the number of residents entering these fields remains insufficient to replace older physicians.[124] Despite growing demand, cardiovascular providers may face challenges in the reimbursement for their services, where stagnating Medicare reimbursement rates may provide further pressure on these providers to provide efficient, high-quality care at lower per-unit costs. While attempting to navigate these issues, providers must continue to withstand increasing regulatory scrutiny related to healthcare fraud and abuse laws. These obstacles may create a challenging environment in which cardiovascular providers will have to be both clinically and economically efficient in order to thrive.

---

1 "Heart Disease Facts" Centers for Disease Control and Prevention, https://www.cdc.gov/heart-disease/data-research/facts-stats/?CDC_AAref_Val=https://www.cdc.gov/heartdisease/facts.htm (Accessed 12/24/24).

2 "2024 Heart Disease and Stroke Statistics: A Report of US and Global Data From the American Heart Association" By Seth S. Martin, et al., Circulation, available at: https://www.ahajournals.org/doi/pdf/10.1161/CIR.0000000000001209?ref=futurecrunch.com https://www.ahajournals.org/doi/10.1161/CIR.0000000000001123 (Accessed 12/24/24), Chart 14-1.

3 *Ibid*, Table 28-2.

4 "Obesity Paradox in Cardiovascular Disease: Where Do We Stand?" By Salvatore Carbone et al., National Library of Medicine, National Institute of Health, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6503652/#:~:text=Obesity%20is%20associated%20with%20an,hemodynamics%20and%20alters%20heart%20structure (Accessed 12/24/24).

5 "What is a Cardiothoracic Surgeon?" The Society of Thoracic Surgeons, https://ctsurgerypatients.org/what-is-a-cardiothoracic-surgeon#what-is-a-cardiothoracic-surgeon (Accessed 12/15/23).

6 *Ibid*.

7 "Cardiologists" Washington University School of Medicine in St. Louis, https://wuphysicians.wustl.edu/medical-services/specialties/cardiology (Accessed 12/15/23).

8 The Society of Thoracic Surgeons-The Patient Guide to Heart, Lung, and Esophageal Surgery, 2023.

9 "What is a Cardiologist?" Texas Heart Institute, https://www.texasheart.org/heart-health/heart-information-center/topics/what-is-a-cardiologist/ (Accessed 12/18/23). "What is Cardiac Rehabilitation?" National Heart, Lung, and Blood Institute, 2023, https://www.heart.org/en/health-topics/cardiac-rehab/what-is-cardiac-rehabilitation (Accessed 12/18/23).

10 "Cardiovascular Disease Policies" American Board of Internal Medicine, https://www.abim.org/certification/policies/internal-medicine-subspecialty-policies/cardiovascular-disease.aspx (Accessed 12/18/23).

11 "Internal Medicine Policies" American Board of Internal Medicine, https://www.abim.org/certification/policies/internal-medicine-subspecialty-policies/internal-medicine.aspx (Accessed 12/18/23); "ACGME Program Requirements for Graduate Medical Education in Internal Medicine" Accreditation Council for Graduate Medical Education, July 1, 2023, https://www.acgme.org/globalassets/pfassets/programrequirements/140_internalmedicine_2023.pdf (Accessed 12/18/23), p. 18-19.

12 American Board of Internal Medicine, https://www.abim.org/certification/policies/internal-medicine-subspecialty-policies/cardiovascular-disease.aspx (Accessed 12/18/23).

13 "ACGME Program Requirements for Graduate Medical Education in Cardiovascular Disease (Internal Medicine)" Accreditation Council for Graduate Medical Education, July 1, 2023, https://www.acgme.org/globalassets/pfassets/reviewandcomment/rc/141_cardiovasculardisease_rc_012023.pdf (Accessed 12/18/23).

14 "Policies and Procedures for Certification" American Board of Internal Medicine, September 2023, https://www.abim.org/~/media/ABIM%20Public/Files/pdf/publications/certification-guides/policies-and-procedures.pdf (Accessed 12/18/23), p. 7.

15 "ACGME Program Requirements for Graduate Medical Education in Advanced Heart Failure and Transplant Cardiology (Subspecialty of Internal Medicine)" Accreditation Council for Graduate Medical Education, July 1, 2023, https://www.acgme.org/globalassets/pfassets/programrequirements/159_advancedheartfailuretransplantcardiology_2023.pdf (Accessed 12/18/23), p. 1.

16 "ACGME Program Requirements for Graduate Medical Education in Clinical Cardiac Electrophysiology (Subspecialty of Internal Medicine)" Accreditation Council for Graduate Medical Education, July 1, 2023, https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/154_ClinicalCardiacElectrophysiology_2019.pdf?ver=2019-06-25-142057-797 (Accessed 12/18/23), p. 1.

17 "ACGME Program Requirements for Graduate Medical Education in Interventional Cardiology (Subspecialty of Internal Medicine)" Accreditation Council for Graduate Medical Education, July 1, 2023, https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/152_InterventionalCardiology_2019_TCC.pdf (Accessed 12/18/23), p. 1.

18 "ACGME Program Requirements for Graduate Medical Education in Adult Congenital Heart Disease (Subspecialty of Internal Medicine)" Accreditation Council for Graduate Medical Education, July 1, 2023, https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/153_AdultCongenitalHeartDisease_2019.pdf?ver=2019-06-25-122714-137 (Accessed 12/18/23), p. 1.

19 "Policies and Procedures for Certification" American Board of Internal Medicine, September 2023, https://www.abim.org/~/media/ABIM%20Public/Files/pdf/publications/certification-guides/policies-and-procedures.pdf (Accessed 12/18/23), p. 7.

20 The Society of Thoracic Surgeons, https://ctsurgerypatients.org/what-is-a-cardiothoracic-surgeon#what-is-a-cardiothoracic-surgeon (Accessed 12/18/23).

21 *Ibid*.

22 *Ibid*.

23 "Pathways to Certification" American Board of Thoracic Surgery, https://www.abts.org/ABTS/CertificationWebPages/Pathways%20to%20Certification.aspx (Accessed 12/18/23).

24 "ACGME Program Requirements for Graduate Medical Education in Thoracic Surgery (Integrated)" Accreditation Council for Graduate Medical Education, July 1, 2022, https://www.acgme.org/globalassets/pfassets/programrequirements/461_thoracicsurgeryintegrated_2022.pdf (Accessed 12/18/23), p. 25.

25 *Ibid*; "ACGME Program Requirements for Graduate Medical Education in General Surgery" Accreditation Council for Graduate Medical Education, July 1, 2022, https://www.acgme.org/globalassets/pfassets/programrequirements/440_generalsurgery_2023.pdf (Accessed 12/18/23), p. 1; "ACGME Program Requirements for Graduate Medical Education in Vascular Surgery" Accreditation Council for Graduate Medical Education, July 1, 2022, https://www.acgme.org/globalassets/pfassets/programrequirements/451_vascularsurgeryintegrated_2022_tcc.pdf (Accessed 12/18/23), p. 1.

26 "ACGME Program Requirements for Graduate Medical Education in Thoracic Surgery (Integrated)" Accreditation Council for Graduate Medical Education, July 1, 2022, https://www.acgme.org/globalassets/pfassets/programrequirements/461_thoracicsurgeryintegrated_2022.pdf (Accessed 12/18/23), p. 1-3.

27 *Ibid*.

28 "Congenital Heart Defects" National Heart, Lung, and Blood Institute, March 24, 2022, https://www.nhlbi.nih.gov/health-topics/congenital-heart-defects#Types (Accessed 3/30/20); "ACGME Program Requirements for Graduate Medical Education in Congenital Cardiac Surgery (Subspecialty of Thoracic Surgery)" Accreditation Council for Graduate Medical Education, July 1, 2022, https://www.acgme.org/globalassets/pfassets/programrequirements/466_congenitalcardiacsurgery_2023.pdf (Accessed 12/18/23), p. 1; "American Board of Thoracic Surgery" American Board of Medical Specialties, https://www.abms.org/board/american-board-of-thoracic-surgery/(Accessed 12/18/23).

29 "A Guide to Surgical Specialists" American College of Surgeons, https://www.facs.org/education/patient-education/patient-resources/specialists#vasc (Accessed 12/15/23).

30 "Angioplasty Treatments - Heart & Vascular Center" St. Vincent's Medical Center, 2018, https://web.archive.org/web/20170712033236/https://www.stvincents.org/Medical-Services/Heart-Vascular/treatment-surgical/angioplasty (Accessed 12/15/23).

31 American College of Surgeons, https://www.facs.org/education/patient-education/patient-resources/specialists#vasc (Accessed 12/15/23).

32 "Conversations with Experts: Spencer King and Christopher White on Peripheral Interventions" American College of Cardiology, October 4, 2013, https://www.acc.org/latest-in-cardiology/articles/2013/10/04/15/58/conversations-with-experts-spencer-king-and-christopher-white-on-peripheral-interventions (Accessed 12/15/23).

33 "Vascular Surgery Training Pathways" Society for Vascular Surgery, https://vascular.org/career-tools-training/vascular-training-programs/vascular-surgery-

training-pathways (Accessed 12/15/23); "Training Pathways – Vascular Surgery" The American Board of Surgery, 2018, http://www.absurgery.org/default.jsp?certvsqe_primarycert (Accessed 12/15/23).

34 Society for Vascular Surgery, https://vascular.org/career-tools-training/vascular-training-programs/vascular-surgery-training-pathways (Accessed 12/15/23).

35 *Ibid*; The American Board of Surgery, http://www.absurgery.org/default.jsp?certvsqe_primarycert (Accessed 12/15/23); "ACGME Program Requirements for Graduate Medical Education in Vascular Surgery" Accreditation Council for Graduate Medical Education, July 1, 2019, https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/451_VascularSurgeryIntegrated_2019.pdf?ver=2019-06-19-133350-287 (Accessed 12/15/23), p. 10-11.

36 Society for Vascular Surgery, https://vascular.org/career-tools-training/vascular-training-programs/vascular-surgery-training-pathways (Accessed 12/15/23).

37 *Ibid*; The American Board of Surgery, 2018, http://www.absurgery.org/default.jsp?certvsqe_primarycert (Accessed 12/15/23); Accreditation Council for Graduate Medical Education, 2022, p. 60.

38 Society for Vascular Surgery, https://vascular.org/career-tools-training/vascular-training-programs/vascular-surgery-training-pathways (Accessed 12/15/23).

39 "Cardiologist demand is on the rise—can hospitals keep up?" By Michael Walter, Cardiovascular Business, November 14, 2024, https://cardiovascularbusiness.com/topics/patient-care/care-delivery/cardiologist-demand-rise-can-hospitals-keep (Accessed 1/9/25).

40 "Heart Disease Facts" Centers for Disease Control and Prevention, https://www.cdc.gov/heart-disease/data-research/facts-stats/?CDC_AAref_Val=https://www.cdc.gov/heartdisease/facts.htm (Accessed 1/9/25).

41 "2024 Heart Disease and Stroke Statistics Update Fact Sheet: At-a-Glance" American Heart Association, available at: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.heart.org/-/media/PHD-Files-2/Science-News/2/2024-Heart-and-Stroke-Stat-Update/2024-Statistics-At-A-Glance-final_2024.pdf (Accessed 1/9/25).

42 *Ibid*.

43 "Forecasting the Economic Burden of Cardiovascular Disease and Stroke in the United States Through 2050: A Presidential Advisory From the American Heart Association" By Dhruv S. Kazi, MD, MSc, MS, FAHA, et al., Circulation, Vol. 150, No. 4 (June 2024), https://www.ahajournals.org/doi/10.1161/CIR.0000000000001258#:~:text=Among%20those%2020%20to%2044%20years%20of,reflecting%20the%20overall%20aging%20of%20the%20population. (Accessed 1/9/25).

44 "Age is the Biggest Risk for Heart Disease, But Lifestyle and Meds Have Impact" Duke Health, Updated October 2, 2019, https://corporate.dukehealth.org/news/age-biggest-risk-heart-disease-lifestyle-and-meds-have-impact#:~:text=DURHAM%2C%20N.C.%20%E2%80%93%20Of%20all%20the,model%20performance%2C%E2%80%9D%20Pencina%20said. (Accessed 1/9/25).

45 "Workforce in Crisis: Charting the Path Forward" American College of Cardiology, Cardiology Magazine, June 2, 2023, https://www.acc.org/Latest-in-Cardiology/Articles/2023/06/01/01/42/Cover-Story-Workforce-in-Crisis-Charting-the-Path-Forward (Accessed 1/21/25).

46 "Cohort Trends in the Burden of Multiple Chronic Conditions Among Aging U.S. Adults" By Nicholas Bishop et al., Journal of Gerontology, Vol. 77, Issue 10, 2022, https://academic.oup.com/psychsocgerontology/article/77/10/1867/6591182?login=false (Accessed 1/9/25).

47 *Ibid*.

48 "Heart Disease and Stroke Statistics – 2023 Update: A Report from the American Heart Association" By Connie W. Tsao et al., Circulation, Vol. 147, No. 8 (2023), https://www.ahajournals.org/doi/10.1161/CIR.0000000000001123 (Accessed 1/9/25).

49 "How is Smoking Linked to Heart Disease and Other Heart Issues" By Kirsten Nunez and Payal Kohli, Healthline, October 20, 2021, https://www.healthline.com/health/smoking/how-does-smoking-affect-your-heart (Accessed 1/9/25).

50 "Tobacco smoking and risk of 36 cardiovascular disease subtypes: fatal and non-fatal outcomes in a large prospective Australian study" By Emily Banks et al., BMC Medicine, July 3, 2019, https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-019-1351-4 (Accessed 1/9/25).

51 "Smoking and Physical Activity" Cleveland Clinic, July 27, 2021, https://my.clevelandclinic.org/health/articles/10643-smoking-and-physical-activity (Accessed 1/9/25).

52 "Health Effects of Overweight and Obesity" Centers for Disease Control and Prevention, September 24, 2022, https://www.cdc.gov/healthy-weight-growth/food-activity/overweight-obesity-impacts-health.html?CDC_AAref_Val=https://www.cdc.gov/healthyweight/effects/ (Accessed 1/9/25).

53 "Adult Obesity Facts" Centers for Disease Control and Prevention, May 17, 2022, https://www.cdc.gov/obesity/adult-obesity-facts/index.html (Accessed 1/9/25).

54 "By 2030, nearly half of all U.S. adults will be obese, experts predict" By Melissa Healy, Los Angeles Times, December 18, 2019, https://www.latimes.com/science/story/2019-12-18/nearly-half-of-us-adults-will-be-obese-by-2030 (Accessed 1/21/25).

55 "The Lancet: Without immediate action nearly 260 million people in the USA predicted to have overweight or obesity by 2050" University of Washington, November 14, 2024, https://www.healthdata.org/news-events/newsroom/news-releases/lancet-without-immediate-action-nearly-260-million-people-usa#:~:text=With%20the%20prevalence%20of%20obesity,be%20concentrated%20in%20southern%20states. (Accessed 1/21/25).

56 "Total Physicians by Specialty: United States and its Territories, 2023" Association of American Medical Colleges, https://www.aamc.org/data-reports/report/us-physician-workforce-data-dashboard (Accessed 1/21/25).

57 "Has Employment of Cardiologists Been a Successful Strategy? – Part 1" American College of Cardiology, November 6, 2019, https://www.acc.org/Membership/Sections-and-Councils/Cardiovascular-Management-Section/Section-Updates/2019/11/06/09/49/Has-Employment-of-Cardiologists-Been-a-Successful-Strategy-Part-1#:~:text=Today%2C%20analyses%20by%20a%20number%20of%20organizations,are%20employed%20by%20hospitals%20or%20health%20systems.&text=The%20result%20is%20that%20an%20estimated%2020,Professional%20Service%20Agreements%20or%20other%20contractual%20models. (Accessed 1/21/25).

58 "U.S. Physician Workforce Data Dashboard" Association of American Medical Colleges, https://www.aamc.org/data-reports/report/us-physician-workforce-data-dashboard (Accessed 1/21/25).

59 *Ibid*.

60 "The Complexities of Physician Supply and Demand: Projections from 2015 to 2030" By Tim Dall et al., IHS Inc., Report for Association of American Medical Colleges, February 2017, available at: https://www.researchgate.net/publication/315156643_The_2017_Update_Complexities_of_Physician_Supply_and_Demand_Projections_from_2015_to_2030/link/58cbf570a6fdcca17870a691/download?_(Accessed 1/9/25), p. 47.

61 *Ibid*.

62 "Which Physician Specialties Retire Early?" By Justin Nabity, Physicians Thrive, November 27, 2024, https://physicianthrive.com/retirement-planning/specialty-retirement/ (Accessed 1/21/25).

63 See, e.g., "Workforce in Crisis: Charting the Path Forward" American College of Cardiology, Cardiology Magazine, June 2, 2023, https://www.acc.org/Latest-in-Cardiology/Articles/2023/06/01/01/42/Cover-Story-Workforce-in-Crisis-Charting-the-Path-Forward (Accessed 1/21/25)

64 "NHE Fact Sheet" Centers for Medicare & Medicaid Services, December 18, 2024, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet (Accessed 1/9/25).

65 "Medicare's Role in Determining Prices Throughout the Health Care System: Mercatus Working Paper" By Roger Feldman et al., Mercatus Center, George Mason University, October 2015, https://www.mercatus.org/research/working-papers/medicares-role-determining-prices-throughout-health-care-system (Accessed 1/9/25), p. 3-5.

66 "Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011; Final Rule" Federal Register Vol. 75, No. 228 (November 29, 2010), p. 73208.

67 *Ibid*; "Introduction to Relative Value Units and How Medicare Reimbursement is Calculated" American College of Radiation Oncology, http://www.acro.org/washington/RVU.pdf (Accessed 12/8/23).

68 "Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011; Final Rule" Federal Register Vol. 75, No. 228 (November 29, 2010).

69 "Documentation and Files: NATIONAL PHYSICIAN FEE SCHEDULE AND RELATIVE VALUE FILES" Centers for Medicare & Medicaid Services, January 8, 2025, https://www.cms.gov/medicare/physician-fee-schedule/search/documentation (Accessed 2/10/25).

70 "Physician Reimbursement Under Medicare" By Alan M. Scarrow, MD, Neurosurgical Focus, Vol. 12, No. 4 (April 2002), p. 2.

71 "Medicare PFS Locality Configuration" Centers for Medicare & Medicaid Services, September 10, 2024, https://www.cms.gov/medicare/payment/fee-schedules/physician/locality-configuration (Accessed 2/10/25).

72 "Physician Reimbursement Under Medicare" By Alan M. Scarrow, MD., Neurosurgical Focus, Vol. 12, No. 4: Article 8 (April 2002), p. 2.

73 "Part B Payments: General Limits and Payment Rules" In "2009 Master Medicare Guide" CCH Health Editorial, Wolters Kluwer, 2009, p. 901.

74 *Ibid*, p. 900.

75 "Medicare Access and CHIP Reauthorization Act of 2015" Pub. L. No. 114-10, § 101, 129 Stat. 87, 89-90.

76 "Calendar Year (CY) 2025 Medicare Physician Fee Schedule Final Rule" Centers for Medicare & Medicaid Services, November 1, 2024, https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2025-medicare-physician-fee-schedule-final-rule (Accessed 11/12/24).

77 "2025 Medicare Physician Fee Schedule Final Rule Deep Dive" American College of Cardiology, ACC News Story, November 7, 2024, https://www.acc.org/latest-in-cardiology/articles/2024/11/07/14/52/2025-medicare-physician-fee-schedule-final-rule-deep-dive#:~:text=The%20Centers%20for%20Medicare%20and,patient%20populations%20and%20services%20offered. (Accessed 2/18/25).

78 "Bipartisan lawmakers introduce bill boosting physician pay by 6.6% from April through December" By Dave Muoio, Fierce Healthcare, January 31, 2025, https://www.fiercehealthcare.com/providers/bipartisan-lawmakers-introduce-bill-boosting-physician-pay-66-april-through-december (Accessed 2/18/25); Letter from Cathleen Biga, MSN, FACC, ACC President, to Representatives Murphy, Panetta, Miller-Meeks, Bera, Miller, Ruiz, Joyce, Schrier, Tenney, and Krishnamoorthi:t, dated February 4, 2025, available at: https://www.acc.org//-/media/Non-Clinical/Files-PDFs-Excel-MS-Word-etc/2025/02/ACC-Letter-of-Support-for-Medicare-Patient-Access-and-Practice-Stabilization-Act-of-2025.pdf (Accessed 2/18/25).

79 "Physician and Other Health Professional Payment System" Medicare Payment Advisory Commission, MedPAC Basics, October 2024, available at: https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_Physician_FINAL_SEC.pdf (Accessed 2/18/25), p. 2.

80 "Comparison of the Anti-Kickback Statute and Stark Law" Health Care Fraud Prevention and Enforcement Action Team (HEAT) Office of Inspector General (OIG), https://oig.hhs.gov/documents/provider-compliance-training/939/StarkandAKSChartHandout508.pdf (Accessed 9/27/23).

81 *Ibid*.

82 "Criminal Penalties for Acts Involving Federal Health Care Programs" 42 USC § 1320a-7b(b)(1).

83 "Re: OIG Advisory Opinion No. 15-10" By Gregory E. Demske, Chief Counsel to the Inspector General, Letter to [Name Redacted], July 28, 2015, https://oig.hhs.gov/fraud/docs/advisoryopinions/2015/AdvOpn15-10.pdf (Accessed 9/27/23), p. 4-5; "U.S. v. Greber" 760 F.2d 68, 69 (3d. Cir. 1985).

84 "Patient Protection and Affordable Care Act" Pub. L. No. 111-148, §§ 6402, 10606, 124 Stat. 119, 759, 1008 (March 23, 2010).

85 "Health Care Fraud and Abuse Laws Affecting Medicare and Medicaid: An Overview" By Jennifer A. Staman, Congressional Research Service, September 8, 2014, https://www.fas.org/sgp/crs/misc/RS22743.pdf (Accessed 9/27/23), p. 5.

86 "Health Care Reform: Substantial Fraud and Abuse and Program Integrity Measures Enacted" McDermott Will & Emery, April 12, 2010, p. 3; "Patient Protection and Affordable Care Act" Pub. L. No. 111-148, § 6402, 124 Stat. 119, 759 (March 23, 2010).

87 42 USC § 1320a-7b(b)(1); "Civil Monetary Penalties" 42 USC § 1320a-7a(a).

88 "False claims" 31 USC § 3729(a)(1)(G); "Civil Monetary Penalties Inflation Adjustments for 2023" Federal Register, Vol. 88, No. 19 (January 30, 2023), p. 5777.

89 "Re: OIG Advisory Opinion No. 15-10" By Gregory E. Demske, Chief Counsel to the Inspector General, Letter to [Name Redacted], July 28, 2015, https://oig.hhs.gov/fraud/docs/advisoryopinions/2015/AdvOpn15-10.pdf (Accessed 9/27/23), p. 5.

90 *Ibid*.

91 "Medicare and State Health Care Programs: Fraud and Abuse; Clarification of the Initial OIG Safe Harbor Provisions and Establishment of Additional Safe Harbor Provisions Under the Anti-Kickback Statute; Final Rule" Federal Register Vol. 64, No. 223 (November 19, 1999), p. 63518, 63520.

92 "Re: Malpractice Insurance Assistance" By Lewis Morris, Chief Counsel to the Inspector General, United States Department of Health and Human Services, Letter to [Name redacted], January 15, 2003, https://oig.hhs.gov/fraud/docs/

alertsandbulletins/malpracticeprogram.pdf (Accessed 9/27/23), p. 1.
93 "Medicare and State Health Care Programs: Fraud and Abuse; Revisions to Safe Harbors Under the Anti-Kickback Statute, and Civil Monetary Penalty Rules Regarding Beneficiary Inducements" Federal Register, Vol. 85, No. 232 (December 2, 2020), p. 77814-77815.
94 *Ibid*.
95 "CRS Report for Congress: Medicare: Physician Self-Referral ("Stark I and II")" By Jennifer O'Sullivan, Congressional Research Service, The Library of Congress, July 27, 2004, available at: http://www.policyarchive.org/handle/10207/bitstreams/2137.pdf (Accessed 9/27/23); "Limitation on certain physician referrals" 42 USC § 1395nn.
96 42 USC § 1395nn(a)(1)(A).
97 42 USC § 1395nn(a)(1)(B); "Definitions" 42 CFR § 411.351 (2015). Note the distinction in 42 CFR § 411.351 regarding what services are included as DHS: "Except as otherwise noted in this subpart, the term 'designated health services' or DHS means only DHS payable, in whole or in part, by Medicare. DHS do not include services that are reimbursed by Medicare as part of a composite rate (for example, SNF Part A payments or ASC services identified at §416.164(a)), except to the extent that services listed in paragraphs (1)(i) through (1)(x) of this definition are themselves payable through a composite rate (for example, all services provided as home health services or inpatient and outpatient hospital services are DHS)."
98 42 USC § 1395nn (a)(2).
99 42 USC § 1395nn (h)(1).
100 42 USC § 1395nn (g).
101 "Comparison of the Anti-Kickback Statute and Stark Law" Health Care Fraud Prevention and Enforcement Action Team (HEAT) Office of Inspector General (OIG), https://oig.hhs.gov/documents/provider-compliance-training/939/StarkandAKSChartHandout508.pdf (Accessed 9/27/23).
102 42 USC § 1395nn.
103 "Comparison of the Anti-Kickback Statute and Stark Law" Health Care Fraud Prevention and Enforcement Action Team (HEAT) Office of Inspector General (OIG), https://oig.hhs.gov/documents/provider-compliance-training/939/StarkandAKSChartHandout508.pdf (Accessed 9/27/23).
104 "Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations" Federal Register, Vol. 85, No. 232 (December 2, 2020), p. 77492.
105 *Ibid*, p. 77510-77528.
106 "Cardiovascular Disease: A Costly Burden For America - Projections Through 2035" American Heart Association, February 14, 2017, https://www.heart.org/-/media/Files/About-Us/Policy-Research/Fact-Sheets/Public-Health-Advocacy-and-Research/CVD-A-Costly-Burden-for-America-Projections-Through-2035.pdf (Accessed 1/13/25).
107 "Minimally invasive surgery" Mayo Clinic, https://www.mayoclinic.org/tests-procedures/minimally-invasive-surgery/about/pac-20384771#:~:text=In%20minimally%20invasive%20surgery%2C%20surgeons,hospital%20stay%20and%20fewer%20complications. (Accessed 1/13/25).
108 "Minimally Invasive and Robotic General Surgery" UTMB Health, https://www.utmbhealth.com/services/general-surgery/minimally-invasive-general-surgery (Accessed 1/13/25).
109 "Intuitive for Cardiac Patients" Intuitive, https://www.intuitive.com/en-us/patients/procedures/cardiac (Accessed 1/13/25).
110 "What is TAVR? (TAVI)" American Heart Association, https://www.heart.org/en/health-topics/heart-valve-problems-and-disease/understanding-your-heart-valve-treatment-options/what-is-tavr (Accessed 1/13/25).
111 "Types of Minimally Invasive Surgery" Johns Hopkins Medicine, https://www.hopkinsmedicine.org/surgery/specialty-areas/minimally-invasive (Accessed 1/13/25).
112 *Ibid*.
113 "Magnetic Resonance Imaging (MRI) of the Heart" Johns Hopkins Medicine, https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/magnetic-resonance-imaging-mri-of-the-heart#:~:text=In%20this%20case%2C%20the%20heart,magnetic%20field%20around%20the%20body. (Accessed 1/13/25).
114 "echocardiography" National Cancer Institute, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/echocardiography (Accessed 1/13/25).
115 *Ibid*.
116 "Cardiac Nuclear Medicine, RadiologyInfo.org, https://www.radiologyinfo.org/en/info/cardinuclear (Accessed 1/13/25).
117 *Ibid*.
118 "Myocardial Perfusion Imaging Using Positron Emission Tomography" By K Carlos El-Tallawi, Methodist Debakey Cardiovascular Journal, Vol. 16, No. 2 (Apr-Jun 2020), available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC7350808/#:~:text=PET%20myocardial%20blood%20flow%20measurement,for%20significant%20left%20main%20or (Accessed 1/13/25).
119 "Cardiovascular PET Will Become Mainstream in the Changing World of Value Imaging" By Gary V. Heller, MD, PhD, Cardiovascular Business, November 22, 2016, http://www.cardiovascularbusiness.com/sponsored/6199/topics/imaging/cardiovascular-pet-will-become-mainstream-changing-world-value (Accessed 1/13/25).
120 "Artificial Intelligence (AI) in Cardiovascular Medicine" Mayo Clinic, https://www.mayoclinic.org/departments-centers/ai-cardiology/overview/ovc-20486648#:~:text=AI%20is%20intelligence%20exhibited%20by,the%20shared%20decision%2Dmaking%20process. (Accessed 1/13/25).
121 *Ibid*.
122 *Ibid*.
123 "Use of Artificial Intelligence in Improving Outcomes in Heart Disease: A Scientific Statement From the American Heart Association" By Antonis A. Armoundas, PhD, Chair, et al., Circulation, Vol. 149, No. 14 (2024), https://www.ahajournals.org/doi/10.1161/CIR.0000000000001201 (Accessed 1/13/25).
124 "The growing shortage or general cardiologists and recruiting crisis in rural America" By Dave Fornell, Cardiovascular Business, April 12, 2024, https://cardiovascularbusiness.com/topics/healthcare-management/healthcare-staffing/growing-shortage-or-general-cardiologists-and-recruiting-crisis-rural-america (Accessed 1/13/25).

Valuation of Anesthesiology Services: Introduction & Competitive Environment

[This is the first article in a three-part series regarding Valuing Anesthesiology Services. This installment was published in May 2025.]

Anesthesiology is a subspecialty of medicine dedicated to the perioperative care of patients through the use of anesthetics.[1] Approximately 40 million anesthetics are administered each year, 90% of which are administered by anesthesiologists.[2] Several types of anesthesia are available, including general anesthesia, monitored anesthesia, regional anesthesia, and local anesthesia.[3] While regional and local anesthesia only numb specific parts of the body, general anesthesia induces unconsciousness.

Anesthesiologists are trained in pain relief and management, as well as monitoring patients undergoing surgical, obstetric, or diagnostic procedures.[4] It is an anesthesiologist's responsibility to evaluate a patient's risk prior to surgery and manage the patient's condition through to the surgery's completion; they are also responsible for managing post-anesthesia recovery. Additionally, anesthesiologists diagnose and treat cancer pain problems, critical illnesses, and severe injuries.[5]

Anesthesiologists can choose to subspecialize in a number of fields, including:

(1) Adult Cardiac Anesthesiology
(2) Critical Care Medicine;
(3) Hospice and Palliative Medicine;
(4) Neurocritical Care;
(5) Pain Medicine;
(6) Pediatric Anesthesiology; and,
(7) Sleep Medicine.[6]

In addition to physicians, the anesthesia care team also includes non-physician professionals such as certified registered nurse anesthetists (CRNAs) and certified anesthesiologist assistants (CAAs). CRNAs administer anesthesia to patients before and after surgery for various procedures, including surgical and obstetric procedures, as well as for pain-related illnesses.[7] Approximately half of states allow CRNAs to work independently, while the other half require physician supervision.[8] CAAs are trained in the delivery and maintenance of anesthesia care as well as advanced patient monitoring techniques. They train and work under physician supervision, and the physician retains responsibility for patient care.[9] Currently, CAAs may practice in 21 states and the District of Columbia.[10] The American Society of Anesthesiologists (ASA) has taken the position that "both CAAs and nurse anesthetists share identical patient care responsibilities - a view in harmony with their equivalent treatment by the Centers for Medicare and Medicaid Services (CMS)."[11]

Physicians pursuing specialization in anesthesiology must complete an anesthesiology residency program, which programs are configured in 36-month and 48-month formats; the longer program includes an additional year of education in fundamental clinical medical skills.[12] The program includes 12,000 to 16,000 hours of clinical training, covering anesthesia care, pain control, and responding to surgical complications and emergencies.[13] Candidates must then pass a series of three certifying examinations administered by the American Board of Anesthesiology (ABA).[14] Anesthesiologists seeking subspecialty certification in one of the above areas must complete an additional one-to-two year fellowship and pass a subspecialty exam.[15]

As a type of advanced practice registered nurse (APRN), CRNAs require more education and training than a registered nurse (RN), including:

(1) A baccalaureate or graduate degree in nursing or a related major;
(2) A valid U.S. RN or APRN license;
(3) One year of full-time work experience as an RN in a critical care setting;
(4) Graduation from an accredited nurse anesthesia program with a master's degree or higher; and,
(5) A passing score on the National Certification Examination.[16]

Of note, recently CMS increased the education requirements for CRNAs. Beginning in 2025, CRNAs are required to hold a doctorate degree, rather than just a master's degree.[17]

CAAs must similarly possess a premedical background and a baccalaureate degree; they must also complete a comprehensive didactic and clinical program and achieve a master's degree.[18] To become certified, students must pass a national certifying exam.[19]

Anesthesiology providers render services in a variety of settings, including hospitals (both inpatient and outpatient settings), ambulatory surgery centers (ASCs), pain management clinics, physician offices, and academic institutions. Approximately 50% of all surgical procedures conducted in the U.S. occur in an ASC.[20] The number of surgical procedures occurring in an outpatient setting has grown significantly over the last two decades, and accelerated even further during the COVID-19 pandemic.[21]

Many surgeons are moving away from hospital settings toward ASCs when performing surgical procedures due to several factors, including the preference of both patients and payors. ASCs provide a lower-cost, and often more convenient, alternative for patients.[22] Moreover, the average procedure time in ASCs was found to be, on

average, 25% shorter, allowing physicians to reduce costs and treat a larger volume of patients.[23] These factors have contributed to the increased demand for ASCs (at the expense of hospitals) from patients and anesthesiologists.

Demand for anesthesiology providers and the services they provide is anticipated to increase going forward, due in part to demographic and regulatory forces. By 2030, one in five Americans will be age 65 or older, primarily due to the aging Baby Boomer population.[24] Compared to other age groups, this demographic is a disproportionately high utilizer of healthcare services,[25] and is believed to account for more than half of all surgical procedures.[26] Further, technological advancements have made surgeries safer, with less recovery time, increasing the volume of elective surgical procedures requiring anesthesiologists.[27]

The COVID-19 pandemic exacerbated the anesthesiology labor shortage, with facilities reporting an anesthesia staffing shortage growing from 35% pre-pandemic to 78% two years post-pandemic.[28] On the other hand, the pandemic created significant financial stress for hospitals and health systems due to rising costs, especially related to staffing.[29] As a result, some healthcare organizations have deviated away from high-cost anesthesiologists and toward lower-cost providers such as CRNAs and CAAs.[30] In fact, the demand for CRNAs and CAAs may be surpassing the demand for anesthesiologists, with the percent change in employment projected to be 40% for CRNAs from 2023 to 2033,[31] in contrast to only 4% for physicians.[32] CRNAs are the highest-paid non-physician practitioners, yet are paid significantly less than anesthesiologists.[33]

Demand for CRNAs and CAAs may not diminish the demand for anesthesiologists, however, as they may instead complement each other. For instance, CRNAs represent more than 80% of anesthesia providers in rural counties,[34] which then can free up anesthesiologists to work in large hospitals and health systems (typically located in urban and suburban settings) that undertake more complex surgical cases.

This demand for anesthesiology services is outpacing the growth in the number of providers. In 2023, there were approximately 43,095 actively practicing anesthesiologists in the U.S., approximately 28% of whom were aged 65 and older and nearly 88% of whom were age 40 and older.[35] As research has found that anesthesiologists retire at a mean age of 62.7, and the number of hours worked decreased with age,[36] it is possible that over 25% of anesthesiologists may retire (or significantly reduce their working hours) in the next couple of years. Combined with the increasing demand for anesthesiology services, this may put the U.S. at risk of a continual shortage of anesthesiologists.

There are approximately 71,133 licensed CRNAs in the U.S., an increase of approximately 68.7% since December 2012.[37] Additionally, there are approximately 4,181 CAAs in the U.S., an increase of nearly 200% (approximately 9.5% annual growth) since December 2012.[38] This growth in the number of CRNAs and CAAs far outpaces that of licensed anesthesiologists, suggesting that there may be a larger supply of these non-physician providers than anesthesiologists in subsequent years.

While 2023 saw a net increase in overall anesthesia staffing of about 400 – approximately 5,200 new anesthesia professionals entered the workforce while nearly 4,800 exited[39] – the increasing demand for anesthesiology services will likely exceed this modest growth in supply. Paired with decreasing Medicare reimbursement over the past few years, anesthesiology providers may be heading toward rough waters, requiring them to be exceptionally efficient (in part through the use of technology) in order to survive. Consequently, future installments in this three-part series on the valuation of anesthesiology services will review the reimbursement and regulatory environments in which anesthesiology providers operate and the technological advancements being leveraged by these providers.

Valuation of Anesthesiology Services: Reimbursement & Regulatory Environments

[This is the second article in a three-part series regarding Valuing Anesthesiology Services. This installment was published in June 2025.]

As discussed in the first installment of this three-part series on the valuation of anesthesiology services, despite the increasing demand for anesthesiology providers, Medicare reimbursement for anesthesiology has decreased over the past few years. Additionally, like other healthcare providers, anesthesiology clinicians face a range of federal and state legal and regulatory constraints that affect their formation, operation, procedural coding and billing, and transactions. Consequently, this second installment will review the reimbursement and regulatory landscapes in which these anesthesiology providers operate.

Reimbursement Environment

The U.S. government is the largest payor of medical costs, through Medicare and Medicaid, and has a strong influence on reimbursement to hospitals. In 2023, Medicare and Medicaid accounted for an estimated $1.030 trillion and $871.7 billion in healthcare spending, respectively.[40] The prevalence of these public payors in the healthcare marketplace often results in their acting as a price setter, and being used as a benchmark for private reimbursement rates.

Medicare reimburses providers for anesthesiology services under the Medicare Physician Fee Schedule (MPFS), but these services are reimbursed differently from other physician services. The MPFS assigns each procedure a number of base units and time units. A base unit represents the complexity of a surgery and associated anesthesia service costs and is assigned to each anesthesia CPT code.[41] Notably, the base units have not been changed since 2022.[42] Time units are calculated by dividing the length of time the patient was under anesthesia by 15.[43] The base units and the time units are then summed and multiplied by a conversion factor (CF), which is different from the MPFS relative value unit (RVU) CF.[44] The CF varies based on the location of the procedure, and is calculated by multiplying the national CF by a weighted average of the area's Geographic Practice Cost Index (GPCI) for labor (work) costs, practice (PE) expense, and malpractice (MP) expense.[45] In this way, payments can be adjusted to suit the cost of providing services in a particular geographic area.

Since 2018, the national anesthesia CF has decreased significantly (-8.43%). Exhibit 1 below sets forth the historical Medicare anesthesia CF amounts.

The process by which the local CF, time units, and payment for anesthesiology services is calculated is illustrated in the below Exhibit 2.

Notably, Exhibit 2 does not include modifiers. Some modifiers can change the payments that Medicare makes to an anesthesiologist. These modifiers are described in Table 1 below.

Table 1: Medicare Payment Modifiers for Anesthesiology Services[46]

Modifier Code	Activity	Modification of Payment
QK	Medical direction of two to four concurrent services	Payment allowance is 50% of that of services which the physician performs personally
AD	Medical supervision of more than four concurrent services	No more than three base units per procedure, plus one base unit if the physician was present at induction
n/a	Anesthesia services associated with multiple bilateral surgeries	Report total time for all procedures in the line item with the highest base unit value

Medicare also reimburses nonphysician practitioners who provide anesthesia services, referred to as qualified nonphysician anesthetists, including Certified Registered Nurse Anesthetists (CRNAs) and Anesthesiologist Assistants (AAs).[47] These providers are reimbursed under the same methodology as physician anesthesiologists; CRNAs are reimbursed at the same rate as physicians, but AAs are reimbursed at 85% of the physician payment rate.[48] If a physician and CRNA are both involved in an anesthesia procedure, each receives 50% of the payment.

Regulatory Environment

Regulatory security has generally increased for healthcare providers over the last decade. Fraud and abuse laws, specifically those related to the federal Anti-Kickback Statute (AKS) and physician self-referral laws (the Stark Law), have significant impact on the operations of anesthesiology providers.

The AKS and Stark Law are generally concerned with the same issue – the financial motivation behind patient referrals. However, while the AKS is broadly applied to payments between providers or suppliers in the healthcare industry and relates to any item or service that may be paid for under any federal healthcare program, the Stark Law specifically addresses the referrals from physicians to entities with which the physician has a financial relationship for the provision of defined services that are paid for by the Medicare program.[49] Additionally, while violation of the Stark Law carries only civil penalties, violation of the AKS carries both criminal and civil penalties.[50]

(1) *Anti-Kickback Statute*

Enacted in 1972, the federal AKS makes it a felony for any person to "*knowingly and willfully*" solicit or receive, or to offer or pay, any "*remuneration*", directly or indirectly, in exchange for the referral of a patient for a healthcare service paid for by a federal healthcare program,[51] even if only one purpose of the arrangement in question is to offer remuneration deemed illegal under the AKS.[52] Notably, a person need not have *actual knowledge* of the AKS or *specific intent* to commit a violation of the AKS for the government to prove a kickback violation,[53] only an awareness that the conduct in question is "*generally unlawful*."[54] Further, a violation of the AKS is sufficient to state a claim under the *False Claims Act* (FCA).[55]

Criminal violations of the AKS are punishable by up to ten years in prison, criminal fines up to $100,000, or both, and civil violations can result in administrative penalties, including exclusion from federal healthcare programs, and civil monetary penalties plus treble damages (or three times the illegal remuneration).[56] In addition to the civil monetary penalties paid under the AKS, if the AKS violation triggers liability under the FCA, defendants can incur additional per-violation civil monetary penalties plus treble damages.[57]

Due to the broad nature of the AKS, legitimate business arrangements may appear to be prohibited.[58] In response to these concerns, Congress created a number of statutory exceptions and delegated authority to the Department of Health & Human Services (HHS) to protect certain business arrangements by means of promulgating several *safe harbors*.[59] These safe harbors set out regulatory criteria that, if met, shield an arrangement from regulatory liability, and are meant to protect transactional arrangements unlikely to result in fraud or abuse.[60] Failure to meet all of the

requirements of a safe harbor does not necessarily render an arrangement illegal.[61] It should be noted that, in order for a payment to meet the requirements of many AKS safe harbors, the compensation must not exceed the range of Fair Market Value and must be commercially reasonable.

(2) *Stark Law*

The Stark Law prohibits physicians from referring Medicare patients to entities with which the physicians or their family members have a financial relationship for the provision of designated health services (DHS).[62] Further, when a prohibited referral occurs, entities may not bill for services resulting from the prohibited referral.[63] Under the Stark Law, DHS include, but are not limited to, the following:

(1) Inpatient and outpatient hospital services;
(2) Radiology and certain other imaging services;
(3) Radiation therapy services and supplies;
(4) Certain therapy services, such as physical therapy;
(5) Durable medical equipment; and,
(6) Outpatient prescription drugs.[64]

Under the Stark Law, financial relationships include ownership interests through equity, debt, other means, and ownership interests in entities also have an ownership interest in the entity that provides DHS.[65] Additionally, financial relationships include compensation arrangements, which are defined as arrangements between physicians and entities involving any remuneration, directly or indirectly, in cash or in kind.[66]

Civil penalties under the Stark Law include overpayment or refund obligations, a potential civil monetary penalty of $15,000 for each service, plus treble damages, and exclusion from Medicare and Medicaid programs.[67] Further, similar to the AKS, violation of the Stark Law can also trigger a violation of the FCA.[68]

Notably, the Stark Law contains a large number of exceptions, which describe ownership interests, compensation arrangements, and forms of remuneration to which the Stark Law does not apply.[69] Similar to the AKS safe harbors, without these exceptions, the Stark Law may prohibit legitimate business arrangements. It must be noted that in order to meet the requirements of many exceptions related to compensation between physicians and other entities, compensation must: (1) not exceed the range of fair market value; (2) not take into account the volume or value of referrals generated by the compensated physician; and, (3) be commercially reasonable. Unlike the AKS safe harbors, an arrangement must fully fall within one of the exceptions in order to be shielded from enforcement of the Stark Law.[70]

The reimbursement and regulatory landscape for anesthesiology services presents a complex web of challenges that significantly impact providers and their operational viability. While Medicare's continued dominance as a price-setter creates predictable revenue streams, the 8.43% decline in the national anesthesia CF since 2018 underscores mounting financial pressures that anesthesiology providers must navigate. Simultaneously, the heightened enforcement environment surrounding the AKS and Stark Law demands sophisticated compliance frameworks that can substantially affect operational costs and transaction structures. These dual pressures—declining reimbursement coupled with increasing regulatory scrutiny—create a need for reliance on emerging technological innovations in anesthesia delivery in order to survive. The last installment in this three-part series will discuss the technological advancements transforming the delivery of anesthesiology services.

Exhibit 1: Historical Medicare Anesthesia CFs

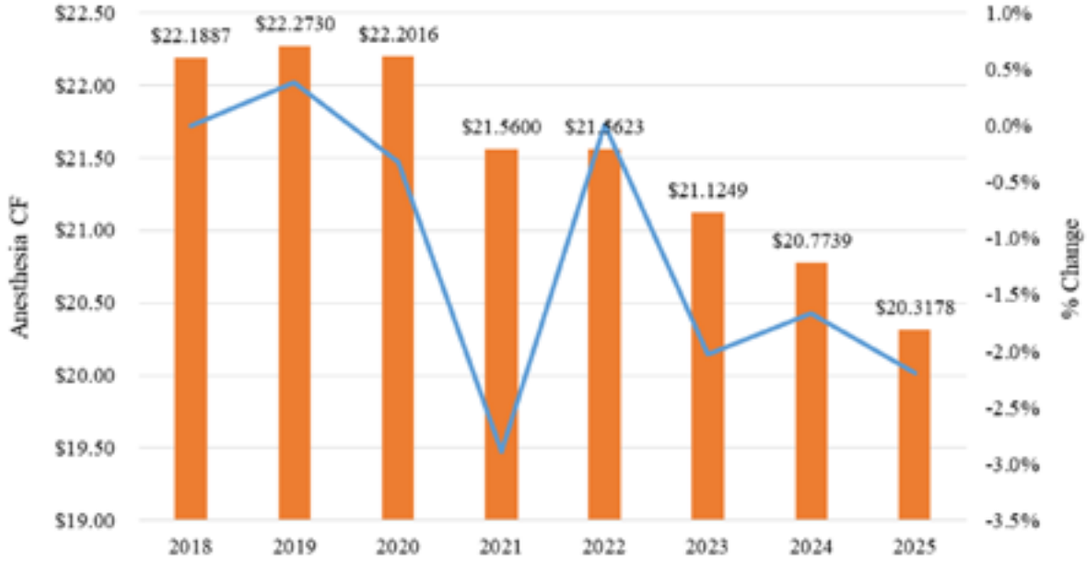


Exhibit 2: Calculation of Payments for Anesthesiology Services

1. Calculation of Local Conversion Factor (Local CF)

$$\left[\begin{array}{l}(\text{Work Share} \times \text{Work GPCI}) + \\ (\text{PE Share} \times \text{PE GPCI}) + \\ (\text{MP Share} \times \text{MP GPCI})\end{array}\right] \times \text{National CF} = \textbf{Local CF}$$

2. Calculation of Time Units

$$\frac{\text{Time (in minutes)}}{15} = \textbf{Time Units}$$

3. Calculation of Anesthesia Payment

$$(\text{Base Units} + \textbf{Time Units}) \times \textbf{Local CF} = \text{Anesthesia Payment}$$

Valuation of Anesthesiology Services: Technological Advancements

[This is the final article in a three-part series regarding Valuing Anesthesiology Services. This installment was published in July 2025.]

As discussed in the first two installments of this three-part series on the valuation of anesthesiology services, despite the increasing demand for anesthesiology providers, Medicare reimbursement for anesthesiology has decreased over the past few years. Additionally, like other healthcare providers, anesthesiology clinicians face a range of federal and state legal and regulatory constraints that affect their formation, operation, procedural coding and billing, and transactions. These dual pressures—declining reimbursement coupled with increasing regulatory scrutiny—create a need for reliance on emerging technological innovations in order to survive. Consequently, this final installment will review the technological advancements impacting the delivery of anesthesiology services.

Anesthesiology is "inextricably dependent" on technology.[71] Anesthesiology differs from other specialties in that the nature of the work relies upon immediate onset, continued and sensitive control, and extremely quick offset, of employed pharmaceuticals.[72] Further, the tools and supplies used during the administration of anesthesia (e.g., intubation), as well as monitoring technology (such as those used to monitor oxygen levels cardiac performance), have accelerated the specialty's advancement over the past few decades. Going forward, it is anticipated that most technological advancements in anesthesia will shift focus "from hardware to software to digital solutions."[73]

Recent innovations in anesthesia include new drugs, improved monitoring systems, and the use of artificial intelligence (AI). New drugs are being added to anesthesiology providers' repertoire, and new applications of existing drugs are being discovered, to improve the inducement of general anesthesia and/or sedation, with the overall goal of creating a hypnotic that has both rapid onset and rapid termination, results in minimal side effects, and is tightly controllable.[74]

As regards monitoring systems, the rise in anesthesia information management systems (AIMS) have improved operating room management, billing, and documentation.[75] AIMS are a unique form of electronic health record (EHR) system that typically provides clinicians with a summary of patient data collected during the perioperative period. This summary is then used to oversee quality, which allows patient information to be reported without biases, increasing the efficacy of the data. The utilization of decision support systems (DSS) can further the advantages of AIMS by limiting or eliminating errors in the delivery of anesthesia services.[76]

These technologies are expected to be further supported by advancements in AI and automation. These technologies may help ameliorate the anesthesiologist shortage by automating mundane, repetitive, and low-value tasks, as well by allowing anesthesiologists to oversee a greater number of clinicians/sites.[77] In addition, research is currently being conducted (with promising results) on using a machine learning algorithm for the continuously automating dosing of propofol.[78] If successful, it may eventually become feasible "for computers to maintain patient unconsciousness with no more drug than is needed, thereby freeing up anesthesiologists for all the other responsibilities they have in the operating room, including making sure patients remain immobile, experience no pain, remain physiologically stable, and receive adequate oxygen."[79]

Given the current conditions of the anesthesiology services industry, providers may experience significant opportunities and challenges in the coming years. The market for anesthesiology services is expected to experience increasing demand in the coming years, due to an aging U.S. population requiring more surgical interventions and procedures, as well as technological advancements that make these interventions possible and safer for a wider array of patients. As demand increases, the supply of anesthesiologists is anticipated to decrease, but the supply of non-physician anesthesiology providers, i.e., certified registered nurse anesthetists (CRNAs) and certified anesthesiologist assistants (CAAs), is expected to increase. Coupled with the promise of technological advancements taking some of the administrative burden off of clinicians, appropriately-structured anesthesia care teams may be able to meet the increasing demand over the next several years.

Although this potential influx of patients may provide valuable revenues, the uncertain reimbursement environment for anesthesiology providers may challenge providers' operations, particularly those whose payor mix is significantly comprised of government payors. While attempting to navigate these issues, anesthesiologists must continue to withstand increasing regulatory scrutiny related to healthcare fraud and abuse laws. These obstacles may create a challenging environment in which anesthesiologists must be both clinically and economically efficient in order to thrive.

---

1 "Anesthesia" Cleveland Clinic, https://my.clevelandclinic.org/health/treatments/15286-anesthesia (Accessed 5/21/25).

2 "The Role of the Anesthesiologist — from Surgical Anesthesia to Critical Care Medicine and Pain Medicine" Texas Society of Anesthesiologists, https://tsa.org/public/anesthesiologist_role.php (Accessed 5/21/25)

3 "Role of Anesthesiologist" American Society of Anesthesiologists, https://madeforthismoment.asahq.org/anesthesia-101/role-of-physician-anesthesiologist/ (Accessed 5/21/25).

4 "American Board of Anesthesiology" The American Board of Medical Specialties, https://www.abms.org/board/american-board-of-anesthesiology/ (Accessed 5/21/25).

5 *Ibid*.

6 *Ibid*.

7 "Nurse Anesthetist (CRNA)" Cleveland Clinic, https://my.clevelandclinic.org/health/articles/22561-nurse-anesthetist-crna (Accessed 5/21/25).

8 "CRNA Supervision Requirements by State" By Rebecca Munday, NurseJournal, November 16, 2023, https://nursejournal.org/nurse-anesthetist/crna-supervision-requirements/ (Accessed 5/21/25).

9 "Statement on Certified Anesthesiologist Assistants (CAAs): Description and Practice" Committee on Anesthesiologist Assistant Education and Practice, American Society of Anesthesiologists, https://www.asahq.org/standards-and-practice-parameters/statement-on-certified-anesthesiologist-assistants-description-and-practice (Accessed 5/21/25).

10 "Anesthesiologist Assistants" American Society of Anesthesiologists, https://www.asahq.org/advocating-for-you/anesthesiologist-assistants (Accessed 5/21/25).

11 *Ibid*.

12 "ACGME Program Requirements for Graduate Medical Education in Anesthesiology" Accreditation Council for Graduate Medical Education, effective July 1 2023, available at: https://www.acgme.org/globalassets/pfassets/programrequirements/040_anesthesiology_2023.pdf (Accessed 5/21/25).

13 "The Importance of Physician-Led Anesthesia Care" American Society of Anesthesiologists, https://madeforthismoment.asahq.org/policymakers/ (Accessed 5/21/25).

14 "Get Certified: Demonstrate your commitment to excellence with the gold standard of certification in anesthesiology" American Board of Anesthesiology, https://www.theaba.org/get-certified/ (Accessed 5/21/25).

15 "Fellowships" University of Rochester School of Medicine & Dentistry, https://www.urmc.rochester.edu/education/graduate-medical-education/prospective-residents/anesthesiology/fellowships.aspx#:~:text=Applicants%20can%20choose%20between%20a,of%20research%20 experience%20and%20education. (Accessed 5/21/25); "Get Certified: Demonstrate your commitment to excellence with the gold standard of certification in anesthesiology" American Board of Anesthesiology, https://www.theaba.org/get-certified/ (Accessed 5/21/25).

16 "What to Know About Becoming a CRNA/nurse anesthesiologist" American Association of Nurse Anesthesiology, https://www.aana.com/about-us/about-crnas/become-a-crna/ (Accessed 5/21/25).

17 "Raising the Bar in CRNA Education: What the 2025 Deadline Means" AMN Healthcare, June 23, 2023, https://www.amnhealthcare.com/blog/physician/locums/raising-the-bar-in-crna-education-what-the-2025-deadline-means/#:~:text=With%20increasing%20complexity%20in%20cases,towards%20requiring%20practice%20doctoral%20degrees. (Accessed 5/21/25).

18 "Statement on Certified Anesthesiologist Assistants (CAAs): Description and Practice" Committee on Anesthesiologist Assistant Education and Practice, American Society of Anesthesiologists, https://www.asahq.org/standards-and-practice-parameters/statement-on-certified-anesthesiologist-assistants-description-and-practice (Accessed 5/21/25).

19 *Ibid*.

20 "Ambulatory surgery center payment models: current trends and future directions" By Heeren S Makanji, Journal of Spine Surgery, Vol. 5, Suppl. 2 (September 2019), https://pmc.ncbi.nlm.nih.gov/articles/PMC6790812/#:~:text=In%202017%2C%20more%20than%2050,this%20massive%20growth%20are%20ASCs. (Accessed 5/21/25).

21 "ASCs: A Positive Trend in Health Care" Ambulatory Surgery Center Association, https://www.ascassociation.org/advancingsurgicalcare/aboutascs/industryoverview/apositivetrendinhealthcare (Accessed 5/21/25); "Performance of General Surgical Procedures in Outpatient Settings Before and After Onset of the COVID-19 Pandemic" By Omair A. Shariqu, MBBS, MS, et al., JAMA Network Open, Vol. 6, No. 3 (March 2, 2023), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2801919?utm_campaign=articlePDF&utm_medium=articlePDFlink&utm_source=articlePDF&utm_content=jamanetworkopen.2023.1198 (Accessed 5/21/25)

22 "These Surgeries Made the Sharpest Turns to Outpatient Setting After COVID" By Elizabeth Short, MedPage Today, March 3, 2023, https://www.medpagetoday.com/surgery/generalsurgery/103386 (Accessed 5/21/25).

23 "Procedures Take Less Time At Ambulatory Surgery Centers, Keeping Costs Down And Ability To Meet Demand Up" By Elizabeth Munnich and Stephen T. Parente, Health Affairs, Vol. 33, No. 5 (May 2014), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.1281 (Accessed 5/21/25).

24 "National 50-state population projections: 2030, 2040, 2050" By Shonel Sen, University of Virginia, July 22, 2024, https://www.coopercenter.org/research/national-50-state-population-projections-2030-2040-2050#:~:text=Between%20now%20and%202050%2C%20the,and%20371%20million%20in%202050. (Accessed 5/21/25).

25 "NHE Fact Sheet" Centers for Medicare & Medicaid Services, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet#:~:text=Reflects%20broad%20increases%20in%20the%20use%20of,population%20of%2093.1%%20%2D%20an%20unprecedented%20high.&text=Per%20person%20personal%20health%20care%20spending%20for,times%20the%20spending%20per%20working%2Dage%20person%20($9%2C154). (Accessed 5/21/25).

26 "The Elderly Are Getting Complex Surgeries. Often It Doesn't End Well." By Paula Span, The New York Times, June 7, 2019, https://www.nytimes.com/205/21/25/health/elderly-surgery-complications.html (Accessed5/21/25).

27 "2024 Compensation Trends and Career Tips for Anesthesiologists and CRNAs" OnCall Solutions, https://oncallsolutions.com/blog/2024-compensation-trends-career-tips-anesthesiologists-crnas/ (Accessed 5/21/25).

28 "Closing the Chasm: Understanding and Addressing the Anesthesia Workforce Supply and Demand Imbalance" By Amr E. Abouleish, et al., Vol. 141, Issue 2 (August 2024), available at: https://anesthesiaexperts.com/uncategorized/closing-chasm-understanding-addressing-anesthesia-workforce-supply-demand-imbalance/ (Accessed 5/21/25).

29 *Ibid*.

30 See e.g., "Wisconsin Hospital Replaces All Anesthesiologists With CRNAs" Medscape, April 5, 2021, https://www.medscape.com/viewarticle/948723#vp_1 (Accessed 5/21/25).

31 "Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners- Summary" Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook, 2024, https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm (Accessed 5/21/25).

32 "Physicians and Surgeons - Summary" Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook, 2024, https://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm (Accessed 5/21/25).

33 "15 Unveiling 7 of the Highest-Paying Nursing Jobs in the US" CareRev, July 11, 2024, https://www.carerev.com/blog/7-highest-paying-nursing-jobs#:~:text=CRNAs%20collaborate%20with%20healthcare%20teams,nursing%20professionals%20in%20the%20US. (Accessed 5/21/25); "2024 Compensation Trends and Career Tips for Anesthesiologists and CRNAs" OnCall Solutions, https://oncallsolutions.com/blog/2024-compensation-trends-career-tips-anesthesiologists-crnas/ (Accessed 5/21/25).

34 "What is the CRNA/nurse anesthesiologist job outlook?" American Association of Nurse Anesthesiology, https://www.aana.com/motion-crna-career-platform/what-is-the-crna-nurse-anesthesiologist-job-outlook/ (Accessed 5/21/25).

35 "U.S. Physician Workforce Data Dashboard" Association of American Medical Colleges, https://www.aamc.org/data-reports/report/us-physician-workforce-data-dashboard (Accessed 5/21/25).

36 "United States anesthesiologists over 50: retirement decision making and workforce implications" By Fredrick K. Orkin, et al., Anesthesiology, Vol. 117, No. 5 (November 2012), https://pubmed.ncbi.nlm.nih.gov/23095532/ (Accessed 5/21/25).

37 "Anesthesia Workforce Trends" Center for Anesthesia Workforce Studies, American Society of Anesthesiologists, January 10, 2025, available at: https://www.asahq.org/-/media/sites/asahq/files/public/research/caws_anesthesia_workforce_trends.pdf (Accessed 5/21/25), p. 5.

38 *Ibid*.

39 "Anesthesia workforce challenges taking center stage" By Tarsilla Moura, OR Manager, August 28, 2024, https://www.ormanager.com/anesthesia-workforce-challenges-taking-center-stage/ (Accessed 5/21/25).

40 "NHE Fact Sheet" Centers for Medicare & Medicaid Services, December 18, 2024, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet (Accessed 1/16/25).

41 "Anesthesia Base Units" U.S. Department of Labor, https://owcpmed.dol.gov/ecams/help/WebHelp/HTML5/Content/Rate_Settings/Anesthesia_Base_Units.

htm#:~:text=They%20represent%20the%20amount%20of,time%20in%20the%20operating%20room. (Accessed 1/17/25).

42 "Anesthesiologists Center' Centers for Medicare & Medicaid Services, https://www.cms.gov/medicare/payment/fee-schedules/physician/anesthesiologists-center (Accessed 1/16/25).

43 "Physician and other Health Professional Payment System" Medicare Payment Advisory Commission, Payment Basics, October 2024, available at: https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_Physician_FINAL_SEC.pdf (Accessed 1/16/25).

44 *Ibid*.

45 "Locality-Adjusted Anesthesia Conversion Factors as a result of the CY 2025 Final Rule" in "Anesthesia CY 2025 locality adjusted CF_floor extension 23DEC24.xlsx" available at: https://www.cms.gov/files/zip/2025-anesthesia-conversion-factors.zip (Accessed 1/16/25).

46 "50 – Payment for Anesthesiology Services" in "Medicare Claims Processing Manual: Chapter 12 – Physicians/Nonphysician Practitioners" Centers for Medicare & Medicaid Services, December 19, 2024, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf (Accessed 1/16/25).

47 "140.1 – Qualified Nonphysician Anesthetists" in "Medicare Claims Processing Manual: Chapter 12 – Physicians/Nonphysician Practitioners" Centers for Medicare & Medicaid Services, December 19, 2024, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf (Accessed 1/16/25).

48 Letter from American Association of Nurse Anesthesiology to Chiquita Brooks-LaSure RE: Request for Information on Medicare, dated August 24, 2022, available at: https://bettermedicarealliance.org/wp-content/uploads/2022/09/American-Association-of-Nurse-Anesthesiology.pdf (Accessed 1/16/25).

49 "Comparison of the Anti-Kickback Statute and Stark Law" Health Care Fraud Prevention and Enforcement Action Team (HEAT) Office of Inspector General (OIG), https://oig.hhs.gov/documents/provider-compliance-training/939/StarkandAKSChartHandout508.pdf (Accessed 8/14/23).

50 *Ibid*.

51 "Criminal Penalties for Acts Involving Federal Health Care Programs" 42 USC § 1320a-7b(b)(1).

52 "Re: OIG Advisory Opinion No. 15-10" By Gregory E. Demske, Chief Counsel to the Inspector General, Letter to [Name Redacted], July 28, 2015, https://oig.hhs.gov/fraud/docs/advisoryopinions/2015/AdvOpn15-10.pdf (Accessed 8/14/23), p. 4-5; "U.S. v. Greber" 760 F.2d 68, 69 (3d. Cir. 1985).

53 "Patient Protection and Affordable Care Act" Pub. L. No. 111-148, §§ 6402, 10606, 124 Stat. 119, 759, 1008 (March 23, 2010).

54 "Health Care Fraud and Abuse Laws Affecting Medicare and Medicaid: An Overview" By Jennifer A. Staman, Congressional Research Service, September 8, 2014, https://www.fas.org/sgp/crs/misc/RS22743.pdf (Accessed 8/14/23), p. 5.

55 "Health Care Reform: Substantial Fraud and Abuse and Program Integrity Measures Enacted" McDermott Will & Emery, April 12, 2010, p. 3; "Patient Protection and Affordable Care Act" Pub. L. No. 111-148, § 6402, 124 Stat. 119, 759 (March 23, 2010).

56 "Criminal Penalties for Acts Involving Federal Health Care Programs" 42 USC § 1320a-7b(b)(1); "Civil Monetary Penalties" 42 USC § 1320a-7a(a).

57 "False claims" 31 USC § 3729(a)(1)(G); "Civil Monetary Penalties Inflation Adjustments for 2023" Federal Register, Vol. 88, No. 19 (January 30, 2023), p. 5777.

58 Demske, Chief Counsel to the Inspector General, Letter to [Name Redacted], July 28, 2015.

59 *Ibid*.

60 "Medicare and State Health Care Programs: Fraud and Abuse; Clarification of the Initial OIG Safe Harbor Provisions and Establishment of Additional Safe Harbor Provisions Under the Anti-Kickback Statute; Final Rule" Federal Register Vol. 64, No. 223 (November 19, 1999), p. 63518, 63520.

61 "Re: Malpractice Insurance Assistance" By Lewis Morris, Chief Counsel to the Inspector General, United States Department of Health and Human Services, Letter to [Name redacted], January 15, 2003, https://oig.hhs.gov/fraud/docs/alertsandbulletins/malpracticeprogram.pdf (Accessed 8/14/23), p. 1.

62 "CRS Report for Congress: Medicare: Physician Self-Referral ("Stark I and II")" By Jennifer O'Sullivan, Congressional Research Service, The Library of Congress, July 27, 2004, available at: http://www.policyarchive.org/handle/10207/bitstreams/2137.pdf (Accessed 8/14/23); "Limitation on certain physician referrals" 42 USC § 1395nn.

63 "Limitation on certain physician referrals" 42 USC § 1395nn(a)(1)(A).

64 "Limitation on Certain Physician Referrals" 42 USC § 1395nn(a)(1)(B); "Definitions" 42 CFR § 411.351 (2015). Note the distinction in 42 CFR § 411.351 regarding what services are included as DHS: "Except as otherwise noted in this subpart, the term 'designated health services' or DHS means only DHS payable, in whole or in part, by Medicare. DHS do not include services that are reimbursed by Medicare as part of a composite rate (for example, ASC services identified at §416.164(a)), except to the extent that services listed in paragraphs (1)(i) through (1)(x) of this definition are themselves payable through a composite rate (for example, all services provided as home health services or inpatient and outpatient hospital services are DHS)."

65 "Limitation on certain physician referrals" 42 USC § 1395nn (a)(2).

66 "Limitation on certain physician referrals" 42 USC § 1395nn (h)(1).

67 "Limitation on certain physician referrals" 42 USC § 1395nn (g).

68 Health Care Fraud Prevention and Enforcement Action Team (HEAT) Office of Inspector General (OIG).

69 "Limitation on certain physician referrals" 42 USC § 1395nn.

70 Health Care Fraud Prevention and Enforcement Action Team (HEAT) Office of Inspector General (OIG).

71 "Recent advances in the technology of anesthesia" By Christian Seger and Maxime Cannesson, F1000 Research, May 18, 2020, https://pmc.ncbi.nlm.nih.gov/articles/PMC7236591/ (Accessed 10/29/24).

72 "Is Anesthesiology Going Soft? Trends in Fragile Pharmacology" By Talmage D. Egan, MD, Anesthesiology, Vol. 111, (2009), p. 229

73 "Closing the Chasm: Understanding and Addressing the Anesthesia Workforce Supply and Demand Imbalance" By Amr E. Abouleish, et al., Vol. 141, Issue 2 (August 2024), available at: https://anesthesiaexperts.com/uncategorized/closing-chasm-understanding-addressing-anesthesia-workforce-supply-demand-imbalance/ (Accessed 10/29/24).

74 "What's New in Intravenous Anaesthesia? New Hypnotics, New Models and New Applications" By Remco Vellinga, et al., Journal of Clinical Medicine, Vol. 11, No. 12 (2022), https://pmc.ncbi.nlm.nih.gov/articles/PMC9224877/#:~:text=Remimazolam%20is%20a%20new%20ultra,ultra%2Dshort%2Dacting%20drug. (Accessed 1/17/25).

75 Abouleish, et al., Vol. 141, Issue 2 (August 2024).

76 "The Impact of Technology on Healthcare" American Institute of Medical Sciences and Education, June 2, 2019, https://www.aimseducation.edu/blog/the-impact-of-technology-on-healthcare/ (Accessed 1/17/25).

77 *Ibid*.

78 "Research advances technology of AI assistance for anesthesiologists" By David Orenstein, MIT News, February 14, 2022, https://news.mit.edu/2022/research-advances-technology-ai-assistance-anesthesiologists-0214 (Accessed 1/17/25).

79 *Ibid*.

Valuation Standards in Healthcare

[Excerpted from the article published in February 2025.]

The term "value" has many different meanings and definitions to different parties. Therefore, at the outset of each valuation engagement, it is critical to define appropriately (and have all parties agree to) the standard of value to be employed in developing the valuation opinion. The standard of value defines the type of value to be determined and answers the question "value to whom?" There are several standards of value that may be sought, including:

(1) **Fair Market Value (FMV):** Value from the perspective of a universe of potential disinterested third parties, i.e., the rational investor. The fair market value standard attempts to assess how the market perceives the value of the business in question. Fair market value is the standard of value typically sought in healthcare valuation engagements, for the reasons discussed below.

(2) **Fair Value:** Value usually assumed in an accounting or regulatory reporting context. While often it falls back on fair market value, the standards are not identical. For example, fair value as a legal standard may, depending on the jurisdiction, be applied in shareholder dispute or marital dissolution cases. The fair value would exclude discounts for lack of marketability and lack of control to ensure that dissenting parties are not penalized for the lack of control from which the dispute arises.

(3) **Investment Value:** Sometimes referred to as strategic value, this standard of value pertains to a company's value to a particular party or investor. The value of the business to certain parties—such as competitors, suppliers, or customers—is typically higher than it would be for a hypothetical rational third-party investor, due to the expectation of business synergies. Investment value varies depending on the value of the business to the specific purchaser; the business may well be more valuable to one competitor than to another, for example.

(4) **Liquidation Value:** The other standards of value are based on the premise that the business will continue to operate, either independently or as part of an acquiring company. A distressed business is obviously worth less than a desirable, healthy business. As a result, liquidation value is based on the assumption that the business will be terminated.

Fair market value is the standard of value applied in most healthcare valuation engagements as a result of various industry regulatory requirements. For example, federal fraud and abuse laws, such as the Anti-Kickback Statute (AKS) and the Stark Law, prohibit certain types of remuneration between healthcare providers, unless that remuneration is based on fair market value. Additionally, for tax-exempt organizations to avoid excess benefit transactions in violation of Internal Revenue Service (IRS) regulations,[1] they must pay "reasonable compensation" for services provided. Because the Fair Market Value standard is regulatory-driven, the following sections describe the main federal laws governing remuneration in the healthcare industry.

Anti-Kickback Statute (AKS)

The federal AKS makes it a felony for any person to "knowingly and willfully" solicit or receive, or to offer or pay, any remuneration, directly or indirectly, in exchange for the referral of a patient for a healthcare service paid for by a federal healthcare program, even if it is only one purpose of the arrangement.[2]

Due to the broad nature of the AKS, legitimate business arrangements may appear to be prohibited.[3] In response to these concerns, the AKS contains a number of statutory exceptions, called "safe harbors," which set forth regulatory criteria that, if met, shield an arrangement from regulatory liability.[4] These safe harbors are meant to protect transactional arrangements unlikely to result in fraud or abuse. In order for a payment to meet the requirements of many AKS safe harbors, the remuneration must not exceed the range of Fair Market Value, defined as:

"arms-length transactions...not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs."[5]

Stark Law

The Stark Law prohibits physicians from referring Medicare patients to entities with which the physicians or their family members have a financial relationship (or billing for services resulting from such referrals) for the provision of certain services, termed designated health services (DHS).[6] Regulated financial relationships include: (1) ownership interests (direct and indirect), through equity, debt, or other means, in an entity that provides DHS; and (2) compensation arrangements between physicians and entities involving any remuneration, directly or indirectly, in cash or in kind.[7] Similar to the AKS safe harbors, without these exceptions, the Stark Law might prohibit legitimate business arrangements. Note that in order to meet the requirements of many exceptions related to compensation between physicians and other entities, compensation must not exceed the range of Fair Market Value.

The Stark Law defines Fair Market Value somewhat differently depending on whether the subject payment is for the rental of equipment, the rental of office space, or for some other, general purpose. The general definition of Fair Market Value is "[t]he value in an arm's-length transaction, consistent with the *general market value* of the subject transaction." [Emphasis added.] General market value is defined, with respect to compensation for services, as: "compensation that would be paid at the time the parties enter into the service arrangement as the result of *bona fide* bargaining between well-informed parties that are not otherwise in a position to generate business for each other."[8]

Excess Benefit Transactions

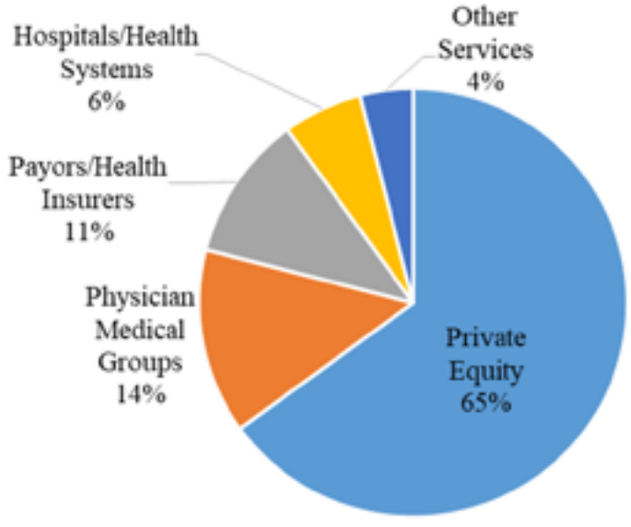
In order to avoid excess benefit transactions, tax-exempt organizations must pay reasonable compensation for services provided. The Internal Revenue Code defines reasonable compensation as the "amount that would ordinarily be paid for like services by the enterprises (whether taxable or tax-exempt) under like circumstances,"[9] and defines Fair Market Value as:

"the price at which property or the right to use property would change hands between a willing buyer and a willing seller, neither being under any compulsion to buy, sell or transfer property or the right to use property, and both having reasonable knowledge of relevant facts."[10]

It is important to note that the consideration of a universe of hypothetical willing buyers of a healthcare enterprise, asset, or service—and not a specific buyer—is required in order to be under the umbrella of Fair Market Value. Typical willing buyers of healthcare physician practices, their assets, or their services include hospitals/health systems, private equity (PE) firms, payors/"payviders," and other providers/medical groups.

When considering the universe of hypothetical and typical willing buyers of a physician practice, note that PE firms, medical groups, and payors have acquired the vast majority of practices during the last five years. Physician polling data shows that most physicians are choosing to become employed rather than operate their own practices due to increased costs and burdens, such as commercial insurer prior authorization requirements. However, the data shows that hospitals are not the primary acquirers of physicians. In fact, other entities have acquired far more individual physicians and physician practices than hospitals, and those acquisition deals have total dollar values that are far greater than those for hospitals (see Figure 1 below).

Figure 1: Percentage of Acquired Physicians by Type, 2019-2023[11]



Each of these potential acquirers are discussed below.

Hospitals/Health Systems

While physicians face increased difficulty in maintaining an independent practice, reduced reimbursement and increased administrative requirements mean that hospitals must play a key role in ensuring continued access to and provision of healthcare services for the communities they serve. As a result, the local hospital has been a natural landing spot for physicians unable to continue in private practice.

Hospitals/health systems are generally oriented toward care delivery, clinical integration, market share, and historical and long-term relationships. They are focused on acquired ancillary services (such as imaging and therapy services) that are convertible to increased hospital-based reimbursement.

The advantages to physicians choosing to sell to or enter employment with hospitals/health systems include the following:

(1) Increased and stable compensation (based on market value)
(2) Increased focus on patient care and reduction/elimination of administrative responsibilities
(3) Insulation from economic dynamics, such as declining reimbursements, increasing practice overhead and capital investment
(4) Improved work-life balance
(5) Increased opportunities to contribute to how care is delivered in the community, as the hospital/healthcare system has greater influence in the market

Private Equity (PE) Firms

PE firms pool money from groups of private investors to invest and acquire a stake in a company with the general goal of making a profit from that investment. PE firms typically buy, restructure, and resell companies.

PE firms focus on readily scalable practices with stable-to-increasing levels of reimbursement and opportunities to manage risk through improved practice performance. PE firms adhere to a "platform-based" strategy, characterized by acquiring a regionally dominant practice that can be utilized as a hub, followed by smaller add-on investments to quickly establish a regional competitive advantage. The strategy is to build scale while taking advantage of synergies resulting from geographic proximity.

The PE model is different from the hospital/health system model in that sellers typically receive larger consideration upfront, with the remaining consideration rolled over into equity in the platform organization. In addition, since physician practices typically distribute all available earnings to the owners, earnings before interest, taxes, depreciation, and amortization (EBITDA) must be "created" through a reduction in post-transaction physician compensation.

PE transactions with medical groups provide immediate capital that may be invested into health tech to streamline operations and incentivize innovation. However, PE also typically involves the relinquishment of physician control/autonomy. It has been argued that PE's focus on profits may come at the expense of high-quality care.

Historically, PE transactions have not been constrained by the same legal or regulatory restrictions on practice acquisition as most health systems. However, federal and state regulatory agencies have recently indicated a renewed focus on antitrust enforcement of PE's role in healthcare. Many states restrict ownership of medical practices and employment of physicians to certain licensed medical providers and facilities. Therefore, in order to comply with this restriction, PE firms have developed a transaction structure that allows an outside investor to share in the profitability of a medical practice through a management services organization (MSO), which may add another layer of complexity from the physician standpoint.

Payors/Payviders

Healthcare payors and providers used to be on opposite sides of the negotiating table; what was good for one was usually bad for the other. However, that relationship began to change with the introduction of the Patient Protection and Affordable Care Act (ACA) and increased acceptance of value-based care. Payors and providers found that working together could benefit both and have undertaken increased cooperation and collaboration, becoming "payviders."

While fee-for-service remains the predominant reimbursement model, payors understand that for value to be achieved, they need to pay for outcomes rather than procedure volume. Therefore, there is an incentive for payors to own medical practices because it is easier to improve outcomes and reduce costs if they can control what is performed in physicians' offices.

Payviders active in medical group acquisitions include Optum (the physician services arm of UnitedHealth Group), Humana, Cigna Medical Group, and Aetna/CVS Health.

Other Providers/Medical Groups

In addition to hospitals/health systems, PE firms, and payviders, other providers, such as larger medical groups and outpatient service providers, are actively acquiring medical groups.

The trend of small medical practices being acquired by larger medical groups is driven by a range of factors, including the high cost of technology, increased competition, and reimbursement challenges, as well as the attraction and retention of talent. These types of acquisitions are typically strategic in nature, as economies of scale and increased bargaining power with payors are the driving motivations for buyers.

Other outpatient service providers—such as dialysis centers, post-acute care providers, and urgent care facilities—are also acquiring medical practices. These acquisitions are driven by the goal of service diversification, the ability to capitalize on the current movement toward ACOs and other advanced payment models, and a longer-term strategy of being acquired by a larger corporate entity (e.g., PE).

Conclusion

Ever-increasing government scrutiny of the business activities of healthcare providers over the past several decades has led to tightened restrictions and increased regulatory enforcement, with both civil and criminal penalties. Enforcement efforts focus on areas such as fraud and abuse, anti-kickback, self-referral, and tax-exempt status. Note that many types of business arrangements, which would be regarded as typical motivations in commercial relationships between parties in other industries, present a significant risk of fraud in the healthcare industry. For example, referral relationships that would be both lawful and expected in other financial industries, may violate both federal and state healthcare fraud and abuse laws when they are found to exist between healthcare providers. Changes in the scope and nature of Medicare fraud and abuse enforcement as it relates to physician self-referral laws has created significant uncertainty for the transactional market for provider entities that provide DHS. As a result, there is a perception of greater risk in the valuation of these enterprises.

This current heightened regulatory environment for the healthcare industry affects the type of data required, the methodology employed, and the entire process of developing and reporting a valuation opinion related to healthcare entities. For example, a valuation analyst should be especially diligent in maintaining appraiser work files and should clearly define the important relationship between the analyst and healthcare legal counsel. In addition, at the outset of each valuation engagement, it is critical to define appropriately (and have all parties agree to) the standard of value to be employed in developing the valuation opinion. The valuation analyst should ensure that the client understands the various standards of value so that he or she can make an informed decision on the standard to be used in the valuation engagement.

---

1 Excess Benefit Transaction, Treas. Reg. § 53.4958-4 (2002) ["any transaction in which an economic benefit is provided by an applicable tax-exempt organization directly or indirectly to or for the use of any disqualified person, and the value of the economic benefit provided exceeds the value of the consideration (including the performance of services) received for providing the benefit"].

2 Criminal Penalties for Acts Involving Federal Health Care Programs, 42 U.S.C. § 1320a-7b(b)(1).

3 "Re: OIG Advisory Opinion No. 15-10," letter from Gregory E. Demske, Chief Counsel to the Inspector General, to [name redacted] (July 28, 2015), 4–5, https://oig.hhs.gov/documents/advisory-opinions/699/AO-15-10.pdf; U.S. v. Greber, 760 F.2d 68, 69 (3d Cir. 1985).

4 Medicare and State Health Care Programs: Fraud and Abuse; Clarification of the Initial OIG Safe Harbor Provisions and Establishment of Additional Safe Harbor Provisions Under the Anti-Kickback Statute; Final Rule, 64 Fed. Reg. 63518–63520 (November 19, 1999).

5 Exceptions, 42 CFR § 1001.952(b)(5).

6 Jennifer O'Sullivan, Cong. Rsch. Serv, RL32494, Medicare: Physician Self-Referral (Stark I and II) (updated 2007), 10–11, available at https://www.everycrsreport.com/reports/RL32494.html; Limitation on Certain Physician Referrals, 42 U.S.C. §1395nn.

7 Limitation on Certain Physician Referrals, 42 U.S.C. §1395nn.

8 Definitions, 42 C.F.R. § 411.351 (2024).

9 Excess Benefit Transaction, Treas. Reg. § 53.4958-4(b)(ii)(a) (2002).

10 *Ibid*.

11 The Advisory Board, "The Physician Landscape, Redefined" (PowerPoint presentation, NALTO/NAPR 2024 Annual Convention, March 7, 2024), 9, citing "Setting the Record Straight: Private Equity and Health Insurers Acquire More Physicians than Hospitals," American Hospital Association, June 2023, https://www.aha.org/system/files/media/file/2023/06/Private-Equity-and-Health-Insurers-Acquire-More-Physicians-than-Hospitals-Infographic.pdf (Only includes values for deals where the number of acquired physicians was reported. Certain acquirer types were also modified to more closely align with the services provided by the acquirer.)

Reimbursement Topics

MPFS Final Rule Cuts Physician Payments: Will It Last?

[Excerpted from the article published in November 2024.]

On November 1, 2024, the Centers for Medicare & Medicaid Services (CMS) released its finalized Medicare Physician Fee Schedule (MPFS) for calendar year (CY) 2025, aiming "to strengthen primary care, expand access to preventive services, and further access to whole-person care."[1] While the finalized fee schedule cuts payments to physicians, Congress is considering legislation to override the cut. This Health Capital Topics article discusses the provisions contained in the MPFS final rule, as well as the proposed "doc fix" legislation.

Payment Rate Updates for MPFS

The overall MPFS payment rates will be reduced by 2.93% in CY 2025.[2] Notably, CMS also anticipates provider expenses to increase by 3.6% in 2025, meaning the 2.93% reduction will effectively amount to a 6.4% cut.[3] The conversion factor will decline by $0.94, to $32.35 – a 2.83% reduction from 2024's conversion factor of $33.29 – marking the fifth straight year that CMS has decreased physician payment rates.[4] The conversion factor translates a relative value unit (RVU) – a geographically-adjusted measure of resources required to perform a procedure – into a payment amount for a given service.[5] This conversion factor is updated annually using a formula that accounts for: (1) the previous year's conversion factor; (2) the estimated percentage increase in the Medicare Economic Index (MEI) for the year (reflecting inflationary changes in office expenses and physician earnings); and (3) an update adjustment factor.[6] All physician services, except anesthesia services, use a single conversion factor.[7] The CY 2025 decrease "reflects the 0% update required by statute for CY 2025, the expiration of the 2.93% temporary increase in payment amounts for CY 2024 required by statute, and a small [0.02%] budget neutrality adjustment necessary to account for changes in valuation for particular services."[8]

Medicare Shared Savings Program (MSSP) Changes

CMS finalized several changes to the Medicare Shared Savings Program (MSSP). For the first time, accountable care organizations (ACOs) with a successful MSSP track record will be able to receive an advance on their earned shared savings. This change aims to "encourage ACO investment in staffing, health care infrastructure, and certain additional services for people with Medicare, such as dental, vision, hearing, healthy meals, and transportation."[9]

CMS also adopted a health equity benchmark to encourage ACOs that serve Medicare and Medicaid beneficiaries located in rural and underserved areas.[10]

Regarding the MSSP financial benchmarking methodology, CMS finalized adjustments related to improper payments. Starting with CY 2024 billing activity, CMS will be able to take into account the impact of improper payments and mitigate the impact of significant, anomalous, and highly suspect (SAHS) billing activity during the annual financial reconciliation.[11]

Telehealth Changes

The *Consolidated Appropriations Act, 2023* temporarily extended telehealth flexibilities, which have been in place since the start of the COVID-19 public health emergency, until December 31, 2024.[12] CMS finalized the flexibilities it could under its authority with the 2025 MPFS Final Rule. For example, CMS will continue to allow certain practitioners to directly supervise auxiliary personnel via virtual means and allow teaching physicians to be virtually present when furnishing telehealth services involving residents in teaching settings.[13] Additionally, a number of services were added to the Medicare Telehealth Services List, including caregiver training services (on a provisional basis) and counseling and safety planning interventions for PrEP (on a permanent basis).[14] However, the power to permanently expand telehealth ultimately lies with Congress. Should Congress not act prior to January 1, 2025, geographic and location restrictions will return (i.e., Medicare beneficiaries across the U.S. will not be able to receive services in their home and other previously-disallowed locations), as will limitations on the types of practitioners who can provide telehealth services to Medicare beneficiaries.[15] The one exception to these limitations is behavioral telehealth, which can continue to be provided to the patient in their home.[16]

A number of bills are under consideration in Congress to permanently extend telehealth for Medicare beneficiaries. The most recent legislation, *Telehealth Modernization Act of 2024*, unanimously advanced out of the House Committee on Energy and Commerce in September 2024.[17] The bill would extend telehealth flexibilities – namely restrictions relating to originating and geographic sites, provider type, and covered services – for two years, and permanently allow federally qualified health centers (FQHCs) and rural health clinics (RHCs) to provide telehealth services for adequate reimbursement.[18]

Advanced Primary Care Management (APCM) Services

CMS established coding and payment for a new set of Advanced Primary Care Management (APCM) services.[19] Starting January 1, 2025, physicians and non-physician practitioners (NPPs) who participate in advanced primary care models can bill the following APCM service codes:

(1) G0556, for patients with one chronic condition;
(2) G0557, for patients with two or more chronic conditions; and
(3) G0558, for patients with two or more chronic conditions and status as a Qualified Medicare Beneficiary.[20]

The services include parts of existing care management and communication technology-based services and reflect the essential parts of advanced primary care delivery, including chronic care management, transitional care management, and principal care management.[21] Further, the codes are not time-based, unlike existing care management codes, so as to reduce the administrative burden.[22] CMS notes that these new codes "represent a step towards paying for primary care services with hybrid payments (a mix of encounter and population-based payments) to support longitudinal relationships between primary care providers and beneficiaries, by paying for care in larger units of service, and also help drive accountable care."[23]

Other Provisions

Other provisions finalized by CMS for 2025 include:

(1) Codifying the *Inflation Reduction Act of 2022*'s mandate that drug companies pay "inflation rebates" if they raise prices for certain Medicare Part B and D drugs faster than the rate of inflation;

(2) Allowing outpatient providers to bill an Evaluation and Management (E/M) visit complexity add-on code when the E/M base code is accompanied by an annual wellness visit, vaccine administration, or other preventative service; and

(3) Technology flexibilities for opioid treatment programs (OTPs), including allowing OTP intake and initiation with methadone to be furnished via telehealth and allowing audio-only visits for follow-up appointments.[24]

Industry Reaction

National provider associations uniformly condemned the MPFS final rule's cuts to physician payments. The American Medical Association (AMA) criticized both CMS and congress, stating, "To put it bluntly, Medicare plans to pay us less while costs go up. You don't have to be an economist to know that is an unsustainable trend…"[25] America's Physician Groups (APG) also expressed their disappointment, pivoting to urging Congress to "blunt the crippling effect of the fee cuts."[26] Similarly, the American Group Management Association (AMGA) communicated its concern that "the cut may force AMGA members to lay off staff and clinicians, further exacerbating patient access to care; not accept new Medicare beneficiaries as patients; and delay investments in social drivers of health."[27] The AMGA also implored Congress to prevent the cuts from taking effect by passing legislation before the end of the year.[28] The Medical Group Management Association (MGMA) weighed in, stating that "CMS and Congress have once again overlooked the sobering financial realities facing our nation's medical practices…further increasing the gap between practice expenses and reimbursement rates. Today's final rule throws the financial viability of physician practices into question and threatens beneficiary access to care."[29] In addition, MGMA sent a letter to congressional leaders imploring them to resolve the significant reimbursement challenges faced by providers. In particular, MGMA asked for leaders' consideration of three issues: "averting the finalized cut to Medicare payment and providing an inflationary update for 2025, passing prior authorization reform, and extending telehealth flexibilities."[30]

Meanwhile, associations commended other MPFS provisions. MGMA applauded CMS for finalizing several telehealth policies and APG and the National Association of ACOs (NAACOS) expressed their general approval of the MSSP changes.[31] However, NAACOS remains "concerned about unresolved issues that threaten ACO participation in the Shared Savings Program," namely "increasingly reduced financial targets over time" and new quality reporting requirements.[32]

In response to the urging of provider associations, a new, bipartisan bill was recently introduced in the U.S. House of Representatives that would increase physician pay by 4.73%,[33] turning CMS's 2.93% pay cut into a 1.80% increase (which equates to half of the Medicare Economic Index for 2025[34]). The bill has garnered support from 155 medical organizations, including the American Medical Association (AMA) and MGMA.[35]

When adjusted for inflation, MPFS reimbursement has declined 29% since 2001.[36] Similarly, MGMA data on physician practices indicate that total operating cost per full-time equivalent (FTE) physician increased by more than 63% between 2013 and 2022, while the MPFS conversion factor increased by only 1.7% over the same timeframe.[37] Physicians have been sounding the alarm on Medicare reimbursement challenges for years. In response to a 2023 survey conducted by MGMA, "87 percent of medical group practices said reimbursement not keeping up with inflation would impact current and future Medicare patient access," and "92 percent of medical groups reported an increase in operating costs in 2024."[38] While provider associations have been calling for a more comprehensive overhaul of physician payment updates, to avoid such end-of-the-year overrides, it is unlikely that any legislation will be passed this year given there are only 12 legislative days left in 2024 (beginning December 1st), meaning that any wholesale changes to the MPFS are likely delayed for at least another year.

1 "HHS Finalizes Physician Payment Rule Strengthening Person-Centered Care and Health Quality Measures" Centers for Medicare & Medicaid Services, November 1, 2024, https://www.cms.gov/newsroom/press-releases/hhs-finalizes-physician-payment-rule-strengthening-person-centered-care-and-health-quality-measures (Accessed 11/12/24).
2 *Ibid*.
3 "New Bill Aims to Increase Physician Pay, Block Medicare Cuts" By Marie DeFreitas, HealthLeaders, November 7, 2024, https://www.healthleadersmedia.com/cfo/new-bill-aims-increase-physician-pay-block-medicare-cuts (Accessed 11/12/24).
4 "Calendar Year (CY) 2025 Medicare Physician Fee Schedule Final Rule" Centers for Medicare & Medicaid Services, November 1, 2024, https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2025-medicare-physician-fee-schedule-final-rule (Accessed 11/12/24).
5 "Physician and Other Health Professional Payment System" Medicare Payment Advisory Commission, Payment Basics, October 2024, https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_Physician_FINAL_SEC.pdf (Accessed 11/12/24).
6 *Ibid*.
7 *Ibid*.
8 Centers for Medicare & Medicaid Services, November 1, 2024.
9 *Ibid*.
10 *Ibid*.
11 *Ibid*.
12 "Bill to extend telehealth flexibilities clears House committee" By Tanya Albert Henry, American Medical Association, August 15, 2024, https://www.ama-assn.org/practice-management/digital/bill-extend-telehealth-flexibilities-clears-house-committee (Accessed 11/12/24).
13 Centers for Medicare & Medicaid Services, November 1, 2024.
14 *Ibid*.
15 *Ibid*.
16 *Ibid*.
17 "H.R.7623 - Telehealth Modernization Act of 2024" Congress.gov, https://www.congress.gov/bill/118th-congress/house-bill/7623?q=%7B%22search%22%3A%22telehealth+modernization%22%7D&s=1&r=2 (Accessed 11/12/24).
18 "Bipartisan telehealth extension bill passes in House committee" By Noah Tong, Fierce Healthcare, September 19, 2024, https://www.fiercehealthcare.com/regulatory/bipartisan-telehealth-extension-bill-passes-house-committee (Accessed 11/12/24); "AHA Letter of Support for the Telehealth Modernization Act (H.R. 7623)" American Hospital Association, April 9, 2024, https://www.aha.org/lettercomment/2024-04-09-aha-letter-support-telehealth-modernization-act-hr-7623 (Accessed 11/12/24).
19 Centers for Medicare & Medicaid Services, November 1, 2024.
20 *Ibid*.
21 *Ibid*.
22 *Ibid*.
23 *Ibid*.
24 *Ibid*.
25 "Congress must act as Medicare pay cut is set" Statement by Bruce A. Scott, MD, November 1, 2024, https://www.ama-assn.org/press-center/press-releases/congress-must-act-medicare-pay-cut-set (Accessed 11/13/24).
26 "Scheduled Medicare Physician Fee Cuts Now In Congress's Lap With Publication Of The Final 2025 Rule, APG Says" America's Physician Groups, November 1, 2024, https://www.apg.org/news/scheduled-medicare-physician-fee-cuts-now-in-congresss-lap-with-publication-of-the-final-2025-rule-apg-says/ (Accessed 11/13/24).
27 "AMGA Calls on Congress to Stop Medicare Cuts" American Group Medical Association, November 1, 2024, https://www.amga.org/about-amga/amga-newsroom/press-releases/11012024 (Accessed 11/13/24).
28 *Ibid*.
29 "CMS Physician Fee Schedule Provokes Protests Among Providers" By Mark Hagland, November 4, 2024, https://www.hcinnovationgroup.com/policy-value-based-care/article/55240499/cms-physician-fee-schedule-provokes-protests-among-providers (Accessed 11/13/24).
30 "MGMA Appeals to Congress to Address MD Reimbursement Issues" By Mark Hagland, Healthcare Innovation, November 12, 2024, https://www.hcinnovationgroup.com/policy-value-based-care/news/55242299/mgma-appeals-to-congress-to-address-md-reimbursement-issues (Accessed 11/13/24).
31 Hagland, November 4, 2024.
32 *Ibid*.
33 "H.R.10073 - Medicare Patient Access and Practice Stabilization Act of 2024" Congress.gov, https://www.congress.gov/bill/118th-congress/house-bill/10073/text (Accessed 11/12/24); "New Bill Aims to Increase Physician Pay, Block Medicare Cuts" By Marie DeFreitas, HealthLeaders, November 7, 2024, https://www.healthleadersmedia.com/cfo/new-bill-aims-increase-physician-pay-block-medicare-cuts (Accessed 11/12/24).
34 Hagland, Healthcare Innovation, November 12, 2024.
35 "Murphy Introduces Bipartisan Legislation to Protect Medicare for Physicians and Patients" Press Release, U.S. Congressman Gregory F. Murphy, MD, October 29, 2024, https://murphy.house.gov/media/press-releases/murphy-introduces-bipartisan-legislation-protect-medicare-physicians-and (Accessed 11/12/24).
36 "Medicare physician pay has plummeted since 2001. Find out why." By Tanya Albert Henry, American Medical Association, June 17, 2024, https://www.ama-assn.org/practice-management/medicare-medicaid/medicare-physician-pay-has-plummeted-2001-find-out-why (Accessed 11/13/24).
37 Letter to The Honorable Mike Johnson, The Honorable Hakeem Jeffries, The Honorable Charles Schumer, and The Honorable Mitch McConnell, from Anders Gilberg, Medical Group Management Association, dated November 12, 2024, Re: MGMA Legislative Imperatives for the End of 2024, available at: https://www.mgma.com/getkaiasset/a1658e5f-2577-49bf-a5ed-14e33cd85ec0/11.12.2024_MGMA%20End%20of%20Year%20Letter.pdf (Accessed 11/13/24).
38 Hagland, Healthcare Innovation, November 12, 2024.

Congressional Spending Bill Excludes Physician Payment Increase

[Excerpted from the article published in December 2024.]

On December 21, 2024, President Biden signed a stopgap spending bill that avoided a government shutdown and funds the federal government through March 14, 2025.[1] Perhaps more notable than what was included in the spending bill was what was excluded. While the COVID-era telehealth waivers were temporarily extended, no physician payment increases were included, meaning physicians will experience a 2.93% pay cut in 2025. This Health Capital Topics article discusses the status of physician payments as well as the status of any future "doc fix" legislation.

Physician payments are updated annually by the Centers of Medicare & Medicaid Services (CMS) via the Medicare Physician Fee Schedule (MPFS) conversion factor. The conversion factor translates a relative value unit (RVU) – a geographically-adjusted measure of resources required to perform a procedure – into a payment amount for a given service.[2] This conversion factor is updated each year using a formula that accounts for:

(1) The previous year's conversion factor;
(2) The estimated percentage increase in the Medicare Economic Index (MEI) for the year (reflecting inflationary changes in office expenses and physician earnings); and
(3) An update adjustment factor.[3]

All physician services, except anesthesia services, use a single conversion factor.[4]

On November 1, 2024, CMS published the MPFS final rule for calendar year (CY) 2025, which reduced the conversion factor by 2.83% (from $33.29 to $32.35), marking the fifth straight year that CMS has decreased the MPFS conversion factor.[5] This update results in an average payment rate reduction of 2.93%, as a result of "the 0% update required by statute for CY 2025, the expiration of the 2.93% temporary increase in payment amounts for CY 2024 required by statute, and a small [0.02%] budget neutrality adjustment necessary to account for changes in valuation for particular services."[6] In addition, CMS noted that it anticipates provider expenses to increase by 3.6% in 2025, meaning the 2.93% reduction will effectively amount to a 6.4% cut.[7]

After the publication of the final rule, provider associations lobbied Congress to pass legislation ameliorating the cuts, resulting in the introduction of a new, bipartisan bill to increase physician pay by 4.73%,[8] turning CMS's 2.93% pay cut into a 1.80% increase (which equates to half of the MEI for 2025[9]). The bill garnered support from 155 medical organizations, including the Medical Group Management Association (MGMA) and the American Medical Association (AMA).[10] Ultimately, that bill did not progress; instead, an increase to physician payments was included in the originally proposed continuing resolution. Specifically, the funding bill contained a 2.5% increase to physician payments, nearly canceling out the cut, as well as two-year extensions for the telehealth waivers and flexibilities.[11] It also eradicated an $8 billion safety-net hospital cut and extended for another year 3.5% bonuses for accountable care organizations (ACOs) participating in advanced payment models (APMs).[12] However, the original spending bill (as well as a second proposed bill) was politically torpedoed. In an effort to keep the government running, legislators passed a last-minute, stripped-down spending bill that excluded all of these measures except for a three-month extension of the telehealth waivers and flexibilities (until April 1, 2025) and a delay of the safety-net hospital cut.[13]

Provider associations lambasted Congress's inability to ameliorate the Medicare physician payment cuts. The MGMA called it "a huge congressional failure to the detriment of the nation's Medicare patients and their physicians."[14] The AMA stated that it "utterly fails to address declining reimbursement rates for Medicare, pushing our health system down a path that will have predictable and deleterious results. For the fifth consecutive year, Congress has adjourned and allowed Medicare cuts. What will be the result? Patients struggling to access health care. Physicians closing or selling their private practices while others opt to leave the profession."[15]

When adjusted for inflation, MPFS reimbursement has declined 33% since 2001.[16] Similarly, MGMA data on physician practices indicate that total operating cost per full-time equivalent (FTE) physician increased by more than 63% between 2013 and 2022, while the MPFS conversion factor increased by only 1.7% over the same timeframe.[17] Physicians have been sounding the alarm on Medicare reimbursement challenges for years. In response to a 2023 survey conducted by MGMA, "87 percent of medical group practices said reimbursement not keeping up with inflation would impact current and future Medicare patient access," and "92 percent of medical groups reported an increase in operating costs in 2024."[18] While provider associations have been calling for a more comprehensive overhaul of physician payment updates, to avoid such end-of-the-year overrides, such legislation has been kicked down the road once again. Provider associations have called on Congress to pass both retroactive physician payment rate increases and comprehensive reform to the MPFS; whether Congress can and will do so remains to be seen.

1 "Congress Adjourns Without Easing Medicare Doc Pay Cut" By Kerry Dooley Young, Medscape, December 23, 2024, https://www.medscape.com/viewarticle/congress-adjourns-without-easing-medicare-doc-pay-cut-2024a1000oxu?ecd=a2a (Accessed 12/24/24).

2 "Physician and Other Health Professional Payment System" Medicare Payment Advisory Commission, Payment Basics, October 2024, https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_Physician_FINAL_SEC.pdf (Accessed 11/12/24).

3 *Ibid*.

4 *Ibid*.

5 "Calendar Year (CY) 2025 Medicare Physician Fee Schedule Final Rule" Centers for Medicare & Medicaid Services, November 1, 2024, https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2025-medicare-physician-fee-schedule-final-rule (Accessed 11/12/24).

6 "HHS Finalizes Physician Payment Rule Strengthening Person-Centered Care and Health Quality Measures" Centers for Medicare & Medicaid Services, November 1, 2024, https://www.cms.gov/newsroom/press-releases/hhs-finalizes-physician-payment-rule-strengthening-person-centered-care-and-health-quality-measures (Accessed 11/12/24).

7 "New Bill Aims to Increase Physician Pay, Block Medicare Cuts" By Marie DeFreitas, HealthLeaders, November 7, 2024, https://www.healthleadersmedia.com/cfo/new-bill-aims-increase-physician-pay-block-medicare-cuts (Accessed 11/12/24).

8 "H.R.10073 - Medicare Patient Access and Practice Stabilization Act of 2024" Congress.gov, https://www.congress.gov/bill/118th-congress/house-bill/10073/text (Accessed 11/12/24); "New Bill Aims to Increase Physician Pay, Block Medicare Cuts" By Marie DeFreitas, HealthLeaders, November 7, 2024, https://www.healthleadersmedia.com/cfo/new-bill-aims-increase-physician-pay-block-medicare-cuts (Accessed 11/12/24).

9 "MGMA Appeals to Congress to Address MD Reimbursement Issues" By Mark Hagland, Healthcare Innovation, November 12, 2024, https://www.hcinnovationgroup.com/policy-value-based-care/news/55242299/mgma-appeals-to-congress-to-address-md-reimbursement-issues (Accessed 11/13/24).

10 "Murphy Introduces Bipartisan Legislation to Protect Medicare for Physicians and Patients" Press Release, U.S. Congressman Gregory F. Murphy, MD, October 29, 2024, https://murphy.house.gov/media/press-releases/murphy-introduces-bipartisan-legislation-protect-medicare-physicians-and (Accessed 11/12/24).

11 "Telehealth and doctors win, PBMs lose as government funding deal nears" By Michael McAuliff, Modern Healthcare, December 17, 2024, https://www.modernhealthcare.com/politics-policy/telehealth-flexibilities-doctor-pay-pbms-government-spending-bill (Accessed 12/23/24).

12 *Ibid*.

13 "Congress votes to keep government open, abandons health package" By Michael McAuliff, Modern Healthcare, December 20, 2024, https://www.modernhealthcare.com/politics-policy/spending-bill-house-healthcare-package (Accessed 12/23/24).

14 "MGMA statement on stopgap funding bill (December 21, 2024)" Medical Group Management Association, Press Release, https://www.mgma.com/press-statements/december-21-2024-mgma-statement-on-stopgap-funding-bill (Accessed 12/24/24).

15 "AMA: Congress fails patients and physicians" American Medical Association, Press Release, December 21, 2024, https://www.ama-assn.org/press-center/press-releases/ama-congress-fails-patients-and-physicians (Accessed 12/24/24).

16 "Medicare updates compared to inflation (2001-2023)" American Medical Association, https://www.ama-assn.org/system/files/ama-medicare-gaps-chart-grassroots-insert.pdf (Accessed 12/24/24); "AMA: Congress fails patients and physicians" American Medical Association, Press Release, December 21, 2024, https://www.ama-assn.org/press-center/press-releases/ama-congress-fails-patients-and-physicians (Accessed 12/24/24).

17 Letter to The Honorable Mike Johnson, The Honorable Hakeem Jeffries, The Honorable Charles Schumer, and The Honorable Mitch McConnell, from Anders Gilberg, Medical Group Management Association, dated November 12, 2024, Re: MGMA Legislative Imperatives for the End of 2024, available at: https://www.mgma.com/getkaiasset/a1658e5f-2577-49bf-a5ed-14e33cd85ec0/11.12.2024_MGMA%20End%20of%20Year%20Letter.pdf (Accessed 11/13/24).

18 Hagland, Healthcare Innovation, November 12, 2024.

MedPAC Recommends Hospital & Physician Payment Updates

[Excerpted from the article published in February 2025.]

During its January 2025 meeting, the Medicare Payment Advisory Commission (MedPAC) reviewed and endorsed recommendations for Medicare payment reform and updates.[1] Among other decisions, the commission recommended revisions to the annual Medicare Physician Fee Schedule (MPFS) update methodology and increased pay rates to hospitals under the Inpatient Prospective Payment System (IPPS). This Health Capital Topics article reviews MedPAC's recommendations, responses from industry stakeholders, and the likelihood that the commission's recommendations will be enacted by Congress.

MedPAC is an independent congressional agency that advises Congress on issues affecting the Medicare program, such as "payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program, [as well as] access to care, quality of care, and other issues affecting Medicare."[2] Additionally, MedPAC is required by law to annually assess the adequacy of Medicare payments for various healthcare delivery sectors and make payment update recommendations.[3] In making that assessment, the commission analyzes factors such as patient access to care, provider access to capital, quality of care, Medicare payments, and provider costs.[4]

On January 16, 2025, MedPAC met to assess "payment adequacy and updating payments" for physician and other health professional services.[5] In providing context to the landscape of physician reimbursement, the presentation to the commission noted several statistics, including that:

- Payment rates for evaluation and management visits increased in 2021, requiring offsetting decreases to the conversion factor to maintain budget neutrality;
- Spending per Medicare fee-for-service (FFS) beneficiary increased 4.2% in 2023;
- Median physician compensation grew 3% in 2023;
- Median advanced practice provider (APP) compensation grew 6% in 2023; and
- The Medicare Economic Index (MEI) peaked at 4.4% in 2022, but is expected to decrease to 2.3% by 2026.[6]

In consideration of the above, two recommendations were proposed to and approved by the commission. The first recommendation was to replace the current FFS updates required by law with a single update to the MEI, minus 1%; this would result in a projected 1.3% increase to physician payments in 2026.[7] The MEI was developed in 1975 by the Centers for Medicare & Medicaid Services (CMS) to measure annual changes in physicians' operating costs and earnings levels, and is currently a significant (but not the only) factor in determining the annual payment update for the MPFS.[8] Similar, bipartisan legislation was proposed in 2024 to tie future MPFS updates directly to the MEI, but did not progress in Congress for a myriad of political reasons.[9] The second recommendation was to enact MedPAC's prior proposal to implement a clinician safety net, which would increase average MPFS payments by 1.7%.[10] MedPAC recommended in 2023 that add-on payments should be established for all MPFS services rendered to low-income beneficiaries. Specifically, MedPAC recommended that primary care physicians receive a 15% boost for services rendered to those beneficiaries, and all other clinicians receive a 5% boost.[11] If both recommendations are ultimately enacted, MedPAC predicts that average MPFS payments would increase by approximately 3% – primary care clinicians' pay would increase 5.7%, while all other clinicians' pay would increase 2.5%.[12] This would increase government spending $2 to $5 billion in the first year, and $10 to $25 billion over five years.[13]

During its January 2025 meeting, MedPAC also voted to recommend an increase in hospital payments (both inpatient and outpatient) for 2026. Specifically, the commission voted in favor of the recommendation to increase the inpatient and outpatient base payment rates for general acute care hospitals by an additional 1%.[14] The commission also approved re-recommending that existing payments to safety-net hospitals be redistributed and that $4 billion be added to that fund.[15] First proposed in 2023, the so-called Medicare Safety-Net Index would direct more funds to hospitals serving more FFS Medicare patients; as a result, those hospitals serving fewer FFS Medicare patients may experience a decrease in funding.[16] The result of this recommendation would increase spending $5 to $10 billion in the first year, and $25 to $50 billion over five years.[17]

The recommendations approved by MedPAC commissioners will become part of MedPAC's June 2025 report to Congress; as noted above, while MedPAC is required to make recommendations to Congress, Congress is not required to follow those recommendations, i.e., draft and pass legislation.

Stakeholders quickly responded to MedPAC's report, with the general consensus that MedPAC's suggested physician payment methodology and hospital payment updates did not go far enough. The American Medical Association (AMA) commended MedPAC for the recommendation to tie Medicare physician updates to an inflation-based index, i.e., the MEI, and expressed its hope that Congress "heed[s] MedPAC's analysis concluding that Medicare payment to physician practices under current law is inadequate and downright threatening to patient access to care."[18] The American Hospital Association (AHA) expressed appreciation for the proposed 1% increase to hospital payment rates, but asserted that "even after the recommended payment update, Medicare's payments to hospitals would remain inadequate."[19] America's Essential Hospitals, speaking on behalf of safety-net hospitals, lauded the additional $4 billion for the hospital safety-net fund, but concern with the "flawed" Medicare Safety-Net Index.[20] Specifically, the organization "opposed" the Index because it "would shift funding away from the largest safety net providers that serve the highest numbers of low-income Medicare patients."[21]

Once MedPAC's recommendations are incorporated into its June 2025 report and delivered to Congress, it will be legislators' turn to take action and pass legislation on these topics. The likelihood of it passing the physician payment recommendations appears high given that similar bipartisan bills have been proposed previously. There is less clarity on the likelihood of legislation taking up MedPAC's hospital payment update recommendations. Providers will have to simply have to wait (or lobby) and see.

---

1 "January 16-17, 2025: Public Meeting" Medicare Payment Advisory Commission, https://www.medpac.gov/meeting/january-16-17-2025/ (Accessed 2/13/25).
2 "What We Do" Medicare Payment Advisory Commission, https://www.medpac.gov/what-we-do/ (Accessed 2/13/25).
3 "Chapter 2: Assessing payment adequacy and updating payments in fee-for-service Medicare" in "Report to the Congress: Medicare Payment Policy Medicare Payment Advisory Commission, March 2024, available at: https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch2_MedPAC_Report_To_Congress_SEC.pdf (Accessed 2/13/25), p. 35.
4 *Ibid*.
5 "Assessing payment adequacy and updating payments: Physician and other health professional services" MedPAC, January 16, 2025, available at: https://www.medpac.gov/wp-content/uploads/2024/08/Tab-C-Physician-payment-adequacy-January-2025-SEC.pdf (Accessed 2/13/25).
6 *Ibid*
7 *Ibid*
8 "Report to the HHS Secretary: Review of the Medicare Economic Index" 2012 Medicare Economic Index Technical Advisory Panel, August 2021, available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/FACA/Downloads/MEI-Review-Report-to-HHS.pdf (Accessed 2/13/25).
9 For more information, see "Looking into the Crystal Ball: 2025 Healthcare Industry Outlook" Health Capital Topics, Vol. 17, Issue 12 (Dec. 2024), https://www.healthcapital.com/hcc/newsletter/12_24/HTML/OUTLOOK/what-to-expect-in-2025.php (Accessed 2/13/25).
10 MedPAC, January 16, 2025.
11 *Ibid*
12 *Ibid*
13 *Ibid*
14 "MedPAC votes to recommend hospital pay increases for 2026" By Dave Muoio, Fierce Healthcare, January 17, 2025, https://www.fiercehealthcare.com/providers/medpac-votes-recommend-hospital-pay-increases-2026 (Accessed 2/13/25).
15 *Ibid*
16 *Ibid*
17 *Ibid*
18 "MedPAC gets it: Tie Medicare payments to inflation" American Medical Association, January 16, 2025, https://www.ama-assn.org/press-center/press-releases/medpac-gets-it-tie-medicare-payments-inflation (Accessed 2/18/25).
19 "AHA Comments in Advance of MedPAC January 2025 Meeting" American Hospital Association, January 10, 2025, https://www.aha.org/2025-01-10-aha-comments-advance-medpac-january-2025-meeting#:~:text=HOSPITAL%20PAYMENT%20UPDATE%20RECOMMENDATIONS&text=Simply%20put%2C%20even%20after%20the,fact%20that%20the%20commission%20recognizes. (Accessed 2/18/25).
20 Letter dated January 15, 2025, from America's Essential Hospitals to Paul Masi, MPP, Executive Director, Medicare Payment Advisory Commission, Re: Effects of proposed Medicare Safety-Net Index on Essential Hospitals, available at: https://essentialhospitals.org/wp-content/uploads/2025/01/MedPAC-MSNI-Letter.pdf (Accessed 2/18/25).
21 *Ibid*

Continuing Resolution Excludes Physician Payment Increase Again

[Excerpted from the article published in March 2025.]

On March 15, 2025, President Donald Trump signed a continuing resolution (CR) that avoided a government shutdown and funds the federal government for the rest of the fiscal year, i.e., through September 30, 2025.[1] Perhaps more notable than what was included in the spending bill was what was once again excluded. While the COVID-era telehealth waivers were temporarily extended, Medicare physician payment rates were not addressed, meaning physicians will continue experiencing a 2.93% pay cut for 2025. This Health Capital Topics article discusses the healthcare provisions included in and excluded from the CR, and the impacts on healthcare providers.

Physician payments are updated annually by the Centers of Medicare & Medicaid Services (CMS) via the Medicare Physician Fee Schedule (MPFS) conversion factor. The conversion factor translates a relative value unit (RVU) – a geographically-adjusted measure of resources required to perform a procedure – into a payment amount for a given service.[2] This conversion factor is updated each year using a formula that accounts for:

(1) The previous year's conversion factor;
(2) The estimated percentage increase in the Medicare Economic Index (MEI) for the year (reflecting inflationary changes in office expenses and physician earnings); and
(3) An update adjustment factor.[3]

The MPFS final rule for calendar year 2025 reduced the conversion factor by 2.83% (from $33.29 to $32.35), marking the fifth straight annual decrease (although Congress eased those cuts the first four years).[4] In addition, CMS noted in the final rule that it anticipates provider expenses to increase by 3.6% in 2025, meaning the conversion factor reduction effectively amounts to a 6.4% cut.[5]

After the publication of the final rule, provider associations lobbied Congress to pass legislation ameliorating the cut, resulting in the introduction of new, bipartisan legislation to increase physician pay. Some increase to physician payment rates was also included in the initial version of the December 2024

CR, but at the last minute, legislators passed a stripped-down spending bill that excluded any physician pay increases but included a three-month extension of the telehealth waivers and flexibilities (until April 1, 2025) and a delay of the safety-net hospital cut.[6] Numerous lawmakers assured the public that the issue would be addressed in the March 2025 CR.

Hours before the CR's March 15, 2025 expiration, Congress passed another, full-year CR that once again kicked the can down the road on both telehealth extensions and physician pay increases.[7] The funding bill extends telehealth flexibilities until September 30, 2025, during which time telehealth visits can occur at an expanded list of locations (including a Medicare patient's home) and allows additional provider types to conduct telehealth visits.[8] The CR also extended funding for community health centers, health centers that operate graduate medical education programs, the hospital at home program, supplemental payments to certain low-volume hospitals, and to Medicare-dependent hospitals and ground ambulances.[9] The bill also delayed a three-year, $24 billion Medicaid disproportionate share hospital payment reduction.[10] However, the CR did not address the Medicare physician pay cut.[11]

Provider associations excoriated the CR and its exclusion of a Medicare physician payment increase. The Medical Group Management Association (MGMA) called it "a massive congressional failure and blatant abdication of duty to our nation's physicians and their beneficiaries."[12] The American Medical Association's (AMA) president stated:

"Physicians across the country are outraged that Congress's proposed spending package locks in a devastating fifth consecutive year of Medicare cuts, threatening access to care for 66 million Medicare patients. Despite repeated warnings, lawmakers are once again ignoring the dire consequences of these cuts and their impact both on patients and the private practices struggling to keep their doors open."[13]

American Medical Group Association (AMGA) noted that "the cuts are compounded by almost 11% in cumulative decreases over the past five years and have created a crisis in healthcare delivery."[14] Further, the AMGA released the results of a survey it conducted related to the 2025 payment cuts, which found that of their surveyed members:

- 61.3% have implemented hiring freezes/delays;
- 40% have eliminated services to Medicare patients;
- 31.3% have laid off or furloughed nonclinical staff;
- 25% have laid off or furloughed clinical staff; and
- 12.5% are not accepting new Medicare patients.[15]

When adjusted for inflation, MPFS reimbursement has declined 33% since 2001.[16] Similarly, MGMA data on physician practices indicate that total operating cost per full-time equivalent (FTE) physician increased by more than 63% between 2013 and 2022, while the MPFS conversion factor increased by only 1.7% over the same timeframe.[17] Physicians have been sounding the alarm on Medicare reimbursement challenges for years. In response to a 2023 survey conducted by MGMA, "87 percent of medical group practices said reimbursement not keeping up with inflation would impact current and future Medicare patient access," and "92 percent of medical groups reported an increase in operating costs in 2024."[18] While provider associations have been calling for a more comprehensive overhaul of physician payment updates, to avoid such end-of-the-year overrides, such legislation has been kicked down the road time and time again. Provider associations have called on Congress to pass both retroactive physician payment rate increases and comprehensive reform to the MPFS; whether Congress can and will do so remains to be seen.

1 "Congress passes Full-Year Continuing Resolution Bill, maintaining global health funding at prior year levels" Kaiser Family Foundation, March 18, 2025, https://www.kff.org/global-health-policy/fact-sheet/congress-passes-full-year-continuing-resolution-bill-maintaining-global-health-funding-at-prior-year-levels/ (Accessed 3/18/25).

2 "Physician and Other Health Professional Payment System" Medicare Payment Advisory Commission, Payment Basics, October 2024, https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_Physician_FINAL_SEC.pdf (Accessed 11/12/24).

3 *Ibid*.

4 "Calendar Year (CY) 2025 Medicare Physician Fee Schedule Final Rule" Centers for Medicare & Medicaid Services, November 1, 2024, https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2025-medicare-physician-fee-schedule-final-rule (Accessed 11/12/24); "Medicaid DSH payment cut again delayed in proposed federal funding bill (updated)" By Nick Hut, Healthcare Financial Management Association, March 11, 2025, https://www.hfma.org/payment-reimbursement-and-managed-care/medicaid-dsh-payment-cut-again-delayed-in-proposed-federal-funding-bill/ (Accessed 3/19/25).

5 "New Bill Aims to Increase Physician Pay, Block Medicare Cuts" By Marie DeFreitas, HealthLeaders, November 7, 2024, https://www.healthleadersmedia.com/cfo/new-bill-aims-increase-physician-pay-block-medicare-cuts (Accessed 11/12/24).

6 "Congress votes to keep government open, abandons health package" By Michael McAuliff, Modern Healthcare, December 20, 2024, https://www.modernhealthcare.com/politics-policy/spending-bill-house-healthcare-package (Accessed 12/23/24).

7 "House votes to extend telehealth for 6 months, sends funding bill to Senate" By Emma Beavins and Dave Muoio, Fierce Healthcare, March 11, 2025, https://www.fiercehealthcare.com/regulatory/house-extends-telehealth-six-months (Accessed 3/18/25).

8 *Ibid*.

9 *Ibid*.

10 *Ibid*; Hut, Healthcare Financial Management Association, March 11, 2025.

11 Emma Beavins and Dave Muoio, Fierce Healthcare, March 11, 2025.

12 "MGMA statement on lack of Medicare physician payment fix in CR" Medical Group Management Association, Press Release, https://www.mgma.com/press-statements/march-14-2025-mgma-statement-on-lack-of-medicare-physician-payment-fix-in-cr (Accessed 3/19/25).

13 "Congress abandons Medicare patients and their physicians" American Medical Association, March 9, 2025, https://www.ama-assn.org/press-center/press-releases/congress-abandons-medicare-patients-and-their-physicians (Accessed 3/18/25).

14 Hut, Healthcare Financial Management Association, March 11, 2025.

15 "Actions Taken due to 2025 Medicare Cuts" American Medical Group Association, available at: https://www.amga.org/getmedia/5c84497e-a9c4-4c31-9180-83af66f5793f/2025-medicare-cuts-impact-survey-results.pdf (Accessed 3/19/25); Hut, Healthcare Financial Management Association, March 11, 2025.

16 "Medicare updates compared to inflation (2001-2023)" American Medical Association, https://www.ama-assn.org/system/files/ama-medicare-gaps-chart-grassroots-insert.pdf (Accessed 12/24/24); "AMA: Congress fails patients and physicians" American Medical Association, Press Release, December 21, 2024, https://www.ama-assn.org/press-center/press-releases/ama-congress-fails-patients-and-physicians (Accessed 12/24/24).

17 Letter to The Honorable Mike Johnson, The Honorable Hakeem Jeffries, The Honorable Charles Schumer, and The Honorable Mitch McConnell, from Anders Gilberg, Medical Group Management Association, dated November 12, 2024, Re: MGMA Legislative Imperatives for the End of 2024, available at: https://www.mgma.com/getkaiasset/a1658e5f-2577-49bf-a5ed-14e33cd85ec0/11.12.2024_MGMA%20End%20of%20Year%20Letter.pdf (Accessed 11/13/24).

18 "MGMA Appeals to Congress to Address MD Reimbursement Issues" By Mark Hagland, Healthcare Innovation, November 12, 2024, https://www.hcinnovationgroup.com/policy-value-based-care/news/55242299/mgma-appeals-to-congress-to-address-md-reimbursement-issues (Accessed 11/13/24).

2026 Proposed Physician Fee Schedule Increases Payments

[Excerpted from the article published in July 2025.]

On July 14, 2025, the Centers for Medicare & Medicaid Services (CMS) released its proposed Medicare Physician Fee Schedule (MPFS) for calendar year (CY) 2026. In addition to the agency's suggested increase to physician payments, the proposed rule also announces a new payment model and more telehealth flexibilities.[1] According to CMS, the "proposed rule is one of several proposed rules that reflect a broader Administration-wide strategy to create a health care system that results in better quality, efficiency, empowerment, and innovation for all Medicare beneficiaries."[2]

The MPFS calculates payments according to Medicare's Resource Based Relative Value Scales (RBRVS) system, which assigns relative value units (RVUs) to individual procedures based on the resources required to perform each procedure. Under this system, each procedure in the MPFS is assigned RVUs for three categories of resources: (1) physician work (wRVUs); (2) practice expense (PE RVUs); and, (3) malpractice expense (MP RVUs). Once the procedure's RVUs have been modified for geographic variance, they are summed, and the total is then multiplied by a conversion factor to convert the number to a dollar amount.

The conversion factor is a fixed monetary amount that is multiplied by the geographically-adjusted RVU to determine the payment amount for a given service.[3] The conversion factor is updated annually according to the predetermined update schedule set forth in the Medicare Access and CHIP Reauthorization Act (MACRA); while this update was 0% from 2020 through 2025, Congress occasionally overrode MACRA and mandated temporary payment increases.[4] For 2026, MACRA mandates a slight annual update for those clinicians who participate in one of the two Quality Payment Program (QPP) tracks: Advanced Alternative Payment Model (APM) participants will receive a 0.75% increase; Merit-based Incentive Payment System (MIPS) participants (and other non-APM participants) will receive a 0.25% increase.[5]

As required by MACRA, CMS proposes two separate conversion factor increases – one for APM participants and one for nonparticipants. The proposed MPFS conversion factor of $33.59 for APM participants is a 3.83% increase from 2025, while the proposed conversion factor of $33.42 for nonparticipants is a 3.62% increase.[6] These increases reflect:

(1) The MACRA updates discussed above;
(2) A one-time 2.5% increase as stipulated in the recently-passed tax bill; and
(3) A 0.55% adjustment to account for proposed wRVU changes.[7]

If finalized as proposed, this will be the first year in the past half-decade that CMS increases the conversion factor.[8]

Based on the proposed rule's chart of specialty impacts, it appears that the "winners" of the proposed rule include physicians specializing in allergy and immunology and vascular surgery, while the "losers" include infectious disease specialists and neurosurgeons.[9] Notably, the payment impacts are widely different depending on the site of service (e.g., in a physician office versus in a hospital).

CMS also proposes the implementation of a -2.5% "efficiency adjustment" to wRVUs for non-time-based services, based on a five-year lookback of the Medicare Economic Index (MEI) medical practice cost inflation.[10] This cut would affect approximately 9,000 codes, but would not apply to e valuation and management services, care management services, behavioral health services or services on the Medicare Telehealth Services List.[11] The calculation of how many wRVUs to attribute to a given procedure was historically determined by the American Medical Association's (AMA's) Relative Value Scale Committee (RUC), based on physician surveys.[12] While CMS states that it "expects that moving away from survey data would lead to more accurate valuation of services over time and help address some of the distortions that have occurred in the MPFS historically," many physician groups, including the AMA, have lambasted the proposal, arguing that it may encourage physicians to increase volume to make up for that lost revenue.[13] Over the years, the AMA has had a strong hand in calculating the wRVUs, and has been criticized over the methodology used and conflict of interest concerns.[14]

In addition to payment rate changes, CMS proposes a new five-year mandatory payment model for specialists. The Ambulatory Specialty Model (ASM) would be a two-sided risk model for specialty care provided to beneficiaries with heart failure or lower back pain starting in 2027.[15] The goal of the model is "to improve prevention and upstream management of chronic disease, [leading] to reductions in avoidable hospitalizations and unnecessary procedures."[16] Similar to the MIPS Value Pathways (MVP),[17] participant performance will be assessed for quality, cost, improvement activities, and improving interoperability.[18]

Other proposals CMS suggests for 2026 include:

(1) Simplifying the process for adding codes to the Medicare Telehealth Services List;
(2) Cutting payments for skin substitutes,[19] which have increased 40-fold over the past five years (costing CMS $10 billion in 2024);[20]
(3) Limiting how long some Medicare Shared Savings Program (MSSP) participants can stay in one-sided risk arrangements; and
(4) Increasing the minimum number of Medicare beneficiaries that MSSP participants must cover to 5,000.[21]

Healthcare stakeholders were cautiously pleased with the MPFS proposed rule, largely due to the prospect of the

payment increase, although many called the increase "underwhelming."[22] The American College of Physicians (ACP) expressed cautious optimism, supporting the new wRVU adjustment.[23] The American Academy of Family Physicians (AAFP) was similarly "encouraged" by the provisions that aim to strengthen primary care, such as the wRVU adjustment and the increase to the conversion factor. However, the AAFP expressed concern that the adjustments underlying the conversion factor increase are temporary, providing physicians no assurance that payment increases will continue, or even keep up with rising costs and inflation.[24] The National Association of ACOs (NAACOS) was also encouraged, but by CMS's "attention to wasteful and abusive billing practices" in the proposed rule, including "new payment policies to pay for skin substitutes."[25] The president and CEO of America's Physician Groups welcomed the payment increases, calling them "positive shifts, which we hope bodes well in terms of making future changes to compensate physicians fairly and preserve access to health care for Medicare beneficiaries."[26]

---

1 "Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) Proposed Rule (CMS-1832-P)" Centers for Medicare and Medicaid Services, July 14, 2025, https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2026-medicare-physician-fee-schedule-pfs-proposed-rule-cms-1832-p (Accessed 7/17/25).

2 *Ibid*.

3 "Physician and Other Health Professional Payment System" Medicare Payment Advisory Commission, Payment Basics, October 2024, https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_Physician_FINAL_SEC.pdf (Accessed 7/17/25).

4 Notably, MACRA also provides for annual bonuses for clinicians who participate in various quality payment programs such as MIPS and APMs. "Chapter 1: Reforming physician fee schedule updates and improving the accuracy of relative payment rates" in "Report to the Congress: Medicare and the Health Care Delivery System" Medicare Payment Advisory Commission, June 2025, available at: https://www.medpac.gov/wp-content/uploads/2025/06/Jun25_Ch1_MedPAC_Report_To_Congress_SEC.pdf (Accessed 7/17/25), p. 1; Medicare Payment Advisory Commission, Payment Basics, October 2024.

5 "MACRA Frequently Asked Questions" Association of American Medical Colleges, https://www.aamc.org/about-us/mission-areas/health-care/macra/faq#:~:text=Beginning%20in%202019%2C%20ECs%20participating,am%20an%20APM%20qualifying%20participant? (Accessed 7/17/25).

6 "Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) Proposed Rule (CMS-1832-P)" Centers for Medicare and Medicaid Services, July 14, 2025, https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2026-medicare-physician-fee-schedule-pfs-proposed-rule-cms-1832-p (Accessed 7/17/25).

7 *Ibid*; "$1T in healthcare cuts pass Congress, head to Trump" By Michael McAuliff, Modern Healthcare, July 3, 2025, https://www.modernhealthcare.com/politics-regulation/mh-tax-bill-house-donald-trump/ (Accessed 7/17/25).

8 Early, Modern Healthcare, July 16, 2025.

9 "Doc Groups Say Proposed Medicare Payment Increase Is Inadequate" By Joyce Frieden, MedPage Today, July 15, 2025, https://www.medpagetoday.com/publichealthpolicy/medicare/116513 (Accessed 7/17/25); "TABLE 92: CY 2026 PFS ESTIMATED IMPACT ON TOTAL ALLOWED CHARGES BY SPECIALTY" in "Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program; Proposed rule, Federal Register, Vol. 90, No. 134 (July 16, 2025), p. 32803-32805.

10 Centers for Medicare and Medicaid Services, July 14, 2025; Early, Modern Healthcare, July 16, 2025.

11 *Ibid*; "Medicare doctor pay plan would hit specialists, curb AMA clout" By Bridget Early, Modern Healthcare, July 22, 2025, https://www.modernhealthcare.com/politics-regulation/mh-cms-physician-fee-schedule-billing-codes/ (Accessed 7/22/25).

12 "Doctors could see 3.8% Medicare pay bump in 2026" By Maya Goldman, Axios, July 15, 2025, https://www.axios.com/2025/07/15/doctors-medicare-pay-bump-2026 (Accessed 7/17/25).

13 Centers for Medicare and Medicaid Services, July 14, 2025; Frieden, MedPage Today, July 15, 2025.

14 "Medicare doctor pay plan would hit specialists, curb AMA clout" By Bridget Early, Modern Healthcare, July 22, 2025, https://www.modernhealthcare.com/politics-regulation/mh-cms-physician-fee-schedule-billing-codes/ (Accessed 7/22/25).

15 "ASM (Ambulatory Specialty Model)" Centers for Medicare and Medicaid Services, July 16, 2025, https://www.cms.gov/priorities/innovation/innovation-models/asm (Accessed 7/17/25).

16 *Ibid*.

17 For more information on MVPs, see "MIPS Value Pathways (MVPs) - The Future of MIPS" MDinteractive, November 18, 2024, https://mdinteractive.com/mips-blog/mips-value-pathways-mvps-future-mips#:~:text=The%20MIPS%20Value%20Pathways%20(MVPs,clinicians%20report%20under%20the%20program. (Accessed 7/17/25).

18 Centers for Medicare and Medicaid Services, July 16, 2025.

19 Skin substitutes, bandages made from dried placenta, are applied to wounds that will not heal.

20 "Trump Administration Will Limit Medicare Spending on Pricey Bandages" By Sarah Kliff and Katie Thomas, The New York Times, July 15, 2025, https://www.nytimes.com/2025/07/15/health/medicare-skin-substitutes-prices.html (Accessed 7/17/25).

21 Centers for Medicare and Medicaid Services, July 14, 2025; Early, Modern Healthcare, July 16, 2025.

22 "CMS proposes new rules for physicians, outpatient care, and ASCs" Advisory Board, July 16, 2025, https://www.advisory.com/daily-briefing/2025/07/16/proposed-rules (Accessed 7/23/25).

23 "Internal Medicine Physicians Cautiously Optimistic about Proposals in the Medicare Fee Schedule" Jason M. Goldman, MD, MACP, American College of Physicians, https://www.acponline.org/acp-newsroom/internal-medicine-physicians-cautiously-optimistic-about-proposals-in-the-medicare-fee-schedule (Accessed 7/17/25).

24 "Family Physicians Respond to 2026 Proposed Medicare Physician Fee Schedule" AAFP, July 15, 2025, https://www.aafp.org/news/media-center/statements/2026-poposed-medicare-physician-fee-schedule.html (Accessed 7/17/25).

25 "NAACOS Responds to Proposed 2026 Medicare Physician Fee Schedule" National Association of ACOs, July 14, 2025, https://www.naacos.com/press-releases-letters-2025/press-release-naacos-responds-to-proposed-2026-medicare-physician-fee-schedule/ (Accessed 7/17/25).

26 "Payment Increase And Other Moves To Spur Value-Based Care Are Welcome Steps In Proposed 2026 Medicare Physician Payment Rule, Says APG" America's Physician Groups, July 14, 2025, https://www.apg.org/news/payment-increase-and-other-moves-to-spur-value-based-care-are-welcome-steps-in-proposed-2026-medicare-physician-payment-rule-says-apg/ (Accessed 7/17/25).

OPPS Final Rule Issued by CMS

[Excerpted from the article published in November 2024.]

On November 1, 2024, the Centers for Medicare & Medicaid Services (CMS) released its Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Final Rule for calendar year (CY) 2025. The rule finalizes payment updates, revises current programs, and establishes new standards to address the ongoing maternal health crisis. This Health Capital Topics article discusses the key OPPS changes and updates included in the Final Rule.

Payment Rate Updates

For CY 2025, CMS will increase OPPS payment rates for hospital outpatient departments (HOPDs) and ASCs meeting specific quality reporting criteria by 2.9%. This increase is slightly higher than both the proposed increase of 2.6% and the CY 2024 increase of 2.8%.[1] The Final Rule sets the HOPD conversion factor at $89.169 and the ASC conversion factor at $54.675.[2] These adjustments are based on a projected hospital market basket percentage increase of 3.4%, reduced by a productivity adjustment of -0.5%.[3] CMS estimates these updates will result in $2.2 billion more in Medicare reimbursement to hospitals in 2025.[4]

In 2019, CMS began applying productivity-adjusted hospital market basket updates traditionally used for HOPD payment rates to ASC rates as part of a five-year test period ending in 2023.[5] Due to the abnormal healthcare utilization during the COVID-19 public health emergency (PHE), CMS extended the test period by two additional years, through CY 2025.[6] This extension allows CMS to gather data unaffected by the COVID-19 PHE to assess whether the hospital market basket updates have successfully shifted services from hospitals to ASCs.[7]

New Obstetrical Services Conditions of Participation (CoPs)

The U.S. is experiencing a maternal health crisis, with maternal mortality rates exceeding those of all other high-income countries and disproportionately affecting people of color. In response, the 2025 OPPS/ASC Payment System Final Rule establishes the first-ever maternal health and safety standards for hospitals.[8] The new CoPs for hospitals and critical access hospitals (CAHs) offering obstetrical services include:

(1) "new requirements for maternal quality assessment and performance improvement (QAPI)";
(2) "baseline standards for the organization, staffing and delivery of obstetrical care"; and
(3) "staff training on evidence-based maternal health practices."[9]

Additionally, CMS has revised CoPs related to emergency readiness and discharge planning. These standards will be phased in incrementally over two years.[10]

Other Provisions

The 2025 OPPS/ASC Payment System Final Rule also includes provisions to:

(1) Add 21 procedures to the ASC Covered Procedures List (ASC-CPL), comprising 19 dental codes and two adipose-derived regenerative cell (ADRC) therapy codes;
(2) Support tribal and Indian Health Services (IHS) facilities in affording high-cost pharmaceuticals;
(3) Cover HIV pre-exposure prophylaxis (PrEP) drugs as an additional preventive service;
(4) Provide temporary additional payments through 2027 for certain non-opioid pain relief treatments (drugs and devices) in HOPD and ASC settings;
(5) Increase healthcare access for recently incarcerated individuals through definitional changes;
(6) Mandate one year of continuous Medicaid and CHIP eligibility for children aged 18 and under; and
(7) Expand and adjust quality reporting programs for inpatient and outpatient hospitals, rural emergency hospitals, and ASCs.[11]

Stakeholder Comments

Reactions to the 2025 OPPS/ASC Payment System Final Rule have been largely critical. The Ambulatory Surgery Center Association (ASCA) described the rule as "a step sideways in time when millions of Medicare beneficiaries need CMS to advance policies that expand access to the safe, convenient and efficient care that surgery centers provide."[12]

Similarly, the American Hospital Association (AHA) condemned the Final Rule, stating:

> "Medicare's sustained and substantial underpayment of hospitals has stretched for almost two decades, and today's final outpatient rule only worsens this chronic problem. The agency's final increase of less than 3% for outpatient hospital services will make the provision of care, investments in the health care workforce, and addressing new challenges, such as cybersecurity threats, more difficult. These inadequate payments will have a negative impact on patient access to care, especially in rural and underserved communities nationwide."[13]

While the AHA acknowledged sharing "CMS' goals of improving maternal health outcomes and reducing inequities in maternal care," it criticized CMS's "excessive use of Conditions of Participation to drive its policy agenda."[14]

1 "CY 2025 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS 1809-FC)" Centers for Medicare and Medicaid Services, November 1, 2024, https://www.cms.gov/newsroom/fact-sheets/cy-2025-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0 (Accessed 11/13/24); "CY 2024 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS 1786-FC)" Centers for Medicare and Medicaid Services, November 2, 2023, https://www.cms.gov/newsroom/fact-sheets/cy-2024-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0 (Accessed 11/13/24).

2 "Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs, including the Hospital Inpatient Quality Reporting Program; Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals; Prior Authorization; Requests for Information; Medicaid and CHIP Continuous Eligibility; Medicaid Clinic Services Four Walls Exceptions; Individuals Currently or Formerly in Custody of Penal Authorities; Revision to Medicare Special Enrollment Period for Formerly Incarcerated Individuals; and All-Inclusive Rate Add-On Payment for High-Cost Drugs Provided by Indian Health Service and Tribal Facilities: Final rule with comment period" Centers for Medicare and Medicaid Services, Unpublished Version, November 1, 2024, available at: https://public-inspection.federalregister.gov/2024-25521.pdf (Accessed 11/13/24), p. 1094, 1636.

3 "CY 2025 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS 1809-FC)" Centers for Medicare and Medicaid Services, November 1, 2024, https://www.cms.gov/newsroom/fact-sheets/cy-2025-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0 (Accessed 11/13/24).

4 "CMS Announces New Policies to Reduce Maternal Mortality, Increase Access to Care, and Advance Health Equity" Centers for Medicare and Medicaid Services, November 1, 2024, https://www.cms.gov/newsroom/press-releases/cms-announces-new-policies-reduce-maternal-mortality-increase-access-care-and-advance-health-equity (Accessed 11/13/24).

5 Centers for Medicare and Medicaid Services, Unpublished Version, November 1, 2024, p. 17.

6 *Ibid*.

7 *Ibid*.

8 Centers for Medicare and Medicaid Services, November 1, 2024.

9 *Ibid*.

10 *Ibid*.

11 *Ibid*; "CMS Releases CY 2025 OPPS and ASC Final Rule" By Miranda A. Franco, Holland & Knight, November 7, 2024, https://www.hklaw.com/en/insights/publications/2024/11/cms-releases-cy-2025-opps-and-asc-final-rule (Accessed 11/13/24).

12 "CMS Releases 2025 Final Payment Rule" Ambulatory Surgery Center Association, November 1, 2024, https://www.ascassociation.org/asca/news-and-publications/news/2024/2025-final-payment-rule (Accessed 11/13/24).

13 "AHA Statement on CY 2025 OPPS Final Rule" American Hospital Association, November 1, 2024, https://www.aha.org/press-releases/2024-11-01-aha-statement-cy-2025-opps-final-rule (Accessed 11/13/24).

14 *Ibid*.

CMS Proposes Updates to the OPPS

[Excerpted from the article published in July 2025.]

On July 15, 2025, the Centers for Medicare & Medicaid Services (CMS) released the proposed rule for the Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System for calendar year (CY) 2026. Among other items, the agency proposes increasing payments to all outpatient providers, eliminating the Inpatient Only (IPO) List, and changing quality reporting programs. This Health Capital Topics article reviews the proposed updates and changes to outpatient reimbursement.

For most procedures, the payment rates under the OPPS and ASC Payment System are the product of: (1) a relative weight (which indicates a procedure's resource intensity relative to other procedures) and (2) a conversion factor.[1] The conversion factor converts the relative weight into a payment amount. Prior to 2019, the ASC conversion factor was updated annually based on the consumer price index for all urban consumers (CPI-U). But in 2019, CMS changed the basis for the annual ASC conversion factor update, instead basing it on the hospital market basket index.[2] With this change, subsequent updates to the ASC conversion factor have been aligned with updates to the OPPS conversion factor, equalizing updates among both types of outpatient facilities.[3]

For CY 2026, CMS proposes to increase OPPS payment rates to hospital outpatient departments (HOPDs) that meet specific quality reporting criteria by 2.4% – calculated from the proposed hospital inpatient market basket percentage increase of 3.2% minus the proposed productivity adjustment of 0.8%.[4] This calculation results in a proposed OPPS conversion factor of $91.747.[5] ASCs that meet the required quality criteria will also receive proposed payment rate increases of 2.4%, by way of the same calculation described above for OPPS payment rates.[6] Consequently, the proposed ASC conversion factor for 2026 is $55.109.[7]

As discussed above, CMS began applying productivity-adjusted hospital market basket updates (i.e., the updates used for HOPD payment rate updates) to ASC payment rates in 2019, for a test period of five years,[8] in order to assess changes in the migration of services and determine if the data trends were consistent.[9] Because of abnormal healthcare utilization in 2020 due to the COVID-19 public health emergency (PHE), CMS then extended the test period until 2025.[10] CMS proposes to extend the test period for an additional year (i.e., through 2026) to continue studying "the impact of the higher update factor on the migration of services from the hospital outpatient setting to the ASC setting."[11]

The Inpatient Only (IPO) List, established as part of the initial implementation of the OPPS, contains approximately 1,730 services for which Medicare makes payment only when they are furnished in the inpatient hospital setting.[12] In the 2021 OPPS/ASC final rule, CMS eliminated the IPO List over a three-year transitional period.[13] In response to stakeholder concerns, the 2022 final rule reversed course and halted the elimination, reinstating most of the services removed in 2021.[14] CMS once again proposes to eliminate the IPO List over the next three years, starting with the removal of 285 procedures, most of which are musculoskeletal, for 2026.[15] The agency states that "the evolving nature of the practice of medicine allows more procedures to be performed on an outpatient basis with a shorter recovery time. This proposal would…[give] physicians greater flexibility in determining the most appropriate site of service."[16]

The 340B Drug Pricing Program allows hospitals and clinics that treat low-income, medically underserved patients to purchase certain "specified covered outpatient drugs" at discounted prices and then receive reimbursement under the OPPS at the same rate as all other providers.[17] This results in a margin for these participants between the amount paid for the drug and the amount received, which enables covered entities to stretch scarce federal resources as far as possible, reaching more patients and providing more comprehensive services.[18] CMS must follow a statutory formula in setting the annual reimbursement rate for 340B drugs. From 2006 to 2018, the reimbursement rate for these outpatient drugs was the drug's average sales price (ASP) *plus* 6%.[19] In the 2018 OPPS, however, CMS finalized a reduction to this reimbursement rate, specific to 340B participants only, of ASP *minus* 22.5%.[20] Hospitals and hospital associations subsequently sued CMS to challenge the cuts, and the U.S. Supreme Court unanimously found in 2022 that CMS exceeded its authority in changing drug reimbursement rates for a subset of hospitals.[21]

In accordance with the Supreme Court ruling, CMS issued its 340B Final Remedy rule in November 2023, which set forth the agency's plan to claw back reimbursements unlawfully paid to some hospitals and reimbursements unlawfully kept from other hospitals. Under the Final Remedy rule, the agency stated that it would repay the amounts owed to approximately 1,600 hospitals in a single lump-sum payment. It also stated that it would recoup funds from those overpaid hospitals by adjusting their OPPS conversion factor by -0.5% starting in 2026, and continuing that adjustment until the full amount is recouped, approximately 16 years.[22] In the 2026 OPPS/ASC proposed rule, CMS instead proposes revising that offset percentage to -2% starting in 2026, which will accelerate the payback period by 10 years.[23]

Other proposals CMS suggests for 2026 include:

- Revising the ASC Covered Procedures List (CPL) to make it easier to add procedures to the list;
- Adding 547 procedures to the ASC CPL (271 of which are also proposed for removal from the IPO List);
- Expanding site-neutral payment policies to drug administration services, which CMS predicts will reduce OPPS spending by $280 million;
- Numerous changes to the hospital price transparency regulations, e.g., requiring the disclosure of the 10th,

median, and 90th percentile allowed amounts of payor-specific negotiated charges when they are based on percentages or algorithms; and

- Revising the quality measures that must be reported under the Hospital Outpatient Quality Reporting (OQR) Program, the Rural Emergency Hospital Quality Reporting (REHQR) Program, and the Ambulatory Surgical Center Quality Reporting (ASCQR) Program.[24]

CMS will receive comments and information on the OPPS/ASC proposed rule until September 15, 2025, and the final rule is expected to be released in November 2025.[25]

---

1 "Chapter 10: Ambulatory Surgical Center Services: Status Report" In "Report to the Congress: Medicare Payment Policy" Medicare Payment Advisory Commission, March 2024, https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch10_MedPAC_Report_To_Congress_SEC.pdf (Accessed 7/21/25), p. 299.
2 *Ibid*.
3 *Ibid*.
4 "Calendar Year 2026 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Proposed Rule (CMS-1834-P)" Centers for Medicare and Medicaid Services, July 15, 2025, https://www.cms.gov/newsroom/fact-sheets/calendar-year-2026-hospital-outpatient-prospective-payment-system-opps-and-ambulatory-surgical (Accessed 7/21/25).
5 "Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency" Federal Register, Vol. 90, No. 135 (July 17, 2025), available at: https://www.govinfo.gov/content/pkg/FR-2025-07-17/pdf/2025-13360.pdf (Accessed 7/21/25), p. 33508-33509.
6 "CY 2025 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule (CMS 1809-P)" Centers for Medicare and Medicaid Services, July 10, 2024, https://www.cms.gov/newsroom/fact-sheets/cy-2025-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center#:~:text=In%20the%20CY%202025%20OPPS,-July%201%2C%202023%2C%20through%20June (Accessed 7/11/24).
7 Centers for Medicare and Medicaid Services, July 15, 2025; "Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency" Federal Register, Vol. 90, No. 135 (July 17, 2025), available at: https://www.govinfo.gov/content/pkg/FR-2025-07-17/pdf/2025-13360.pdf (Accessed 7/21/25), p. 33753.
8 Centers for Medicare and Medicaid Services, July 10, 2024.
9 "CMS-1695-FC (PDF)" Centers for Medicare and Medicaid Services, https://www.cms.gov/node/671966 (Accessed 7/18/24).
10 Centers for Medicare and Medicaid Services, July 10, 2024.
11 Centers for Medicare and Medicaid Services, July 15, 2025.
12 "CMS Releases CY 2026 Outpatient Prospective, ASC Payment System Proposed Rule" By Miranda A. Franco & Sarah Starling Crossan, Holland & Knight, July 21, 2025, https://www.hklaw.com/en/insights/publications/2025/07/cms-releases-cy-2026-outpatient-prospective-asc-payment-system#:~:text=Changes%20to%20the%20IPO%20List,of%20285%20mostly%20musculoskeletal%20services. (Accessed 7/21/25).
13 Federal Register, Vol. 85, NO. 249 (December 29, 2020), p. 85869.
14 "Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency" Federal Register, Vol. 90, No. 135 (July 17, 2025), available at: https://www.govinfo.gov/content/pkg/FR-2025-07-17/pdf/2025-13360.pdf (Accessed 7/21/25), p. 33665.
15 Centers for Medicare and Medicaid Services, July 15, 2025.
16 *Ibid*.
17 "Supreme Court Will Determine Whether 340B Hospitals Retain Discounts on Medicare Part B Drugs" Allison Hoffman, Commonwealth Fund, November 21, 2021, https://www.commonwealthfund.org/blog/2021/supreme-court-340b-hospitals-discounts-medicare-part-b (Accessed 7/21/25).
18 "340B Drug Pricing Program", HRSA, December 2021, https://www.hrsa.gov/opa (Accessed 7/21/25).
19 "Federal Court Says 2018 OPPS 340B Program Rate Cuts Unlawful, Orders Briefing to Avoid Havoc on Medicare Program" By Lee Nutini, JDSupra, January 3, 2019, https://www.jdsupra.com/legalnews/federal-court-says-2018-opps-340b-87971/ (Accessed 7/21/25).
20 "CMS Issues Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System and Quality Reporting Programs Changes for 2018 (CMS-1678-FC)" Centers for Medicare & Medicaid Services, November 1, 2017, https://www.cms.gov/newsroom/fact-sheets/cms-issues-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-payment (Accessed 7/21/25).
21 "American Hospital Association et al. v. Becerra, Secretary of Health and Human Services, et al." 596 U.S. ___ (2022), Slip Opinion, Certiorari to the United States Court of Appeals for the District of Columbia Circuit, available at: https://www.supremecourt.gov/opinions/21pdf/20-1114_09m1.pdf (Accessed 7/21/25).
22 "HHS issues final remedy for its unlawful 340B payment cuts from 2018 to 2022" American Hospital Association, November 2, 2023, https://www.aha.org/news/headline/2023-11-02-hhs-issues-final-remedy-its-unlawful-340b-payment-cuts-2018-2022 (Accessed 7/21/25).
23 Centers for Medicare and Medicaid Services, July 15, 2025.
24 *Ibid*.
25 "Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency" Federal Register, Vol. 90, No. 135 (July 17, 2025), available at: https://www.govinfo.gov/content/pkg/FR-2025-07-17/pdf/2025-13360.pdf (Accessed 7/21/25), p. 33476.

CMS Proposes Increasing Inpatient & Long Term Care Payments

[Excerpted from the article published in May 2025.]

On April 11, 2025, the Centers for Medicare & Medicaid Services (CMS) released its proposed rules for the payment and policy updates for the Medicare inpatient prospective payment system (IPPS) and long-term care hospital prospective payment system (LTCH PPS) for fiscal year (FY) 2026.[1] This Health Capital Topics article will discuss the proposed rule and the implications for stakeholders.

By law, CMS is required to update IPPS and LTCH payment rates annually while accounting for changes in the prices of goods and services used by hospitals in the treatment of Medicare beneficiaries.[2] Under the two payment systems (IPPS and LTCH PPS), base payment rates are set by CMS prospectively for inpatient stays based on the severity of the illness, the services utilized, the treatment provided, the cost of labor in the locality, and the patient's diagnosis.[3] Hospitals receive a lump payment for each hospitalization, dependent on the Diagnosis-Related Group (MS-DRG) classification assigned at discharge.[4]

CMS proposes increasing the IPPS base rate by 2.4%, which amounts to $4 billion in additional funding for FY 2026.[5] This percentage increase is comprised of a projected FY 2026 hospital market basket increase of 3.2%, reduced by a 0.8% productivity adjustment.[6] This proposed increase is lower than the FY 2024 payment increase of 2.9%.[7] For FY 2026, the LTCH standard payment rate is expected to increase by 2.6%, based a projected FY 2026 LTCH PPS market basket increase of 3.4%, reduced by a 0.8% productivity adjustment.[8] For FY 2025, the LTCH PPS payments increased by 3.0%.[9] CMS expects payments for LTCH discharges paid the standard rate to increase approximately $52 million, or 2.2%, due to the 2.6% update and a projected decrease (0.3%) in high-cost outlier payments as a portion of all LTCH PPS payments.[10] Additionally, CMS proposes to again increase the LTCH outlier threshold for FY 2026 to comply with statutory requirements that outlier payments may only comprise a certain proportion of total payments.[11]

Included in the proposed rule are requests for information (RFIs). One of the RFIs focuses "on approaches and opportunities to streamline regulations and reduce burdens on those participating in the Medicare program."[12] Released in response to a January 2025 Executive Order calling for federal agencies to eliminate at least 10 prior regulations for each new regulation issued,[13] CMS asks commentators for answers in response to questions including:

- "Are there existing regulatory requirements---that could be waived, modified, or streamlined to reduce administrative burdens without compromising patient safety or the integrity of the Medicare program?"
- "Which specific Medicare administrative processes or quality and data reporting requirements create the most significant burdens for providers?"
- "Are there specific Medicare administrative processes, quality, or data reporting requirements, that could be automated or simplified to reduce the administrative burden on facilities and providers?"
- "Are there opportunities to reduce the frequency or complexity of reporting for Medicare providers?"
- "How can Medicare better align its requirements with best practices and industry standards without imposing additional regulatory requirements, particularly in areas such as telemedicine, transparency, digital health, and integrated care systems?"[14]

The proposed rule also includes updates to the mandatory episode-based Transforming Episode Accountability Model (TEAM) that is set to take effect on January 1, 2026,[15] and aims to improve "quality of care for people with Medicare undergoing certain high-expenditure, high-volume surgical procedures [such as joint replacements, bowel surgeries, and spinal fusions], reducing rehospitalization and recovery time while lowering Medicare spending and driving equitable outcomes."[16] Proposed updates include adding new participant hospitals, revising quality metrics and pricing methodology, and eliminating certain reporting elements.[17]

Healthcare industry stakeholders expressed frustration with CMS's proposals, arguing that the proposed payment increase is insufficient. The American Hospital Association (AHA) expressed its disappointment that CMS

> "proposed an inadequate inpatient hospital payment update…including of particular concern an extremely high proposed productivity cut….We are very concerned that this update will hurt our ability to care for our communities. Indeed, many hospitals across the country, especially those in rural and underserved communities, already operate under unsustainable financial situations, including negative margins. We urge CMS to reconsider its policy in the final rule to enable all hospitals to provide high-quality, around-the-clock, essential care for their patients and communities."[18]

The Federation of American Hospitals (FAH) issued a similar statement, asserting that "the reality is that patient care still faces the twin problems of hangover cost increases from hyperinflation and the cumulative effect of inadequate payment over time from Medicare and Medicaid." Alluding to the spending bill currently working its way through Congress, which includes over $716 billion in Medicaid cuts (the largest in program history),[19] FAH went on to state that it is "mission critical Congress protects Medicaid coverage by avoiding funding cuts..."[20]

Notwithstanding the payment update criticism, the AHA expressed appreciation for the RFI on streamlining regulations and reducing burdens for providers, given that "America's hospitals and health systems spend too many resources each year on regulatory requirements, forcing many of our clinicians to focus more time completing paperwork than treating patients."[21]

1 "FY 2026 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) Proposed Rule — CMS-1833-P Fact Sheet" Centers for Medicare & Medicaid Services, April 11, 2025, https://www.cms.gov/newsroom/fact-sheets/fy-2026-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospital-prospective (Accessed 5/22/25).
2 *Ibid*.
3 *Ibid*.
4 *Ibid*.
5 *Ibid*.
6 *Ibid*.
7 "FY 2025 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) Final Rule –- CMS-1808-F" Centers for Medicare & Medicaid Services, August 1, 2024, https://www.cms.gov/newsroom/fact-sheets/fy-2025-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospital-prospective-0 (Accessed 5/22/25).
8 FY 2026 Proposed Rule — CMS-1833-P Fact Sheet" Centers for Medicare & Medicaid Services, April 11, 2025.
9 "FY 2024 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) Final Rule — CMS-1785-F and CMS-1788-F Fact Sheet" Newsroom, Centers for Medicare and Medicaid Services, August 1, 2023, https://www.cms.gov/newsroom/fact-sheets/fy-2024-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospital-prospective-0 (Accessed 4/19/24).
10 "FY 2026 Proposed Rule — CMS-1833-P Fact Sheet" Centers for Medicare & Medicaid Services, April 11, 2025.
11 *Ibid*.
12 *Ibid*.
13 "Unleashing Prosperity Through Deregulation" Executive Order 14192, Federal Register Vol. 90, No. 24 (January 31, 2025), available at: https://www.govinfo.gov/content/pkg/FR-2025-02-06/pdf/2025-02345.pdf (Accessed 5/22/25), p. 9065-9067.
14 *Ibid*.
15 "CMS issues hospital IPPS proposed rule for FY 2026" American Hospital Association, April 11, 2025, https://www.aha.org/news/headline/2025-04-11-cms-issues-hospital-ipps-proposed-rule-fy-2026 (Accessed 5/22/25).
16 "The next generation of Medicare bundled payments: Considerations regarding TEAM" By Alyssa Pennini, et al., Milliman, May 12, 2025, https://www.milliman.com/en/insight/next-generation-medicare-bundled-payments-considerations-team (Accessed 5/22/25).
17 "Cheat Sheet: FY 2026 Inpatient Prospective Payment System (IPPS) Proposed Rule" CHiME, April 23, 2025, https://chimecentral.org/resource-post/cheat-sheet-fy-25-ipps-proposed-rule (Accessed 5/22/25).
18 American Hospital Association, April 11, 2025.
19 "By the Numbers: House Bill Takes Health Coverage Away From Millions of People and Raises Families' Health Care Costs" Center on Budget and Policy Priorities, May 21, 2025, https://www.cbpp.org/research/health/by-the-numbers-house-bill-takes-health-coverage-away-from-millions-of-people-and (Accessed 5/22/25).
20 "FAH Statement on CMS Proposed Rules for Fiscal Year 2026" Federation of American Hospitals, April 11, 2025, https://www.fah.org/blog/fah-statement-on-cms-proposed-rules-for-fiscal-year-2026/ (Accessed 5/22/25).
21 American Hospital Association, April 11, 2025.

CMS Releases 2026 IPPS Final Rule

[Excerpted from the article published in August 2025.]

On July 31, 2025, the Centers for Medicare & Medicaid Services (CMS) released its finalized payment and policy updates for the Medicare Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) for fiscal year (FY) 2026.[1] The final rule authorized Medicare inpatient reimbursement increases for 2026 and moved forward with improvements to quality measurement, and provided more information on a new value-based payment model. This Health Capital Topics article will discuss the IPPS final rule and stakeholder reactions.

CMS reimburses acute care hospitals prospectively determined rates per inpatient stay under the IPPS for two different payments: (1) the operating payment; and, (2) the capital payment.[2] The operating payment covers labor and non-labor (i.e., supplies) costs, while the capital payment covers costs for depreciation, interest, rent, and property-related insurance and taxes.[3] The capital base payment rates under the IPPS have grown minimally, if at all, each year for the past decade. Growth rates in the operating base payment rates have been higher for FYs 2020 through 2022, likely due to the COVID-19 pandemic, but before this period, the rate typically exhibited relatively slow growth. After adjusting the base payment rates for regional wage variations and the patient's Medicare Severity Diagnosis Related Group (MS-DRG) classification, the IPPS payment may be further modified by several factors that account for each hospital's specific characteristics. CMS annually updates the IPPS payment rates, including "updates to the base rates, wage indexes, MS-DRG definitions and weights, and the outlier fixed loss amount."[4] The base rates are updated, similar to the other Medicare payment programs, based on the applicable market basket index and productivity adjustments.[5]

CMS reimburses LTCHs (which are differentiated from acute care hospitals by their average length of stay – typically in excess of 25 days) similarly, paying a per-discharge rate that is meant to cover the operating and capital costs of "efficient providers" and are adjusted geographically and for case mix.[6] CMS annually updates LTCH PPS payment rates similar to the IPPS, based on the applicable market basket index and productivity adjustments.[7]

The final rule includes a 2.6% payment increase for hospitals that report quality data through the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful users of electronic health records (EHRs).[8] This rate increase, which is 0.2% higher than the proposed payment rate,[9] is comprised of a projected hospital market basket percentage increase of 3.3%, reduced by a 0.7% productivity adjustment. [10] CMS estimates hospital payments to increase by an adjusted total (after various decreases) of $5 billion in FY 2026 (including an increase in payments to disproportionate share hospitals of $2 billion).[11]

Additionally, CMS finalized LTCH-PPS payment increases of approximately 2.7%, comprised of a projected LTCH PPS market basket percentage increase of 3.4%, reduced by a 0.7% productivity adjustment.[12] This is expected to increase LTCH PPS payments by approximately $72 million.[13] CMS also increased the LTCH outlier threshold for FY 2026, based on updated data; this is in response to "the statutory requirements that estimated outlier payments are approximately 8% of total payments."[14]

The IPPS/LTCH Final Rule ends CMS's low wage index hospital policy, in response to a federal court ruling that HHS lacked authority to adopt the policy.[15] The policy, which began in FY 2020, provided additional reimbursement to hospitals in certain low-wage areas (largely rural hospitals).[16] CMS will phase out the policy via a transitional year for FY 2026 for low wage index hospitals significantly impacted by the policy discontinuation.[17]

Beyond payment changes, the IPPS/LTCH Final Rule includes numerous changes to quality reporting programs. The Hospital Inpatient Quality Reporting (IQR) Program and Long-Term Care Hospital Quality Reporting Program (LTCH QRP) are pay-for-reporting quality programs that require the submission of certain quality data to CMS and reduces payments to hospitals that do not meet program requirements.[18] In the Final Rule, CMS modifies four current Hospital IQR Program measures (largely technical updates and reducing the performance period sought) and removes the following four measures:

(1) Hospital Commitment to Health Equity;
(2) COVID–19 Vaccination Coverage among Health Care Personnel;
(3) Screening for Social Drivers of Health; and
(4) Screen Positive Rate for Social Drivers of Health.[19]

CMS also revises the LTCH QRP measures, modifying one reporting requirement and removing four social determinants of health patient assessment data elements.[20]

In addition to not reporting under the Hospital IQR Program or the LTCH QRP, Medicare payments can also be reduced for hospitals that:

(1) Have excess readmissions (Hospital Readmissions Reduction Program);
(2) Have a relatively high incidence of hospital-acquired conditions (Hospital-Acquired Condition [HAC] Reduction Program); or
(3) Otherwise do not perform well relative to other hospitals on certain value-based measures (Hospital Value-Based Purchasing [VBP] Program).[21]

The IPPS/LTCH Final Rule made changes to all three of these programs. For FY 2027, the Hospital Readmissions

Reduction Program will, among other changes add Medicare Advantage data to the six readmission measures and shorten the performance period from three years to two years. The HAC Reduction Program will update the CDC National Healthcare Safety Network (NHSN) healthcare-associated infections (HAI) chart-abstracted measures with the new 2022 baseline.[22] The VBP Program will remove the health equity adjustment from the program scoring methodology, as well as modify and make technical updates to certain quality and mortality measures and establish performance standards for FYs 2027 through 2031.[23]

In the IPPS/LTCH Final Rule, CMS finalized updates to the mandatory episode-based Transforming Episode Accountability Model (TEAM) that is set to take effect on January 1, 2026.[24] TEAM is a five-year mandatory episode-based payment model for selected acute care hospitals treating Traditional Medicare patients who are undergoing one of the following five surgical procedures:

- Lower extremity joint replacement (LEJR);
- Surgical hip femur fracture treatment (SHFFT);
- Spinal fusion;
- Coronary artery bypass graft (CABG); and
- Major bowel procedure.[25]

The model builds upon prior payment models, including the Bundled Payments for Care Improvement (BPCI) Advanced and Comprehensive Care for Joint Replacement (CJR) Models.[26] CMS will provide a "target price" for the entire 30-day episode (both surgery and follow up) for participants to meet.[27] TEAM, which aims to "incentivize care coordination, improve patient care transitions, and decrease the risk of avoidable readmission," will be comprised of three tracks:

(1) Track 1: no downside risk, less reward for up to three years;
(2) Track 2: lower levels of risk and reward for years two through five; and
(3) Track 3: higher levels of risk and reward for years one through five.[28]

Industry trade groups were largely positive in their response to the IPPS/LTCH Final Rule. The Federation of American Hospitals President and CEO Chip Kahn stated that, "It's encouraging that today's [IPPS] rule provides a slightly higher market basket rate and increased support to hospitals that treat a disproportionately high number of uninsured patients, but the anticipated increase is not sufficient to make up for the recent historic levels of inflation nor expected increases in the number of uninsured Americans."[29] Similarly, the American Hospital Association's (AHA's) senior vice president of public policy analysis and development stated:

"The AHA appreciates CMS' recognition of the importance of an appropriate balance of burden and value in quality measurement programs, especially the sunsetting of the COVID-19 vaccination coverage among healthcare personnel measure. The AHA is also pleased that CMS' payment updates and support for hospitals that treat a disproportionately high number of low-income patients are improved in this final rule. However, we are still concerned that these updates are not adequate enough for the many hospitals that are struggling in today's challenging operating environment, especially those in rural and underserved communities."[30]

The FY 2026 final rule will take effect October 1, 2025.[31]

---

1 "FY 2026 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) Final Rule — CMS-1833-F" Centers for Medicare & Medicaid Services, July 31, 2025, https://www.cms.gov/newsroom/fact-sheets/fy-2026-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospital-prospective-0 (Accessed 8/18/25).
2 "Hospital Acute Inpatient Services Payment System" Medicare Payment Advisory Commission, Payment Basics, October 2024, https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_hospital_FINAL_SEC.pdf (Accessed 8/18/25).
3 *Ibid*.
4 *Ibid*.
5 *Ibid*.
6 "Long-Term Care Hospitals Payment System" Medicare Payment Advisory Commission, Payment Basics, October 2024, https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_LTCH_FINAL_SEC-2.pdf (Accessed 8/19/25).
7 *Ibid*.
8 Centers for Medicare & Medicaid Services, July 31, 2025.
9 Centers for Medicare & Medicaid Services, April 11, 2025.
10 Centers for Medicare & Medicaid Services, July 31, 2025.
11 *Ibid*.
12 *Ibid*.
13 *Ibid*.
14 *Ibid*.
15 *Ibid*; Bridgeport Hosp. v. Becerra, 108 F.4th 882, 887-91 & n.6 (D.C. Cir. 2024).
16 Centers for Medicare & Medicaid Services, July 31, 2025.
17 *Ibid*.
18 *Ibid*.
19 *Ibid*.
20 *Ibid*.
21 *Ibid*.
22 *Ibid*.
23 *Ibid*.
24 "CMS finalizes updates to the Transforming Episode Accountability Model Program" By Whitney Phelps and Mukta Chilakamarri, Nixon Peabody, August 15, 2025, https://www.nixonpeabody.com/insights/alerts/2025/08/15/cms-finalizes-updates-to-the-transforming-episode-accountability-model-program?utm_medium=alert&utm_source=interaction&utm_campaign=healthcare (Accessed 8/19/25).
25 "Transforming Episode Accountability Model (TEAM)" Centers for Medicare & Medicaid Services, https://www.cms.gov/priorities/innovation/innovation-models/team-model (Accessed 8/19/25).
26 *Ibid*.
27 *Ibid*.
28 *Ibid*.
29 "CMS finalizes inpatient, LTC hospital Medicare payment hikes" By Bridget Early, Modern Healthcare, July 31, 2025, https://www.modernhealthcare.com/politics-regulation/mh-medicare-pay-inpatient-hospitals-final-2026/ (Accessed 8/19/25).
30 "CMS issues hospital IPPS final rule for FY 2026" American Hospital Association, July 31, 2025, https://www.aha.org/news/headline/2025-07-31-cms-issues-hospital-ipps-final-rule-fy-2026 (Accessed 8/19/25).
31 Phelps and Chilakamarri, Nixon Peabody, August 15, 2025.

Record-Breaking Savings for ACOs in 2023

[Excerpted from the article published in November 2024.]

On October 29, 2024, the Centers for Medicare & Medicaid Services (CMS) announced Performance Year (PY) 2023 results for accountable care organizations (ACOs) participating its Medicare Shared Savings Program (MSSP). Notably, MSSP ACOs garnered the largest net savings in MSSP's history – more than $2.1 billion.[1] This Health Capital Topics article discusses MSSP performance in 2023 and how this may inform value-based care going forward.

In general, the ACO model holds groups of healthcare providers responsible for the quality and cost of healthcare delivery provided to an ACO's patient population.[2] ACOs are controlled by the provider members who work together to control costs, improve quality, and coordinate care. Those ACOs that achieve payor-designated spending and quality targets receive a share of the cost savings.[3] Most ACOs adhere to one of three primary structures: (1) hospital-led; (2) physician-led; and (3) jointly-led.[4] ACOs vary significantly in the services delivered to patients, the types of providers included in an ACO group, and their range of capabilities, which may include care management, advanced analytics, and shared interdisciplinary decision making.[5] In general, ACOs are associated with improved patient satisfaction and other patient-reported measures,[6] many of which improvements are concentrated in high-need, high-cost populations.[7] However, there is significant variance in ACO performance, with some ACOs achieving savings and others spending far more after formation.[8]

Most ACOs participate in the federal accountable care models offered by CMS; the MSSP is the one of the largest value-based payment models in the U.S., with 480 participating ACOs, comprised of over 608,000 clinicians providing care to approximately 11 million Medicare beneficiaries.[9] MSSP ACOs are comprised of hospitals, physicians, and other healthcare providers that collaborate to provide coordinated, high quality care to Medicare beneficiaries, while focusing on delivering the appropriate care at the correct time and avoiding unnecessary medical errors and services.[10] When an ACO succeeds in delivering high quality care and spending healthcare dollars wisely, it may be eligible to share in the savings it achieves for Medicare.[11] A 2020 study of 513 MSSP ACO participants found that 67% of participating ACOs generated a gross shared savings of $2.3 billion.[12] Between 2016 and 2020, the percentage of ACOs with positive shared savings grew 21% annually.[13] In 2022, 84% of ACOs achieved savings for Medicare, with 63% of ACOs earning shared savings.[14]

In 2023, 69% of MSSP ACOs earned shared savings payments of approximately $3.1 billion and net savings of over $2.1 billion, the highest amounts in the program's 10-year history.[15] Among MSSP ACOs, the primary care provider (PCP)-led ACOs garnered much higher net per capita savings than those ACOs with fewer PCPs.[16] Not only did ACOs generate record-breaking cost savings, they also increased the quality of care provided, scoring higher on numerous quality measures compared to 2022, as well as compared to other physician groups. In particular, ACOs increased quality on "measures related to diabetes and blood pressure control, breast cancer and colorectal cancer screening, screening for future fall risk, statin therapy for prevention and treatment of cardiovascular disease, and depression screening and follow-up."[17]

The MSSP's success is a bright spot for CMS's Center for Medicare and Medicaid Innovation (CMMI), which has faced a number of critics after an unfavorable Congressional Budget Office (CBO) analysis was released in September 2023. The CBO found that in its 10 years of existence, CMMI had tested 49 models, but approved only 5 expansions; this low rate of expansions is due to the Patient Protection & Affordable Care Act's strict requirements regarding the metrics a model must meet to be expanded.[18] Additionally, during the past decade, the CBO found that CMMI has not saved any Medicare spending – in fact, it increased spending by $5.4 billion.[19] This is in direct contrast to the CBO's 2010 projections that CMMI would reduce spending by $2.8 billion.[20] Over the next 10 years, the CBO projects that CMMI will increase federal spending by an additional $1.4 billion.[21] However, proponents of CMMI (and CMMI itself) argue that CMMI was established to be an incubator – to try a bunch of approaches to accountable care, and assess what worked. In many cases, although a model was not expanded, CMMI learned what does and does not work, and a model's positive facets were applied to other programs, such as the MSSP.[22]

PY 2023 is the seventh straight year of savings for the MSSP, and the strongest to date, due in part to the various modifications and variations the program has undergone in its history (thanks to those unsuccessful test models) to strengthen the program, add new features, and reduce participation barriers. While CMMI has piloted a number of accountable care test models over the last decade (as discussed above), none have had the staying power of the MSSP. Leaning on this track record, and the belief that it has learned from the various test models it has operated over the years, CMMI announced in 2021 its goal to enroll all Traditional Medicare beneficiaries in an accountable care arrangement by 2030.[23] At the start of 2024, approximately half of Traditional Medicare beneficiaries were in an accountable care arrangement.[24] Healthcare industry experts assert that progress toward the 100% goal is at an "inflection point," as CMMI needs to solve for "sunsetting incentives and declining rewards," in order to incentivize enough clinicians to participate in accountable care relationships.[25] For example, certain bonuses for participating in an ACO are set to expire at the end of 2026 barring congressional intervention, which is disincentivizing participation by some providers, particularly those in high-risk accountable care models, such as ACO REACH.[26] Additionally, CMS and CMMI continue to try and solve for the problem of the "benchmark ratchet," wherein ACOs who achieve cost savings face increasingly difficult benchmarks to meet (i.e., ACOs must achieve more and more savings every year), effectively "punishing success."[27] Whether these efforts will be enough to meet CMMI's goal, and accelerate the shift toward value-based care, remains to be seen.

1 "Medicare Shared Savings Program Continues to Deliver Meaningful Savings and High-Quality Health Care" Centers for Medicare & Medicaid Services, October 29, 2024, https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-continues-deliver-meaningful-savings-and-high-quality-health-care (Accessed 11/15/24).

2 "Accountable Care Organizations — The Risk of Failure and the Risks of Success" By Lawrence P. Casalino, The New England Journal of Medicine, Vol. 371, Issue 18 (October 2014), p. 1750; "Moving Forward with Accountable Care Organizations: Some Answers, More Questions" By Carrie H. Colla, JAMA Internal Medicine, Vol. 177, No. 4 (April 2017), p. 527.

3 "Shared Savings Program" Centers for Medicare & Medicaid Services, https://www.cms.gov/medicare/payment/fee-for-service-providers/shared-savings-program-ssp-acos (Accessed 11/15/24).

4 "A taxonomy of accountable care organizations for policy and practice" By Stephen M. Shortell, et al., Health Services Research, Vol. 49, Issue 6, December 2014, p. 1883-1895; "Assessing Differences between Early and Later Adopters of Accountable Care Organizations Using Taxonomic Analysis" By Frances M. Wu, Stephen M. Shortell, Valerie A. Lewis, Carrie H. Colla, and Elliott S. Fisher, Health Services Research, Vol. 51, Issue 6 (December 2016), p. 2318-2329.

5 "First National Survey Of ACOs Finds That Physicians Are Playing Strong Leadership And Ownership Roles" By Carrie H. Colla, Valerie A. Lewis, Stephen M. Shortell, and Elliott S. Fisher, Health Affairs, Vol. 33, No. 6 (June 2014), p. 967-970.

6 "Changes in Patients' Experiences in Medicare Accountable Care Organizations" By J. Michael McWilliams, Bruce E. Landon, Michael E. Chernew, and Alan M. Zaslavsky, The New England Journal of Medicine, Vol. 371, Issue 18 (October 2014), p. 1715.

7 "Association Between Medicare Accountable Care Organization Implementation and Spending Among Clinically Vulnerable Beneficiaries" By Carrie H. Colla, Valerie A. Lewis, Lee-Sien Kao, et al, JAMA Internal Medicine, Vol. 176, Issue 8 (August 2016), p. 1168; "Changes in Patients' Experiences in Medicare Accountable Care Organizations" By J. Michael McWilliams, Bruce E. Landon, Michael E. Chernew, and Alan M. Zaslavsky, The New England Journal of Medicine, Vol. 371, Issue 18 (October 2014), p. 1715.

8 "Association of Pioneer Accountable Care Organizations vs Traditional Medicare Fee for Service With Spending, Utilization, and Patient Experience" By David J. Nyweide, Woolton Lee, Timothy T. Cuerdon, et al, JAMA, Vol. 313, Issue 21 (June 2015), p. 2152-2161; JAMA Internal Medicine, Vol. 176, Issue 8 (August 2016), p. 1167-1175.

9 "Moving Forward with Accountable Care Organizations: Some Answers, More Questions" By Carrie H. Colla, JAMA Internal Medicine, Vol. 177, No. 4 (April 2017), p. 527; "Medicare Shared Savings Program Continues to Deliver Meaningful Savings and High-Quality Health Care" Centers for Medicare & Medicaid Services, October 29, 2024, https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-continues-deliver-meaningful-savings-and-high-quality-health-care (Accessed 11/15/24).

10 "Shared Savings Program" Centers for Medicare & Medicaid Services.

11 *Ibid*.

12 "Financial Performance of Accountable Care Organizations: A 5-Year National Empirical Analysis" By Joseph Coyne et al., Journal of Healthcare Management, Foundation of the American College of Healthcare Executives, February 2024, https://pubmed.ncbi.nlm.nih.gov/38175536/ (Accessed 11/15/24).

13 *Ibid*.

14 "Medicare ACOs Saved $4.2 Billion in 2022 Shared Savings ACOs Continue to Deliver Savings, Improve Health" National Association of ACOs, August 24, 2023, https://www.naacos.com/press-release--medicare-acos-saved--4-2-billion-in-2022 (Accessed 11/15/24).

15 Centers for Medicare & Medicaid Services, October 29, 2024; "Performance Year Financial and Quality Results" Centers for Medicare & Medicaid Services, 2023, https://data.cms.gov/medicare-shared-savings-program/performance-year-financial-and-quality-results (Accessed 11/15/24).

16 Centers for Medicare & Medicaid Services, October 29, 2024.

17 *Ibid*.

18 "CMMI's Accountable Care Strategy: A Perspective" By Jeffrey Davis and Simeon Niles, McDermott+, October 10, 2024, https://www.mcdermottplus.com/blog/regs-eggs/cmmis-accountable-care-strategy-a-perspective/ (Accessed 11/15/24).

19 "Federal Budgetary Effects of the Activities of the Center for Medicare & Medicaid Innovation" Congressional Budget Office, September 28, 2023, https://www.cbo.gov/publication/59274 (Accessed 11/15/24).

20 *Ibid*.

21 *Ibid*.

22 "CMS' 2030 value-based care goal at 'inflection point'" By Michael McAuliff, Modern Healthcare, October 15, 2024, https://www.modernhealthcare.com/policy/cms-2030-value-based-care-goals-medicare (Accessed 11/15/24).

23 "Innovation Center Strategy Refresh" Centers for Medicare & Medicaid Services, 2021, https://www.cms.gov/priorities/innovation/strategic-direction-whitepaper (Accessed 11/15/24), p. 13.

24 "Expanding Permanent Pathways In Medicare For Accountable Care" By Purva Rawal, et al., Health Affairs Forefront, September 30, 2024, https://www.healthaffairs.org/content/forefront/expanding-permanent-pathways-medicare-accountable-care (Accessed 11/15/24).

25 McAuliff, Modern Healthcare, October 15, 2024.

26 *Ibid*.

27 *Ibid*.

Four Medicare Payment Models Ended Early

[Excerpted from the article published in March 2025.]

In the latest iteration of Trump Administration healthcare cuts, the Centers for Medicare & Medicaid Services (CMS) announced on March 12, 2025 that four Center for Medicare and Medicaid Innovation (CMMI) payment models would be sunset at the end of 2025, earlier than originally scheduled.[1] Cutting these models, which decision was based on "a comprehensive and data-driven review of [CMS's] model portfolio," are anticipated to save nearly $750 million (although the source of these savings was not detailed).[2] This Health Capital Topics article discusses the models being ended and the impact on healthcare stakeholders.

The CMMI was created by the Patient Protection & Affordable Care Act (ACA) to "test new payment and delivery models to lower costs and improve quality in government healthcare programs."[3] CMMI models "are time-limited experiments that provide a controlled environment to determine, through rigorous evaluation, what approaches should be expanded nationwide, what specific components of an approach need further testing in successor models and what approaches are not viable for expansion."[4] CMMI currently operates 23 payment models.[5]

The four models ending on December 31, 2025 are:

- The Primary Care First (PCF) model (original end date: 2026);
- The Maryland Total Cost of Care model (original end date: 2026);
- The End-Stage Renal Disease (ESRD) Treatment Choices (ETC) model (original end date: 2027); and
- The Making Care Primary (MCP) model (original end date: 2034).[6]

The PCF model, which began in 2021, has approximately 2,100 participating practices and 17 payor partners across 26 regions.[7] The model aims to advance primary care practices and seeks to remove from clinicians the financial risks that they face from administrative drains and provide more performance-based payments.[8] There are two PCF payment model options: the first model is for physicians treating general populations, and the second model is for physicians treating high need populations.[9] With both PCF payment model options, Medicare pays a risk-adjusted professional population-based payment with a flat primary care fee visit.[10]

The Maryland Total Cost of Care model, which began in 2019, builds on the Maryland All-Payer Model (2014-2018), wherein Maryland hospitals received a fixed amount of revenue from payors each year, by adding new primary care investments.[11] Notably, the model reduced Medicare net spending by $689 million in its first three years.[12]

The ETC model, which began in 2021, aims to "encourage greater use of home dialysis and kidney transplants for Medicare beneficiaries with ESRD" through payment adjustments, "while reducing Medicare expenditures and preserving or enhancing the quality of care furnished to beneficiaries with ESRD."[13] Approximately 30% of ESRD facilities participate in the mandatory model.[14]

The MCP model, a 10.5-year model that began in 2024 and has 117 participants and 772 practices across eight states, was built upon previous primary care models such as the Maryland Primary Care Program (MDPCP), the PCF model, and the Comprehensive Primary Care (CPC/CPC+) Model.[15] The model aims to improve the coordination and management of care, enable primary care clinicians to form relationships with healthcare specialists, and form community-based connections to address the health needs of patients, as well as health-related social needs such as nutrition and housing.[16] The goal of this model is to transform the delivery of healthcare, especially in primary care, through three major parts: (1) community integrations, which will address social needs that are related to health; (2) care management, where participants will offer support services; and (3) care integration, where primary care providers will align with specialists.[17]

The agency explained that "[a]s is the nature of innovation, not every model will work, and the center must be efficient and effective in its response."[18] As specifically regards the Primary Care First model, CMS affirmed that "[p]rimary care remains a foundational component of [CMMI's] strategy. The early termination of the PCF and MCP models does not signal a retreat from [CMMI's] support of primary care providers, but rather a need to focus on different approaches that are consistent with [CMMI's] statutory mandate and produce savings."[19]

In addition to ending these models early, CMS will no longer implement two announced but not yet implemented demonstrations aimed at improving prescription drug access and affordability:

- The Medicare $2 Drug List, which aimed to cap out-of-pocket costs for generic drugs at $2 per month; and
- The Accelerating Clinical Evidence model.[20]

Further, the Vermont All-Payer ACO Model and the Maternal Opioid Misuse Model will reportedly not be renewed at the end of 2025.[21] The agency is also considering ways to scale back the Integrated Care for Kids (InCK) model (original end date: 2026), which seeks to imrpove quality of pediatric care through "prevention, early identification and treatment of behavioral and physical health needs."[22] Notably, CMS declined to comment on the future of the Medicare Shared Savings Program for accountable care organizations, which program conservatives have recommended cancelling, or the ACO Realizing Equity, Access and Community Health (ACO REACH) model, which is scheduled to sunset at the end of 2026.[23]

While it is common for new presidential administrations to end or modify some payment models at the beginning of a term, the uncertainty that comes with these abrupt endings render it difficult for providers to fully participate and invest in these models.[24] As to what's next, CMMI "plans to announce a new strategy based on guiding principles to make Americans healthier by preventing disease through evidence-based practices, empowering people with information to make better decisions, and driving choice and competition."[25] A timeline for this new strategy was not disclosed.

---

1 "Statement on CMS Innovation Center Aligning Portfolio with Statutory Obligation" Centers for Medicare & Medicaid Services, March 12, 2025, https://www.cms.gov/newsroom/press-releases/statement-cms-innovation-center-aligning-portfolio-statutory-obligation (Accessed 3/20/25); "CMS Innovation Center Announces Model Portfolio Changes to Better Protect Taxpayers and Help Americans Live Healthier Lives" Centers for Medicare & Medicaid Services, March 12, 2025, https://www.cms.gov/newsroom/fact-sheets/cms-innovation-center-announces-model-portfolio-changes-better-protect-taxpayers-and-help-americans (Accessed 3/20/25).

2 "CMS Innovation Center Announces Model Portfolio Changes to Better Protect Taxpayers and Help Americans Live Healthier Lives" Centers for Medicare & Medicaid Services, March 12, 2025, https://www.cms.gov/newsroom/fact-sheets/cms-innovation-center-announces-model-portfolio-changes-better-protect-taxpayers-and-help-americans (Accessed 3/20/25).

3 "CMMI cancels 4 payment models early" By Emily Olsen, Healthcare Dive, March 13, 2025, https://www.healthcaredive.com/news/cms-innovation-center-cancels-payment-models-early/742424/ (Accessed 3/20/25).

4 Centers for Medicare & Medicaid Services, March 12, 2025.

5 Olsen, Healthcare Dive, March 13, 2025.

6 Centers for Medicare & Medicaid Services, March 12, 2025.

7 "Primary Care First Model Options" Centers for Medicare & Medicaid Services, https://www.cms.gov/priorities/innovation/innovation-models/primary-care-first-model-options (Accessed 3/20/25).

8 *Ibid*.

9 *Ibid*.

10 *Ibid*.

11 "Scoop: Trump Medicare center to cancel some payment trials" By Maya Goldman, Axios, March 12, 2025, https://www.axios.com/2025/03/12/medicare-innovation-center-cancels-projects (Accessed 3/20/25).

12 "Maryland Total Cost of Care Model: Evaluation of the First Four Years (2019–2022)"Centers for Medicare & Medicaid Services Center for Medicare and Medicaid Innovation, Findings at a Glance, available at: https://www.cms.gov/priorities/innovation/data-and-reports/2024/md-tcoc-1st-progress-rpt-aag (Accessed 3/2/25).

13 "ESRD Treatment Choices (ETC) Model" Centers for Medicare and Medicaid Services, https://www.cms.gov/priorities/innovation/innovation-models/esrd-treatment-choices-model (Accessed 3/20/25).

14 *Ibid*.

15 "Making Care Primary (MCP) Model" Centers for Medicare and Medicaid Services, July 10, 2024, https://www.cms.gov/priorities/innovation/innovation-models/making-care-primary (Accessed 3/20/25).

16 *Ibid*.

17 "CMS pilot program aims to boost value-based primary care" By Victoria Turner, Modern Healthcare, June 8, 2023, https://www.modernhealthcare.com/politics-policy/cms-debuts-making-care-primary-model-promote-value-based-care (Accessed 6/9/23).

18 Centers for Medicare & Medicaid Services, March 12, 2025.

19 *Ibid*.

20 Olsen, Healthcare Dive, March 13, 2025.

21 "CMMI to cut participation in payment models, estimates $750M in savings" By Noah Tong, Fierce Healthcare, March 12, 2025, https://www.fiercehealthcare.com/regulatory/cmmi-cut-short-payment-models-estimates-750m-savings (Accessed 3/20/25).

22 Centers for Medicare & Medicaid Services, March 12, 2025; Tong, Fierce Healthcare, March 12, 2025.

23 "CMS terminates 4 Medicare pay models ahead of schedule" By Bridget Early, Modern Healthcare, March 12, 2025, https://www.modernhealthcare.com/policy/cms-terminates-medicare-payment-models (Accessed 3/20/25).

24 Goldman, Axios, March 12, 2025.

25 "Statement on CMS Innovation Center Aligning Portfolio with Statutory Obligation" Centers for Medicare & Medicaid Services, March 12, 2025, https://www.cms.gov/newsroom/press-releases/statement-cms-innovation-center-aligning-portfolio-statutory-obligation (Accessed 3/20/25).

The Shift to Value-Based Care: Evidence of Progress

[Excerpted from the article published in May 2025.]

A recent joint report by the National Association of Accountable Care Organizations (NAACOS) and Innovaccer Inc., a healthcare artificial intelligence (AI) company, found tangible evidence that the U.S. healthcare delivery system is indeed moving toward value-based care (VBC). Fifteen years after the passage of the Patient Protection and Affordable Care Act (ACA), which promoted VBC through the advent of ACOs and other alternative payment models, there is finally evidence that providers are actually moving in that direction. This Health Capital Topics article reviews the joint report on "The State and Science of Value-based Care 2025."

VBC is a healthcare model that shifts the focus from the volume of services provided to the quality and outcomes (i.e., value) of patient care. Instead of being paid for each test or procedure (i.e., fee-for-service, or FFS), providers are incentivized to keep patients healthy, effectively manage chronic conditions, and prevent complications. This approach aims to improve patient health, enhance the patient experience, and reduce overall healthcare costs by promoting coordinated, preventive, and patient-centered care.[1] While the trend toward VBC initiatives is not new, nor is the policy movement away from FFS arrangements, there has been much talk but seemingly little action in the past 15 years.

The joint report "examines the evolving landscape of healthcare payment models and [VBC] across U.S. healthcare."[2] Nearly 170 leaders at 142 healthcare organizations across care settings were surveyed on "the progress, pain points, and investment signals driving [VBC] strategies forward."[3] As of 2025, over 60% of organizations have increased their participation in VBC programs, highlighting the momentum behind the shift toward VBC.[4] Notably, 30% of surveyed organizations indicated that a quarter of their revenue is tied to VBC contracts, and over 20% stated that at least half of their revenue comes from fully capitated or downside risk contracts, "a strong indicator of advancing maturity in VBC adoption."[5] Nearly 65% of leaders expect to see revenue gains from VBC in 2025 compared to 2024.[6]

The report also surveyed leaders about what is keeping them from further VBC adoption. The top barriers to VBC adoption were reported to be, perhaps unsurprisingly:

(1) Financial risk (87%);
(2) Provider readiness (80%);
(3) Lack of interoperability (75%); and
(4) High cost of technology (67%).[7]

In order to propel VBC adoption, 74% of responding organizations asserted that additional financial support is needed.[8] However, the needed capital does not appear to be a complete bar to VBC for organizations, as over 50% of survey respondents plan to increase their investment in technology solutions in 2025 to better support their VBC efforts.[9] Top among those priorities are:

(1) Data analytics and AI, with 31.2% of organization investing; and
(2) Care management solutions, with 30% of organizations investing.[10]

As regards AI, approximately 65% of respondents are optimistic about AI's "potential to enhance predictive and prescriptive analytics in [VBC] arrangements."[11] Overall, it seems that the use of technology to make sense of all the health data being captured from patients, which is crucial to identifying the appropriate treatment plan and actions for each individual patient, may be the key to full-fledged, long-term acceptance of VBC.

These trends are particularly encouraging given that the Centers for Medicare and Medicaid Services (CMS) Innovation Center announced on May 13, 2025 that alternative payment model participants may be required to accept downside risk in their VBC arrangements going forward.[12] In other words, the shift toward VBC is accelerating, regardless of provider readiness.

The report authors summarize that the "study reveals an industry in transition, with organizations showing measured progress despite significant operational and financial challenges."[13] President and CEO of NAACOS, Emily D. Brower, noted that "[t]his report highlights how technology, collaboration, and infrastructure can support providers in accountable care to drive innovation in care delivery."[14] The cofounder and CEO of Innovaccer, Abhinav Shashank, added: "[a]s the shift to [VBC] accelerates, the research highlights a critical truth: successful transformation demands more than just intent, it requires deep investments in data, technology, and partnerships."[15]

---

1 "Healthcare Valuation: The Four Pillars of Healthcare Value" By Robert James Cimasi, Volume 1, Hoboken, NJ: John Wiley & Sons (2014), p. 231.
2 "The State and Science of Value-based Care 2025" A Joint Research by Innovaccer and NAACOS, available at: https://innovaccer.com/resources/industry-reports/innovaccer-naacos-state-and-science-of-vbc-report-2025?pdf=362 (Accessed 5/21/25).
3 "NAACOS and Innovaccer Latest Report Shows 64% of Healthcare Leaders Expect Revenue Gains from Value-Based Care in 2025" Innovaccer, May 15, 2025, https://innovaccer.com/resources/news/naacos-innovaccer-latest-report-shows-healthcare-leaders-expect-revenue-gains-vbc-2025 (Accessed 5/21/25).
4 A Joint Research by Innovaccer and NAACOS, available at: https://innovaccer.com/resources/industry-reports/innovaccer-naacos-state-and-science-of-vbc-report-2025?pdf=362 (Accessed 5/21/25).
5 *Ibid*.
6 Innovaccer, May 15, 2025.
7 *Ibid*.
8 *Ibid*.
9 A Joint Research by Innovaccer and NAACOS, available at: https://innovaccer.com/resources/industry-reports/innovaccer-naacos-state-and-science-of-vbc-report-2025?pdf=362 (Accessed 5/21/25).
10 *Ibid*.
11 *Ibid*.
12 "CMS Innovation Center Strategy to Make America Healthy Again" By Abe Sutton, Cneters for Medicare & Medicaid Services, May 13, 2025, https://www.cms.gov/priorities/innovation/about/cms-innovation-center-strategy-make-america-healthy-again (Accessed 5/21/25).
13 A Joint Research by Innovaccer and NAACOS, available at: https://innovaccer.com/resources/industry-reports/innovaccer-naacos-state-and-science-of-vbc-report-2025?pdf=362 (Accessed 5/21/25).
14 Innovaccer, May 15, 2025.
15 *Ibid*.

Healthcare Spending Surged in 2023

[Excerpted from the article published in December 2024.]

On December 18, 2024, the Centers for Medicare & Medicaid Services (CMS) released its annual report on U.S. healthcare spending. The report highlighted accelerated spending growth in 2023, driven by increased insurance coverage and utilization, raising concerns about long-term cost sustainability.[1] Total healthcare spending grew 7.5% in 2023 (to $4.9 trillion), much faster than the 4.6% and 3.2% increases in 2022 and 2021, respectively.[2] Healthcare spending as a share of the U.S. gross domestic product (GDP) increased from 17.4% in 2022 to 17.6% in 2023 while the overall GDP increased only 2.9% in 2023, substantially slower than the 9.1% increase in 2022.[3]

Examining the expenditures across service categories, hospital expenditures grew 10.4% in 2023 (comprising 31% of overall healthcare spending), over three times the growth rate observed in 2022 (3.2%).[4] Similarly, expenditures on physician and clinical services increased 7.4% (comprising 20% of healthcare spending), much faster than the 4.6% growth in 2022. Increases in both categories were a result of "nonprice factors," including increased utilization and the rendering of more high-intensity services.[5] Retail prescription drug expenditures increased 11.4% in 2023 (comprising 9% of healthcare spending), a faster rate than 2022's spending increase of 7.8%.[6] This increase was attributed to increase in diabetes and obesity drugs (which are typically higher-cost, brand-name drugs), as well as growth in prescription drug prices.[7]

Analyzing expenditures by sponsor, the federal government predictably continued to account for the largest share of healthcare spending (32%), followed by households (27%), private businesses (18%), state and local governments (16%), and other private revenues (7%).[8] Federal government spending increased 3.4% in 2023, after only 1.9% growth in 2022.[9] This was driven largely by Medicare's spending increase of 12.9% (compared to only 1.11% growth in 2022, which was attributable to the Inflation Reduction Act's initial impacts and more spending for Medicare hospital, physician, and clinical services. Household health spending increased 6.8% in 2023, slower than the 7.7% increase in 2022.[10] State and local governments experienced a substantial spending growth in 2023, with spending increasing by 11.6% compared to the 6.0% increase in 2022. This increase can be attributed to the phasing-out of some state Medicaid funding under the *Families First Coronavirus Response Act*.[11] Finally, spending by private businesses increased 11.0% in 2023, which was faster than the 6.8% increase in 2022.[12] This was largely due to the increase in private health insurance enrollment and the increased share of employer-sponsored health insurance paid for by the employer.[13]

In terms of insurance coverage, the number of uninsured individuals in 2023 decreased to 24.9 million from 26.6 million in 2022.[14] Enrollment increased in Medicare, Medicaid, private insurance, and the Affordable Care Act (ACA) Marketplace plans.[15] In fact, the national insurance rate reached a record high of 92.5% in 2023, breaking 2022's record of 92%. However, the end of the COVID-19 public health emergency in May 2023 resulted in a reversion to previous Medicaid criteria, resulting in a marked decrease in Medicaid enrollment compared to the previous year (a growth of only 0.8%).[16]

The numbers and trends above indicate that 2023 may close out the COVID era of healthcare spending. Although spending trends were more erratic during this time, on average, its growth and contraction largely mirrored the GDP. In 2023, the share of the economy devoted to healthcare was similar to that in 2019.[17] While spending grew significantly, this was driven by utilization from a record high insured population. This may indicate that significant year-over-year spending increases may become the norm as the last of the Baby Boomers enroll in Medicare and require more healthcare services. Economic experts believe that "Although there is uncertainty about the future, expectations are that the traditional economic and demographic drivers of health spending will lead to the return of health care accounting for a larger share of the economy."[18]

---

1 "National Health Expenditures In 2023: Faster Growth As Insurance Coverage And Utilization Increased" By Anne B. Martin, et al., Health Affairs, December 18, 2024, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2024.01375 (Accessed 12/19/24).

2 "National Health Expenditures 2023 Highlights" Office of the Actuary, Centers for Medicare and Medicaid Services, December 19, 2024, https://www.cms.gov/files/document/highlights.pdf (Accessed 12/19/24); "National Health Expenditures 2022 Highlights" Office of the Actuary, Centers for Medicare and Medicaid Services, December 13, 2023, https://www.cms.gov/newsroom/fact-sheets/national-health-expenditures-2022-highlights (Accessed 12/20/24).

3 *Ibid*.

4 Martin, et al., Health Affairs, December 18, 2024.

5 *Ibid*.

6 Office of the Actuary, Centers for Medicare and Medicaid Services, December 19, 2024.

7 Martin, et al., Health Affairs, December 18, 2024.

8 Office of the Actuary, Centers for Medicare and Medicaid Services, December 19, 2024.

9 *Ibid*.

10 Martin, et al., Health Affairs, December 18, 2024.

11 *Ibid*.

12 Office of the Actuary, Centers for Medicare and Medicaid Services, December 19, 2024.

13 *Ibid*.

14 *Ibid*.

15 *Ibid*.

16 *Ibid*.

17 Martin, et al., Health Affairs, December 18, 2024.

18 *Ibid*.

Healthcare Spending Projected to Exceed $8.5 Trillion by 2033

[Excerpted from the article published in June 2025.]

On June 25, 2025, the Centers for Medicare & Medicaid Services (CMS) released its forecast on U.S. healthcare spending through 2033. The analysis, published in Health Affairs, estimated healthcare spending growth in 2024 and projected the growth into 2033. CMS found that overall healthcare spending growth has decreased slightly but is still elevated compared to pre-pandemic levels, and is expected to continue to moderately grow. This Health Capital Topics article examines the factors underlying the forecasts.

Total healthcare spending grew an estimated 8.2% in 2024 (to over $5.2 trillion), but is expected to moderate over the next few years, to an average of 5.8% annual growth, culminating in projected national health expenditures exceeding $8.5 trillion by 2033.[1] Healthcare spending as a share of the U.S. gross domestic product (GDP) slightly increased from 2023 to 2024, from 17.6% to 18.0%; the healthcare share of GDP is anticipated to reach 20.3% by 2033, as the overall GDP is expected to increase at an annual average of only 4.3%.[2]

Examining healthcare expenditures across service categories, hospital expenditures grew 10.4% in 2023 and 9.2% in 2024, the highest growth rates since the early 1990s.[3] Hospital care spending is expected to grow 5.9% per year from 2024 to 2033, comprising 31% of overall healthcare spending.[4] Similarly, expenditures on physician and clinical services are expected to increase 5.5% annually (comprising 20% of healthcare spending), slower than the 7.8% growth in 2024.[5] Growth in both categories are a result of nonprice factors, including utilization and insurance enrollment.[6] Prescription drug expenditures increased 10.1% in 2024 (comprising 9% of healthcare spending), a slightly slower rate than 2023's spending increase of 11.4%.[7] This slowdown, despite increased use of diabetes and obesity drugs (which are typically higher-cost, brand-name drugs), is attributed to a decrease in private health insurance drug spending and a decline in Medicaid enrollment.[8]

Analyzing expenditures by payor, the federal government will continue to account for an increasingly larger share of healthcare spending (from 39% in 2024 to 44% in 2033), followed by households (27%), private businesses (18%), state and local governments (15 to 16%), and other private revenues (6 to 7%).[9]

Federal government spending jumped over three percentage points from 2023 to 2024, and is expected to grow at an accelerated annual rate of 6.4% through 2033.[10] This is driven largely by Medicare's spending increase of 8.3% in 2024 (similar to 2023) and is attributable to a mix of factors, including a deceleration in Medicare Advantage capitation rates and accelerated growth in both fee-for-service payments and Medicare prescription drug spending.[11] Through 2033, the spending growth is expected to average approximately 7.4%; this moderation is largely due to the last of the Baby Boomers entering Medicare by 2029 and reductions in Medicare drug spending as a result of various Inflation Reduction Act (IRA) provisions.[12]

State and local governments experienced a substantial spending growth of 17.3% in 2024 (down from 18.4% in 2023), with spending decelerating to 6-8% between 2025 and 2033.[13] Household health spending increased an estimated 7.5% in 2024, up from 6.8% in 2023.[14] Finally, spending by private businesses increased approximately 8% in 2024, a notable deceleration from 2023's 11% increase.[15] Notably, this growth is expected to significantly slow to 3.9% by 2033, largely due to an anticipated 1.3 million enrollment increase.[16]

In terms of insurance coverage, the number of uninsured individuals increased slightly in 2024, to 26.6 million.[17] Enrollment increased in Medicare and private insurance, but decreased in Medicaid.[18] The Medicaid enrollment drop can be attributed to the post-pandemic reversion to previous Medicaid criteria.[19] However, CMS cautioned against relying on Medicaid spending projects due to external factors rendering projections difficult.[20] Although the national insurance rate decreased slightly in 2024, it is still near the record high of 92.5% set in 2023.[21] Through 2033, the insured population is expected to continue to moderately decrease, to 91.3%.[22]

The 2024 estimated healthcare spending appears to reflect the last of the pent-up utilization from the COVID-19 pandemic, leading (in theory) to moderated spending going forward. However, it appears that healthcare spending may be subject to ongoing volatility and unpredictability if the budget reconciliation bill, which includes approximately $1 trillion in healthcare cuts, is passed through Congress.[23] As noted by CMS:

> "many notable enrollment changes are expected to occur (including the completion of Medicaid unwinding and the expiration of the IRA's temporarily enhanced premium tax subsidies for Marketplace plans in 2026), leading to a somewhat lower insured share of the population. Although the projections presented here reflect current law, future legislative and regulatory health policy changes could have a significant impact on the projections of health insurance coverage, health spending trends, and related cost-sharing requirements, and they thus could ultimately affect the health share of GDP by 2033."[24]

---

1 "National Health Expenditure Projections, 2024–33: Despite Insurance Coverage Declines, Health To Grow As Share Of GDP" By Sean P. Keehan, et al., Health Affairs, June 25, 2025, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2025.00545 (Accessed 6/26/25).
2 *Ibid.*
3 *Ibid.*
4 *Ibid.*
5 *Ibid.*
6 *Ibid.*
7 *Ibid.*
8 *Ibid.*
9 *Ibid.*
10 *Ibid.*
11 *Ibid.*
12 *Ibid.*
13 *Ibid.*
14 *Ibid.*
15 *Ibid.*
16 *Ibid.*
17 *Ibid.*
18 *Ibid.*
19 *Ibid.*
20 *Ibid.*
21 *Ibid.*
22 *Ibid.*
23 "US health spending projected to hit $8.6T by 2033" By Bridget Early, Modern Healthcare, June 25, 2025, https://www.modernhealthcare.com/finance/mh-us-health-spending-2033/ (Accessed 6/26/25).
24 Keehan, et al., Health Affairs, June 25, 2025.

Hospital Finances Held Steady in First Month of 2025

[Excerpted from the article published in March 2025.]

In the first month of 2025, hospital revenue and expenses both increased, balancing each other out and resulting in continued steady financial performance for hospitals, according to Kaufman Hall's January 2025 *National Hospital Flash Report*.[1] Revenues grew more quickly in the inpatient setting, as more patients were treated in the hospital and emergency department than in outpatient settings.[2] While expense increases were largely driven by drug costs, the rate of that growth has significantly slowed.[3] This Health Capital Topics article reviews the Report and the current state of hospital operations.

The *National Hospital Flash Report*, a monthly report authored by healthcare management consulting firm Kaufman Hall (which is owned by Vizient, a healthcare data and improvement company), samples hospital data collected over the previous three years from over 1,300 hospitals, of all sizes and types, across the U.S., collected by Strata Decision Technology.[4]

Hospitals' median monthly operating margin index in January 2025 was 8%, the highest margin of the last 12 months.[5] On the revenue side, hospitals experienced increases across a wide swath of metrics in January compared to December 2024, including increases in:

(1) Discharges per calendar day (5% increase);
(2) Adjusted discharges per calendar day (2% increase);
(3) Equivalent patient days per calendar day (6% increase);
(4) Adjusted patient days per calendar day (4% increase);
(5) Average length of stay (2% increase);
(6) Operating room minutes per calendar day (2% increase);
(7) Inpatient revenue (8% increase);
(8) Outpatient revenue (3% increase); and
(9) Net operating revenue (1% increase).[6]

Further, bad debt and charity as a percentage of gross revenue decreased by 6% year-over-year.[7]

On the expense side, total expense per calendar day increased 1%, due in large part to the growth in labor expenses (2%) and drug expenses (1%), which remain high compared to pre-pandemic levels.[8]

For the first time, the January 2025 Report included hospital margin performance as well as all allocations for the cost of shared services received from the hospital's respective health system, e.g., corporate office expenses.[9] The median monthly operating margin index, under this measurement, was 4.4% in January 2025, an increase over December 2024's 3.7% rate as well as the 2.1% rate for the 2024 calendar year.[10]

In a statement following the release of the report, Erik Swanson, managing director and group leader of data and analytics at Kaufman Hall, stated that:

> "January was a relatively stable month for hospitals, as more people received care due in part to seasonal challenges like flu and other respiratory diseases. Hospitals are also experiencing more rapid revenue growth from inpatient than outpatient services. Expenses are also rising, driven primarily by drug costs, though the rate of cost growth has slowed."[11]

In a subsequent interview with Healthcare Finance News, Swanson added that: "Hospitals are seeing some relief from extreme cost spikes, but drug and supply chain expenses continue to be a major concern. Many organizations are joining group purchasing organizations, seeking generic substitutions, or exploring biosimilar drugs to control spending."[12] On the revenue side, recent increases in bad debt and charity care, possibly as a result of the post-COVID Medicaid disenrollments, are problematic, with Swanson advising that "Hospitals need to prepare for potential further increases depending on changes in Medicaid policy."[13]

Hospitals have been especially slow to financially recover from the COVID-19 pandemic.[14] As recently as November 2024, Kaufman Hall reported decreases in hospital patient volumes across emergency department and outpatient visits, with adjusted discharges per calendar day decreasing 4% during the month, while expenses remained high.[15] While the January 2025 figures are encouraging, hospitals would be well-served to remain vigilant in their operations, with an eye toward state and federal regulatory changes that may decrease revenues and/or increase costs (e.g., Medicaid cuts).

---

1 "National Hospital Flash Report" Kaufman Hall, January 2025, available at: https://www.Kaufman Hall.com/sites/default/files/2025-03/KH_NHFR-Report-Jan-2025-Metrics.pdf (Accessed 3/24/25).
2 *Ibid*.
3 *Ibid*.
4 *Ibid*; "Hospitals kick off 2025 with modest operating margin gains, high inpatient revenue" By Dave Muoio, Fierce Healthcare, March 18, 2025, https://www.fiercehealthcare.com/providers/hospitals-kick-2025-modest-operating-margin-gains-high-inpatient-revenue (Accessed 3/25/25).
5 Kaufman Hall, January 2025; "Hospital Margins Stable to Start 2025 Due to Offsetting Rise in Volume, Expenses" By Jay Asser, HealthLeaders, March 24, 2025, https://www.healthleadersmedia.com/ceo/hospital-margins-stable-start-2025-due-offsetting-rise-volume-expenses (Accessed 3/24/25).
6 Asser, HealthLeaders, March 24, 2025.
7 "Healthcare M&A activity signals shaky financial recovery" By Jacqueline LaPointe, TechTarget, January 14, 2025, https://www.techtarget.com/revcyclemanagement/news/366617976/Healthcare-MA-activity-signals-shaky-financial-recovery (Accessed 3/24/25).
8 Asser, HealthLeaders, March 24, 2025; "Increased patient volumes stabilize hospitals' financial performance" By Nathan Eddy, Healthcare finance, March 24, 2025, https://www.healthcarefinancenews.com/news/increased-patient-volumes-stabilize-hospitals-financial-performance (Accessed 3/25/25).
9 Kaufman Hall, January 2025; "Hospital financial performance stable as volumes rise" By Jacqueline LaPointe, Rev Cycle Management, March 18, 2025, https://www.techtarget.com/revcyclemanagement/news/366620902/Hospital-financial-performance-stable-as-volumes-rise#:~:text=Hospital%20financial%20performance%20was%20offset,hospital%20expenses%2C%20especially%20drug%20costs.&text=Hospital%20financial%20performance%20remains%20stable,high%20expenses%2C%20Kaufman%20Hall%20reports. (Accessed 3/25/25).
10 Kaufman Hall, January 2025; Muoio, Fierce Healthcare, March 18, 2025.
11 "Hospital Performance Remains Stable as Greater Volume and Expenses Contribute to Financial Balance" Kaufman Hall, March 17, 2025, https://www.Kaufman Hall.com/news/hospital-performance-remains-stable-greater-volume-and-expenses-contribute-financial-balance (Accessed 3/24/25).
12 "Increased patient volumes stabilize hospitals' financial performance" By Nathan Eddy, Healthcare finance, March 24, 2025, https://www.healthcarefinancenews.com/news/increased-patient-volumes-stabilize-hospitals-financial-performance (Accessed 3/25/25).
13 *Ibid*.
14 LaPointe, TechTarget, January 14, 2025.
15 *Ibid*; Kaufman Hall, January 9, 2025.

MA Plan Rates Substantially Increased for 2026

[Excerpted from the article published in April 2025.]

On April 7, 2025, the Centers for Medicare & Medicaid Services (CMS) published their 2026 Rate Announcement for Medicare Advantage (MA) and Medicare Part D Prescription Drug Plans.[1] For 2026, the payment rate to MA plans will increase 5.06%, the largest increase in the past ten years, and up significantly from the 2.2% rate increase proposed by the Biden Administration.[2] This Health Capital Topics article will review the Rate Announcement.

MA plans, also known as Part C plans, serve as a supplement or an alternative to Traditional fee-for-service (FFS) Medicare Part A and Part B coverage, but they are still part of the Medicare program.[3] MA was created by Congress to provide seniors an alternative to Traditional Medicare, with an emphasis on treating and managing the health of the whole patient. MA plans are offered to Medicare beneficiaries by Medicare-approved private companies that must follow rules set by Medicare.[4] These plans can be advantageous for beneficiaries because they limit out-of-pocket costs for covered services (although out-of-pocket costs vary by plan) and may cover additional healthcare services (e.g., fitness programs, vision, dental, hearing) as well as other benefits (e.g., transportation to appointments, drugs/services that promote wellness).[5] However, to manage costs, an MA plan's network is often much narrower than that of Traditional Medicare. Likely due to these benefits, MA plan enrollment has increased steadily over the past two decades, at a much faster pace than Traditional Medicare.[6] As of 2024, 32.8 million Americans – 54% of all eligible Medicare beneficiaries – were enrolled in an MA plan.[7]

MA plans are reimbursed differently by Medicare depending on the category of the plan. Local MA plans (a type of MA plan that can take a number of different forms, and serve one or more counties[8]) are reimbursed a fixed amount (capitated payment) per month. That amount is determined annually, based on a combination of:

(1) The plan's annual bid, in which they propose to Medicare the amount it would take to cover an average beneficiary, including administrative costs and the plan's profit;
(2) The bid is compared to the local benchmark, which looks at average FFS spending per Medicare beneficiary in each county. Plans are then assigned to a benchmark based on FFS spending in the subject counties in the previous year (those counties with higher spending are assigned lower benchmarks);
(3) The plan's Medicare star ratings; and,
(4) The plan's patient geographic and health risk characteristics.[9]

The below Exhibit 1 illustrates the methodology.[10]

The payment methodology for regional MA plans (preferred provider organizations that serve all of a region designated by CMS[11]) is more complex in that the benchmark formula includes the bids submitted by MA plans, as shown in the below Exhibit 2.[12]

Notably, although MA plan bids are typically cheaper than Traditional Medicare (i.e., MA plans are more cost effective), Medicare does not realize these cost savings – those cost savings are shared by the specific plans and their enrollees, in the form of extra benefits.[13] In fact, Medicare spends 22% more on MA enrollees than on Traditional Medicare enrollees, an $83 billion annual difference.[14]

CMS's 2026 Rate Announcement will increase payments to MA plans by 5.06%, a $25 billion increase.[15] The annual payment update is a sum of the percentage impact of various "policy changes and updates on MA plan payment parameters relative to last year," including:

(1) The effective growth rate, which is updated annually according to statute, "represents the average expected change in benchmarks based on the growth in Medicare per capita costs."[16] For 2026, that percent impact is estimated to be 9.04% (much higher than the proposed 5.93%), due to the final calculation's inclusion of data through the fourth quarter of 2024.

(2) Rebasing/re-pricing, which is based on the average geographic adjustment index and is estimated at -0.28% for 2026.

(3) Change in MA Star Ratings, which "reflects the estimated effect of changes in the Quality Bonus Payments for the upcoming payment year." This change is estimated to be -0.69% for 2026.

(4) Risk model revision and FFS normalization, which reflects the impact of the update to the FFS normalization factors for MA risk adjustment. This combined impact is estimated to be a change of -3.01% for 2026.[17]

CMS explained that the significant increase in payment rates between the proposed and final announcements is due to the utilization of more recent data in its calculation, which reflects higher Medicare spending (the starting point for MA benchmarks).[18] However, industry analysts have noted that the actual MA rate increase for 2026 will be even greater – approximately 7.2% – due to the impact of risk scoring changes, as the payment update "does not include an adjustment for underlying coding trend in MA," i.e., the documentation of more/higher-acuity care by MA plans,[19] which CMS expects will increase risk scores by 2.1%.[20]

In 2024, CMS finalized an updated Risk Adjustment Model, called the 2024 CMS-HCC model, to be phased in over three years.[21] The third and final year of that phase-in will be 2026 , during which CMS will calculate 100% of the MA plans' risk scores using solely the 2024 CMS-HCC model (in previous years CMS used a hybrid approach with both the new and old models).[22]

Most in the healthcare industry anticipated that the Trump Administration would act favorably toward MA plans, given CMS Administrator Dr. Mehmet Oz's previously expressed support for MA generally, as well as for more investment in the program.[23] However, this increase may have exceeded even the most optimistic expectations, as MA insurer stock prices soared following the announcement.[24] As the Trump Administration and Capitol Hill continue their push to cut federal spending in the healthcare industry,[25] it now appears clear that the MA program will not be part of that conversation.

Exhibit 1:

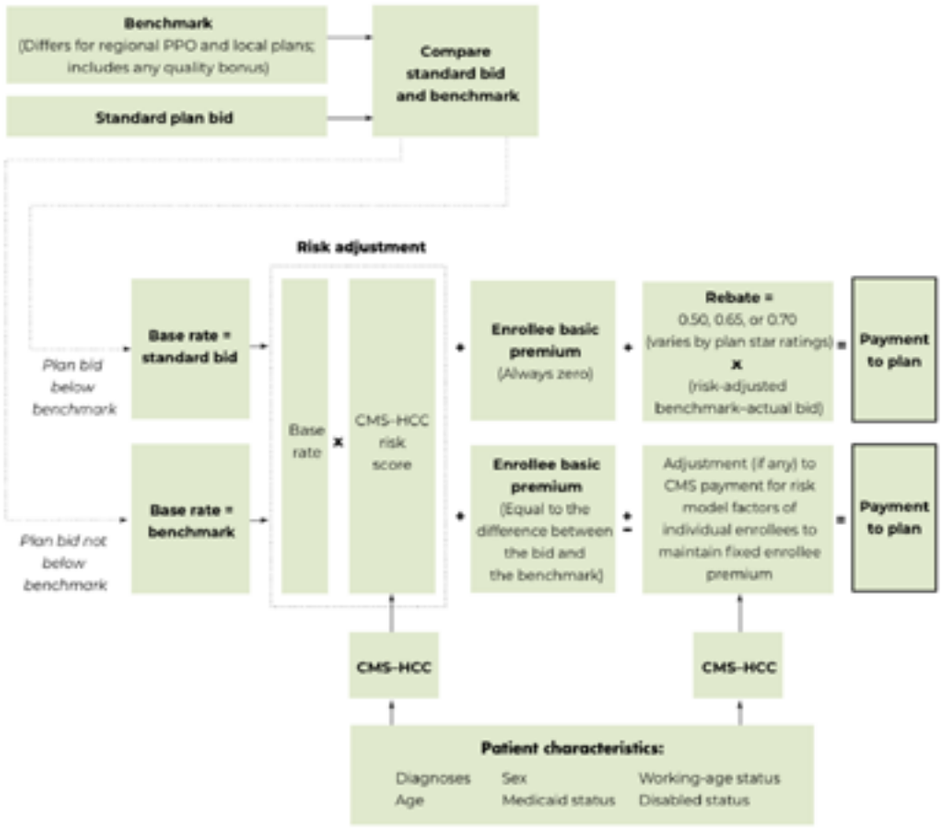
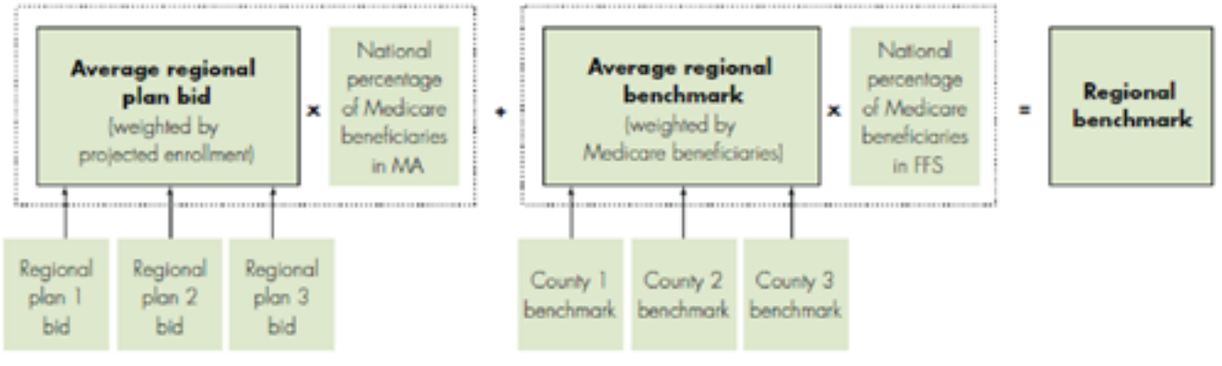


Exhibit 2:



1 "CMS Finalizes 2026 Payment Policy Updates for Medicare Advantage and Part D Programs" Centers for Medicare & Medicaid Services, April 7, 2025, https://www.cms.gov/newsroom/press-releases/cms-finalizes-2026-payment-policy-updates-medicare-advantage-and-part-d-programs (Accessed 4/17/25).

2 "Trump's CMS dramatically raises payments to Medicare Advantage plans" By Rebecca Pifer, Healthcare Dive, April 8, 2025, https://www.healthcare-dive.com/news/medicare-advantage-2026-payment-rates-trump-humana-unitedhealth/744682/ (Accessed 4/17/25).

3 "Medicare Advantage Plans" Medicare.gov, https://www.medicare.gov/sign-upchange-plans/types-of-medicare-health-plans/medicare-advantage-plans (Accessed 4/18/25).

4 *Ibid*.

5 *Ibid*.

6 "Medicare Advantage in 2024: Enrollment Update and Key Trends" Kaiser Family Foundation, August 8, 2024, https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/ (Accessed 4/17/25).

7 Kaiser Family Foundation, August 8, 2024.

8 For more information on types of MA plans, please see "Valuation of MA Plans: Introduction & Competitive Environment" Health Capital Topics, Vol. 16, Issue 3 (March 2023), https://www.healthcapital.com/hcc/newsletter/03_23/HTML/PLANS/convert_val_ma_plans_intro_competiton.php (Accessed 4/17/25).

9 *Ibid*.

10 "Medicare Advantage Program Payment System" Medicare Payment Advisory Commission, October 2024, https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_MA_FINAL_SEC.pdf (Accessed 4/18/25).

11 For more information on Regional MA plans, see the first installment in this series: "Valuation of MA Plans: Introduction & Competitive Environment" Health Capital Topics, Vol. 16, Issue 3 (March 2023), https://www.healthcapital.com/hcc/newsletter/03_23/HTML/PLANS/convert_val_ma_plans_intro_competiton.php (Accessed 4/24/23).

12 Medicare Payment Advisory Commission, October 2024.

13 "Chapter 12: The Medicare Advantage program: Status report and mandated report on dual-eligible special needs plans" in "Report to the Congress: Medicare Payment Policy" Medicare Advisory Payment Commission, March 2022, available at: https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch12_SEC.pdf (Accessed 3/3/23), p. 411.

14 "Growth in Medicare Advantage Raises Concerns" By Paul N. Van de Water, Center on Budget and Policy Priorities, January 10, 2025, https://www.cbpp.org/research/health/growth-in-medicare-advantage-raises-concerns#:~:text=-MA%20plans%20are%20substantially%20overpaid,%2483%20billion%20in%20annual%20spending. (Accessed 4/17/25).

15 2026 Medicare Advantage and Part D Rate Announcement" Centers for Medicare & Medicaid Services, April 7, 2025, https://www.cms.gov/newsroom/fact-sheets/2026-medicare-advantage-and-part-d-rate-announcement (Accessed 4/17/25).

16 "CMS Finalizes 2026 Payment Policy Updates for Medicare Advantage and Part D Programs" Centers for Medicare & Medicaid Services, April 7, 2025, https://www.cms.gov/newsroom/press-releases/cms-finalizes-2026-payment-policy-updates-medicare-advantage-and-part-d-programs (Accessed 4/17/25).

17 Centers for Medicare & Medicaid Services, April 7, 2025.

18 "Trump's CMS dramatically raises payments to Medicare Advantage plans" By Rebecca Pifer, Healthcare Dive, April 8, 2025, https://www.healthcare-dive.com/news/medicare-advantage-2026-payment-rates-trump-humana-unitedhealth/744682/ (Accessed 4/17/25).

19 "Medicare Advantage Payments to Increase Again" By Jeannie Fuglesten Biniek, Kaiser Family Foundation, Quick Takes, April 9, 2025, https://www.kff.org/quick-take/medicare-advantage-payments-to-increase-again/ (Accessed 4/17/25).

20 Centers for Medicare & Medicaid Services, April 7, 2025; Pifer, Healthcare Dive, April 8, 2025.

21 Centers for Medicare & Medicaid Services, April 7, 2025.

22 *Ibid*.

23 "Democrats question Oz over Medicare Advantage advocacy, UnitedHealth stock" By Emily Olsen, Healthcare Dive, December 12, 2024, https://www.healthcaredive.com/news/democrats-criticize-oz-cms-administrator-pick-medicare-advantage-warren-wyden/735262/ (Accessed 4/17/25).

24 "Health Insurer Stocks Soar on Medicare Rate Boost" By Anna Wilde Mathews, The Wall Street Journal, April 8, 2025, https://www.wsj.com/health/healthcare/private-medicare-plans-to-get-big-payment-boost-from-trump-administration-017d9aaa?mod=health_lead_pos1&utm_source=newsletter&utm_medium=email&utm_campaign=newsletter_axiosvitals&stream=top (Accessed 4/17/25).

25 "Leaked HHS budget signals $40B in cuts, assumes ACA subsidies expire" By Noah Tong, Fierce Healthcare, April 17, 2025, https://www.fiercehealthcare.com/regulatory/hhs-budget-slashed-40-billion-first-look-hhs-reorganization-leaked-document (Accessed 4/17/25).

Regulatory Topics

Recent Court Actions Provide Insight into Future of Fraud & Abuse Laws

[Excerpted from the article published in October 2024.]

Two recent court actions may serve as harbingers for the future of healthcare fraud and abuse laws. In September 2024, a federal judge in the Southern District of West Virginia ordered parties in a *qui tam* False Claims Act and Stark Law case to brief the court on the implications of *Loper Bright Enterprises v. Raimondo* on the interpretation of the Stark Law to the case at hand.[1] That same month, a federal judge in the Middle District of Florida dismissed a *qui tam* lawsuit on a novel theory that the False Claims Act's whistleblower provisions are unconstitutional. This Health Capital Topics article discusses these cases and the potential impact on federal fraud and abuse laws.

The Stark Law prohibits physicians from referring Medicare patients to entities (such as hospitals) with which the physicians or their family members have a direct or indirect financial relationship for the provision of designated health services (DHS).[2] DHS include, but are not limited to, the following:

(1) Inpatient and outpatient hospital services;
(2) Radiology and certain other imaging services;
(3) Radiation therapy services and supplies;
(4) Certain therapy services, such as physical therapy;
(5) Durable medical equipment; and,
(6) Outpatient prescription drugs.[3]

Under the Stark Law, financial relationships include ownership interests through equity, debt, other means, and ownership interests in entities also have an ownership interest in the entity that provides DHS.[4] Additionally, financial relationships include compensation arrangements, which are defined as arrangements between physicians and entities involving any remuneration, directly or indirectly, in cash or in kind.[5]

On its face, the Stark Law may prohibit legitimate business arrangements. However, the law contains a large number of exceptions, which describe ownership interests, compensation arrangements, and forms of remuneration to which the Stark Law does not apply.[6] An arrangement must fully fall within one of the exceptions in order to be shielded from enforcement of the Stark Law.[7] Notably, "the Stark Law statutory framework is relatively skeletal and its application to many common situations is ambiguous."[8] Therefore, parties must rely on the "extensive, complex" regulations that have been developed over the past three decades to provide guidance and clarify those ambiguities.[9]

Civil penalties under the Stark Law include overpayment or refund obligations, a potential civil monetary penalty of $15,000 for each service, plus treble damages, and exclusion from Medicare and Medicaid programs.[10] Further, violation of the Stark Law can also trigger a violation of the False Claims Act (FCA), which prohibits any person from knowingly submitting, or causing to submit, false claims to the government.[11] FCA violators are liable for treble damages (i.e., "three times the government damages"), as well as a monetary penalty linked to inflation.[12] Not only does the FCA give the U.S. government the ability to pursue fraud, it also enables private citizens to file suit on behalf of the federal government through what is known as a "*qui tam,*" "*whistleblower,*" or "*relator*" suit.[13] Notably, Congress increased incentives for whistleblowers in 1986, significantly increasing the number of *qui tam* suits brought each year.[14] Both of the lawsuits noted above were originally filed under the *qui tam* provisions of the FCA, but in both cases, the government ultimately decided not to intervene.

On June 28, 2024, the U.S. Supreme Court issued a seismic decision explicitly overruling the "*Chevron* doctrine."[15] Under this doctrine, more commonly referred to as *Chevron* deference, courts were mandated to defer to a federal agency's interpretation of an ambiguous federal statute as long as it was reasonable.[16] However, the June 2024 ruling in *Loper Bright Enterprises v. Raimondo* (*Loper Bright*) has shifted the authority to interpret statutes and regulations to the courts, and placed significantly more scrutiny on executive agencies such as the Department of Health and Human Services (HHS) and their ability to implement omnibus laws passed by Congress.[17] In its decision, the Court stated that courts must determine a statute's "best reading," i.e., the "statute's meaning 'at the time of enactment" and…'the reading the court would have reached if no agency were involved.'"[18]

The question of when and how the *Loper Bright* decision will affect courts' interpretation of fraud and abuse laws will first be answered by parties in *United States ex rel. Kyer v. Thomas Health System, Inc.* (*Kyer*). An FCA case brought in the Southern District of West Virginia by a former nurse for the defendant health system broadly alleges that various direct and indirect physician compensation arrangements violated the Stark Law and Anti-Kickback Statute, giving rise to FCA liability.[19] After the Department of Justice (DOJ) declined to intervene for the time being (but reserved its "right to intervene for cause at a later time"), the relator filed her amended complaint and the defendants filed a motion to dismiss the case – all of which pleadings were filed prior to the *Loper Bright* decision.[20] On September 12, 2024, the federal district judge ordered the parties to brief the effect of *Loper Bright*, if any, on the relator's Stark Law claim, as both the amended complaint and the motion to dismiss "rely heavily" on Stark regulations.[21] The judge noted that "the Stark Law has grown complex, nuanced, and reliant on agency regulation to define key terms and safe harbors," and "under *Chevron*, federal courts could wade through Stark Law claims by deferring and defaulting to an agency's interpretation."[22] However, *Loper Bright* has made such deference unacceptable. In order to assess the relator's claims and rule on the motion to dismiss, the court must determine "the contours of the [Stark] statute…without blindly deferring to any agency interpretation."[23]

In response to the judge's order, both parties argued similarly – that the relator's Stark Law claim can be decided without deferring to an agency interpretation of the law – but for different reasons. The relator argues that the amended complaint does not challenge an agency action, so *Loper Bright* would not be implicated at this stage. Further, the relator asserts that the amended complaint sufficiently alleges that the defendants had a compensation arrangement involving remuneration with physicians, the exact action policed by the plain language of the Stark Law statute.[24] On the other hand, the defendants argue that "[t]his Court can determine – from the Stark Law itself – that relator has not stated a claim upon which relief may be granted."[25]

Meanwhile, on September 30, 2024 a judge in the Middle District of Florida dismissed an FCA whistleblower case. In *United States ex rel. Zafirov v. Florida Medical Associates, LLC*, a former physician of the defendant medical practice alleged that the defendant had misrepresented patient diagnoses to Medicare in seeking reimbursement (i.e., they filed false claims). Notably, the DOJ declined to intervene in the case. Subsequently, the defendants moved for a judgment on the pleadings.[26] In its motion, the defendants argued in part that the FCA's "*qui tam* provisions empower relators to act as officers of the United States without being duly appointed, violating the Appointments Clause of Article II of the U.S. Constitution."[27] The judge agreed, reasoning that relators are Officers of the United States (as defined by the constitution and the Supreme Court) because they "possess[] civil enforcement authority on behalf of the United States…and the position mirrors the role of a bank receiver or special prosecutor in its duration and non-personal nature." Because the relators are Officers occupying a continuing position established by law, they are consequently subject to the constitution's Appointments Clause.[28] While this is the first federal court decision finding the FCA *qui tam* provisions unconstitutional,[29] it is not a wholly novel concept or argument. First, although the FCA was enacted over 160 years ago during the Civil War, "the widespread use of the FCA *qui tam* provision appears to be of relatively modern vintage."[30] Second, the arguments utilized in the defendants' motion and the court's decision echo a U.S. Supreme Court dissent issued in 2023. In *US ex rel. Polansky v. Executive Health Resources Inc.*, Justice Thomas questioned the constitutionality of the FCA's *qui tam* provision: "There are substantial arguments that the *qui tam* device is inconsistent with Article II and that private relators may not represent the interests of the United States in litigation."[31] Justices Kavanaugh and Barrett concurred, indicating that at least three Supreme Court justices may be open to visiting the circuit split that now exists as a result of the ruling of Judge Kathryn Kimball Mizelle who, notably, clerked for Justice Thomas.[32] In fact, Judge Mizelle's decision breaks from a number of other federal circuits.[33] It is expected that the decision will be appealed to the Eleventh Circuit.

By themselves, either of these cases are groundbreaking news, representing a significant potential change in the interpretation, and adjudication, of fraud and abuse laws. Taken together, however, these cases could be the harbingers of paradigm shifts in federal fraud and abuse enforcement. Over 75% of all FCA cases are brought by relators, and in approximately 10% of those cases, the government declines to intervene.[34] If the Supreme Court ultimately ruled the FCA's *qui tam* provision to be unconstitutional, those cases would likely never be adjudicated; while the federal government could potentially choose to stay on those cases in which it might otherwise have declined to intervene, resource constraints render that option improbable. The impact of *Loper Bright* on Stark and other complex federal healthcare laws reliant on agency regulation is yet unknown. But Judge Joseph Goodwin of the Southern District of West Virginia rightly forecasts that "[i]nevitably, *Loper Bright* will begin to ripple through the Stark Regulations. The only question for courts is when and how."[35] Certainly, the burden placed on the government if every case involving the Stark Law must rest upon a complete *de novo* consideration of the regulations implicated in the case could force the DOJ to reduce its workload. In other words, depending on the ultimate outcome of these cases, these potential trends could ultimately result in reduced regulatory enforcement.

1 United States of America ex rel. Liesa Kyer, v. Thomas Health System, Inc., et al., Case No. 2:20-cv-00732, Order (S.D. W.Va. September 12, 2024) ECF Doc. 63, available at: https://www.wvsd.uscourts.gov/sites/wvsd/files/opinions/2-20-cv-732.pdf (Accessed 10/9/24).

2 "CRS Report for Congress: Medicare: Physician Self-Referral ("Stark I and II")" By Jennifer O'Sullivan, Congressional Research Service, The Library of Congress, July 27, 2004, available at: http://www.policyarchive.org/handle/10207/bitstreams/2137.pdf (Accessed 6/13/24); "Limitation on certain physician referrals" 42 USC § 1395nn.

3 42 USC § 1395nn(a)(1)(B); "Definitions" 42 CFR § 411.351.

4 42 USC § 1395nn(a)(2).

5 42 USC § 1395nn(h)(1).

6 42 USC § 1395nn.

7 "Comparison of the Anti-Kickback Statute and Stark Law" Health Care Fraud Prevention and Enforcement Action Team (HEAT) Office of Inspector General (OIG), https://oig.hhs.gov/documents/provider-compliance-training/939/StarkandAKSChartHandout508.pdf (Accessed 6/13/24).

8 "The Future of the Stark Law is Clouded by Uncertainty" By Charles B. Oppenheim, et al., Hooper Lundy Bookman, September 19, 2024, https://hooperlundy.com/the-future-of-the-stark-law-is-clouded-by-uncertainty/ (Accessed 10/14/24).

9 *Ibid*.

10 42 USC § 1395nn(g).

11 "The False Claims Act" U.S. Department of Justice, February 2, 2022, https://www.justice.gov/civil/false-claims-act (Accessed 1/3/24).

12 *Ibid*.

13 *Ibid*.

14 "False Claims Act Settlements and Judgments Exceed $2.68 Billion in Fiscal Year 2023" Office of Public Affairs, U.S. Department of Justice, Press Release, February 22, 2024, https://www.justice.gov/opa/pr/false-claims-act-settlements-and-judgments-exceed-268-billion-fiscal-year-2023 (Accessed 10/15/24).

15 "Loper Bright Enterprises, et al. v. Raimondo, Secretary of Commerce, et al." Supreme Court of the United States, June 28, 2024, https://www.supremecourt.gov/opinions/23pdf/22-451_7m58.pdf (Accessed 7/12/24); "Supreme Court strikes down Chevron, curtailing power of federal agencies" By Amy Howe, SCOTUSblog, June 28, 2024, https://www.scotusblog.com/2024/06/supreme-court-strikes-down-chevron-curtailing-power-of-federal-agencies/ (Accessed 7/12/24).

16 "Supreme Court strikes down Chevron, curtailing power of federal agencies" By Amy Howe, SCOTUSblog, June 28, 2024, https://www.scotusblog.com/2024/06/supreme-court-strikes-down-chevron-curtailing-power-of-federal-agencies/ (Accessed 7/12/24).

17 "Supreme Court Decision Limiting the Authority of Federal Agencies Could Have Far-Reaching Impacts for Health Policy" By Kaye Pestaina, Michelle Long, and Justin Lo, Kaiser Family Foundation, July 1, 2024, https://www.kff.org/private-insurance/issue-brief/supreme-court-decision-limiting-the-authority-of-federal-agencies-could-have-far-reaching-impacts-for-health-policy/ (Accessed 7/12/24).

18 "US ex rel. Kyer v. Thomas Health System, Inc. et al." No. 2:20-cv-00732, Defendant's Brief Addressing Loper Bright's Effect on the Stark Law and Relator's Claims (S.D.W.Va. Mar. 12, 2024), p. 3 (citing "Loper Bright Enterprises, et al. v. Raimondo, Secretary of Commerce, et al." 144 S.Ct. 2244, 2266 (Jun. 28, 2024)).

19 "US ex rel. Kyer v. Thomas Health System, Inc. et al." No. 2:20-cv-00732, First Amended Complaint and Demand for Jury Trial (S.D.W.Va. Mar. 12, 2024).

20 "Stark Law Comes under Loper Bright Spotlight" By Samantha Groden and Christopher Janney, Dentons on Call, September 19, 2024, https://www.dentonshealthlaw.com/stark-law-comes-under-loper-bright-spotlight/#5a9b983a-463c-4698-82d7-00f2d6a97af9-link (Accessed 10/14/24).

21 No. 2:20-cv-00732, Order (S.D.W.Va. Sept. 12, 2024).

22 *Ibid*, p. 1, 7-8.

23 *Ibid*, p. 2.

24 *Ibid*, p. 8.

25 *Ibid*, p. 11.

26 "A motion for judgment on the pleadings…is designed to dispose of cases before trial where the material facts are not in dispute and a judgment on the merits can be rendered by looking to the substance of the pleadings and any judicially noticed facts.…This motion is similar to a motion to dismiss for failure to state a claim, but it is filed after the pleadings are closed." "Litigation, Overview - Motion for Judgment on the Pleadings" Bloomberg Law, https://www.bloomberglaw.com/external/document/XEITU4AO000000/litigation-overview-motion-for-judgment-on-the-pleadings (Accessed 10/15/24).

27 "Foley Secures Precedent-Setting Victory in Constitutional Challenge to the False Claims Act's Qui Tam Provisions" Foley & Lardner LLP, October 3, 2024, https://www.foley.com/news/2024/10/foley-secures-precedent-setting-victory-in-constitutional-challenge-to-the-false-claims-acts-qui-tam-provisions/ (Accessed 10/14/24).

28 "US ex rel. Zafirov v. Florida Medical Associates, LLC, et al." Case No. 8:19-cv-01236-KKM-SPF, Order (M.D. Fla. Sept. 30, 2024), available at: https://storage.courtlistener.com/recap/gov.uscourts.flmd.364103/gov.uscourts.flmd.364103.346.0.pdf (Accessed 10/14/24), p. 16-17, 30.

29 Foley & Lardner LLP, October 3, 2024.

30 Case No. 8:19-cv-01236-KKM-SPF, Order (M.D. Fla. Sept. 30, 2024), p. 45-47.

31 "US ex rel. Polansky v. Executive Health Resources Inc." Case No. 21-1052, Slip Opinion (S.Ct. Jun. 16, 2023), available at: https://www.supremecourt.gov/opinions/22pdf/21-1052_fd9g.pdf (Accessed 10/14/24).

32 "False Claims Act Insights - Are the FCA's Qui Tam Provisions Unconstitutional? One Federal Judge Says 'Yes'" Podcast by Jonathan A. Porter, Jody L. Rudman and Lorinda G. Holloway, Husch Blackwell, October 9, 2024, https://www.huschblackwell.com/newsandinsights/false-claims-act-insights-are-the-fcas-qui-tam-provisions-unconstitutional-one-federal-judge-says-yes (Accessed 10/14/24).

33 See, e.g., "Riley v. St. Luke's Episcopal Hospital" 252 F.3d 749, 758 (5th Cir. 2001); "US ex rel. Lagatta v. Reditus Laboratories, LLC" Case No. 1:22-CV-01203, 2024 WL 4351862 (C.D. Ill. Sept. 30, 2024); "US ex rel. Wallace v. Exactech, Inc." 703 F. Supp. 3d 1356 (N.D. Ala. 2023); "US ex rel. Miller v. ManPow, LLC" Case No. 2:21-cv-05418-VAP-ADSx, 2023 WL 8290402, at *1 (C.D. Cal. Aug. 30, 2023); "US ex rel. Thomas v. Care" Case No. CV-22-00512-PHX-JAT, 2023 WL 7413669, at *4 (D. Ariz. Nov. 9, 2023); "US ex rel. CLJ, LLC v. Halickman" Case No. 20-cv-80645, 2024 WL 3332055, at *21 n. 5 (S.D. Fla. Jun. 14, 2024); "US ex rel. Butler v. Shikara" 2024 WL 4354807, at *10-13 (S.D. Fla. Sept. 6, 2024).

34 "FRAUD STATISTICS – OVERVIEW: October 1, 1986 - September 30, 2023: Civil Division, U.S. Department of Justice" available at: https://www.justice.gov/opa/media/1339306/dl?inline (Accessed 10/15/24).

35 No. 2:20-cv-00732, Order (S.D.W.Va. Sept. 12, 2024), p. 8.

OIG Recommends Higher Scrutiny of RPM

[Excerpted from the article published in October 2024.]

On September 24, 2024, the Office of Inspector General (OIG) of the Department of Health & Human Services (HHS) issued a report recommending additional oversight of remote patient monitoring (RPM).[1] This Health Capital Topics article reviews the report and discusses industry reactions.

RPM, also called remote physiologic monitoring, "is the use of digital devices to monitor a patient's health."[2] RPM allows a patient to collect physiologic data, such as their blood pressure, heart rate, or glucose levels, via a digital device, which data is automatically transmitted to the healthcare provider in order to (remotely) monitor and treat a patient's chronic and acute conditions.[3] RPM, a type of telehealth that Medicare began covering in 2018, is comprised of three components, with each component building off the one before it:

- Patient education and device setup (CPT code 99453);
- Device supply (CPT code 99454); and
- Treatment management (CPT codes 99091, 99457, or 99458).[4]

RPM has been used to monitor chronic conditions including cardiac diseases (e.g., through blood pressure monitors, Holter monitors), diabetes (e.g., through blood glucose meters), and asthma (e.g., through handheld spirometers, oximeters).[5] Most Medicare patients who receive RPM utilize it to monitor/treat hypertension (high blood pressure).[6] In practice, an RPM lifecycle may look as follows: a patient has high blood pressure, such that the patient's healthcare provider determines RPM to be medically necessary; the patient is provided a connected blood pressure cuff and is educated by their provider on how to use the cuff; the patient regularly uses the device to obtain blood pressure readings, which readings are automatically transmitted by the cuff to the provider; and the provider reviews the provided data, determines the patient's treatment, and communicates with the patient.[7]

Studies have found RPM to be "a significant factor that improved or maintained the quality of care" and beneficial in managing "chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF), resulting in fewer emergency department visits, hospital readmission avoidance, and reduced hospital length of stay."[8] RPM usage accelerated during the COVID-19 public health emergency – between 2019 and 2022, the number of Medicare beneficiaries utilizing RPM increased from 55,000 to 570,000 patients, an over tenfold increase.[9] During the same timeframe, Medicare payments for RPM increased by more than twentyfold, from just $15 million in 2019 to $311 million in 2022; on a per-enrollee basis, payments doubled, from $266 in 2019 to $545 in 2022.[10] OIG reported that the payment increase was partially due to the increased length of time patients received RPM services.[11]

OIG's report, which examined RPM claims between 2019 and 2022, focuses on three main issues: (1) providers failing to use RPM as intended; (2) fraud and abuse concerns related to RPM; and (3) a lack of information related to the use of RPM for Medicare patients. First, OIG found that approximately 43% of Medicare RPM recipients did not receive at least one of the three components. While OIG acknowledged that the Centers for Medicare & Medicaid Services (CMS) does not require providers to bill for all three components, because the components build off of one another, OIG questioned whether RPM "services are being used as intended."[12] The component least often billed was the first component – patient education and device setup. In order to bill, and be reimbursed, for this component, the patient must receive education about how to use the device or support setting it up; receive a connected device from their provider; or take/transmit health data readings on at least 16 days in a given month.[13] Additionally, 12% of Medicare beneficiaries did not receive treatment management, i.e., at least 20 minutes of management services for a patient's treatment plan, including at least one conversation between the patient and provider, raising questions as to whether RPM was necessary to treat the patient's condition.[14]

Second, OIG reiterated its previously-raised concerns about fraud in RPM, citing its November 2023 Consumer Alert.[15] In that Alert, OIG expressed concern related to Medicare patients being recruited to receive medically unnecessary RPM services. For example, companies were reportedly "cold calling" patients with whom they had no established patient-provider relationship to market their provision of RPM services.[16]

Third, OIG found that "Medicare lacks key information for oversight of [RPM]."[17] Medicare does not receive any information about the types of health data being collected or the devices used and does not always receive information related to the specific condition being treated/monitored or who ordered/performed the RPM services.[18] This lack of transparency creates oversight challenges.

In conclusion, the OIG made the following recommendations to strengthen RPM oversight:

- "Implement additional safeguards to ensure that remote patient monitoring is used and billed appropriately in Medicare";
- "Require that remote patient monitoring be ordered and that information about the ordering provider be included on claims and encounter data for remote patient monitoring";
- "Develop methods to identify what health data are being monitored";
- "Conduct provider education about billing of remote patient monitoring"; and
- "Identify and monitor companies that bill for remote patient monitoring."[19]

CMS "concurred with" recommendations 1, 4, and 5 and "stated that it would take into consideration" recommendations 2 and 3.[20]

Healthcare industry stakeholders pushed back on the OIG report, asserting the report's claims were "confusing, inaccurate and could jeopardize the future of the [RPM] service.[21] In particular, the Alliance for Connected Care, which advocates for telehealth and RPM on behalf of healthcare and technology organizations, sent a letter asking OIG to consider retracting its report and revising it to "more accurately reflect the way that RPM services are required to be delivered in Medicare."[22] Among the inaccuracies claimed by the Alliance and other stakeholders is OIG's conclusion that RPM services "are not being used as intended since patients may not have received all three components of monitoring…based on claims reviewed," listing a number of reasons why a patient may not bill for one of the RPM components.[23] Another stakeholder reasoned that some conditions, such as obesity, do not require 16 days of monitoring each month.[24] While OIG asserts that, per CMS commentary in the 2021 Medicare Physician Fee Schedule (MPFS), the agency "considers the RPM codes a family of codes that should be billed together," the Alliance for Connected Care noted that CMS overruled this consideration in the 2024 MPFS commentary, with the agency clarifying in the final rule that "the 16 day data collection requirement does not apply to CPT codes 99457, 99458, 98980, and 98981. These CPT codes are treatment management codes that account for time spent in a calendar month and do not require 16 days of data collection in a 30-day period."[25]

In a subsequent interview, OIG asserted that the goal of the report was to "raise areas of concern" for CMS and clarified that the report does not assert that fraud is occurring in RPM, but that some of the billing patterns raise questions that need to be addressed to prevent misuse.[26]

Notably, efforts have been underway for years to overhaul the RPM CPT codes, now that the codes have been in use long enough to inform next steps. Some of the efforts include reducing the 16-day reporting requirement and provide an option to bill for less than 15 days of collection (probably at a lower rate), as well as decreasing the patient communication threshold from 20 minutes to 10.[27]

With the rapid increase in the provision of RPM services has come increased regulatory scrutiny, first with the Consumer Alert, and then with an OIG report. Health lawyers predict continued, and perhaps increased, oversight and enforcement going forward.[28]

---

1 "Additional Oversight of Remote Patient Monitoring in Medicare Is Needed" Department of Health and Human Services Office of Inspector General, September 2024, OEI-02-23-00260, available at: https://oig.hhs.gov/documents/evaluation/10001/OEI-02-23-00260.pdf (Accessed 10/21/24).

2 "Telehealth and Remote Patient Monitoring" Telehealth.HHS.gov, last updated August 28, 2024, https://telehealth.hhs.gov/providers/best-practice-guides/telehealth-and-remote-patient-monitoring#:~:text=Remote%20patient%20monitoring%20is%20the,and%20provider %2C%20and%20patient%20engagement. (Accessed 10/21/24).

3 "OIG report recommends increased oversight of Medicare's reimbursement for Remote Patient Monitoring (RPM)" By Harsh Parikh, Adam Tarosky and Andrew Maglione, Nixon Peabody, October 8, 2024, https://www.nixonpeabody.com/insights/alerts/2024/10/08/oig-report-recommends-increased-oversight-of-medicares-reimbursement-for-remote-patient-monitoring (Accessed 10/21/24).

4 Department of Health and Human Services Office of Inspector General, September 2024, p. 20.

5 "Remote Patient Monitoring" By Colton Hood, MD, MBI, et al., Patient Safety Network, March 15, 2023, https://psnet.ahrq.gov/perspective/remote-patient-monitoring (Accessed 10/21/24).

6 Department of Health and Human Services Office of Inspector General, September 2024, p. 3.

7 *Ibid*.

8 "Remote Patient Monitoring" By Colton Hood, MD, MBI, et al., Patient Safety Network, March 15, 2023, https://psnet.ahrq.gov/perspective/remote-patient-monitoring (Accessed 10/21/24).

9 "Remote Patient Monitoring During COVID-19: An Unexpected Patient Safety Benefit" By Peter J. Pronovost, et al., Journal of the American Medical Association, Vol. 327, No 12 (2022), https://jamanetwork.com/journals/jama/fullarticle/2789635 (Accessed 10/21/24); Nixon Peabody, October 8, 2024.

10 Department of Health and Human Services Office of Inspector General, September 2024, p. 5-6.

11 *Ibid*, p. 6.

12 *Ibid*, p. 9.

13 *Ibid*.

14 *Ibid*, p. 10.

15 *Ibid*.

16 Nixon Peabody, October 8, 2024.

17 Department of Health and Human Services Office of Inspector General, September 2024, p. 11.

18 *Ibid*, p. 12.

19 *Ibid*, p. 2.

20 *Ibid*, p. 2; Nixon Peabody, October 8, 2024.

21 "HHS watchdog flags potential remote monitoring fraud. Stakeholders say concerns about misuse are overblown" By Emma Beavins, Fierce Healthcare, September 24, 2024, https://www.fiercehealthcare.com/regulatory/hhs-watchdog-calls-out-rpm-fraud-stakeholders-say-oig-doesnt-understand-codes (Accessed 10/21/24).

22 Letter from Krista Drobac, Alliance for Connected Care, to Ms. Christi Grimm, Inspector General, dated September 24, 2024, available at: https://connectwithcare.org/wp-content/uploads/2024/09/Alliance-Letter-to-HHS-OIG-on-RPM-Report-September-24-2024-1.pdf (Accessed 10/21/24).

23 *Ibid*.

24 Beavins, Fierce Healthcare, September 24, 2024.

25 "Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program: Final rule" Federal Register Vol. 88, No. 220 (November 16, 2023), p. 78884.

26 Beavins, Fierce Healthcare, September 24, 2024.

27 *Ibid*.

28 Nixon Peabody, October 8, 2024.

Where the Candidates Stand on Healthcare

[Excerpted from the article published in October 2024.]

With the Presidential Election just weeks away, healthcare has once again come front and center of national political discourse, as voters rank healthcare as an important issue,[1] and Vice President Kamala Harris and former President Donald Trump tout their respective healthcare agendas. While details related to future healthcare proposals have been light, both candidates do have political track records that can be examined for clues as to their priorities should they become president. This Health Capital Topics article explores where the candidates stand on various issues related to healthcare.

Healthcare reform in the U.S. became a highly politicized concept in the 20th century. In the 21st century, several issues brought healthcare to the forefront of both consumer and political discourse, which led to the passage of the 2010 *Patient Protection and Affordable Care Act* (ACA), including the persistent disproportionate rise in the cost of healthcare, the perceived disproportionate breakdown of healthcare costs across industry segments, the socioeconomic disparities in access and quality, the falling rank of U.S. health status as compared to other developed nations, and the perceived threats of budget deficits and national debt related to the cost of care for the aging Baby Boomer population. As summarized by Professor Paul Starr:

"The search for a remedy to America's problems in health care has turned into a peculiarly arduous struggle – peculiar in its duration, its rancor, and its salience and centrality in national politics. Other democracies long ago resolved whether they have an obligation to provide care for the sick and protection against medical costs. For a century the United States has been fighting over that issue, and instead of subsiding, the disagreements have intensified and at times shaken the political arena."[2]

On the whole, the two presidential candidates are "polar opposites" in their views of the government's role in healthcare and how to address healthcare spending.[3] In general, Harris has focused on expanding healthcare coverage and affordability, while Trump has stressed reducing government spending.[4]

The ACA

During the Trump Administration, Republican legislators were unsuccessful in their attempted repeal of the ACA, but did pass a bill negating the penalty for noncompliance with the Individual Mandate.[5] However, a public may be far less receptive to a full ACA repeal, as the law has grown in popularity over the past decade, with 62% of adults having a favorable view of the ACA as of April 2024.[6] Trump has stated he would replace the ACA only if there was a better alternative, but to date has provided no detail regarding any potential alternative.[7] Harris, on the other hand, has pledged to protect, and expand, the ACA. This is a step back from her support for a "Medicare for All" plan during her Democratic presidential campaign in 2019, which a spokesperson has since stated she "will not push…as president."[8] In particular, Harris has proposed permanently extending ACA marketplace premium subsidies that are currently set to expire in December 2025.[9] Additionally, Harris supports an increase on taxes for Americans earning over $400,000 annually to support Medicare solvency.[10]

Healthcare Costs

Both Trump and Harris seem interested in decreasing the costs of prescription drugs, but their approaches in achieving that goal would likely diverge. In 2020, Trump signed multiple executive orders that, among other things, allowed pharmacies and wholesalers to import drugs from Canada and attempted to force pharmacy benefit managers (PBMs) to pass large discounts to beneficiaries.[11] Later in 2020, Trump signed into law the *No Surprises Act*, which seeks to protect patients from unexpected out-of-network medical bills; the Biden Administration implemented the law and even enacted stronger penalties for noncompliance.[12] During her 2019 campaign, Harris similarly proposed allowing the Department of Health & Human Services (HHS) the authority to use international reference prices to set the prices of various drugs, which would reduce the prices for those drugs at lower prices in other developed countries.[13] As Vice President, Harris cast the tie-breaking vote on the *Inflation Reduction Act* (IRA), which allowed HHS to negotiate prices for select drugs for the first time ever and capped insulin prices for Medicare beneficiaries at $35 per month and Plan D prescription drug out-of-pocket costs at $2,000 per year;[14] Trump has stated his desire to roll back the IRA.[15] Further, Harris supports extending these drug cost protections to non-Medicare beneficiaries.[16]

Medicaid

Harris has worked during her vice presidency to encourage states to adopt the postpartum Medicaid coverage extension (increased from two months to 12), included in the *American Rescue Plan Act*, in an effort to reduce maternal mortality and morbidity; as of August 1, 2024, 46 states and the District of Columbia have implemented the 12-month extension, and two additional states plan to implement it.[17] Additionally, Harris is expected to work on expanding Medicaid in the last ten states that have not yet expanded.[18] During his presidency, Trump proposed restructuring Medicaid financing into a block grant or per capita cap; he also proposed limiting Medicaid eligibility and benefits.[19] None of these proposals, which would have cut Medicaid spending approximately $1 trillion over 10 years, ultimately moved forward.[20] Additionally, the Trump Administration approved Medicaid work requirements in some states, which were subsequently withdrawn by the Biden Administration.[21] During COVID-19, Trump signed legislation that required Medicaid programs to keep beneficiaries enrolled for the duration of the public health emergency in exchange for increased funding.[22]

Conclusion

With the election currently a dead heat, the issues considered most important to voters on Election Day, and the candidates' stance on those issues, may be what wins the presidency. A May 2024 poll found that 48% of Republicans and 65% of Democrats believe that the affordability of healthcare is a very big problem in the U.S.; notably, this "concern tops illegal immigration, the federal budget deficit, gun violence, and drug addiction."[23] As of September 2024, 67% of adults believed that healthcare is not receiving enough attention thus far during the 2024 presidential campaign, and only 27% believe it's receiving the right amount of attention.[24] The same poll found that a "candidate's position on protecting Medicare and Social Security is either the single most important or among the most important healthcare-related issues in determining nearly two-thirds of Americans' votes in the upcoming election."[25] Also top of voters' minds is reducing the cost of healthcare (57% ranked it as the single most important/among the most important healthcare issue), lowering drug costs (47%), and policies related to mental health access (43%).[26]

---

1 60% of polled Americans stated that reducing healthcare costs should be a top priority for the president and Congress to address in 2024, the fourth highest ranked priority. "State of the Union 2024: Where Americans stand on the economy, immigration and other key issues" By Anna Jackson, Pew Research Center, March 7, 2024, https://www.pewresearch.org/short-reads/2024/03/07/state-of-the-union-2024-where-americans-stand-on-the-economy-immigration-and-other-key-issues/ (Accessed 10/15/24).

2 "Remedy and Reaction" By Paul Starr, New Haven, CT: Yale University Press, 2012, p. 279-280.

3 "Your guide to the presidential candidates' views on healthcare" By Emily Alpert Reyes, Los Angeles Times, October 9, 2024, https://www.latimes.com/politics/story/2024-10-03/2024-election-harris-trump-healthcare-voter-guide (Accessed 10/15/24).

4 *Ibid*.

5 "Compare the Candidates on Health Care Policy" Kaiser Family Foundation, October 8, 2024, https://www.kff.org/compare-2024-candidates-health-care-policy/ (Accessed 10/16/24).

6 "Where Harris and Trump Stand on Top Issues in Healthcare" By Shannon Firth, MedPage Today, August 13, 2024, https://www.medpagetoday.com/washington-watch/electioncoverage/111499 (Accessed 10/15/24); "KFF Health Tracking Poll: The Public's Views on the ACA" Kaiser Family Foundation, May 15, 2024, https://www.kff.org/interactive/kff-health-tracking-poll-the-publics-views-on-the-aca/#?response=Favorable--Unfavorable&aRange=all (Accessed 10/15/24).

7 Reyes, Los Angeles Times, October 9, 2024.

8 *Ibid*; "Where Harris and Trump Stand on Top Issues in Healthcare" By Shannon Firth, MedPage Today, August 13, 2024, https://www.medpagetoday.com/washington-watch/electioncoverage/111499 (Accessed 10/15/24).

9 Reyes, Los Angeles Times, October 9, 2024.

10 "Where Harris and Trump Stand on Top Issues in Healthcare" By Shannon Firth, MedPage Today, August 13, 2024, https://www.medpagetoday.com/washington-watch/electioncoverage/111499 (Accessed 10/15/24).

11 "Trump Signs Executive Orders On Drug Prices" By Sydney Lupkin, National Public Radio, July 24, 2020, https://www.npr.org/2020/07/24/895290378/trump-signs-executive-orders-on-drug-prices (Accessed 10/15/24).

12 Reyes, Los Angeles Times, October 9, 2024.

13 "Kamala Harris's plan to reduce prescription drug costs, explained" By Li Zhou, Vox, July 16, 2019, https://www.vox.com/2019/7/16/20696192/kamala-harris-plan-prescription-drug-costs (Accessed 10/15/24).

14 Firth, MedPage Today, August 13, 2024.

15 "Harris Backs Slashing Medical Debt. Trump's 'Concepts' Worry Advocates." By Noam Levey, KFF Health News, National Public Radio, October 16, 2024, https://www.npr.org/sections/shots-health-news/2024/10/16/nx-s1-5153930/medical-debt-relief-kamala-harris-donald-trump-campaign (Accessed 10/16/24).

16 Firth, MedPage Today, August 13, 2024.

17 "Medicaid Postpartum Coverage Extension Tracker" Kaiser Family Foundation, August 1, 2024, https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/ (Accessed 10/16/24).

18 Firth, MedPage Today, August 13, 2024.

19 "Compare the Candidates on Health Care Policy" Kaiser Family Foundation, October 8, 2024, https://www.kff.org/compare-2024-candidates-health-care-policy/ (Accessed 10/16/24).

20 *Ibid*.

21 Reyes, Los Angeles Times, October 9, 2024.

22 Kaiser Family Foundation, October 8, 2024.

23 "Wide partisan gaps in views of most national problems, from inflation and illegal immigration to gun violence and climate change" Pew Research Center, May 23, 2024, https://www.pewresearch.org/politics/2024/05/23/publics-positive-economic-ratings-slip-inflation-still-widely-viewed-as-major-problem/pp_2024-5-23_economy_00-02/ (Accessed 10/16/24); "Harris-Walz Ticket Sharpens Contrast With Trump-Vance on Health Care" By Stephanie Armour, KFF Health News, August 19, 2024, https://kffhealthnews.org/news/article/harris-walz-ticket-health-policy-contrast-trump-vance-dnc/ (Accessed 10/16/24).

24 "The healthcare issues voters care about most, in 5 charts" The Advisory Board, October 7, 2024, https://www.advisory.com/daily-briefing/2024/10/07/healthcare-issues (Accessed 10/15/24).

25 *Ibid*.

26 *Ibid*.

Looking into the Crystal Ball: 2025 Healthcare Industry Outlook

[Excerpted from the article published in December 2024.]

With a (kind of) new presidential administration entering the White House in January 2025, and many other changes on the horizon, the healthcare industry is poised for significant industry transformation in the New Year.[1] This Health Capital Topics article reviews those anticipated changes from Washington that will affect the healthcare industry in 2025.

President Trump Re-Takes Washington

Donald Trump was elected to a second, non-consecutive presidential term in November 2024. Since his election victory, he has named a number of his choices to lead the nation's federal healthcare agencies, which indicate his healthcare priorities for the next four years.

President-Elect Trump has tapped Robert F. Kennedy Jr., an environmental lawyer and politician who has no healthcare or medical background, to serve as secretary of the Department of Health & Human Services (HHS). While Kennedy is a pharmaceutical industry critic and founder of a prominent anti-vaccine group, his views on Medicare, Medicaid, and the *Patient Protection and Affordable Care Act* (ACA) are largely unknown.[2] During his own presidential run, Kennedy discussed enforcing mental health parity laws on insurers, improving Black maternal health, and aligning U.S. drug prices with those in other developed countries.[3] A list of other priorities Kennedy has mentioned include:

(1) "Making America Healthy Again";
(2) Conducting additional studies on vaccines;
(3) Reexamine federal vaccine recommendations for children;
(4) Removing fluoride from public drinking water;
(5) Cracking down on food dyes;
(6) Removing ultra-processed food from school cafeterias; and
(7) Increasing access to raw (i.e., unpasteurized) milk.[4]

In addition, former cardiothoracic surgeon, Columbia University professor, television personality, and (more recently) politician Dr. Mehmet Oz has been tapped to lead the Centers for Medicare & Medicaid Services (CMS). Dr. Oz is a longtime Medicare Advantage (MA) proponent who campaigned on expanding MA to the greater population during his 2022 Senate run.[5] He also promised to work on reducing prescription drug prices.[6] In his statement announcing the pick, President-Elect Trump asserted that Dr. Oz will crack down on healthcare "waste and fraud."[7]

Notably, these appointees still must be confirmed by the Senate (which first requires the Senate Finance Committee to recommend the candidate to the Senate), unless the president-elect convinces incoming Senate Majority Leader John Thune (R-S.D) to greenlight him to make temporary recess appointments, which can substantially delay hearings, and allow the appointees to lead the departments in the meantime. Both Kennedy's and Oz's confirmation prospects are currently uncertain.[8]

Beyond his cabinet secretary appointments, President-Elect Trump has been fairly vague on his own healthcare priorities. It is safe to predict that certain Biden Administration regulations will be rolled back, including those related to public health, the ACA, and reproductive health.[9] Industry analysists also anticipate that the incoming Trump Administration will be pro-MA. Trump was bullish on MA during his first presidential term, and may reduce the additional scrutiny MA plans received during the Biden Administration.[10]

Legislative Landscape

Congress failed to pass any major healthcare legislation in 2024 (likely due to it being a presidential election year), despite several bills being proposed. Significant legislation could be passed in 2025, including bills related to telehealth, the Medicare Physician Fee Schedule (MPFS), artificial intelligence (AI), and pharmacy benefit managers (PBMs).

As noted in another article in this month's issue,[11] Congress passed a continuing resolution on December 21, 2024. This short-term funding bill kicks the can down the road on a number healthcare priorities, providing Congress time to decide on permanent extensions to Medicare telehealth coverage, among other issues.

Many Capitol Hill observers expect 2025 may be the year that the MPFS is finally reformed. When adjusted for inflation, MPFS reimbursement has declined 29% since 2001.[12] Similarly, Medical Group Management Association (MGMA) data on physician practices indicate that total operating cost per full-time equivalent (FTE) physician increased by more than 63% between 2013 and 2022, while the MPFS conversion factor increased by only 1.7% over the same timeframe.[13] The 2025 MPFS marks the fifth straight year of reimbursement cuts; Congress has stepped in the last four years to mitigate those cuts.[14] Provider associations have been lobbying for a more comprehensive overhaul of physician payment updates, to avoid annual end-of-the-year overrides. In response, some legislative bills were introduced in 2024. The *Physician Fee Stabilization Act* would increase Medicare's budget neutrality threshold for the first time since 1992, from $20 million to $53 million, and automatically increase every five years thereafter.[15] Another, similar proposal suggests tying the MPFS update to the Medicare Economic Index (MEI).[16] With a number of physician congressmen nearing retirement, it is anticipated that they may push their colleagues to pass legislation before they leave Washington.[17]

In November 2024, the Senate Commerce Committee's Subcommittee on Consumer Protection, Product Safety, and Data Security held a hearing on "Protecting Consumers from Artificial Intelligence Enabled Fraud and Scams," wherein witnesses testified about how AI enables fraud and scams.[18] Senators seemed focused on how federal laws can be crafted to curb these issues. During the hearing, five AI bills currently floating around Capitol Hill were discussed, including:

(1) The *Future of AI Innovation Act*, which would establish the Artificial Intelligence Safety Institute and create non-mandatory AI standards and guidelines;

(2) The *VET Artificial Intelligence Act*, which would the development of "voluntary guidelines and specifications" for AI assurance;

(3) The *Artificial Intelligence Research, Innovation, and Accountability Act (ARIA)*, which would authorize research on "content provenance and authentication for human and AI-generated works" and federal "statutory, regulatory, and policy barriers to the use of AI," as well as formalize standard definitions of common AI terms, require disclosures regarding the use of AI, and require certain reporting for "high-impact" AI systems;

(4) *The Content Origin Protection and Integrity from Edited and Deepfaked Media* Act (The COPIED Act), which would develop standards for AI-generated content detection, establish AI disclosure requirements, and forbid the unauthorized use of copyrighted content in training AI models; and

(5) *The Tools to Address Known Exploitation by Immobilizing Technological Deepfakes on Websites and Networks Act (The TAKE IT DOWN Act)*, which would outlaw the publication of non-consensual intimate imagery (including some deepfakes) and require social media companies to develop processes for removing such imagery.[19]

Which of these bills (or some other AI bill) may move forward in Congress is currently indeterminate, but there is bipartisan support to address AI, indicating some momentum on the issue heading into 2025.

Similarly, there is strong desire among lawmakers across the aisle to break up PBMs. The short-term spending bill includes a number of provisions to increase transparency and reporting and change the way PBMs are paid.[20] These changes add to the mounting opposition to PBMs. President-Elect Trump recently stated his interest to remove PBMs and recently-released legislation would require companies that own health insurance plans or PBMs to divest of those assets; if passed, this would force the breakup of UnitedHealth Group, CVS Health, and Cigna.[21]

The *Tax Cuts and Jobs Act* (TCJA), which was passed in 2017 during Trump's first term, has many provisions sun-setting at the end of 2025. A non-healthcare bill with significant healthcare impacts, the tax cut provisions in the TCJA are anticipated to be extended, although how exactly that works out remains to be seen.[22] Extending the TCJA tax cuts would add almost $4 trillion to the U.S. deficit over the next decade, unless federal funding is cut elsewhere. The president-elect has already stated that Social Security and Medicare would not be cut.[23] However, Medicaid, the next largest source of federal healthcare spending, as well as the ACA are likely targets for cuts. Trump has been silent on Medicaid to date, rendering it impossible to predict what, if any cuts, to the program may occur. As more than half of Americans support the ACA, it seems unlikely that Trump and Republicans would repeal the law, but they may cut funding related to the law's various programs.[24] In fact, certain ACA premium subsidies are scheduled to sunset at the end of 2025; not extending these subsidies is estimated to reduce the federal deficit by $335 billion over the next 10 years.[25] It would also result in an estimated four million Americans losing health insurance coverage due to affordability issues.[26]

Conclusion

While nothing is for certain, one thing seems clear: 2025 will be a year of change in the healthcare industry. The incoming presidential administration appears poised to shake up the government's healthcare priorities, and Congress is mulling a number of bills that would have a significant effect on the overall healthcare industry. However, the industry will have to wait and see whether and how political platitudes translate to enforceable healthcare policy.

1 "Medicare Shared Savings Program Continues to Deliver Meaningful Savings and High-Quality Health Care" Centers for Medicare & Medicaid Services, October 29, 2024, https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-continues-deliver-meaningful-savings-and-high-quality-health-care (Accessed 11/15/24).

2 "Washington healthcare world steels itself for RFK Jr.'s HHS" By Bridget Early, Modern Healthcare, November 15, 2024, https://www.modernhealthcare.com/politics-policy/robert-f-kennedy-jr-rfk-hhs-cms-medicare-medicaid-regulation (Accessed 12/18/24).

3 *Ibid*.

4 "Changes RFK Jr. could make as HHS secretary, from vaccines to raw milk" By Dan Diamond, et al., The Washington Post, November 15, 2024, https://www.washingtonpost.com/health/2024/11/15/rfk-jr-department-health-human-services-changes/ (Accessed 12/18/24).

5 "Trump picks Dr. Oz to be CMS administrator" By Ben Leonard and Robert King, Politico, November 19, 2024, https://www.politico.com/news/2024/11/19/dr-oz-cms-administrator-trump-00189456 (Accessed 12/18/24).

6 "What to know about Dr. Oz, the TV physician Trump tapped to run Medicare" By Frances Vinall, The Washington Post, November 20, 2024, https://www.washingtonpost.com/politics/2024/11/20/dr-oz-trump-cms-credentials-controversy/ (Accessed 12/19/24).

7 Politico, November 19, 2024.

8 "Will RFK Jr. be confirmed as health secretary?" The Washington Post, https://www.washingtonpost.com/health/2024/12/17/rfk-will-the-senatre-ratify-hhs-nomination/ (Accessed 12/18/24).

9 "Trump win tees up regulatory rollbacks and uncertainty" By Michael McAuliff, Modern Healthcare, November 6, 2024, https://www.modernhealthcare.com/politics-policy/trump-healthcare-policy-medicare-aca-second-term (Accessed 12/18/24).

10 *Ibid*.

11 See "Congressional Spending Bill Excludes Physician Payment Increase" Health Capital Topics, Vol. 17, Issue 12 (December 2024).

12 "Medicare physician pay has plummeted since 2001. Find out why." By Tanya Albert Henry, American Medical Association, June 17, 2024, https://www.ama-assn.org/practice-management/medicare-medicaid/medicare-physician-pay-has-plummeted-2001-find-out-why (Accessed 11/13/24).

13 Letter to The Honorable Mike Johnson, The Honorable Hakeem Jeffries, The Honorable Charles Schumer, and The Honorable Mitch McConnell, from Anders Gilberg, Medical Group Management Association, dated November 12, 2024, Re: MGMA Legislative Imperatives for the End of 2024, available at: https://www.mgma.com/getkaiasset/a1658e5f-2577-49bf-a5ed-14e33cd85ec0/11.12.2024_MGMA%20End%20of%20Year%20Letter.pdf (Accessed 11/13/24).

14 "Reps back reforms to Medicare Physician Fee Schedule, starting with physician reimbursement" By Richard Payerchin, Medical Economics, October 15, 2024, https://www.medicaleconomics.com/view/reps-back-reforms-to-medicare-physician-fee-schedule-starting-with-physician-reimbursement (Accessed 12/19/24).

15 "Bill seeks better fix to Medicare Physician Fee Schedule cuts" American Optometric Association, August 8, 2024, https://www.aoa.org/news/advocacy/federal-advocacy/bill-seeks-better-fix-to-medicare-physician-fee-schedule-cuts?sso=y (Accessed 12/19/24).

16 *Ibid*.

17 "Scoop: Ways and Means weighs doc pay markup" By Peter Sullivan and Victoria Knight, Axios, September 11, 2024, https://www.axios.com/pro/health-care-policy/2024/09/11/ways-and-means-weighs-doc-fix (Accessed 12/19/24).

18 "Protecting Consumers from Artificial Intelligence Enabled Fraud and Scams" U.S. Senate Committee on Commerce, Science, & Transportation, November 19, 2024, https://www.commerce.senate.gov/2024/11/protecting-consumers-from-artificial-intelligence-enabled-fraud-and-scams (Accessed 12/18/24).

19 "Senators Hold Hearing on AI Fraud and Scams, Vow to Pass AI Bills in Coming Weeks — AI: The Washington Report" By Bruce D. Sokler, et al., Mintz, November 22, 2024. (Accessed 12/18/24).

20 "Telehealth and doctors win, PBMs lose as government funding deal nears" By Michael McAuliff, Modern Healthcare, December 17, 2024, https://www.modernhealthcare.com/politics-policy/telehealth-flexibilities-doctor-pay-pbms-government-spending-bill (Accessed 12/19/24).

21 "Warren, Hawley propose PBM Act to break up CVS, UnitedHealth" By Michael McAuliff, Modern Helahtcare, December 11, 2024, https://www.modernhealthcare.com/politics-policy/pbm-act-cvs-unitedhealth-cigna-elizabeth-warren-josh-hawley (Accessed 12/19/24).

22 "Trump could target Affordable Care Act and Medicaid to help pay for lower taxes, experts say" By Kate Gibson, CBS News, December 17, 2024, https://www.cbsnews.com/news/trump-medicaid-aca-obamacare-affordable-care-act-tax-cuts/ (Accessed 12/18/24).

23 *Ibid*.

24 *Ibid*.

25 *Ibid*.

26 "Millions at risk of losing health insurance after Trump's victory" By Berkeley Lovelace Jr., NBC News, November 7, 2024, https://www.nbcnews.com/health/health-news/millions-risk-losing-health-insurance-trumps-victory-rcna179146 (Accessed 12/19/24).

Trump Administration's Day-One Healthcare Moves

[Excerpted from the article published in January 2025.]

In the first days of his second (nonconsecutive) presidential term, Donald Trump and his administration took a number of actions that will affect the healthcare industry in the near- and long-term. Further, the Trump Administration is reportedly poised to take a number of additional actions to pause, end, or otherwise change Biden-era initiatives. Meanwhile, President Trump's cabinet pick for the Department of Health & Human Services (HHS) hangs in the balance. This Health Capital Topics article reviews the new administration's actions impacting the healthcare industry as of the date of publication.

On January 21, 2025, the Trump Administration directed HHS and its subagencies, including the Centers for Medicare and Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the Health Resources and Services Administration (HRSA), the National Institutes of Health (NIH), and the Substance Abuse and Mental Health Services Administration (SAMHSA) to pause all external communications.[1] The directive did not state when the pause on communications such as health advisories, weekly reports, website updates, and social media posts would be lifted or whether there were exceptions for urgent situations such as disease outbreaks.[2] While such pauses are not uncommon during administration transitions, the scope and length of this pause are exceptional.[3]

The Trump Administration also froze all healthcare rulemaking. Federal agencies may not issue new rules for 60 days; this includes proposed rules that are not yet finalized and finalized rules that are not yet effective.[4] Rules that the 60-day freeze affects includes the proposed updates to the HIPAA Security Rule (which includes new cybersecurity requirements) and a proposed rule for prescribing controlled substances via telehealth (which proposes a three-tiered system for remotely prescribing controlled substances).[5] Such pauses are fairly common, often employed by new administrations to review regulations and decide which to scrap and which to proceed with.[6] The administration also ordered a hiring freeze for all federal agencies, which expected to remain in place for 90 days.[7]

On January 20, 2025 (Inauguration Day), Trump rescinded 78 of former President Biden's executive orders, a number of which affect the healthcare industry.[8] Among those nixed orders include:

(1) A January 2022 executive order that established a special open enrollment period for federal health insurance exchanges and directed states to reexamine Medicaid work requirements;

(2) Five COVID-19 executive orders, including directing the implementation of new pandemic management strategies, the creation of a COVID-19 health equity task force, and other measures;

(3) A 2023 executive order that built on the Inflation Reduction Act of 2022 (IRA)[9] by directing the Center for Medicare and Medicaid Innovation to develop drug pricing models to lower the cost of expensive medications, require the coverage of generic drugs by Medicare Part D plans, and improve access to gene therapy. Notably, three models were developed but had not yet been implemented; and

(4) A 2023 executive order directing federal agencies to construct a regulatory framework for AI safety and transparency.[10]

Additionally, several affirmative executive orders were signed, including the withdrawal from the World Health Organization (WHO).

Beyond executive orders, the Trump Administration has worked to quickly appoint acting cabinet secretaries to serve until the Senate confirmation process is completed for the permanent appointments. Dorothy Fink, MD, an endocrinologist and longtime civil servant who previously led HHS's Office on Women's Health, was appointed acting HHS secretary.[11] Robert F. Kennedy Jr., an environmental lawyer and politician, was tapped to serve as permanent HHS secretary, and began appearing before Senate committees regarding his nomination to the position starting January 29th.[12]

Along with border security, energy, and production, healthcare appeared to be a large target for executive action during the Trump Administration's first days in the White House. What comes next, and how this will ultimately impact healthcare providers and patients, remains to be seen.

---

1 "Trump officials pause health agencies' communications, citing review" By Lena H. Sun, Dan Diamond, and Rachel Roubein, The Washington Post, January 21, 2025, https://www.washingtonpost.com/health/2025/01/21/trump-hhs-cdc-fda-communication-pause/ (Accessed 1/2/25).

2 *Ibid*; "Trump freezes HHS communications: report" By Bridget Early, Modern Healthcare, January 22, 2025, https://www.modernhealthcare.com/politics-policy/hhs-external-communications-paused-trump-administration (Accessed 1/22/25).

3 The Washington Post, January 21, 2025.

4 What Trump's first day orders mean for healthcare: Ditched drug models, pauses on rules and hiring" Fierce Healthcare, January 21, 2025, https://www.fiercehealthcare.com/regulatory/what-trumps-first-day-orders-mean-healthcare-ditched-drug-models-pauses-rules-and-hiring (Accessed 1/22/25).

5 *Ibid*.

6 *Ibid*.

7 *Ibid*.

8 *Ibid*.

9 Among other things, the IRA lowered the cost of prescription drugs by adding capping out-of-pocket pharmacy costs and implementing a $35 monthly cap per insulin prescription covered by Medicare. "Executive Order 14087—Lowering Prescription Drug Costs for Americans" UC Santa Barbara, The American Presidency Project, October 14, 2022, https://www.presidency.ucsb.edu/documents/executive-order-14087-lowering-prescription-drug-costs-for-americans (Accessed 1/23/25).

10 "The Trump executive orders that impact healthcare" By Bridget Early, Modern Healthcare, January 22, 2025, https://www.modernhealthcare.com/policy/trump-executive-orders-insurance-drug-pricing (Accessed 1/22/25).

11 "Trump team taps Dorothy Fink to serve as interim HHS secretary" By Dan Diamond, The Washington Post, January 19, 2025, https://www.washingtonpost.com/health/2025/01/19/trump-hhs-appointments-interim-secretary/ (Accessed 1/23/25).

12 Of note, Mr. Kennedy must first achieve a favorable majority vote by the Senate Finance Committee in order to advance his nomination to the full Senate. "RFK Jr. to face key Senate committee hearings next week" By Rachel Cohrs Zhang, Stat News, January 22, 2025, https://www.statnews.com/2025/01/22/trump-hhs-pick-rfk-jr-senate-finance-hearing-scheduled/ (Accessed 1/23/25).

Fast & Furious: Healthcare Policy Edition

[Excerpted from the article published in February 2025.]

During his first month in office, President Donald Trump's administration has rolled out edicts calling for significant changes at a fast and furious pace, with a number of healthcare agencies and programs across the U.S. Department of Health & Human Services (HHS) targeted. In an attempt to keep up with the latest actions of the legislative and executive branches of the federal government, this Health Capital Topics article summarizes recent events in Washington and the impact of these changes (both imminent and impending) on providers and patients.

Agency Workforce Reduction

Along with other federal agency workers, over 5,000 staffers at HHS and its agencies, including the Centers for Medicare and Medicaid Services (CMS), the Center for Medicare and Medicaid Innovation (CMMI), the Health Resources and Services Administration (HRSA), the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention (CDC), and the National Institutes of Health (NIH), received layoff notices on February 15, 2025, following an Executive Order directing federal agencies to enact "large-scale" employee cuts.[1] According to Bloomberg, the "full scope of the cuts remains unclear"; the layoffs appear to have largely targeted probationary employees, i.e., those employed in their current position for less than one to two years.[2]

This significant staff reduction has raised concerns about the effect it could have on the healthcare industry. For example, industry stakeholders are concerned that staff reductions could reduce agency guidance and communication, leaving industry players unsure on how to interpret and proceed in compliance with federal regulations.[3] Additionally, government workforce shortages may mean that agencies will not have the bandwidth to enforce healthcare regulations as they have previously. How reduced healthcare enforcement will affect healthcare entities, and their transactions, remains to be seen. Other possible consequences of diminishing staff resources may include:

- CMMI payment models such as the kidney care model, dementia care model, and maternal health model, being hindered;
- Enforcement of critical, time-sensitive issues such as prior authorization being undermined; and
- Approval process for new drugs and medical devices being slowed.[4]

Medicaid on the Chopping Block?

Along with the executive branch's efforts to significantly reduce federal government staff, the legislative branch is working to significantly reduce spending, including (and perhaps particularly) in healthcare. On February 12, 2025, Republicans in the U.S. House of Representatives' Budget Committee published its budget blueprint for 2025, which the House voted to pass on February 25th).[5] The budget resolution directs the Energy and Commerce Committee (the House's primary healthcare committee) to find $880 billion in healthcare spending over the next decade to cut.[6] Of note, and perhaps coincidentally, Medicaid expenditures were approximately $880 billion in fiscal year 2023.[7] While there was no additional direction, e.g., which programs should be cut, Medicare and Medicaid are the largest federal government healthcare programs and command a large portion of the federal government's healthcare budget.[8] President Trump has previously committed to not cutting Medicare; if that commitment remains, then Medicaid will likely experience significant cuts.[9] The House Speaker, Mike Johnson (R-La.) has previously stated the Republican Party's intention to restrict Medicaid eligibility requirements and impose work requirements, both of which would reduce the number of enrollees and consequently decrease spending.[10]

Notably, the $880 billion in cuts is less than the original proposals, wherein Republicans compiled a list totaling over $3 trillion in healthcare cuts over the next decade, comprised of policies including but not limited to:

- Eliminating hospitals' nonprofit status;
- Eradicating hospital facility and telehealth fees;
- Implementing "site-neutral" Medicare payments for outpatient services;
- Ending Medicare funding for hospital bad debt;
- Increasing Medicare physician reimbursement;
- Slashing graduate medical education funding;
- Repealing the nursing home staffing mandate;
- Eliminating enhanced federal payments to Medicaid expansion states;
- Constricting access to health insurance exchange subsidies; and
- Slashing Medicaid.[11]

Some of these programs will cost money to implement, meaning that deeper cuts will have to be made to fund those programs as well as other proposed tax cuts (i.e., the extension of the *Tax Cuts and Jobs Act*).

Proposed Medicaid cuts are predicted to negatively affect both providers and patients. In general, enacting Medicaid cuts, or restricting Medicaid eligibility, would reduce the number of Medicaid enrollees. This would hurt both low-income individuals, who may not otherwise be able to afford health insurance, and healthcare providers, chiefly safety-net providers, who would lose revenue – both by losing Medicaid reimbursement and by experiencing increased costs through the provision of uncompensated care. In particular, the Kaiser Family Foundation (KFF) stated that "Medicaid cuts could gut home care access" and exacerbate the current homecare workforce shortage.[12] KFF estimates approximately 4.5 million adults and children receive home care services through Medicaid.[13] As

Medicaid is jointly funded by federal and state governments (with the federal government responsible for at least 50%),[14] state governments may have to fill the funding gap themselves (e.g., through raising taxes) or cut Medicaid programs such as those that pay current home care workers and recruit additional workers to ameliorate critical workforce shortages.

Whether such large cuts to Medicaid are practically, or politically, feasible is indeterminate. As Republicans saw in 2017, large cuts in health coverage can have significant, negative political ramifications.[15]

Deregulation

On January 31, 2025, President Trump issued a "massive" deregulation initiative, in which federal agencies were directed to eliminate "at least 10 existing rules, regulations, or guidance documents" for each new rule, regulation, or guidance document issued.[16] The executive order is intended to keep agencies from enacting new regulations that will cost more money, requiring that "the total incremental cost of all new regulations, including repealed regulations, be significantly less than zero."[17]

The order is expected to have nominal ramifications for CMS because most of its regulations are statutorily mandated.[18] During President Trump's first term, he issued a similar, two-for-one deregulation executive order, and it had a *de minimus* effect on healthcare regulation.[19] However, there is concern this time around that CMS may attempt to compile various policies into fewer, broader rules, and issue less guidance,[20] which could impair healthcare providers and their professional advisors who are seeking direction in order to ensure regulatory compliance. Healthcare attorneys also anticipate that health agency rulemaking will slow.[21]

Kennedy Confirmed as HHS Secretary

On February 13, 2025, Robert F. Kennedy Jr., an environmental lawyer and politician, was confirmed as HHS Secretary.[22] While Kennedy is a pharmaceutical industry critic and founder of a prominent anti-vaccine group, his views on Medicare, Medicaid, and the *Patient Protection and Affordable Care Act* (ACA) are largely unknown.[23] During his own presidential run, Kennedy discussed enforcing mental health parity laws on insurers, improving Black maternal health, and aligning U.S. drug prices with those in other developed countries.[24] A list of other priorities Kennedy has mentioned include:

- "Making America Healthy Again";
- Conducting additional studies on vaccines;
- Reexamine federal vaccine recommendations for children;
- Removing fluoride from public drinking water;
- Cracking down on food dyes;
- Removing ultra-processed food from school cafeterias; and
- Increasing access to raw (i.e., unpasteurized) milk.[25]

Despite some skepticism from Republicans ahead of his confirmation, Kennedy was confirmed by the Senate 52-48.[26] Kennedy reportedly secured votes from skeptical senators by "publicly and privately pledging not to interfere with standard federal vaccine policies or science."[27]

In his first speech to HHS staff on February 18th, Kennedy asserted that "'nothing is going to be off limits' in his pursuit to reduce chronic disease."[28] Among other priorities comprising his "Make America Healthy Again" agenda, Kennedy mentioned investigating electromagnetic radiation, anti-depression drugs, ultra-processed foods, and glysophates (an herbicide found in some foods).[29]

Relatedly, former cardiothoracic surgeon, Columbia University professor, television personality, and (more recently) politician Dr. Mehmet Oz was tapped to serve as CMS Administrator, although his confirmation hearing has yet to be scheduled.[30] Dr. Oz is a longtime Medicare Advantage (MA) proponent who campaigned on expanding MA to the greater population during his 2022 Senate run.[31] He also promised to work on reducing prescription drug prices.[32] In his statement announcing the pick, President Trump asserted that Dr. Oz will crack down on healthcare "waste and fraud."[33]

Conclusion

While nothing is for certain, one thing seems clear: 2025 will be a year of unpredictability and change in the healthcare industry. The Trump Administration is making good on its promise to shake up the federal government, and Congress's budgeting priorities are likely to have a significant effect on the overall healthcare industry. However, the industry will have to wait and see whether and how political platitudes translate to enforceable healthcare policy.

Health Capital Consultants will continue to closely monitor these developments and will provide in-depth analysis and updates in forthcoming issues of Health Capital Topics.

1 "HHS layoffs expand to Medicare, FDA" By Rachel Cohrs Zhang, Jeannie Baumann and Kelsey Butler, Modern Healthcare, February 18, 2025, https://www.modernhealthcare.com/labor/hhs-layoffs-medicare-fda (Accessed 2/20/25); "Implementing The President's "Department of Government Efficiency" Workforce Optimization Initiative" Executive Order, February 11, 2025, https://www.whitehouse.gov/presidential-actions/2025/02/implementing-the-presidents-department-of-government-efficiency-workforce-optimization-initiative/ (Accessed 2/20/25); "Mass firings at HHS: Court allows Trump to proceed with firings but admin faces new lawsuit" By Noah Tang, Fierce Healthcare, February 20, 2025, https://www.fiercehealthcare.com/regulatory/mass-layoffs-hhs-cdc-cuts-1300-probationary-workers-reports-say (Accessed 2/21/25).
2 Modern Healthcare, February 18, 2025.
3 "Layoffs at HHS Spark Concern from Providers" By Bridget Early, Modern Healthcare, February 19, 2025, https://www.modernhealthcare.com/policy/federal-layoffs-hhs-fda-cms (Accessed 2/20/25).
4 *Ibid*.
5 "House GOP eyes $880B in healthcare cuts" By Michael McAuliff, Modern Healthcare, February 12, 2025, https://www.modernhealthcare.com/politics-policy/house-budget-healthcare-cuts-2025 (Accessed 2/20/25); "House sets up potential Medicaid cuts with budget bill passage" By Michael McAuliff, Modern Healthcare, February 25, 2025, https://www.modernhealthcare.com/politics-policy/house-budget-passes-medicaid (Accessed 2/26/25).
6 Modern Healthcare, February 12, 2025.
7 "Republicans want to make deep cuts in Medicaid. Can they?" By Michael McAuliff, Modern Healthcare, January 22, 2025, https://www.modernhealthcare.com/politics-policy/medicaid-cuts-gop-reconciliation-bill-budget (Accessed 2/20/25).
8 Modern Healthcare, February 12, 2025.
9 *Ibid*.
10 *Ibid*.
11 "Republicans outline trillions in healthcare cuts" By Michael McAuliff, Modern Healthcare, January 17, 2025, https://www.modernhealthcare.com/politics-policy/medicaid-cuts-gop-block-grants (Accessed 2/20/25).
12 "Medicaid cuts could gut home care access, workforce: KFF" By Diane Eastabrook, Modern Healthcare, February 19, 2025, https://www.modernhealthcare.com/providers/medicaid-cuts-home-care-kff (Accessed 2/20/25).
13 *Ibid*.
14 "Medicaid Financing: The Basics" Kaiser Family Foundation, By Elizabeth Williams, et al., Kaiser Family Foundation, January 29, 2025, https://www.kff.org/medicaid/issue-brief/medicaid-financing-the-basics/#:~:text=Medicaid%20financing%20is%20shared%20by,)%202026%20(Figure%201). (Accessed 2/20/25).
15 Modern Healthcare, January 22, 2025.
16 "Fact Sheet: President Donald J. Trump Launches Massive 10-to-1 Deregulation Initiative" The White House, Fact Sheets, January 31, 2025, https://www.whitehouse.gov/fact-sheets/2025/01/fact-sheet-president-donald-j-trump-launches-massive-10-to-1-deregulation-initiative/ (Accessed 2/20/25).
17 *Ibid*.
18 "CMS may evade Trump's sweeping deregulation order" By Bridget Early, Modern Healthcare, February 14, 2025, https://www.modernhealthcare.com/policy/trump-deregulation-executive-order-cms (Accessed 2/20/25).
19 *Ibid*.
20 *Ibid*.
21 *Ibid*.
22 "RFK Jr. confirmed as HHS secretary" By Michael McAuliff, Modern Healthcare, February 13, 2025, https://www.modernhealthcare.com/politics-policy/rfk-jr-full-senate-vote-hhs (Accessed 2/20/25).
23 "Washington healthcare world steels itself for RFK Jr.'s HHS" By Bridget Early, Modern Healthcare, November 15, 2024, https://www.modernhealthcare.com/politics-policy/robert-f-kennedy-jr-rfk-hhs-cms-medicare-medicaid-regulation (Accessed 12/18/24).
24 *Ibid*.
25 "Changes RFK Jr. could make as HHS secretary, from vaccines to raw milk" By Dan Diamond, et al., The Washington Post, November 15, 2024, https://www.washingtonpost.com/health/2024/11/15/rfk-jr-department-health-human-services-changes/ (Accessed 12/18/24).
26 Modern Healthcare, February 13, 2025.
27 *Ibid*.
28 "'Nothing … off limits': Kennedy lays out plan for HHS" By Chelsea Cirruzzo and Adam Cancryn, Politico, February 18, 2025, https://www.politico.com/news/2025/02/18/kennedy-lays-out-hhs-plan-00204675 (Accessed 2/20/25).
29 *Ibid*.
30 "Dr. Oz plans to sell insurance, hospital, and pharma stocks, step down from supplement company if confirmed" By Tara Bannow, Stat, February 19, 2025, https://www.statnews.com/2025/02/19/dr-oz-ethics-financial-disclosures-net-worth-trump-pick-cms-unitedhealth-hca-stock/ (Accessed 2/20/25).
31 "Trump picks Dr. Oz to be CMS administrator" By Ben Leonard and Robert King, Politico, November 19, 2024, https://www.politico.com/news/2024/11/19/dr-oz-cms-administrator-trump-00189456 (Accessed 12/18/24).
32 "What to know about Dr. Oz, the TV physician Trump tapped to run Medicare" By Frances Vinall, The Washington Post, November 20, 2024, https://www.washingtonpost.com/politics/2024/11/20/dr-oz-trump-cms-credentials-controversy/ (Accessed 12/19/24).
33 Politico, November 19, 2024.

2 Fast 2 Furious: HHS Cuts on the Horizon

[Excerpted from the article published in April 2025.]

During the first 90 days of the Republican Party's government trifecta (controlling the White House, Senate, and House of Representatives), both the Trump Administration and Congress have laid the groundwork for seismic change to the U.S. healthcare industry. In an attempt to track the latest actions of the federal government's legislative and executive branches affecting the healthcare industry since the first installment in our February issue,[1] this Health Capital Topics article summarizes recent events in Washington and the impact of these changes on providers and patients.

HHS Facing $40 Billion in Cuts

A recently-leaked Office of Management and Budget (OMB) preliminary budget document outlined the Trump Administration's proposal to cut the Department of Health & Human Services' (HHS's) 2026 discretionary budget by one third.[2] HHS's $40 billion budget reduction would largely come from:

(1) Eliminating several HHS rural health programs under the Health Resources and Services Administration (HRSA);[3]
(2) Cutting the budget for the Centers for Disease Control and Prevention (CDC) by approximately 44%, in part by eliminating the agency's global health center and disease prevention programs;[4]
(3) Cutting the budget for the National Institutes of Health by over 40%, in part by reducing the agency's 27 research institutes and centers to eight;[5] and
(4) Capping indirect payments to universities to 15%, although this recently-enacted cut has been halted by the courts.[6]

The HHS budget reduction would also be partly accomplished by reorganizing the agency through firings, reductions in force (RIFs), office eliminations, and consolidating multiple programs and departments into the Administration for a Healthy America (AHA).[7]

Additionally, proposed budget cuts to the Centers for Medicare & Medicaid Services (CMS) assume "a decline in Federal Exchange enrollment due to the expiration of the enhanced premium tax credits."[8] In other words, the enhanced Affordable Care Act (ACA) subsidies, which are provided to lower-income individuals to purchase health insurance on the ACA insurance exchanges, and have been in place since 2021, would be allowed to sunset at the end of 2025.[9] While this may be an upfront cost savings, a recent Commonwealth Fund report found that letting the enhanced ACA premium subsidies expire would cost states $34 billion in gross domestic product reductions and $2 billion in tax revenue.[10] Revenues of hospitals and healthcare providers would be especially affected by these cuts, as an estimated 4 million Americans will lose their insurance and premiums will increase by a projected 4.3%.[11]

Healthcare Payments Frozen

The U.S. Department of Government Efficiency (DOGE) has started a new effort called "Defend the Spend" to restrain billions of dollars in federal healthcare grants.[12] Federal officials are now required "to manually review and approve previously routine payments…[leaving] thousands of payments backed up, including funding for doctors' and nurses' salaries at federal health centers for the poor."[13] While the effort is intended to force both the government and grantees to justify the spending and enhance transparency, agencies are reporting "inconsistent instructions on how to proceed" and "immediate backlogs in processing payments."[14] Federal health centers, which rely on regular drawdowns in promised grant money to pay for clinicians' salaries and supplies, are already experiencing the negative impact of these backlogs and could ultimately close if funding continues to be withheld.[15]

Tariff Implications on Healthcare Organizations

The Trump Administration's tariffs war has ebbed and flowed during the first 90 days, with the president instituting substantial tariffs on most U.S. trading partners, then announcing on April 9, 2025 that the administration would pause most reciprocal tariffs for 90 days.[16] Because medical supplies and devices tend to come from overseas, hospitals and other healthcare organizations are significantly concerned about rising costs and the uncertain availability of supplies.[17] A recent Black Book Market Research study of 200 industry professionals found that 80% of respondents expect hospitals' and health systems' costs to increase at least 15% in the next several months due to import cost increases.[18] America's Essential Hospitals and other healthcare groups and organizations sent a letter to the U.S. trade representative asserting that the tariffs:

"ultimately place[] further financial pressure on providers, hospitals, and health systems, particularly those located in rural and medically underserved areas… increased costs on medical and dental supplies could impede [organizations'] ability to improve treatment outcomes, foster innovation, and meet the growing needs of pediatric and adult populations. This could result in longer wait times, reduced access to necessary treatments, and greater financial strain on health care systems that are already under pressure.[19]

While tariffs do not currently apply to pharmaceuticals, President Trump has stated that a "major" tariff on pharmaceuticals will be implemented "very shortly."[20] In 2024, the U.S. imported nearly $213 billion worth of pharmaceuticals,[21] meaning that any pharmaceutical tariff will likely have a far-reaching impact on the healthcare industry.

Conclusion

Healthcare organizations are experiencing significant unpredictability and uncertainty as a result of these abrupt and capricious federal policy changes. With organizations already operating on thin margins, changes that result in higher expenses and/or decreased revenue could be a death knell for hospitals and other providers, with the ultimate consequence of significantly reducing patients' access to healthcare services.

Health Capital Consultants will continue to closely monitor these developments and will provide in-depth analysis and updates in forthcoming issues of Health Capital Topics.

---

1 "Fast & Furious: Healthcare Policy Edition" Health Capital Topics, Vol. 18, Issue 2 (February 2025), https://www.healthcapital.com/hcc/newsletter/02_25/HTML/GOV/convert_govt-hc-updates-topics.php (Accessed 4/17/25).

2 "Internal budget document reveals extent of Trump's proposed health cuts" By Lena H. Sun, et al., The Washington Post, April 16, 2025, https://www.washingtonpost.com/health/2025/04/16/hhs-budget-cut-trump/ (Accessed 4/21/25).

3 *Ibid*.

4 "Internal Trump administration document reveals massive budget cut proposal for federal health agencies" By Sarah Owermohle and Meg Tirrell, CNN, April 16, 2025, https://www.cnn.com/2025/04/16/politics/trump-rfk-jr-budget-cut-health/index.html (Accessed 4/17/25).

5 Sun, et al., The Washington Post, April 16, 2025.

6 "Leaked HHS budget signals $40B in cuts, assumes ACA subsidies expire" By Noah Tong, Fierce Healthcare, April 17, 2025, https://www.fiercehealthcare.com/regulatory/hhs-budget-slashed-40-billion-first-look-hhs-reorganization-leaked-document (Accessed 4/17/25).

7 *Ibid*.

8 *Ibid*.

9 "Five Things to Know about the Renewal of Extra Affordable Care Act Subsidies in the Inflation Reduction Act" By Cynthia Cox, Kaiser Family Foundation, August 11, 2022, https://www.kff.org/policy-watch/five-things-to-know-about-renewal-of-extra-affordable-care-act-subsidies-in-inflation-reduction-act/#:~:text=Subsidies%20in%20the%E2%80%A6-,Five%20Things%20to%20Know%20about%20the%20Renewal%20of%20Extra%20Affordable,in%20the%20Inflation%20Reduction%20Act&text=As%20part%20of%20the%20Inflation,previously%20priced%20out%20of%20coverage. (Accessed 4/21/25).

10 "The Cost of Eliminating the Enhanced Premium Tax Credits: Economic, Employment, and Tax Consequences" By Leighton Ku, et al., The Commonwealth Fund, Issue Briefs, March 3, 2025, https://www.commonwealthfund.org/publications/issue-briefs/2025/mar/cost-eliminating-enhanced-premium-tax-credits (Accessed 4/17/25).

11 Tong, Fierce Healthcare, April 17, 2025.

12 "DOGE begins to freeze health-care payments for extra review" By Dan Diamond, et al., The Washington Post, April 17, 2025, https://www.washingtonpost.com/politics/2025/04/17/doge-trump-grants-hhs-nih-backlog/?utm_campaign=wp_post_most&utm_medium=email&utm_source=newsletter&carta-url=https%3A%2F%2Fs2.washingtonpost.com%2Fcar-ln-tr%2F4228cad%2F680278c809671829d6cd43ef%2F596adcaeade4e24119a8edff%2F26%2F52%2F680278c809671829d6cd43ef (Accessed 4/21/25).

13 *Ibid*.

14 *Ibid*.

15 *Ibid*.

16 "Tariff turmoil: Hospitals, device makers welcome pause, but fear long-term pain" By Susanna Vogel and Susan Kelly, Healthcare Dive, April 10, 2025, https://www.healthcaredive.com/news/tariff-turmoil-hospitals-device-makers/745093/#:~:text=%E2%80%9CThis%20ultimately%20places%20further%20financial,continue%20caring%20for%20their%-20communities.%E2%80%9D (Accessed 4/21/25).

17 *Ibid*.

18 Letter to The Honorable Jameison Greer, U.S. Trade Representative, AdvaMed, et al., dated April 1, 2025, available at: https://www.advamed.org/wp-content/uploads/2025/04/Health-Group-Tariff-Letter-to-USTR-4-1-25.pdf (Accessed 4/21/25).

19 *Ibid*.

20 "Pharmaceutical stocks rise as Trump pauses tariffs but not for China" By Annika Kim Constantino, CNBC, April 9, 2025, https://www.cnbc.com/2025/04/09/trump-pharmaceutical-tariffs-announcement.html (Accessed 4/21/25).

21 *Ibid*.

CON Laws: Current Landscape and Future Outlook

[Excerpted from the article published in January 2025.]

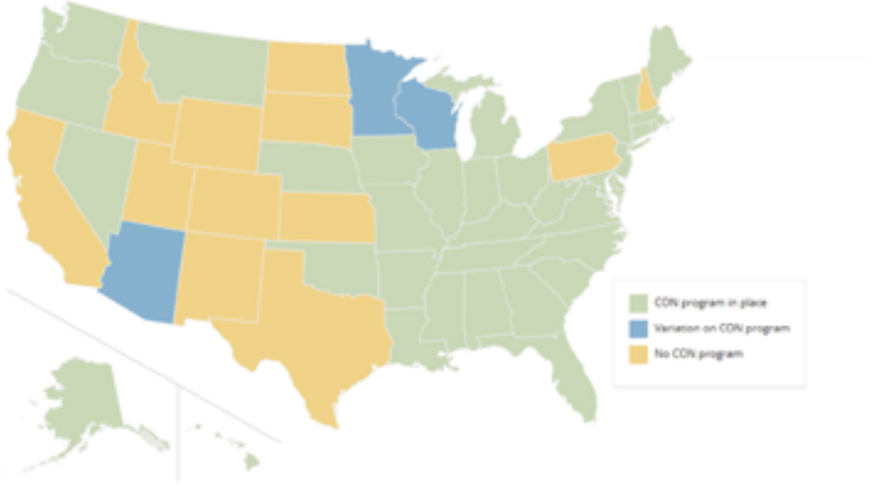
With Republicans taking back the White House, Senate, and House of Representatives, much talk has focused on the party's deregulation priorities. However, one of the largest and most restrictive state-based regulatory schemes has been left out of the conversation: certificate of need (CON) laws. While many states have recently made changes to their CON programs, ranging from full repeal to smaller reductions in what the program regulates, there has been discussion in the media and in the courts as to the future of CON programs. This Health Capital Topics article discusses the history of CON laws, the current landscape, and what the future may hold for CON.

The History of CON

At its core, a state CON program is one in which a government determines where, when, and how major capital expenditures (e.g., funds spent on public healthcare facilities, services, and key equipment) will be made.[1] The theory behind CON regulations is that, in an unregulated market, healthcare providers will provide the latest costly technology and equipment, regardless of duplication or need, resulting in increased costs for consumers.[2] For example, hospitals may raise prices to pay for underused services, equipment, or empty beds.[3] Proponents of this system argue that CON programs are necessary to limit healthcare spending because healthcare consumers are unable to "shop" for goods and services, as most of these are ordered by physicians.[4] Opponents of the system assert that restricting new entrants to the market may reduce competition, and create a "burdensome approval process for establishing new facilities and services," ultimately resulting in higher healthcare prices.[5] Ideally though, CON programs would not prevent change in the healthcare market but merely provide a way for the public and stakeholders to give input and allow for an evaluation process. This regulatory scheme may serve to distribute care to disadvantaged or underserved populations and block the entry of low-volume facilities, which may provide a lower quality of care.[6] Wide variations among different state CON programs, however, mean that the criteria required to prove need are inconsistent.[7]

The first CON law was established in New York in 1964.[8] Twenty-six states subsequently enacted similar laws over the next ten years.[9] Typically, these early programs regulated expenditures greater than $100,000, as well as bed capacity expansion, expansion of services, and the establishment of new services and facilities.[10] The *National Health Planning and Resources Development Act of 1974* required that federal agencies pass health policy planning guidelines and establish "a statement of national health planning goals;" it also guaranteed federal funding for state CON review programs that met certain federal guidelines, causing all states to enact CON programs by 1982.[11] The Act was repealed five years later, and many states subsequently repealed or modified their CON laws.[12] However, 35 states still retain some sort of CON program, as illustrated below in Exhibit 1.

CON State Laws[13]



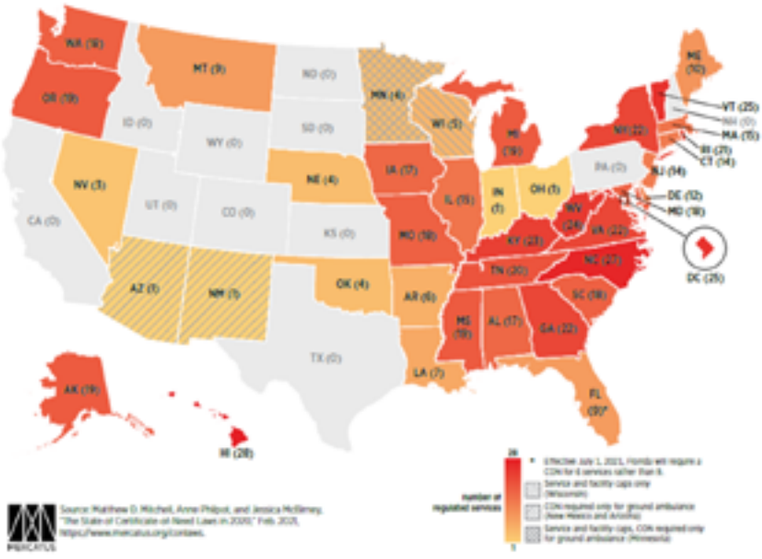
CON Landscape

Current CON regulation varies widely among states, with regulations based on various state statutes, rules, and regulations that designate an agency or board for reviewing and approving applications.[14] The majority of states' CON programs cover general hospitals, with some also addressing long-term care facilities and rural facilities.[15] Activities that commonly require a CON review include:

(1) The establishment of a new healthcare facility;
(2) A change in bed capacity;
(3) Capital expenditure greater than a state's minimum cost threshold; and,
(4) Adding new services.[16]

The number of services regulated by CON laws (or similar requirements) by state are set forth below in Exhibit 2.

Number of Regulated Healthcare Services by State, 2020[17]



CON application processes vary by state as well. In 20 states, applications are reviewed by the Department of Health or other state agency, while 15 states utilize an independent board or council appointed by the state government.[18] The typical application process involves submission of an application for review, followed by agency review for consistency with planning criteria, and a public hearing and issuance of a decision by the granting authority.[19] During a CON review, information such as how well the proposal demonstrates and fills a community need, alternatives to the proposed project, long-term project viability, the applicant's experience in providing their proposed services, and considerations for populations of interest, including elderly or low-income residents, may be considered.[20] Each state has their own unique criteria and thresholds related to the type of CON "review" that is required, e.g., Non-Substantive (no full review required), Substantive (full reviews on an individual basis), and Comparative (two or more applicants compete for projects where need is limited).[21] The grant or denial of a CON application frequently results in complex and costly litigation (starting first by exhausting a party's administrative remedies, then through appeal to the appropriate state court).

Present and Future CON Reform

Recent CON reform has focused on deregulating ambulatory surgical center (ASC) transactions. In Georgia, the state legislature has exempted single-specialty ASCs from the CON process if the entity is owned by a single physician or group and does not exceed certain operating room and capital expenditure thresholds. In North Carolina, parties seeking to establish an ASC in a county with more than 125,000 residents will not have to undergo the CON process starting November 21, 2025, although they will have to satisfy certain charity care requirements.[22] South Carolina fully repealed CON laws related to all ASCs, although they still must satisfy charity care requirements.[23] Tennessee similarly repealed CON laws for ASCs, although that repeal is not effective until December 1, 2027; post-repeal, ASCs that are not hospital-based will be required to participate in Medicaid and provide a certain amount of Medicaid and charity care.[24] In many other states, legislators have tried repeatedly to repeal part or all of a given CON law, often to no avail, reportedly due to strong lobbying efforts by industry groups in support of the laws.[25]

Recent court cases challenging CON laws may potentially lead to broader reform. A case in Mississippi is challenging the state's moratorium on new home health agencies, as a new agency has not been established in over 40 years despite growing need for home health services.[26] Another, particularly important CON case worth following in North Carolina (arguably the most restrictive CON program in the country) may result in a full repeal of the state's CON laws. In this case, a vision center wanted to begin performing eye surgeries, but was unable to do so because the state agency projected there was no need for the services in the county.[27] This meant that the only way the eye surgeon could perform procedures such as cataract surgeries was at a hospital, which cost patients over $4,200 more due to the facility fee associated with a hospital-based procedure.[28] The physician filed suit in 2020 challenging the CON law's constitutionality, arguing that although the law's goal is to keep healthcare costs down, it actually serves only to "protect[] established providers from competition."[29] In October 2024, the case reached the North Carolina Supreme Court, which vacated lower court rulings against the ophthalmologist and ordered the court to address whether the CON law violates the North Carolina Constitution.[30] If in fact the law is ultimately overturned, its effects are projected to ripple across the country, and potentially impact other CON states.[31]

Health Capital Consultants (HCC) has assisted various healthcare organizations with drafting and submitting, as well as contesting, CON applications in numerous states. Visit us at www.healthcapital.com to learn more about our services and discuss how we may be able to help.

1 "Certificate of Need State Laws" National Conference of State Legislatures, February 26, 2024, https://www.ncsl.org/health/certificate-of-need-state-laws (Accessed 1/22/25).
2 *Ibid*.
3 *Ibid*.
4 *Ibid*.
5 *Ibid*.
6 *Ibid*; "Why Do Some States Still Require Certificates of Need?" By Maggy Bobek Tieché, Definitive Healthcare, April 2, 2023, https://www.definitivehc.com/blog/why-do-some-states-still-require-certificates-of-need (Accessed 1/22/25).
7 National Conference of State Legislatures, February 26, 2024.
8 *Ibid*.
9 *Ibid*.
10 *Ibid*.
11 Pub. L. 93-641, §§ 1525-1529, 88 Stat. 2225, 2244-46 and 2249-50 (1975), 42 USC § 300k-1, 300m-4, 300m-5.
12 National Conference of State Legislatures, February 26, 2024.
13 *Ibid*.
14 "50-State Scan Shows Diversity of State Certificate-of-Need Laws" By Johanna Butler, Adney Rakotoniaina and Deborah Fournier, National Academy for State Health Policy, May 22, 2020, https://www.nashp.org/50-state-scan-shows-diversity-of-state-certificate-of-need-laws/ (Accessed 1/22/25).
15 *Ibid*.
16 *Ibid*.
17 "CON Laws in 2020: About the Update" By Matthew D. Mitchell, et al., Mercatus Center George Mason University, February 19, 2021, https://www.mercatus.org/publication/con-laws-2020-about-update (Accessed 1/22/25).
18 National Academy for State Health Policy, May 22, 2020.
19 *Ibid*.
20 *Ibid*.
21 See, e.g., "Submit a CON Application" Michigan Department of Health and Human Services, https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5106-120981--,00.html (Accessed 2/23/21).
22 "How Certificate of Need Reform Is Impacting Ambulatory Surgery Centers and What It Means for Your Business" By LauraLee R. Lawley, Parker Poe, September 27, 2024, https://www.parkerpoe.com/news/2024/09/how-certificate-of-need-reform-is-impacting-ambulatory#:~:text=Effective%20November%2021%2C%202025%2C%20there,state%20on%20an%20annual%20basis. (Accessed 1/22/25).
23 *Ibid*.
24 *Ibid*.
25 "Health care start-ups are trying to open. An old law stands in their way." By Shannon Najmabadi, The Washington Post, January 2, 2025, https://www.washingtonpost.com/business/2025/01/02/certificate-of-need-competition-health-care/ (Accessed 1/22/25).
26 *Ibid*; Slaughter v. Dobbs, 3:20-cv-00789 (S.D. Miss.), https://www.courtlistener.com/docket/18726726/parties/slaughter-v-dobbs/ (Accessed 1/22/25).
27 "NC court case on health care law may turbocharge Atrium and Novant competition" By Chase Jordan, The Herald, November 4, 2024, https://www.heraldonline.com/news/business/article294878134.html#storylink=cpy (Accessed 1/22/25).
28 *Ibid*.
29 *Ibid*.
30 Jay Singleton D.O. and Singleton Vision Center, PA v. North Carolina Department of Health and Human Services, et al., No. 260PA22, Opinion of the Court (N.C. Sup. Ct. October 18, 2024), available at: https://appellate.nccourts.org/opinions/?c=1&pdf=44132 (Accessed 1/22/25).
31 "Physician lawsuit could heat up Novant, Atrium rivalry" By Francesca Mathewes, Becker's ASC Review, November 5, 2024, https://www.beckersasc.com/asc-transactions-and-valuation-issues/physician-lawsuit-could-heat-up-novant-atrium-rivalry-8-things-to-know.html (Accessed 1/22/25).

CMMI's Evolving Strategy: Initial Indications from Recent Actions

[Excerpted from the article published in May 2025.]

On May 13, 2025, the Centers for Medicare & Medicaid Services (CMS) Center for Medicare & Medicaid Innovation (CMMI) introduced a new strategic plan for its models going forward. After ending four payment models early and canceling two not-yet-implemented models in March 2025, the agency had promised to release a new strategy.[1] Nearly two weeks later, CMMI released that strategy, as well as a preliminary evaluation of, and changes to, one of its core payment models. This Health Capital Topics article will review CMMI's recent actions and what initial indications these actions provide.

CMMI was created by the Patient Protection & Affordable Care Act (ACA) to "test new payment and delivery models to lower costs and improve quality in government healthcare programs."[2] CMMI models "are time-limited experiments that provide a controlled environment to determine, through rigorous evaluation, what approaches should be expanded nationwide, what specific components of an approach need further testing in successor models and what approaches are not viable for expansion."[3] CMMI currently operates 23 payment models.[4]

One of these models, the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) model, is an "advanced" ACO initiative that "provides novel tools and resources for health care providers [both primary and specialty care] to work together in an ACO to improve the quality of care for people with Traditional Medicare."[5] The model is a revision and replacement of the Global and Professional Direct Contracting (GPDC) model and its subset, Geographic Direct Contracting (Geo Model) model, which launched in 2021.[6] The ACO REACH model advances health equity, increases access, and drives affordable accountable care more comprehensively than the GPDC model,[7] specifically by promoting:

(1) A greater focus on health equity and closing disparities in care;
(2) An emphasis on provider-led organizations and strengthening beneficiary voices to guide the work of model participants;
(3) Stronger beneficiary protections through ensuring robust compliance with model requirements;
(4) Increased screening of model applicants and increased monitoring of model participants;
(5) Greater transparency and data sharing on care quality and financial performance of model participants; and
(6) Stronger protections against inappropriate coding and risk score growth.[8]

The GPDC Model converted to ACO REACH in 2023, and currently has 103 participants across three types:

(1) **Standard ACOs**: Providers that have experience in a Medicare alternative payment model and are already aligned to an ACO voluntarily or though claims-based alignment;

(2) **New Entrant ACOs**: Providers that do not have previous experience in a Medicare alternative payment model or ACO, which typically achieve members through voluntary alignment; and

(3) **High Needs Population ACOs:** Providers that serve Medicare beneficiaries with complex needs and utilize a care model designed for patients with complex needs to coordinate care.[9]

ACO REACH participants may select between two voluntary risk-sharing options:

(1) **Professional**: A 50% risk sharing arrangement and a risk-adjusted monthly capitation payment for primary care services; or

(2) **Global**: A 100% risk- sharing arrangement and either a risk-adjusted monthly capitation payment for primary care services or a risk-adjusted monthly capitation payment for all services (including specialty care).[10]

On May 21, 2025, CMMI released a preliminary evaluation of the ACO REACH model through Performance Year (PY) 2023 (Evaluation Report) and its "impact on Medicare [fee-for-service (FFS)] spending, health services utilization, and quality of care for beneficiaries."[11] In PY 2023, the 132 ACO REACH participants served over 2 million beneficiaries, mostly through Standard ACOs.[12] Earlier reports found that REACH participants generated over $1.64 billion in gross savings; after accounting for shared savings and losses, CMS realized $694.6 million in net savings (a substantial increase from the $371.5 million in net savings achieved in PY 2022), while ACOs retained $948.4 million.[13] Notably, 73% of participating ACOs achieved net savings, with High Needs Population ACOs demonstrating particularly strong performance.[14] The evaluation also highlighted improvements in quality measures. The average total quality score across all ACOs was 79.4%, with High Needs Population ACOs achieving an even higher average of 86.73%.[15] These results suggest that the ACO REACH model is effectively promoting patient-centered care, reducing costs, and improving quality within the Medicare FFS population, which is important given that the model is set to expire at the end of 2026 unless CMMI extends the program.

For PY 2026, the last year of ACO REACH, CMS announced six changes "that are expected to improve the model test by adjusting the financial methodology to improve model sustainability based on" the Evaluation Report's findings that although gross savings are increasing, the model is still operating at a "net cost to the government."[16] For example, financial benchmarks and risk-adjustment formulas will be updated. Perhaps most notably, the threshold at which ACOs must share savings/losses with CMS will be reduced from 25% to 10%. This means if an ACO saves (or loses) 10% more than the benchmark, anything above that must be shared with the government.[17] ACOs will also have to achieve higher quality thresholds to receive additional savings (as CMS holds back a portion of savings that can be clawed back by achieving certain quality scores).[18]

These changes are in line with CMMI's recently-released strategic plan to prioritize "shared risk and prospective payments, streamlined quality measurement, artificial intelligence and other technologies…"[19] CMMI "will be guided by three interrelated strategic pillars": "prevention, individual empowerment, and choice and competition."[20] Notably, CMS is abandoning its goal set four years prior to enroll all FFS Medicare beneficiaries in an accountable care arrangement by 2030.[21] Nevertheless, CMMI commits to "mov[ing] forward with value-based payment and care delivery models that show the greatest promise for expansion."[22]

Although CMS has not yet commented on ACO REACH's future, participants are hopeful that the priorities highlighted in CMMI's strategic plan, the savings being generated by the model to date, and the tweaks made to the model for PY 2026 indicate CMS's interest in extending the ACO REACH model beyond its 2026 expiration.[23]

---

1 For more information, see "Four Medicare Payment Models Ended Early" Health Capital Topics, Vol. 18, Issue 3 (March 2025), https://www.healthcapital.com/hcc/newsletter/03_25/HTML/PAYMENT/convert_payment-models.php (Accessed 5/27/25).

2 "CMMI cancels 4 payment models early" By Emily Olsen, Healthcare Dive, March 13, 2025, https://www.healthcaredive.com/news/cms-innovation-center-cancels-payment-models-early/742424/ (Accessed 3/20/25).

3 "CMS Innovation Center Announces Model Portfolio Changes to Better Protect Taxpayers and Help Americans Live Healthier Lives" Centers for Medicare & Medicaid Services, March 12, 2025, https://www.cms.gov/newsroom/fact-sheets/cms-innovation-center-announces-model-portfolio-changes-better-protect-taxpayers-and-help-americans (Accessed 3/20/25).

4 "CMMI cancels 4 payment models early" By Emily Olsen, Healthcare Dive, March 13, 2025, https://www.healthcaredive.com/news/cms-innovation-center-cancels-payment-models-early/742424/ (Accessed 3/20/25).

5 "ACO REACH" Centers for Medicare & Medicaid Services, https://www.cms.gov/priorities/innovation/innovation-models/aco-reach (Accessed 5/27/25); "Preview of Findings from the Evaluation of ACO REACH Model for Performance Year 2023" Center for Medicare & Medicaid Innovation, May 21, 2025, available at: https://www.cms.gov/priorities/innovation/data-and-reports/2025/aco-reach-preview-py2023-evaluation (Accessed 5/27/25).

6 "CMS Redesigns Accountable Care Organization Model to Provide Better Care for People with Traditional Medicare" Centers for Medicare and Medicaid Services, February 24, 2022, https://www.cms.gov/newsroom/press-releases/cms-redesigns-accountable-care-organization-model-provide-better-care-people-traditional-medicare (Accessed 3/4/22).

7 "CMS Overhauls Direct Contracting Payment Model" Health Law Weekly, February 25, 2022, https://www.americanhealthlaw.org/content-library/health-law-weekly/article/a840dc94-86f3-49e2-88c9-fa7807717381/CMS-Overhauls-Direct-Contracting-Payment-Model?utm_campaign=Weekly%20eNewsletters&utm_medium=email&_hsmi=205088688&_hsenc=p2ANqtz-_lyv3kN2sui0H7r-y5RpQDN0l3q_xokdufCVKrAulBfDEkbo2PMdHcSgQGDW7ixpT3LxSVW1lV2FbENT_CNN3g5ly3gTfKmHuJvfwoKEQPBnFj_i4&utm_content=205088688&utm_source=hs_automation (Accessed 8/18/23).

8 Centers for Medicare and Medicaid Services, February 24, 2022.

9 "ACO REACH" Centers for Medicare & Medicaid Services, https://www.cms.gov/priorities/innovation/innovation-models/aco-reach (Accessed 5/27/25).

10 *Ibid*.

11 "Preview of Findings from the Evaluation of ACO REACH Model for Performance Year 2023" Center for Medicare & Medicaid Innovation, May 21, 2025, https://www.cms.gov/priorities/innovation/data-and-reports/2025/aco-reach-preview-py2023-evaluation (Accessed 5/27/25).

12 *Ibid*.

13 Centers for Medicare & Medicaid Services, https://www.cms.gov/priorities/innovation/aco-reach-py2023-financial-and-quality-performance-results-fact-sheet (Accessed 5/27/25).

14 *Ibid*.

15 *Ibid*.

16 "CMS revises ACO REACH benchmark, risk policies" By Bridget Early, Modern Healthcare, May 22, 2025, https://www.modernhealthcare.com/policy/aco-reach-risk-adjustment-cms-2026 (Accessed 5/27/25); "ACO REACH Model Performance Year 2026 Model Update – Quick Reference" Centers for Medicare & Medicaid Services, https://www.cms.gov/aco-reach-model-performance-year-2026-model-update-quick-reference (Accessed 5/27/25).

17 Early, Modern Healthcare, May 22, 2025.

18 *Ibid*.

19 "Downside risk, upside payment highlight new CMS innovation agenda" By Bridget Early, Modern Healthcare, May 13, 2025, https://www.modernhealthcare.com/policy/cmmi-strategy-medicare-advantage-ratings (Accessed 5/27/25).

20 "CMS Innovation Center Strategy to Make America Healthy Again" By Abe Sutton, Centers for Medicare & Medicaid Services, https://www.cms.gov/priorities/innovation/about/cms-innovation-center-strategy-make-america-healthy-again (Accessed 5/27/25).

21 Early, Modern Healthcare, May 13, 2025.

22 Sutton, Centers for Medicare & Medicaid Services.

23 "CMS shift sparks hope for high-needs ACO REACH extension" By Bridget Early, Modern Healthcare, May 22, 2025, https://www.modernhealthcare.com/policy/aco-reach-cms-cmmi-mehmet-oz-abe-sutton (Accessed 5/27/25).

"Big Beautiful Bill" Not so Beautiful for Healthcare

[Excerpted from the article published in June 2025.]

On May 22, 2025, the U.S. House of Representatives moved President Trump's budget proposal forward, sending to the Senate a budget reconciliation bill (with a one-vote margin) – the *One Big Beautiful Bill Act of 2025* – that renews expiring tax cuts and enacts new ones at a cost of almost $4 trillion. These costs would largely be paid for by cuts to other programs, including to federal healthcare programs, which cuts will have significant ramifications for the healthcare industry.[1] This Health Capital Topics article reviews the current status of the budget bill and healthcare industry implications.

The House bill contains a number of provisions negatively affecting insurance coverage, which could result in nearly 11 million Americans expected to lose their health insurance coverage.[2] First, the bill also includes over $1 trillion in federal healthcare program cuts, including upwards of $864 billion in Medicaid cuts.[3] Second, the bill proposes numerous changes to Medicaid, including:

- The introduction of federal work requirements by December 31, 2026, which require Medicaid recipients to work a certain number of hours per month to maintain coverage;
- The implementation of new enrollment/ reenrollment paperwork requirements;
- The establishment of a moratorium on new or increased provider taxes, or even a complete eradication of these taxes, which states levy on healthcare providers as one avenue of financing Medicaid payments back to providers caring for Medicaid recipients; and
- The increase of the cost-sharing requirement for states that expanded Medicaid.[4]

In total, the nonpartisan Congressional Budget Office (CBO) predicts that the House bill and the December 31, 2025 sunset of the enhanced Affordable Care Act (ACA) subsidies[5] will result in 16 million Americans becoming uninsured by 2034.[6] This substantial reduction in insured individuals would have negative reverberating effects throughout the healthcare industry. Increasing the number of uninsured individuals could be financially devastating for some hospitals whose emergency departments would still be legally required to care for these individuals regardless of insurance coverage, as well as other providers who currently provide a large portion of their care to Medicaid enrollees.[7]

On June 16, 2025, the Senate Finance Committee released its draft of the legislation. This Senate version, while largely similar to the House-passed bill, notably includes even greater Medicaid cuts. Namely, the Senate-proposed bill expands the application of work requirements (from just childless adults to also include adults with children over age 14) and further clamps down on Medicaid provider taxes (not just establishing a moratorium on new taxes but by reducing the current tax cap from 6% to 3.5%).[8] Although Senate Republicans reportedly considered some cuts to Medicare (primarily focused on overpayments to Medicare Advantage plans),[9] those cuts were not ultimately included in the draft legislation passed out of committee.

On June 26, 2025, the Senate Parliamentarian found that provisions of the Senate bill, including those limiting state provider taxes (discussed above), are ineligible for the reconciliation process, rendering the future of those provisions uncertain.[10] While the Senate could still include those provisions in the bill, they would require 60 votes, more than the Republicans' majority of 53 votes.[11]

The healthcare industry's response has been widely critical, with hospital trade associations such as the Federation of American Hospitals and the Catholic Health Association opposing the legislation.[12] The American College of Emergency Physicians (ACEP) expressed its deep concern that drastic changes to Medicaid under consideration will disproportionately affect emergency departments:

"Emergency departments are one of the few settings where patients are treated 24/7/365, regardless of their insurance status or ability to pay. The impact of policies that will leave millions of people without any health coverage falls squarely onto emergency physicians and patients. Patients with unmet health care needs will delay treatment and their conditions will worsen, leaving them with no other option than the emergency department. This creates avoidable health risks and threatens the viability of an already strained health care safety net."[13]

America's Essential Hospitals has sent a letter to the Senate sharing their "deep concern with the proposed Medicaid policies from the Senate Finance Committee." The trade group estimates "that both proposed cuts in Medicaid payments and additional costs for uninsured individuals will add $443.4 billion to hospitals' uncompensated care costs from 2025 to 2034," over two-thirds of which costs "come from cuts in payments for benefits provided to eligible Medicaid beneficiaries, which increases hospitals' Medicaid shortfall."[14]

Public opinion on the healthcare cuts is similarly negative, with most respondents to a Kaiser Family Foundation (KFF) survey believing that the bill would "cause people to lose health coverage, negatively affect healthcare providers, and make it harder for their families to get and afford care."[15] Specifically, 54% believe the bill would be bad for them and their families personally, 71% believe it would hurt providers, and 72% believe it would make people uninsured.[16] Another KFF survey found that public disapproval of the bill increases when survey respondents were told that the legislation would decrease funding for local hospitals and would increase the number of uninsured individuals by approximately 10 million.[17] The American Hospital Association (AHA) is highlighting these public concerns, and hoping to parlay public opinion into public pushback against the legislation, through its launch of an ad campaign to "Protect Hospital Care."[18]

Whether legislators can resolve their differences by President Trump's requested July 4th passage deadline is indeterminate,[19] as the House must now vote on the Senate version. However, the Washington Post reports that, "[b]ecause of the power dynamics between the two chambers …the Senate bill is more likely to become law."[20] However, growing public opposition to the healthcare cuts contained in the legislation – particularly when educated about possible health impacts[21] – may derail Republicans' plans.

Health Capital Consultants will continue to closely monitor these developments and will provide in-depth analysis and updates in forthcoming issues of Health Capital Topics.

---

1 "Health Provisions in the 2025 Federal Budget Reconciliation Bill" Kaiser Family Foundation, May 22, 2025, https://www.kff.org/tracking-the-affordable-care-act-provisions-in-the-2025-budget-bill/#:~:text=On%20May%2022%2C%20the%20House,Medicare%20and%20Health%20Savings%20Accounts. (Accessed 6/10/25); "H.R.1 - One Big Beautiful Bill Act" 119th Congress (2025-2026), https://www.congress.gov/bill/119th-congress/house-bill/1/text (Accessed 6/12/25).

2 "Close to 11 million people would lose health insurance under Big Beautiful Bill" By Susan Morse, Healthcare Finance, June 6, 2025, https://www.healthcarefinancenews.com/news/close-11-million-people-would-lose-health-insurance-under-big-beautiful-bill (Accessed 6/11/25).

3 "GOP tax bill will cost health sector $1T: CBO" By Michael McAuliff, Modern Healthcare, June 4, 2025, https://www.modernhealthcare.com/politics-policy/tax-bill-medicaid-cuts-cbo-gop (Accessed 6/11/25).

4 Morse, Healthcare Finance, June 6, 2025; "New CBO estimates show 2025 reconciliation bill would have impacts similar in magnitude to 2017 ACA repeal bills" By Christen Linke Young, Brookings, June 4, 2025, https://www.brookings.edu/articles/new-cbo-estimates-show-2025-reconciliation-bill-would-have-impacts-similar-in-magnitude-to-2017-aca-repeal-bills/ (Accessed 6/11/25).

5 For more information the sunset of the enhanced ACA subsidies, see "2 Fast 2 Furious: HHS Cuts on the Horizon" Health Capital Topics, Vol. 18, Issue 4 (April 2025), https://www.healthcapital.com/hcc/newsletter/04_25/HTML/UPDATES/convert_govt-hc-updates.php (Accessed 6/24/25).

6 "House Budget Bill and Tax Credit Expiration Will Make It Harder to Get and Afford Marketplace Health Plans" By Sara R. Collins and Carson Richards, The Commonwealth Fund, June 5, 2025, https://www.commonwealthfund.org/blog/2025/house-budget-bill-and-tax-credit-expiration-marketplace-affordability#:~:text=Millions%20More%20Uninsured%20and%20Sicker,poorer%20health%2C%20and%20shorter%20lives. (Accessed 6/12/25).

7 Morse, Healthcare Finance, June 6, 2025.

8 "Senate Bill Would Make Deep Cuts to Medicaid, Setting Up Fight With House" By Catie Edmondson, et al., The New York Times, June 16, 2025, https://www.nytimes.com/2025/06/16/us/politics/senate-bill-medicaid-cuts.html (Accessed 6/24/25); "Senate overhauls Trump's tax bill, setting up brawl with the House" By Jacob Bogage, The Washington Post, June 16, 2025, https://www.washingtonpost.com/business/2025/06/16/trump-tax-bill-senate-republicans-child-tax-credit/ (Accessed 6/24/25).

9 "Medicare is a target as Senate GOP faces megabill math issues" By Jordain Carney, Meredith Lee Hill and Robert King, Politico, June 5, 2025, https://www.politico.com/news/2025/06/05/medicare-is-a-target-as-senate-gop-faces-megabill-math-issues-00389537 (Accessed 6/11/25).

10 "Provider tax, other healthcare provisions ruled out of Senate tax bill" By Michael McAuliff, Modern Healthcare, June 26, 2025, https://www.modernhealthcare.com/politics-regulation/mh-tax-bill-medicaid-provider-taxes/ (Accessed 6/27/25).

11 *Ibid*.

12 "GOP Senators mull Medicare cuts in bid to get megabill over the finish line: media report" By Noah Tong and Paige Minemyer, Fierce Healthcare, June 5, 2025, https://www.fiercehealthcare.com/payers/house-gop-advances-budget-megabill-imposing-stricter-medicaid-work-requirements (Accessed 6/11/25).

13 *Ibid*.

14 Letter dated June 23, 2025 from Bruce Siegel, MD, MHP, President and CEO of America's Essential Hospitals, Re: Medicaid Priorities in Budget Reconciliation Negotiations, available at: https://essentialhospitals.org/wp-content/uploads/2025/06/Letter-to-Leadership-on-Budget-Reconciliation-Senate-Text.pdf (Accessed 6/24/25).

15 "Polls and politics look grim for One Big Beautiful Bill" By Michael McAuliff, Modern Healthcare, June 6, 2025, https://www.modernhealthcare.com/politics-policy/medicaid-cuts-one-big-beautiful-bill-act-kff (Accessed 6/11/25).

16 *Ibid*; "KFF Health Tracking Poll: The Public's Views of Funding Reductions to Medicaid" By Audrey Kearney, et al., Kaiser Family Foundation, June 6, 2025, https://www.kff.org/medicaid/poll-finding/kff-health-tracking-poll-the-publics-views-of-funding-reductions-to-medicaid/ (Accessed 6/11/25).

17 Kirzinger, et al., Kaiser Family Foundation, June 17, 2025.

18 "AHA launches ad campaign to push back on potential Medicaid cuts" By Caroline Hudson, Modern Healthcare, June 23, 2025, https://www.modernhealthcare.com/providers/mh-american-hospital-association-ad-tax-bill/ (Accessed 6/24/25).

19 Edmondson, et al., The New York Times, June 16, 2025.

20 "Senate overhauls Trump's tax bill, setting up brawl with the House" By Jacob Bogage, The Washington Post, June 16, 2025, https://www.washingtonpost.com/business/2025/06/16/trump-tax-bill-senate-republicans-child-tax-credit/ (Accessed 6/24/25).

21 "Poll: Public Views "Big Beautiful Bill" Unfavorably by Nearly a 2-1 Margin; Democrats, Independents and Non-MAGA Republicans Oppose It, While MAGA Supporters Favor It; Favorability Erodes When People Hear About Possible Health Impacts" Kaiser Family Foundation, June 17, 2025, https://www.kff.org/affordable-care-act/press-release/poll-public-views-big-beautiful-bill-unfavorably-by-nearly-a-2-1-margin-democrats-independents-and-non-maga-republicans-oppose-it-while-maga-supporters-favor-it-favorability-ero/ (Accessed 6/24/25).

DOJ-HHS FCA Working Group Revived

[Excerpted from the article published in July 2025.]

On July 2, 2025, the Department of Justice (DOJ) and Department of Health & Human Services (HHS) announced during the American Health Law Association (AHLA) Annual Meeting that the agencies have reestablished a Working Group to "strengthen" their ongoing collaboration, specifically as relates to the False Claims Act (FCA).[1] This Health Capital Topics article discusses the Working Group's priorities and the implications for providers.

The FCA was enacted in 1863 in response to defense contractor fraud committed during the Civil War.[2] The FCA prohibits any person from knowingly submitting, or causing to submit, false claims to the federal government.[3] Violators are liable for treble damages, along with a penalty linked to inflation.[4] Not only does the FCA give the U.S. government the ability to pursue fraud, it also enables private citizens to file suit on behalf of the federal government through what is known as a "qui tam" or "whistleblower" suit.[5] FCA enforcement is a powerful governmental tool; in fiscal year 2024 alone, the DOJ obtained nearly $3 billion in settlements and judgments involving fraud and false claims.[6]

The DOJ and HHS have a "long history of partnering" to use the FCA "to combat healthcare fraud."[7] The FCA Working Group was originally established in 2020, but there was little-to-no reporting about its activities over the past few years.[8] The group is being "reinvigorated" in order to "formalize and enhance" the cross-agency collaboration.[9]

The Working Group's goal is to facilitate clearer lines of communication between the two agencies. The group will focus its enforcement on both traditional and less traditional areas of healthcare fraud, including:

- Medicare Advantage;
- Kickbacks;
- Intellectual property (IP);
- Defective medical devices;
- Patient access to care barriers, such as violations of network adequacy requirements;
- Manipulation of electronic health (EHR) systems to drive inappropriate utilization; and
- Pharmacy benefit manager and manufacturer agreements on biosimilars, allegations of fraud in connection with specialty pharmacy agreements with large physician practices, and agreements between medical device manufacturers and physician practices.[10]

Other priorities include enhancing the efficiency of investigations and qui tam dismissals.[11]

The group will be led by HHS General Counsel, Chief Counsel to HHS Office of Inspector General (OIG), and the Deputy Assistant Attorney General of the Commercial Litigation Branch; membership will include "leadership from the HHS Office of General Counsel, the Centers for Medicare & Medicaid Services Center for Program Integrity, the Office of Counsel to…HHS-OIG…and DOJ's Civil Division, with designees representing U.S. Attorneys' Offices."[12]

Notably, the revival of the FCA Working Group comes less than one week after the 2025 National Healthcare Fraud Takedown, in which the DOJ executed the largest healthcare fraud takedown in history, criminally charging 324 defendants (including 96 medical professionals) with over $14.6 billion in alleged fraud schemes.[13]

The announcement of the DOJ-HHS FCA Working Group is in line with the Trump Administration's emphasis on pursuing healthcare fraud and waste.[14] Healthcare legal experts assert that this Working Group "signals a renewed and intensified focus on [FCA] investigations, particularly in sectors where federal healthcare dollars and compliance risk intersect."[15] Experts anticipate that the group will lead to "new priorities and perspectives on various issues that arise in FCA cases, especially those involving HHS programs."[16]

---

1 "DOJ-HHS False Claims Act Working Group" U.S. Department of Health and Human Services, Press Release, July 2, 2025, https://www.hhs.gov/press-room/hhs-doj-false-claims-act-working-group.html (Accessed 7/22/25).

2 "The False Claims Act" U.S. Department of Justice, January 15, 2025, https://www.justice.gov/civil/false-claims-act (Accessed 7/22/25).

3 *Ibid*.

4 *Ibid*.

5 *Ibid*.

6 "False Claims Act Settlements and Judgments Exceed $2.9B in Fiscal Year 2024" U.S. Department of Justice, Press Release, January 15, 2025, https://www.justice.gov/archives/opa/pr/false-claims-act-settlements-and-judgments-exceed-29b-fiscal-year-2024 (Accessed 7/22/25).

7 "DOJ-HHS False Claims Act Working Group" U.S. Department of Health and Human Services, Press Release, July 2, 2025, https://www.hhs.gov/press-room/hhs-doj-false-claims-act-working-group.html (Accessed 7/22/25).

8 "DOJ-HHS False Claims Act Working Group re-established" By Jonah Retzinger, et al., Nixon Peabody, July 22, 2025, https://www.nixonpeabody.com/insights/alerts/2025/07/22/doj-hhs-false-claims-act-working-group-re-established?utm_medium=alert&utm_source=interaction&utm_campaign=healthcare (Accessed 7/23/25).

9 "DOJ and HHS Relaunch False Claims Act Working Group, Sharpen Healthcare Enforcement Priorities" By Melissa Taylormoore, White & Case, July 18, 2025, https://www.whitecase.com/insight-alert/doj-and-hhs-relaunch-false-claims-act-working-group-sharpen-healthcare-enforcement (Accessed 7/22/25).

10 "HHS, DOJ Announce Reinvigoration of FCA Working Group at AHLA Annual Meeting" American Health Law Association July 11, 2025, https://www.americanhealthlaw.org/content-library/health-law-weekly/article/ade43694-12f1-4257-b7c0-33dbc011dc20/HHS-DOJ-Announce-Reinvigoration-of-FCA-Working-Gro?Token=b1a0c32b-8af4-4a0f-a09c-6379c9216c38 (Accessed 7/22/25); "DOJ-HHS False Claims Act Working Group" U.S. Department of Health and Human Services, Press Release, July 2, 2025, https://www.hhs.gov/press-room/hhs-doj-false-claims-act-working-group.html (Accessed 7/22/25).

11 U.S. Department of Health and Human Services, Press Release, July 2, 2025.

12 *Ibid*.

13 "National Health Care Fraud Takedown Results in 324 Defendants Charged in Connection with Over $14.6 Billion in Alleged Fraud" Office of Public Affairs, U.S. Department of Justice, Press Release, June 30, 2025, https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-324-defendants-charged-connection-over-146 (Accessed 7/22/25).

14 "DOJ-HHS Announces False Claims Act Working Group, Emphasizes Healthcare Fraud Enforcement Priorities" By Heath R. Ingram, et al., Goodwin, July 21, 2025, https://www.goodwinlaw.com/en/insights/publications/2025/07/alerts-otherindustries-hltc-doj-hhs-announces-false-claims-act-working (Accessed 7/22/25).

15 "DOJ and HHS Relaunch False Claims Act Working Group, Sharpen Healthcare Enforcement Priorities" By Melissa Taylormoore, White & Case, July 18, 2025, https://www.whitecase.com/insight-alert/doj-and-hhs-relaunch-false-claims-act-working-group-sharpen-healthcare-enforcement (Accessed 7/22/25).

16 Ingram, et al., Goodwin, July 21, 2025.

New HHS-CMS Committee Announced

[Excerpted from the article published in August 2025.]

On August 21, 2025, the U.S. Department for Health & Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) announced the formation of a new Healthcare Advisory Committee.[1] The Committee is expected to be comprised of a group of experts who will make strategic recommendations to HHS Secretary Robert F. Kennedy Jr. and CMS Administrator Dr. Mehmet Oz. This Health Capital Topics article discusses this announcement and potential implications on the healthcare industry.

CMS is currently seeking, and accepting nominations for, "[i]ndividuals with expertise in chronic disease prevention and management, federally administered health care financing, and delivery system reform."[2] Fifteen members are expected to be appointed by Administrator Oz before the end of 2025 and serve two-year terms.[3] The makeup of those members is currently undetermined, although the members must "consist of an appropriate selection of individuals that have practical and tactical experience or expertise working in all aspects of the US healthcare system, which may include experts from the medical field, manufacturing, government, academia, health insurance/payment programs, or health economics."[4]

The Committee is expected to offer recommendations on how to improve the financing and delivery of healthcare in Medicare, Medicaid, and Children's Health Insurance Program (CHIP), as well as in the Health Insurance Marketplace, consistent with President Trump's February 2025 Executive Order on "Establishing the Make American Healthy Again Commission."[5] Specifically, the Committee anticipates:

- "Developing a set of actionable policy initiatives that can promote chronic disease prevention and management, as consistent with the Make America Healthy Again policy agenda;
- Identifying opportunities to move towards a regulatory framework of accountability for safety and outcomes that reduce unnecessary red tape and allow providers to focus on improving patient health outcomes not filling out paperwork;
- Sharing actionable levers to advance a real-time data system, enabling a new standard of excellence in care, rapid claims processing, rapid quality measurement and rewards;
- Identifying structural opportunities to improve quality for the most vulnerable in the Medicaid program (outside of more funding for the current system); and
- Securing the sustainability of the Medicare Advantage program, specifically identifying opportunities to modernize risk adjustment and quality measures that assess and improve health outcomes."[6]

HHS's and CMS's authority for creating the Committee is derived from the Federal Advisory Committee Act (FACA), which establishes guidelines for federal advisory committees. Historically, there have been a number of federal healthcare advisory committees. Some recent examples include:

- The Advisory Committee on Ground Ambulance and Patient Billing (GAPB), which advises on balance billing prevention;[7]
- The Advisory Committee on Air Ambulance Quality and Patient Safety, which provides recommendations on standards for air ambulance services;[8] and
- The Health Information Technology Advisory Committee (HITAC), which recommends health information technology standards.[9]

In the announcement of the Committee's formation, Secretary Kennedy stated that "Every American [deserves] high-quality, affordable care – without red tape, corporate greed, or excessive costs. This new advisory committee will unite the best minds in healthcare to help us deliver real results, hold the system accountable, and drive forward our mission to Make America Healthy Again." Administrator Oz added, "This is a moment for action. This committee will help us cut waste, reduce paperwork, expand preventive care, and modernize CMS programs with real-time data and accountability, all while keeping patients at the center."[10]

---

1 "HHS Drives Reform to Restore Patient-Centered Care, Announces Request for Nominations of Members to Serve on Federal Healthcare Advisory Committee" Centers for Medicare & Medicaid Services, August 21, 2025, https://www.cms.gov/newsroom/press-releases/hhs-drives-reform-restore-patient-centered-care-announces-request-nominations-members-serve-federal (Accessed 8/22/25).

2 *Ibid*.

3 "Request for Nominations of Members To Serve on the Healthcare Advisory Committee: Notice" Federal Register, Vol. 90, No. 161 (August 22, 2025), p. 41089.

4 *Ibid*.

5 "Establishing the President's Make America Healthy Again Commission" Executive Order No. 14212, February 13, 2025, available at: https://www.whitehouse.gov/presidential-actions/2025/02/establishing-the-presidents-make-america-healthy-again-commission/ (Accessed 8/22/25).

6 Federal Register, Vol. 90, No. 161 (August 22, 2025), p. 41089.

7 "Advisory Committee on Ground Ambulance and Patient Billing (GAPB)" Centers for Medicare & Medicaid Services, https://www.cms.gov/medicare/regulations-guidance/advisory-committees/advisory-committee-ground-ambulance-and-patient-billing-gapb#:~:text=A%20Federal%20Register%20Notice%20was,consumers%20on%20August%2028%2C%202024.&text=The%20Committee%20Issued%20its%20Report%20on%20August%2028%2C%202024%20which,on%2011/16/2021. (Accessed 8/22/25).

8 "Advisory Committee on Air Ambulance Quality and Patient Safety" Centers for Medicare & Medicaid Services, https://www.cms.gov/medicare/regulations-guidance/advisory-committees/advisory-committee-air-ambulance-quality-and-patient-safety#:~:text=The%20Committee%20must%20be%20established,Advisory%20Committee%20Act%20(FACA).&text=The%20No%20Surprises%20Act%20(Section,in%20relation%20to%20the%20Committee. (Accessed 8/22/25).

9 "Health Information Technology Advisory Committee (HITAC)" Assistant Secretary for Technology Policy, https://www.healthit.gov/hitac/committees/health-information-technology-advisory-committee-hitac (Accessed 8/22/25).

10 Centers for Medicare & Medicaid Services, August 21, 2025.

Healthcare Policy Disputes Threaten Government Shutdown

[Excerpted from the article published in September 2025.]

With hours to go until the midnight deadline on September 30, 2025 to fund the government, lawmakers appear deadlocked over whether certain healthcare provisions should be included in the temporary funding bill. Should this deadlock continue, the federal government will shut down beginning October 1 and remain shut down until that deadlock is resolved. This Health Capital Topics article provides an update on the developing saga.

Congress passed the most recent temporary funding bill, known as a continuing resolution (CR), on March 14, 2025, funding the government through the remainder of fiscal year 2025, until September 30, 2025.[1] While House Republicans unilaterally passed a stopgap measure extending funding until November 21, it failed in the Senate, where Democrats assert that they will not vote for a spending bill that does not protect healthcare access, including renewing the *Affordable Care Act* (ACA) marketplace enhanced premium tax credits and repealing the *One Big Beautiful Bill Act* (OBBBA) Medicaid provisions.[2] Senate Democrats subsequently proposed an alternative stopgap bill to fund the government through October 31, permanently extend the ACA subsidies, and reverse the OBBBA Medicaid cuts; that bill also failed.[3] Senate Republicans have a narrow majority, but require Democratic backing to meet the 60-vote threshold needed to pass an extension.

The ACA marketplace enhanced premium tax credits, which are provided to lower-income individuals to purchase health insurance on the ACA insurance exchanges, and have been in place since 2021, are currently set to sunset at the end of 2025.[4] The Urban Institute estimates that if the ACA enhanced premium tax credits ultimately expire, 22 million Americans would see increased health insurance costs, and healthcare providers would lose $32.5 billion in revenue and take on an additional $7.7 billion in uncompensated care costs next year.[5] Democrats pushed to include an extension to the tax credits in OBBBA, but were unsuccessful. OBBBA provisions also included over $911 billion in Medicaid cuts and new conditions on eligibility, which are expected to increase the number of uninsured people by 10 million.[6]

In addition to the furlough of thousands of federal workers and significant disruption across the country, the failure to pass any sort of spending bill results in the expiration of several healthcare program and policy extenders,[7] including Medicare telehealth flexibilities, the hospital-at-home waiver, and community health center funding.[8] More than 6.7 million seniors (25% of eligible Medicare beneficiaries) participated in a telehealth visit in 2024, and approximately 31,000 seniors received care in their homes from over 400 hospitals under the hospital-at-home waiver through October 2024.[9] The abrupt discontinuation of these services could meaningfully disrupt senior healthcare.

Other healthcare priorities that would be cut in the event of a government shutdown include:

- Medicaid disproportionate share hospital (DSH) payments, by $8 billion;
- Increased reimbursement for Medicare-dependent hospitals and low-volume hospitals;
- Graduate medical education (GME) funding;
- Ambulance add-on Medicare payments for rural and underserved urban areas; and
- Emergency preparedness programs (the *Pandemic and All-Hazards Preparedness Act of 2006* has already partially lapsed).[10]

As of the time of publication, lawmakers have not reached agreement on a CR, and the federal government faces imminent shutdown. Healthcare organizations should prepare for potential disruptions regardless of whether a shutdown is ultimately averted. The brinkmanship surrounding healthcare provisions in this funding debate underscores the persistent volatility in federal healthcare policy and the vulnerability of temporary program extensions. Health Capital Topics will continue to track this evolving situation and provide updates as events unfold.

---

1 "Healthcare Extenders Tracker (July 2025 Update)" By Rachel Stauffer, et al., McDermott+, July 11, 2025, https://www.mcdermottplus.com/insights/healthcare-extenders-tracker/ (Accessed 9/29/25).

2 "Trump to Meet With Congressional Leaders as Shutdown Looms" By Michael Gold, New York Times, September 29, 2025, https://www.nytimes.com/2025/09/29/us/politics/trump-shutdown-meeting-schumer-jeffries-johnson.html# (Accessed 9/29/25).

3 "Key health programs face cliff as government funding bill falls" By Michael McAuliff, September 19, 2025, https://www.modernhealthcare.com/politics-regulation/telehealth-medicaid-dsh-stopgap-funding-bill/ (Accessed 9/29/25); "Why ACA tax credits for 22 million Americans are at the center of the government shutdown drama" By Aimee Picchi, CBS News, September 30, 2025, https://www.cbsnews.com/news/government-shutdown-affordable-care-act-enhanced-premium-tax-credit/ (Accessed 9/30/25).

4 "Five Things to Know about the Renewal of Extra Affordable Care Act Subsidies in the Inflation Reduction Act" By Cynthia Cox, Kaiser Family Foundation, August 11, 2022, https://www.kff.org/policy-watch/five-things-to-know-about-renewal-of-extra-affordable-care-act-subsidies-in-inflation-reduction-act/#:~:text=Subsidies%20in%20the%E2%80%A6-,Five%20Things%20to%20Know%20about%20the%20Renewal%20of%20Extra%20Affordable,in%20the%20Inflation%20Reduction%20Act&text=As%20part%20of%20the%20Inflation,previously%20priced%20out%20of%20coverage. (Accessed 4/21/25).

5 "Providers face $32.1B in lost 2026 revenue if enhanced ACA subsidies expire" By Dave Muoio, Fierce Healthcare, September 26, 2025, https://www.fiercehealthcare.com/providers/providers-face-321b-lost-2026-revenue-if-aca-enhanced-premiums-expire (Accessed 9/29/25).

6 "Allocating CBO's Estimates of Federal Medicaid Spending Reductions Across the States: Enacted Reconciliation Package" By Rhiannon Euhus, Kaiser Family Foundation, July 23, 2025, https://www.kff.org/medicaid/allocating-cbos-estimates-of-federal-medicaid-spending-reductions-across-the-states-enacted-reconciliation-package/ (Accessed 9/30/25).

7 "Many healthcare programs are extended for specific time periods, as short as one or two years or as long as 10, and are usually attached to a larger piece of must-pass legislation." "Healthcare Extenders Tracker (July 2025 Update)" By Rachel Stauffer, et al., McDermott+, July 11, 2025, https://www.mcdermottplus.com/insights/healthcare-extenders-tracker/ (Accessed 9/29/25).

8 "McDermott+ Check-Up: September 26, 2025" JDSupra, September 29, 2025, https://www.jdsupra.com/legalnews/mcdermott-check-up-september-26-2025-9311052/ (Accessed 9/29/25).

9 "Millions of seniors could lose access to telehealth without deal in Congress" By Lauren Weber and Trisha Thadani, The Washington Post, September 30, 2025, https://www.washingtonpost.com/health/2025/09/30/shutdown-threatens-senior-telehealth/ (Accessed 9/30/25).

10 "Key health programs face cliff as government funding bill falls" By Michael McAuliff, September 19, 2025, https://www.modernhealthcare.com/politics-regulation/telehealth-medicaid-dsh-stopgap-funding-bill/ (Accessed 9/29/25).

Competition Topics

Leadership on the Brink: Healthcare Executives Eyeing the Exits

[Excerpted from the article published in April 2025.]

While the healthcare industry has been dealing with high employee turnover since the start of the COVID-19 pandemic, that turnover was largely among clinical staff. However, a recent survey found that significant healthcare leadership turnover may also be on the horizon. AMN Healthcare subsidiary B.E. Smith found that nearly half of healthcare executives plan to leave their organization in the next year.[1] This Health Capital Topics article reviews the survey and the reasons behind the intended exits.

B.E. Smith's survey, conducted in October and November 2024, garnered responses from 588 healthcare executives, 39% of whom were c-suite/trustees, 11% of whom were senior vice presidents or vice presidents, and 46% of whom were directors/managers.[2] Survey respondents largely worked in health systems and hospitals (73%) or clinics/group practices (10%).[3] The revenue size of these employer organizations were well-distributed. Nearly half of respondents (43%) had worked at their employer organization for over a decade and another 18% had been employed at their organization for over 6 years.[4]

The survey reported that 46% of the 588 surveyed leaders "intend to leave their organization within twelve months."[5] This notable percentage seems even more significant given that, across industries, the turnover rate is 5.45% for top executives and 7.6% for management.[6]

Potential reasons for this desire to exit current employment appear elsewhere within the survey:

- 43% of respondents, largely from smaller organizations, "consider their ability to attract quality leadership candidates to be extremely or very challenging";
- While hospitals' financial outlook has improved since the lows of the COVID-19 pandemic, leaders worry that the lingering financial and operation challenges "are not transitory" and are "resistant to near-term improvement";
- Only 34% of respondents anticipate better organizational health in 2025 compared to the year prior, and 48% anticipate no change. Notably, this response rate was 53% and 24% last year, respectively;[7] and
- Nearly 75% have been offered a job opportunity in the last six months (17% pursued the opportunity).

Further, respondents identified the following forces as those most likely to disrupt healthcare in the next one to two years:

- Financial pressures and constraints (57%);
- Workforce issues (50%);
- Government regulations (34%)
- Advanced technology (21%);
- Changing leadership requirements (15%); and
- Non-traditional competition (13%).[8]

The survey authors noted that "[a]ll of these forces are up noticeably from last year, suggesting greater risk intensity and volatility."[9]

Hospitals have experienced particularly difficult financial and operational challenges since the beginning of the pandemic, and was one of the slowest recovering healthcare subsectors.[10] As recently as November 2024, hospital patient volumes across emergency department and outpatient visits were decreasing.[11] Even while revenues (stemming from these patient volume decreases) were sluggish, expenses remained high.[12] While a January 2025 report found that hospitals' financials generally looked more encouraging, anticipated state and federal regulatory changes may (further) decrease revenues and/or increase costs (e.g., Medicaid cuts).[13]

The survey summarized that "this year's Trends results confirmed an ongoing slow erosion in satisfaction, though levels remain reasonably strong."[14] While 79% reported feeling extremely or somewhat satisfied with their job, that percentage is down from 82% the year prior.[15] For organizations seeking to retain their top leaders, the survey did provide some insight. Among the factors that most influence respondents to remain at their current organization include, perhaps unsurprisingly: organizational culture (44%), colleagues (39%); and compensation (38%).[16]

Ultimately, the B.E. Smith survey paints a concerning picture of a healthcare delivery system bracing for significant potential leadership departures, adding another layer of complexity to an already strained industry grappling with financial pressures, clinical workforce challenges, and regulatory uncertainty.

---

1 "Healthcare Leadership Trends for 20205: Must-Know Leadership Trends Healthcare Decision Makers Can't Ignore" B.E. Smith Leadership Solutions, 2025, available at: https://online.flippingbook.com/view/825932016/25/ (Accessed 4/16/25).
2 *Ibid*.
3 *Ibid*.
4 *Ibid*.
5 *Ibid*.
6 *Ibid*.
7 *Ibid*.
8 *Ibid*.
9 *Ibid*.
10 "Healthcare M&A activity signals shaky financial recovery" By Jacqueline LaPointe, TechTarget, January 14, 2025, https://www.techtarget.com/revcyclemanagement/news/366617976/Healthcare-MA-activity-signals-shaky-financial-recovery (Accessed 3/24/25).
11 *Ibid*; "National Hospital Flash Report: November 2024 Data" Kaufman Hall, January 9, 2025, https://www.Kaufman Hall.com/insights/research-report/national-hospital-flash-report-november-2024-data
12 LaPointe, TechTarget, January 14, 2025; Kaufman Hall, January 9, 2025.
13 "5 Key Facts About Medicaid and Hospitals" By Scott Hulver, et al., Kaiser Family Foundation, March 5, 2025, https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-and-hospitals/ (Accessed 4/16/25).
14 "Healthcare Leadership Trends for 20205: Must-Know Leadership Trends Healthcare Decision Makers Can't Ignore" B.E. Smith Leadership Solutions, 2025, available at: https://online.flippingbook.com/view/825932016/25/ (Accessed 4/16/25), p. 11.
15 *Ibid*.
16 *Ibid*, p. 14.

Oregon Bans Corporate Control of Physicians

[Excerpted from the article published in June 2025.]

On June 9, 2025, Oregon's governor signed into law the country's strictest corporate practice of medicine (CPOM) prohibition. Senate Bill (SB) 951 will severely curtail the involvement of private equity firms and other corporations in the state's medical practices. This Health Capital Topics reviews the bill and discusses the implications on the healthcare industry.

CPOM laws prohibit corporations or other non-physician entities from practicing medicine or employing physicians.[1] The doctrine was developed in the 19th century to preserve medical decision autonomy by prohibiting the "commercialization or exploitation"[2] of medical professionals, under the reasoning that "the practice of medicine requires something more than the financial ability to hire competent persons to do the actual work."[3] Today, state laws and regulations, as well as case law and medical licensing board regulations, have further established CPOM prohibitions.[4] While approximately 33 states have some form of CPOM regulation in place, they vary significantly in what is regulated.[5] Nevertheless, the majority of states have adopted all or some of the following measures in the four key areas addressed by the doctrine:

(1) Prohibiting business entities from employing physicians to provide medical care;
(2) Requiring that licensed medical doctors own and operate facilities providing medical services;
(3) Not allowing professional fee splitting between licensed practitioners and non-licensed individuals or entities; and,
(4) Mandating that management service agreements (MSAs) adhere to fair market value (FMV) standards.[6]

In particular, MSAs and management service organizations (MSOs) have received increased scrutiny in recent years. MSAs allow outside companies (e.g., private equity, health insurers) to manage "friendly" or "captive" medical practices or groups.[7] Fees for these management services must be consistent with FMV, and state laws and regulations establish certain standards for decisions that must be made by a licensed physician and how much revenue an MSO may receive from the practice.[8]

CPOM exceptions also differ by state. All states have exceptions for professional corporations, which are designed and created specifically to render a professional service, but states may specify the ownership structure for these organizations.[9] Many states also allow for physicians to be employed by certain entities, including hospitals (especially nonprofit hospitals), while others allow for restricted non-physician ownership.[10]

Although Oregon has historically prohibited CPOM, SB 951 ups the ante by significantly restricting the interaction between MSOs and professional medical corporations.[11] Specifically, the law explicitly prohibits MSOs and their owners, directors, officers, and employees from:

- Owning a majority interest in a medical practice they manage;
- Serving as a director, officer, employee or independent contractor to the medical practice they manage (with some exceptions);
- Exercising proxy voting rights;
- Controlling share transfers (e.g., through continuity planning arrangements setting forth the terms of succession or restricting the transfer of stocks); or
- Otherwise exercising de facto control or ultimate decision-making authority over key aspects of the medical practice's business or clinical operations.[12]

Other expressly MSO-prohibited activities include:

- Negotiating or executing payor agreements on behalf of the medical practice;
- Setting the prices, rates, or amounts charged for medical services;
- Making hiring and termination decisions;
- Setting staffing levels or clinical schedules;
- Making diagnostic coding decisions;
- Setting clinical standards or policies;
- Setting policies for patient, client, or customer billing and collection;
- Advertising under the MSO's name; and
- Issuing or managing medical practice equity or dividends.[13]

These prohibitions do not apply in limited circumstances, e.g., if the MSO is owned by a professional medical entity, or if a licensed physician serves – without pay – as a director of officer of the MSO.[14]

Perhaps most notably, SB 951 prohibits non-licensees (e.g., MSOs) from using contractual or financial arrangements to exert indirect control over medical practice decision making or operations.[15]

Other provisions in SB 951 include:

- An increase to the number of practice voting shares and board seats that medical professionals must hold;
- The eradication of most restrictive covenants (e.g., noncompete agreements); and
- The establishment of a private right of action, which will allow medical professionals and their entities to bring civil suit to enforce the law's ownership and control restrictions (rather than just state regulators);

Interestingly, despite the above added restrictions, SB 951 does not change or increase the current law's requirement that 51% of a medical clinic be owned by licensed medical providers (a comparatively moderate threshold).[16]

The law will be phased in over the next few years. New entities must comply starting January 1, 2026, and preexisting entities must come into compliance by January 1, 2029.[17]

As noted by one legal analysis, the Oregon law's "unprecedented and comprehensive approach to the CPOM is sure to reshape compliance strategy and investment risk profiles across the healthcare sector."[18] Whether the Oregon law will be a one-off or a harbinger of a new, emboldened wave of MSO regulatory scrutiny remains to be seen. Considering that a number of states have recently considered legislation to increase transparency and control costs, particularly where private equity is involved, in the healthcare industry,[19] healthcare industry stakeholders would be well-served to monitor the legislative efforts of other states to regulate CPOM.

---

1 "The Corporate Practice of Medicine 50-State Guide" Permit Health, April 29, 2025, https://www.permithealth.com/post/the-corporate-practice-of-medicine-50-state-guide (Accessed 6/24/25).
2 See, e.g., United States v. American Medical Ass'n, 110, F.2d 703 (D.C. Cir. 1940) (citing People v. United Medical Service, 200 N.E. 157, 163 (Ill. 1936)).
3 *Ibid*.
4 "3 Steps to Navigate Through the Corporate Practice of Medicine" By Jennifer Brunkow, Becker's Hospital Review, March 26, 2012, https://www.beckershospitalreview.com/legal-regulatory-issues/3-steps-to-navigate-through-the-corporate-practice-of-medicine/ (Accessed 6/24/25).
5 "The Corporate Practice of Medicine 50-State Guide" Permit Health, April 29, 2025, https://www.permithealth.com/post/the-corporate-practice-of-medicine-50-state-guide (Accessed 6/24/25).
6 Brunkow, Becker's Hospital Review, March 26, 2012.
7 "Understanding the Corporate Practice of Medicine Doctrine and the Role of the Management Services Organization" Leech Tishman, June 6, 2011, https://www.leechtishman.com/insights/blog/understanding-the-corporate-practice-of-medicine-doctrine-and-the-role-of-the-management-services-organization/ (Accessed 6/24/25).
8 *Ibid*.
9 Permit Health, April 29, 2025.
10 *Ibid*.
11 "Oregon Rewrites the Rules on MSOs—And the Risk Calculus for Investors" By Danika Rothwell, Michael Montgomery, and Kate Sullivan Morgan, Dentons On Call, June 13, 2025, https://www.dentonshealthlaw.com/oregon-rewrites-the-rules-on-msos-and-the-risk-calculus-for-investors/?utm_medium=email (Accessed 6/24/25).
12 SB 951 A: Staff Measure Summary" 83rd Oregon Legislative Assembly – 2025 Regular Session, available at: https://olis.oregonlegislature.gov/liz/2025R1/Downloads/MeasureAnalysisDocument/89020 (Accessed 6/24/25).
13 "Senate Bill 951" 83rd Oregon Legislative Assembly – 2025 Regular Session, available at: https://olis.oregonlegislature.gov/liz/2025R1/Downloads/MeasureDocument/SB951 (Accessed 6/24/25).
14 Rothwell, Michael Montgomery, and Kate Sullivan Morgan, Dentons On Call, June 13, 2025.
15 *Ibid*.
16 "SB 591 Frequently Asked Questions" From the Desk of Senator Deb Patterson, available at: https://olis.oregonlegislature.gov/liz/2025R1/Downloads/FloorLetter/4296 (Accessed 6/24/25).
17 Rothwell, Michael Montgomery, and Kate Sullivan Morgan, Dentons On Call, June 13, 2025.
18 *Ibid*.
19 For more information, see "California Passes Bill Regulating Private Equity Deals" Health Capital Topics, Vol. 17, Issue 9 (September 2024), https://www.healthcapital.com/hcc/newsletter/09_24/HTML/PE/convert_ca-passes-bill-regulating-pe-deals.php (Accessed 6/24/25).

Take A Break To Learn More About HCC!

Health Capital Consultants (HCC) is a nationally recognized healthcare economic and financial consulting firm specializing in the valuation of healthcare enterprises, assets, and services. For over 30 years, HCC has provided its clients with the following professional services:

Valuation of Healthcare Businesses

- Hospitals and Health Systems
- Physician Medical Practices
- Service Lines of Hospitals and Practices
- Ambulatory Surgical Centers (ASCs)
- Diagnostic Imaging Centers
- Managed Care Organizations
- Long-Term Care Providers
- Accountable Care Organizations (ACOs)
- Home Healthcare and Hospice Providers
- Radiation Oncology Centers
- Rehabilitation Centers
- Other Healthcare Enterprises

Valuation of Healthcare Business Assets

- Tangible Personal Property (i.e., furniture, fixtures and equipment)
- Trained and Assembled Workforce
- Custodial Rights of Medical Charts and Records
- Noncompete Covenants
- Certificates of Need
- Managed Care and Provider Service Agreements
- Lease Agreements
- Intellectual Property
- Accountable Care Organization Participation
- Branding Rights
- Other Healthcare Tangible and Intangible Assets

Valuation of Healthcare Services

- Professional Physician Services
- Service Line Co-Management Services
- Management Services
- Medical Directorship Services
- Physician On-Call Coverage Services
- Advanced Practice Clinician (APC) Services
- Physician Administrative, Executive, and Management Services
- POD Compensation Models
- Value-Based Payment Compensation
- Income Guarantee Arrangement Models
- Other Healthcare Services

The HCC team of qualified, experienced and certified healthcare valuation professionals with: specific healthcare industry focus; in-depth understanding of, and extensive experience with, the healthcare market on a local, regional, and national basis; and, strong dedication to in-depth research and analysis, sets us apart from otherwise qualified "*generalists*" in the valuation profession.

HCC
HEALTH CAPITAL CONSULTANTS

WEB: www.healthcapital.com ♦ **PHONE:** (800) FYI-VALU [394-8258] ♦ **E-MAIL:** solutions@healthcapital.com

Hospital Acquisitions of Physician Practices Increase Prices

[Excerpted from the article published in August 2025.]

A recent study of hospital physician acquisition and employment found that such acquisitions decrease competition and raise prices. A National Bureau of Economic Research (NBER) working paper, released in July 2025, "empirically analyze[d] the effects of mergers between complementary firms on competition and pricing," and found hospital prices increased by an average of 3.3%, while physician prices increased by an average of 15.1%.[1] This Health Capital Topics article reviews the study's findings and implications for the healthcare industry.

In response to the advent and emergence of accountable care and value-based reimbursement (VBR) models, which rely on achieving better outcomes at lower cost, hospitals have increasingly sought closer relationships with physicians, including direct employment, contracting, co-management, and joint ventures. The American Medical Association (AMA) found that the proportion of physicians who practiced in an independent practice decreased significantly between 2012 and 2024, from 60% to 45.2% (a decrease of approximately 80,000 physicians).[2] The AMA cites "inadequate payment rates, costly resources, and burdensome regulatory and administrative requirements [as] longstanding and important drivers of this change."[3]

The NBER study reviewed a sample of 276 "physician integration events" (hospital physician practice acquisitions) and 66 "hospital integration events" (one-year periods during which the share of physicians practicing at a hospital increased sharply) between 2008 and 2016.[4] The study's goal was "to analyze whether mergers of hospitals and physician practices lead to price increases and whether any observed price increases are a function of a lessening of competition."[5]

An examination of obstetrician and gynecologist (OB-GYN) claims from a large insurer indicated hospital/OB-GYN mergers increase both hospital and physician prices – average hospital price increased 3.3% (or $475) and average physician price increased 15.1% (or $502) for labor and delivery services provided two years after an integration event.[6] The researchers also found price increases of 9% for physician services provided by already-integrated physicians after the hospital acquired additional physicians in the same specialty.[7] These price increases were even larger in certain situations, such as when a hospital had more power than the local insurance network.[8]

The study then "show[s] that the price increases we observe are a function of a lessening of competition and are unlikely to be caused by alternative theories consistent with consumer benefit."[9] For example, the study found no evidence that quality measures changed post-integration or were better among the higher-priced services, indicating that the price increases may instead be due to decreased competition post-integration/acquisition.[10]

The NBER study authors concluded that:

> "Taken together, our results support three anticompetitive effects of physician–hospital mergers. We find evidence that physician–hospital mergers often increase prices and, when they do, they do so in ways consistent with: (1) greater foreclosure of rivals, (2) improving negotiating parties' outside options through recapture, and (3) increasing concentration in physician markets."[11]

The NBER study is not the first to find a linkage between physician practice acquisitions and higher prices. A January 2025 JAMA Health Forum study reviewed prices for services provided by 198,097 primary care physicians (PCPs) in 2022, and found that negotiated prices for office visits of hospital-affiliated PCPs were 11% higher, and office visits of private equity-affiliated PCPs were 8% higher, than those of independent PCPs.[12]

Corresponding with the growing trends toward VBR and care coordination discussed above, there has been increased federal, state, and local regulatory oversight regarding the legal permissibility of these arrangements, under both fraud and abuse laws and antitrust laws. Notably, however, nearly every practice/integration reviewed by the researchers did not meet the threshold for mandatory antitrust reporting and investigation. Consequently, the issues identified in the NBER study relating to competition may "pose a challenge for antitrust enforcement agencies," as these agencies typically review large, horizontal mergers among two competitors in the same market.[13] However, as the authors point out, their "estimates suggest the scale of consumer harm generated by these transactions in aggregate is similar in magnitude to that of horizontal hospital mergers, which have been of great interest to regulators."[14]

---

1 "Are Hospital Acquisitions of Physician Practices Anticompetitive?" By Zack Cooper, et al., National Bureau of Economic Research, Working Paper 34039 (July 2025), https://www.nber.org/papers/w34039 (Accessed 8/19/25).

2 "Physician Practice Characteristics in 2024: Private Practices Account for Less Than Half of Physicians in Most Specialties" By Carol K. Kane, PhD, American Medical Association, Policy Research Perspectives, 2025, available at: https://www.ama-assn.org/system/files/2024-prp-pp-characteristics.pdf (Accessed 8/19/25).

3 *Ibid*.

4 "Hospitals' physician practice acquisitions reduce competition, raise prices, analysis finds" By Dave Muoio, Fierce Healthcare, July 21, 2025, https://www.fiercehealthcare.com/providers/hospitals-physician-practice-acquisitions-reduce-competition-raise-prices-analysis-finds (Accessed 8/19/25).

5 "Are Hospital Acquisitions of Physician Practices Anticompetitive?" By Zack Cooper, et al., National Bureau of Economic Research, Working Paper 34039 (July 2025), https://www.nber.org/papers/w34039 (Accessed 8/19/25).

6 *Ibid*.

7 Muoio, Fierce Healthcare, July 21, 2025.

8 *Ibid*.

9 Cooper, et al., National Bureau of Economic Research, Working Paper 34039 (July 2025).

10 Muoio, Fierce Healthcare, July 21, 2025.

11 Cooper, et al., National Bureau of Economic Research, Working Paper 34039 (July 2025).

12 "Growth of Private Equity and Hospital Consolidation in Primary Care and Price Implications" By Yashaswini Singh, PhD, MPA, Nandita Radhakrishnan, BA, Loren Adler, MS, et al., JAMA Health Forum, Vol. 6, No. 1 (2025), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2829224 (Accessed 8/19/25).

13 Muoio, Fierce Healthcare, July 21, 2025.

14 Cooper, et al., National Bureau of Economic Research, Working Paper 34039 (July 2025).

FTC Walks Away From Noncompete Ban

[Excerpted from the article published in September 2025.]

On September 5, 2025, the Federal Trade Commission (FTC) voted to dismiss its appeals in two court cases, effectively terminating the Biden Administration's pursuit of a comprehensive noncompete ban.[1] The 3-1 Commission vote[2] represents a fundamental shift in federal competition enforcement strategy. This Health Capital Topics article reviews the history of the noncompete ban, the FTC's recent activities regarding competition, and the implications for healthcare organizations.

Noncompete Background

Noncompete agreements are defined as "employment provisions that ban workers at one company from going to work for, or starting, a competing business within a certain period of time after leaving a job."[3] Approximately 30 million Americans are bound by noncompete clauses, which restrict them from pursuing other employment opportunities.[4] Further, workers in states where noncompete enforcement is easier typically experience lower wages.[5] Specific to healthcare, the FTC previously reported that noncompetes increase healthcare costs and a noncompete ban would result in upwards of $194 billion in reduced healthcare spending over a ten-year period.[6]

The presence, or absence, of noncompete agreements can impact the value of a business by:

(1) Restricting the ability of owners or workers to leave and start a competing business or work for a competitor;
(2) Impeding a potential buyer's ability to employ key personnel or enter specific markets; and/or,
(3) Providing the business a competitive advantage.

If a noncompete agreement is too restrictive, it could also lower the value of a business by limiting its ability to retain and attract new employees, and by reducing the business's ability to develop and expand.[7] It is important to note that the FTC's ban does not apply to noncompetes entered into by a person pursuant to a bona fide sale of a business entity, of the person's ownership interest in a business entity, or of all or substantially all of a business entity's operating assets.

Under the FTC's now-defunct final rule, finalized in April 2024, existing noncompetes for the majority of workers would have been unenforceable beginning September 4, 2024.[8] Notably, noncompetes for senior executives would have remained in force, but employers could not have entered into, or attempted to enforce, any new noncompetes, even for senior executives.[9] The rule also did not apply to non-profit entities, as the FTC acknowledged that it has no jurisdiction over these entities.[10]

Lawsuits Challenging Noncompete Ban

A number of lawsuits challenging the noncompete ban were filed subsequent to the issuance of the FTC's final rule. Most notably, a tax company, the U.S. Chamber of Commerce, Business Roundtable, Texas Association of Business, and Longview Chamber of Commerce filed a lawsuit in the U.S. District Court for the Northern District of Texas to block the FTC from implementing the ban.[11] On July 3, 2024, the court granted a limited preliminary injunction in the case, staying the FTC's ban only for the plaintiffs involved in the case (i.e., the ruling did not extend to other businesses in the U.S.).[12] In that decision, the court stated that the FTC "lacked substantive rule-making authority with respect to unfair methods of competition" and noted that "the plaintiffs were likely to succeed on the merits of their challenge."[13]

In its August 20, 2024 ruling on the plaintiffs' motion for summary judgment, the court struck down the FTC ban in its entirety, and applied its ruling nationwide, finding that the FTC exceeded its statutory authority in promulgating its final rule banning noncompetes.[14] The court also found the rule to be arbitrary and capricious, stating that the FTC's ban is "unreasonably overbroad without a reasonable explanation."[15] The court added that "[t]he Rule imposes a one-size-fits-all approach with no end date, which fails to establish a 'rational connection between the facts found and the choice made.'"[16]

Other FTC Actions Regarding Competition

The FTC's abandonment of the noncompete ban coincided with launch of a multi-pronged enforcement strategy targeting noncompete practices.

On September 4, 2025, the FTC issued a comprehensive Request for Information (RFI) seeking public comment on the "scope, prevalence, and effects of employer noncompete agreements," with a 60-day comment period ending November 3, 2025.[17] The RFI requests identification of employers using noncompete agreements (i.e., tips for potential enforcement actions). Specific to healthcare, the FTC seeks comment on whether:

- "any noncompete agreements covering workers in the healthcare sector [have] affected wages, labor mobility, or the availability, quality, or cost of healthcare services in particular";
- "any noncompete agreements [have] made it more difficult for providers of healthcare services to hire physicians, nurses, or other professionals"; and
- "the provision of or the competition within any specific healthcare service in a geographic area [has] been substantially affected by noncompete agreements."[18]

On September 10th, FTC Chairman Andrew Ferguson issued warning letters to major healthcare employers and staffing companies, specifically requesting review of non-compete agreements that may "unreasonably limit employment

options for vital roles like nurses, physicians, and other medical professionals," nothing that "[n]oncompetes may have particularly harmful effects in healthcare markets where they can restrict patients' choices of who provides their medical care—including, critically, in rural areas where medical services are already stretched thin."[19] These letters emphasize the FTC's particular scrutiny of healthcare industry noncompetes, given their potential impact on essential services and worker mobility.

On September 17th, the FTC announced it would host a hybrid workshop on October 8th titled "Moving Forward: Protecting Workers from Anticompetitive Noncompete Agreements."[20] The workshop will include "public statements from FTC Commissioners, victims of unfair and anticompetitive noncompete agreements, and leading experts in the field."[21]

Healthcare Sector Implications

Healthcare organizations now operate within a bifurcated regulatory framework. The comprehensive federal ban is eliminated, but targeted FTC enforcement actions against healthcare employers create ongoing compliance obligations and strategic considerations.

Further, the elimination of the federal noncompete ban perpetuates the complex state law landscape governing noncompetes. In 2025 alone, numerous states (Arkansas, Colorado, Illinois, Indiana, Montana, Oregon, Texas, and Utah) passed new legislation banning or limiting noncompetes and other restrictive covenants in healthcare provider employment agreements.[22]

Conclusion

Recent FTC actions suggest that, although the agency has retreated from comprehensive noncompete regulation, it is moving to a more targeted approach in assessing an employment agreement's potential benefits and harm. The shift from categorical rules to targeted enforcement creates a more nuanced compliance environment where case-specific factors may determine enforcement exposure.

The FTC's coordinated approach of abandoning broad rulemaking while launching targeted enforcement actions, warning letters, and information gathering initiatives creates a complex regulatory environment. Healthcare organizations would be well-served to keep abreast of developments and review employment contracts in order to navigate this evolving landscape.

---

1 "FTC to walk away from noncompete ban and legal fight" By Alex Kacik, Modern Healthcare, September 8, 2025, https://www.modernhealthcare.com/providers/mh-ftc-noncompete-ban-lawsuits-dropped/ (Accessed 9/18/25).
2 "Federal Trade Commission Files to Accede to Vacatur of Non-Compete Clause Rule" Federal Trade Commission, September 5, 2025, https://www.ftc.gov/news-events/news/press-releases/2025/09/federal-trade-commission-files-accede-vacatur-non-compete-clause-rule (Accessed 9/18/25).
3 "Noncompete Agreements" By Alexander Colvin and Heidi Shierholz, Economic Policy Institute, December 10, 2019, https://www.epi.org/publication/noncompete-agreements/ (Accessed 9/18/25).
4 "FTC Announces Rule Banning Noncompetes" Federal Trade Commission, April 23, 2024, https://www.ftc.gov/news-events/news/press-releases/2024/04/ftc-announces-rule-banning-noncompetes (Accessed 9/18/25).
5 "Noncompetes in the U.S. Labor Force" By Evan Starr, J.J. Prescott, and Norman Bishara, Journal of Law and Economics, Revised April 5, 2023, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2625714 (Accessed 9/18/25).
6 "Noncompete Rule" Federal Trade Commission, https://www.ftc.gov/legal-library/browse/rules/noncompete-rule (Accessed 9/18/25).
7 "FTC's Proposed Ban on Non-Compete Agreements - Impact on Business Valuation" By Achille Ekeu, The Washington Valuation Group, March 20, 2023, https://www.washingtonvaluation.com/post/ftc-s-proposed-ban-on-non-compete-agreements-impact-on-business-valuation (Accessed 9/18/25).
8 Federal Trade Commission, April 23, 2024.
9 *Ibid*.
10 "16 CFR Part 910" Federal Trade Commission, April 23, 2024, https://www.ftc.gov/system/files/ftc_gov/pdf/noncompete-rule.pdf (Accessed 9/18/25).
11 "Ryan LLC et al. v. FTC" No. 3:24-CV-00986-E, Memorandum Opinion & Order (N.D. Tex., July 3, 2024).
12 *Ibid*, p. 10, 32.
13 *Ibid*.
14 "Ryan LLC et al. v. FTC" No. 3:24-CV-00986-E, Memorandum Opinion & Order (N.D. Tex., August 20, 2024).
15 *Ibid*, p. 23-24.
16 *Ibid*, p. 24.
17 "Request for Information Regarding Employer Noncompete Agreements" The Federal Trade Commission, https://www.ftc.gov/system/files/ftc_gov/pdf/2025-Noncompete-RFI.pdf (Accessed 9/18/25).
18 *Ibid*.
19 "FTC Chairman Ferguson Issues Noncompete Warning Letters to Healthcare Employers and Staffing Companies" Federal Trade Commission, September 10, 2025, https://www.ftc.gov/news-events/news/press-releases/2025/09/ftc-chairman-ferguson-issues-noncompete-warning-letters-healthcare-employers-staffing-companies (Accessed 9/18/25); Letter from FTC Chairman Andrew N. Ferguson, available at: https://www.ftc.gov/system/files/ftc_gov/pdf/noncompete-warning-letter-template.pdf (Accessed 9/18/25).
20 "FTC Announces Workshop on Noncompete Agreements" The Federal Trade Commission, September 17, 2025, https://www.ftc.gov/news-events/news/press-releases/2025/09/ftc-announces-workshop-noncompete-agreements (Accessed 9/18/25).
21 *Ibid*.
22 "FTC Drops Noncompete Ban, Signals Ongoing Enforcement" By Roy Maurer, SHRM, September 17, 2025, https://www.shrm.org/topics-tools/news/talent-acquisition/ftc-drops-noncompete-ban-signals-ongoing-enforcement (Accessed 9/18/25).

GAO Report: Rising Physician Consolidation Increases Prices

[Excerpted from the article published in September 2025.]

On September 22, 2025, the Government Accountability Office (GAO) released a report estimating "the Extent and Effects of Physician Consolidation."[1] The GAO, the non-partisan audit, evaluation, and investigative arm of Congress, undertook the analysis of physician consolidation in response to lawmakers' request.[2] This Health Capital Topics article reviews the GAO report and stakeholder reactions.

As discussed in a recent Health Capital Topics issue,[3] physician consolidation has increased over the past couple of decades. The proportion of physicians practicing independently decreased significantly between 2012 and 2024, from 60% to 42%, as a result of "inadequate payment rates, costly resources, and burdensome regulatory and administrative requirements."[4] On the other hand, hospitals have increasingly sought closer relationships with physicians, including direct employment, contracting, co-management, and joint ventures, in response to emerging accountable care and value-based reimbursement models that require providers to coordinate care and achieve better outcomes at lower cost. While proponents argue that consolidation leads to operational efficiency, efficiencies of scale, and greater leverage in health insurer negotiations, opponents assert that consolidation in healthcare has resulted in increased prices, with no increase in the quality of care.[5]

In response to the 2022 directive from the U.S. House of Representatives Committee on Appropriations that the GAO "study the extent health care consolidation is taking place across Medicare and Medicaid, and how the involvement of private equity in healthcare could be contributing to consolidation,"[6] the agency conducted a literature review of 100 peer-reviewed studies and reports published between 2021 and July 2025; interviewed officials in the U.S. Department of Health and Human Services (HHS); and consulted with 14 stakeholders, including groups representing physicians, hospitals, health insurers, private equity firms, and retail companies.[7] The report "describes what available research indicates about (1) the extent of physician consolidation, including practice ownership by hospital systems, corporate entities, or private equity firms; and (2) the effects of these types of physician consolidation on health care spending and prices, quality of care, and access."[8]

The GAO report confirmed the increasing consolidation of physicians, noting that "at least 47 percent of physicians were employed by or affiliated with hospital systems in 2024, up from less than 30 percent in 2012," and approximately 6.5% of physician practices are owned or invested in by private equity firms.[9]

Some of the findings in the GAO-analyzed studies include:

- Increased Medicare spending when physicians were consolidated in a hospital system, by virtue of providing services in more expensive hospital-based settings.
- Higher Medicare spending when physicians were consolidated in a hospital system, by virtue of providing more services in hospital-based settings, including one analysis that found total spending per Medicare patient increased by 5% for select elective surgeries from 2010 to 2015, in part due to replacing doctor's office visits with pricier hospital outpatient visits.
- Mixed findings on the effect of hospital-physician consolidation on commercial insurance spending, with one finding decreased per-patient spending (even with office visit prices increasing 17%), and another finding a 6% increase in per-patient spending in Massachusetts post-consolidation.
- No change to, or decreases in, the quality of care provided after a hospital-physician consolidation.[10]

The GAO noted that, due to the dearth of data available, "the effects of physician consolidation with health insurers, other corporate entities, or private equity firms on spending, prices, and quality were less clear or unknown," as was "the effects of physician consolidation with any entity type on access to care."[11]

Physician stakeholders interviewed by the GAO argued alternative reasons for cost increases, including:

- Post-acquisition spending could rise due to increased utilization and access to care: "Hospitals may expect primary care physicians to see more patients in shorter duration appointments, which could increase patient referrals for additional diagnostic testing or visits with specialists."
- Hospital acquirers sometimes incur costs to improve the financial stability of purchased practices.[12]

The GAO found gaps where additional research would be helpful, including "the effects of consolidation by hospital systems on patient access to care; consolidation by insurers or other corporate entities on spending, prices, quality, or access; and private equity investment on quality and access."[13]

A number of physician stakeholder groups lauded the GAO's work, with the American College of Emergency Physicians (ACEP) noting it was:

> "pleased that federal policymakers and expert healthcare economics researchers continue to analyze the effects of various business practices across health care. The ongoing efforts to increase transparency related to consolidation of healthcare entities and the role of private equity are critical to identifying future strategies for improvements to the healthcare delivery system."[14]

The Community Oncology Alliance (COA) added that the report:

> "reinforces what the …COA…has been saying for years: as physicians are bought out or forced to close their practices by hospital systems or insurers, patients suffer from higher costs, reduced care access, and often lower quality of care…. This GAO report should serve as a wake-up call for Congress and CMS to take action and shift the balance in health care back toward greater patient satisfaction at lower costs."[15]

While physician practice acquisitions – and the concerns surrounding it – are not new, the GAO report "appears to be among the most comprehensive seeking to answer the extent and effects of physician consolidation on areas like spending, pricing, care quality and access."[16] Importantly, the GAO report identifies significant gaps in available data, particularly regarding consolidation involving health insurers, corporate entities, and private equity firms. These informational gaps impede policymakers' ability to craft evidence-based regulations and highlight the need for improved data collection and transparency requirements. The GAO's findings underscore the urgency for federal and state regulators to develop more robust oversight mechanisms while balancing the potential efficiency gains of consolidation against cost increases.

---

1 "HEALTH CARE CONSOLIDATION: Published Estimates of the Extent and Effects of Physician Consolidation" U.S. Government Accountability Office, GAO-25-107450, September 22, 2025, https://files.gao.gov/reports/GAO-25-107450/index.html (Accessed 9/29/25).

2 *Ibid*; "About" U.S. Government Accountability Office, https://www.gao.gov/about (Accessed 9/29/25); "Provider consolidation is rising, fueling higher prices, GAO study confirms" By Dave Muoio, Fierce Healthcare, September 24, 2025, https://www.fiercehealthcare.com/providers/provider-consolidation-rising-fuels-higher-prices-government-accountability-office-study (Accessed 9/29/25); "H. Rept. 117-403 - Departments of Labor, Health And Human Services, and Education, and Related Agencies Appropriations Bill, 2023" U.S. House of Representatives Committee on Appropriations, July 5, 2022, available at: https://www.congress.gov/committee-report/117th-congress/house-report/403/1 (Accessed 9/29/25).

3 "Hospital Acquisitions of Physician Practices Increase Prices" Health Capital Topics, Vol. 18, Issue 8 (August 2025), https://www.healthcapital.com/hcc/newsletter/08_25/HTML/HPA/convert_hosp-phys-practice-acquisition-study.php (Accessed 9/29/25).

4 "Provider consolidation is rising, fueling higher prices, GAO study confirms" By Dave Muoio, Fierce Healthcare, September 24, 2025, https://www.fiercehealthcare.com/providers/provider-consolidation-rising-fuels-higher-prices-government-accountability-office-study (Accessed 9/29/25); "Physician Practice Characteristics in 2024: Private Practices Account for Less Than Half of Physicians in Most Specialties" By Carol K. Kane, PhD, American Medical Association, Policy Research Perspectives, 2025, available at: https://www.ama-assn.org/system/files/2024-prp-pp-characteristics.pdf (Accessed 8/19/25).

5 "Ten Things to Know About Consolidation in Health Care Provider Markets" By Zachary Levinson, et al., Kaiser Family Foundation, April 19, 2024, https://www.kff.org/health-costs/ten-things-to-know-about-consolidation-in-health-care-provider-markets/ (Accessed 9/29/25).

6 "H. Rept. 117-403 - Departments of Labor, Health And Human Services, and Education, and Related Agencies Appropriations Bill, 2023" U.S. House of Representatives Committee on Appropriations, July 5, 2022, available at: https://www.congress.gov/committee-report/117th-congress/house-report/403/1 (Accessed 9/29/25).

7 "GAO finds increase in doctor acquisitions" By Lauren Brensel and Ruth Reader, Politico, September 23, 2025, https://www.politico.com/newsletters/future-pulse/2025/09/23/gao-finds-increase-in-doctor-acquisitions-00575760 (Accessed 9/29/25).

8 "HEALTH CARE CONSOLIDATION: Published Estimates of the Extent and Effects of Physician Consolidation" U.S. Government Accountability Office, GAO-25-107450, September 22, 2025, https://files.gao.gov/reports/GAO-25-107450/index.html (Accessed 9/29/25).

9 *Ibid*.

10 *Ibid*; "Physician practice acquisitions on the rise: GAO" By Emily Olsen, Healthcare Dive, September 24, 2025, https://www.healthcaredive.com/news/physician-practice-acquistions-healthcare-consolidation-rising-government-accountability-office-gao/760919/ (Accessed 9/29/25).

11 U.S. Government Accountability Office, GAO-25-107450, September 22, 2025.

12 "Physician practice acquisitions on the rise: GAO" By Emily Olsen, Healthcare Dive, September 24, 2025, https://www.healthcaredive.com/news/physician-practice-acquistions-healthcare-consolidation-rising-government-accountability-office-gao/760919/ (Accessed 9/29/25).

13 U.S. Government Accountability Office, GAO-25-107450, September 22, 2025.

14 "New Analyses Highlight Gaps and Emerging Risks of Health Care Consolidation and the Role of Private Equity in Health Care" American College of Emergency Physicians, September 25, 2025, https://www.acep.org/news/acep-newsroom-articles/new-analyses-highlight-gaps-and-emerging-risks-of-health-care-consolidation-and-the-role-of-private-equity-in-health-care (Accessed 9/29/25).

15 "New Report on Health Care Consolidation Shows Need to Protect Independent Community Oncology" Community Oncology Alliance, September 25, 2025, https://mycoa.communityoncology.org/news-updates/press-releases/COA-statement-on-GAO-consolidation-report (Accessed 9/29/25).

16 "Provider consolidation is rising, fueling higher prices, GAO study confirms" By Dave Muoio, Fierce Healthcare, September 24, 2025, https://www.fiercehealthcare.com/providers/provider-consolidation-rising-fuels-higher-prices-government-accountability-office-study (Accessed 9/29/25).

Technology Topics

Amazon's Healthcare Pivot

[Excerpted from the article published in January 2025.]

During the January 2025 J.P. Morgan Healthcare Conference, Teladoc's executives announced the company has partnered with Amazon Health Services, joining its Health Benefits Connector program.[1] The program was rolled out in January 2024 and connects Amazon customers with virtual care benefits covered by their insurance plan or employer; if eligible, customers are able to apply to join the program(s).[2] Teladoc is the fifth company to join Amazon's Health Benefits Connector program (formerly known as Health Conditions Programs), along with digital physical therapy company Hinge Health; chronic condition management company Omada; online therapy and mental health firm Rula; and behavioral healthcare provider Talkspace.[3]

Teladoc has been providing virtual chronic condition management programs, including for diabetes, pre-diabetes, hypertension, and weight management, for over 20 years and has over one million active enrollees.[4] With over half of American adults living with at least one chronic condition, and nearly 25% of Americans unaware of all of the insurance benefits available to them, Teladoc sees a large market for their services, to which the Amazon partnership will increase access.[5] In particular, Teladoc hopes the partnership will drive enrollment in its chronic care offerings.[6]

Amazon has widely publicized its intention to disrupt the healthcare industry,[7] and this latest partnership – and the Health Benefits Connector program generally – appears to play into its larger strategic vision. Its strategy is a "carefully orchestrated multi-pronged approach that leverages its existing infrastructure and technological capabilities" and encompasses three main pillars: pharmacy operations, artificial intelligence (AI) integration, and telehealth services.[8]

Amazon acquired PillPack (an online pharmacy) in June 2018 for $753 million,[9] and subsequently expanded its pharmaceutical footprint through its 2020 launch of Amazon Pharmacy, a full-service digital pharmacy providing transparent drug pricing, free medication delivery, and 24/7 pharmacist access.[10] The service has since expanded to all 50 states, and in 2023, Amazon commenced RxPass, a low-cost, generic drug subscription service targeting those with common, chronic conditions.[11] In June 2024, Amazon Prime's RxPass subscription savings program became available to over 50 million Medicare beneficiaries. The Prime-exclusive benefit provides "affordable access to common medications; fast, free delivery each month; and the ability to connect with a pharmacist 24/7."[12] Amazon estimates that Medicare beneficiaries could save at least $70 per year on their medications through RxPass.[13] In October 2024, Amazon Pharmacy announced it would open pharmacies in 20 new U.S. cities in 2025; this expansion will allow for same-day medication deliveries to nearly half of the country, addressing the growth of "pharmacy deserts."[14]

Perhaps Amazon's real differentiator in the healthcare market is its technology. In 2023, Amazon announced it formed a strategic collaboration with AI company Anthropic, which includes an Amazon investment of up to $4 billion.[15] Subsequently, Amazon launched an AI tool, HealthScribe, to transcribe and summarize physician visits, as well as manage files, with the goal of alleviating the administrative burden related to documentation.[16] To improve Amazon Pharmacy's efficiency and accuracy, it is using AI to "fill prescriptions more quickly and accurately, make customer service faster and more helpful, and ensure the right quantities of medications are stocked for customers."[17] Amazon is also developing AI applications to provide more transparent medication pricing to allow customers to shop for the best prices.[18]

In what was characterized as its "potentially most significant move" in the healthcare market, Amazon acquired primary care network One Medical – and its 836,000 associated members and 221 medical offices across 27 markets – in July 2022 for $3.9 billion.[19] However, less than two years post-acquisition, One Medical reported operating losses of nearly $500 million, worse than the losses reported by the company prior to Amazon's acquisition.[20] In an effort to cut nearly $100 million in costs, Amazon closed corporate offices and laid off One Medical staff.[21] In October 2024, Amazon One Medical and Cleveland Clinic announced a collaboration wherein Amazon will open a primary care office in Northeast Ohio in 2025 "offering same and next-day appointment availability, onsite lab services and wrap-around virtual care support for members."[22]

As alluded to above, Amazon has not been immune to the difficulties faced by other large corporate disrupters, particularly those who attempted to disrupt the primary care space.[23] Amazon's other failed healthcare ventures include: Haven, a healthcare-specific joint venture with JPMorgan Chase and Berkshire Hathaway, was disbanded less than three years after its 2018 launch; Amazon Care, an Amazon-launched virtual health clinic, lasted only a couple of years; and, most recently, Amazon Clinic's telehealth marketplace was nixed after only 19 months in operation and consolidated into One Medical.[24] Nevertheless, Amazon has persisted. While many in the healthcare industry wondered if the challenges encountered by Amazon would result in a retreat from the primary care space. Instead, the moves now appear to have simply been a pivot away from what was not working, and continuing refinement of its overall healthcare strategy.

In general, the corporate behemoths that have sought to disrupt the U.S. healthcare industry, and the primary care space specifically, have been largely unable to deliver. In 2024 alone, Walmart announced the closure of Walmart Health; Walgreens shut down 80% of its VillageMD clinics; and CVS Health announced 2,900 layoffs, closing or selling 29 retail pharmacy locations, and other significant cost-cutting measures.[25] However, despite the hurdles it has faced, Amazon seems committed to the healthcare space, and it appears that the layoffs and cost-cutting measures have been strategic, learning from its failures and pivoting as need be, refining its path forward in healthcare. Whether these various recalibrations, including the new partnership with Teladoc, are successful remains to be seen.

1 "Teladoc joins Amazon's digital health benefits program" By Emily Olsen, HealthcareDive, January 15, 2025, https://www.healthcaredive.com/news/teladoc-amazon-health-benefits-program-chronic-condition-management/737407/ (Accessed 1/21/25).
2 *Ibid*.
3 *Ibid*.
4 *Ibid*.
5 "Amazon Expands Health Care Offerings via Teladoc Partnership" By Harrison Miller, Investor's Business Daily, January 14, 2025, https://www.investors.com/news/amazon-amzn-stock-teladoc-tdoc-health-care-offerings-partnership/ (Accessed 1/21/25).
6 Olsen, HealthcareDive, January 15, 2025.
7 "How Amazon built its healthcare strategy from Haven to One Medical" By Brock Turner and Caroline Hudson, Modern Healthcare, February 23, 2023, https://www.modernhealthcare.com/digital-health/amazon-healthcare-strategy-one-medical-rxpass-andy-jassy-neil-lindsay (Accessed 6/24/24).
8 "Amazon's Healthcare Gamble: A New Era of Medical Disruption" By Jeffrey Neal Johnson, Entrepreneur, December 10, 2024, https://www.entrepreneur.com/finance/amazons-healthcare-gamble-a-new-era-of-medical/484115 (Accessed 1/21/25).
9 "How Amazon, CVS and others have grown into healthcare powerhouses" By Caroline Hudson and Tim Broderick, Modern Healthcare, February 9, 2023, https://www.modernhealthcare.com/mergers-acquisitions/healthcare-deals-cvs-amazon-walmart-walgreens-one-medical-aetna (Accessed 6/24/24); "Amazon acquires start-up Health Navigator, its first health-related purchase since PillPack" By Christina Farr, NBC, October 23, 2019, https://www.cnbc.com/2019/10/23/amazon-acquires-digital-health-start-up-health-navigator.html (Accessed 6/24/24).
10 "RxPass from Amazon Pharmacy expands access to Prime members on Medicare" Amazon, June 18, 2024, https://www.aboutamazon.com/news/retail/amazon-pharmacy-rxpass-affordable-medication-medicare (Accessed 1/21/25).
11 "How Amazon built its healthcare strategy from Haven to One Medical" By Brock Turner and Caroline Hudson, Modern Healthcare, February 23, 2023, https://www.modernhealthcare.com/digital-health/amazon-healthcare-strategy-one-medical-rxpass-andy-jassy-neil-lindsay (Accessed 6/24/24).
12 Amazon, June 18, 2024.
13 *Ibid*.
14 "Amazon announces 7 new innovations that power your shopping and delivery experience" Amazon, October 9, 2024, https://www.aboutamazon.com/news/operations/amazon-innovations-ai-robotics-delivery-sustainability (Accessed 1/21/25); "'Reimagining healthcare': Amazon Pharmacy announces expansion of US same-day drug delivery" By Molly Bowcott, C+D, October 17, 2024, https://www.chemistanddruggist.co.uk/news/business/reimagining-healthcare-amazon-pharmacy-announces-expansion-of-us-same-day-drug-delivery-2KC4B3EBJ5GQRC5MV6DAM3EY7M/
15 "How Amazon's $4B investment in AI company Anthropic impacts healthcare" By Heather Landi, Fierce Healthcare, https://www.fiercehealthcare.com/health-tech/how-amazons-4b-investment-ai-company-anthropic-impacts-healthcare (Accessed 1/21/25).
16 "AI At The Doctor? Amazon Launches New Service As Google, Microsoft Aim At Merging Healthcare With Artificial Intelligence" By Mary Whitfill Roeloffs, Forbes, July 26, 2023, https://www.forbes.com/sites/maryroeloffs/2023/07/26/ai-at-the-doctor-amazon-launches-new-service-as-google-microsoft-aim-at-merging-healthcare-with-artificial-intelligence/ (Accessed 1/21/25).
17 "5 ways Amazon is using AI to help transform health care" Amazon, August 7, 2024, https://www.aboutamazon.com/news/retail/how-amazon-uses-ai-healthcare (Accessed 1/21/25).
18 *Ibid*.
19 Turner and Caroline Hudson, Modern Healthcare, February 23, 2023.
20 "Amazon, CVS, and Walgreens went all in on primary care. Their bets are bleeding money." By Shelby Livingston, Business Insider, March 6, 2024, https://www.businessinsider.com/cvs-walgreens-amazon-primary-care-acquisition-strategy-2024-3 (Accessed 6/25/24).
21 *Ibid*.
22 "Cleveland Clinic and Amazon One Medical Announce Collaboration to Expand Access to High-Quality Coordinated Care in the Cleveland Area" October 21, 2024, https://newsroom.clevelandclinic.org/2024/10/21/cleveland-clinic-and-amazon-one-medical-announce-collaboration-to-expand-access-to-high-quality-coordinated-care-in-the-cleveland-area (Accessed 1/21/25).
23 "Corporate Entrants in Healthcare Struggle" Health Capital Topics, Vol. 17, Issue 6 (June 2024), https://www.healthcapital.com/hcc/newsletter/06_24/HTML/WALMART/convert_corporate_entrants_in_hc_struggle.php (Accessed 1/21/25).
24 Turner and Caroline Hudson, Modern Healthcare, February 23, 2023; "Amazon folds telehealth clinic into One Medical" By Brock E.W. Turner, Modern Healthcare, June 27, 2024, https://www.modernhealthcare.com/digital-health/amazon-clinic-one-medical-combined?utm_source=modern-healthcare-daily-finance-thursday&utm_medium=email&utm_campaign=20240627&utm_content=article6-headline (Accessed 6/28/24).
25 "Corporate Entrants in Healthcare Struggle" Health Capital Topics, Vol. 17, Issue 6 (June 2024), https://www.healthcapital.com/hcc/newsletter/06_24/HTML/WALMART/convert_corporate_entrants_in_hc_struggle.php (Accessed 1/21/25); "Walgreens, CVS and Walmart Scale Back on Health Care amid Financial Strain" American Hospital Association, November 5, 2024, https://www.aha.org/aha-center-health-innovation-market-scan/2024-11-05-walgreens-cvs-and-walmart-scale-back-health-care-amid-financial-strain (Accessed 1/21/25).

About HCC

Firm Profile

Health Capital Consultants (HCC) is a nationally recognized healthcare economic and financial consulting firm specializing in valuation consulting; financial analysis, forecasting and modeling; litigation support & expert testimony; mergers and acquisitions; certified intermediary services; provider integration, consolidation & divestiture; certificate-of-need and other regulatory consulting; and, industry research services for healthcare providers and their advisors.

Founded in 1993, HCC has developed significant research resources; a staff of experienced professionals with strong credentials; a dedication to the discipline of process and planning; and, an organizational commitment to quality client service as the core ingredients for the cost-effective delivery of professional consulting services. HCC has served a diverse range of healthcare industry & medical professional clients nationwide including hospitals & health systems (both tax exempt & for profit); outpatient & ambulatory facilities; management services organizations; clinics, solo & group private practices in a full range of medical specialties, subspecialties & allied health professions; managed care organizations; ancillary service providers; Federal and State agencies; public health and safety agencies; other related healthcare enterprises and agencies; and, these clients' advisory professionals.

The HCC project team's exclusive focus on the healthcare industry has provided a unique advantage for our clients. Over the years, our industry specialization has allowed HCC to maintain instantaneous access to a comprehensive library collection of healthcare industry-focused literature and data comprised of both historically-significant resources, as well as the most recent information available. HCC's information resources and network of healthcare industry resources, enhanced by our professional library and research staff, ensures that the HCC project team maintains the highest level of knowledge of the profession regarding the current and future trends of the specific industry or specialty market related to the project, as well as the U.S. healthcare industry overall.

Clients have recognized HCC as setting the gold standard for the valuation of healthcare enterprises, assets, and services, in providing professional services such as:

- Valuation in all healthcare sectors & specialties, including:
  - Acute care hospitals, rehabilitation facilities, skilled nursing facilities, and other inpatient facilities;
  - Ambulatory surgery centers, diagnostic imaging centers, urgent care, and other outpatient facilities;
  - Compensation for professional clinical services, including physician administrative services, executive administrative services, board positions, and other healthcare related services;
  - Tangible and intangible assets, including covenants not to compete, rights to first refusal, and intellectual property;
- Commercial Reasonableness opinions;
- Accountable Care Organization (ACO) value metrics, capital formation, and development and integration;
- Financial feasibility analyses, including the development of forecasts, budgets and income distribution plans;
- Healthcare provider related merger and acquisition services, including integration, affiliation, acquisition and divestiture;
- Certificate of Need (CON) and related regulatory consulting;
- Litigation support and expert witness services; and,
- Industry research services.

The accredited healthcare professionals at HCC are supported by an experienced research and library support staff to maintain a thorough and extensive knowledge of the healthcare reimbursement, regulatory, technological and competitive environments.

Firm Leadership

Todd A. Zigrang, MBA, MHA, FACHE, CVA, ASA, ABV, is the President of HCC, where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 30 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 2,500 transactions and joint ventures involving acute care hospitals and health systems; physician practices; ambulatory surgery centers; diagnostic imaging centers; accountable care organizations, managed care organizations, and other third-party payors; dialysis centers; home health agencies; long-term care facilities; and, numerous other ancillary healthcare service businesses. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

Mr. Zigrang is the co-author of "The Adviser's Guide to Healthcare - 2nd Edition" [AICPA - 2015], numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: The Guide to Valuing Physician Compensation and Healthcare Service Arrangements (BVR/AHLA); The Accountant's Business Manual (AICPA); Valuing Professional Practices and Licenses (Aspen Publishers); Valuation Strategies; Business Appraisal Practice; and, NACVA QuickRead. Additionally, Mr. Zigrang has served as faculty before professional and trade associations such as the American Society of Appraisers (ASA); the National Association of Certified Valuators and Analysts (NACVA); the American Health Lawyers Association (AHLA); the American Bar Association (ABA); the Association of International Certified Professional Accountants (AICPA); the Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute. He also serves on the Editorial Board of The Value Examiner and QuickRead, both of which are published by NACVA.

Mr. Zigrang holds a Master of Science in Health Administration (MHA) and a Master of Business Administration (MBA) from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives (FACHE) and holds the Certified Valuation Analyst (CVA) designation from NACVA. Mr. Zigrang also holds the Accredited in Business Valuation (ABV) designation from AICPA, and the Accredited Senior Appraiser (ASA) designation from the American Society of Appraisers, where he has served as President of the St. Louis Chapter. He is also a member of the America Association of Provider Compensation Professionals (AAPCP), AHLA, AICPA, NACVA, NSCHBC, and, the Society of OMS Administrators (SOMSA).

Click Here for Todd's CV

HCC
HEALTH CAPITAL CONSULTANTS

Firm Leadership

Jessica L. Bailey-Wheaton, Esq., serves as Senior Vice President and General Counsel of Health Capital Consultants (HCC). Her work focuses on the areas of Certificate of Need (CON) preparation and consulting, as well as project management and consulting services related to the impact of both federal and state regulations on healthcare transactions. In that role, Ms. Bailey-Wheaton provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services.

Additionally, Ms. Bailey-Wheaton heads HCC's CON and regulatory consulting service line. In this role, she prepares CON applications, including providing services such as: health planning; researching, developing, documenting, and reporting the market utilization demand and "need" for the proposed services in the subject market service area(s); researching and assisting legal counsel in meeting regulatory requirements relating to licensing and CON application development; and, providing any requested support services required in litigation challenging rules or decisions promulgated by a state agency. Ms. Bailey-Wheaton has also been engaged by both state government agencies and CON applicants to conduct an independent review of one or more CON applications and provide opinions on a variety of areas related to healthcare planning. She has been certified as an expert in healthcare planning in the State of Alabama.

Ms. Bailey-Wheaton is the co-author of numerous peer-reviewed and industry articles in publications such as: The Health Lawyer (American Bar Association); Physician Leadership Journal (American Association for Physician Leadership); The Journal of Vascular Surgery; St. Louis Metropolitan Medicine; Chicago Medicine; The Value Examiner (NACVA); and QuickRead (NACVA). She has previously presented before the American Bar Association (ABA), the American Health Law Association (AHLA), the National Association of Certified Valuators & Analysts (NACVA), the National Society of Certified Healthcare Business Consultants (NSCHBC), and the American College of Surgeons (ACS).

She serves on the editorial board of NACVA's QuickRead and as a Member-at-Large of the ABA Health Law Section (HLS) Governing Counsel. Additionally, she serves as Vice Chair of the ABA HLS Marketing Committee and a member on the ABA HLS Emerging Issues in Healthcare Law (EMI) Conference Planning Committee. She was awarded the 2023-2024 Volunteer of the Year by ABA Health Law Section.

Ms. Bailey-Wheaton is a member of the Missouri and Illinois Bars and holds a Juris Doctorate, with a concentration in Health Law, from Saint Louis University School of Law, where she served as Fall Managing Editor for the Journal of Health Law & Policy. She received her Bachelor of Arts degrees in Political Science and Foreign Languages from West Virginia University.

Click Here for Jessica's CV

HCC
HEALTH CAPITAL CONSULTANTS

Firm Leadership

Janvi R. Shah, MBA, MSF, CVA, serves as Senior Financial Analyst of HCC. Mrs. Shah holds a M.S. in Finance from Washington University Saint Louis and the Certified Valuation Analyst (CVA) designation from the National Association of Certified Valuators and Analysts (NACVA). She develops fair market value and commercial reasonableness opinions related to healthcare enterprises, assets, and services. In addition she prepares, reviews and analyzes forecasted and pro forma financial statements to determine the most probable future net economic benefit related to healthcare enterprises, assets, and services and applies utilization demand and reimbursement trends to project professional medical revenue streams and ancillary services and technical component (ASTC) revenue streams.

Click Here for Janvi's CV

HEALTH CAPITAL CONSULTANTS

Thank you for your interest in Health Capital Topics!

For more information
Please visit: www.healthcapital.com