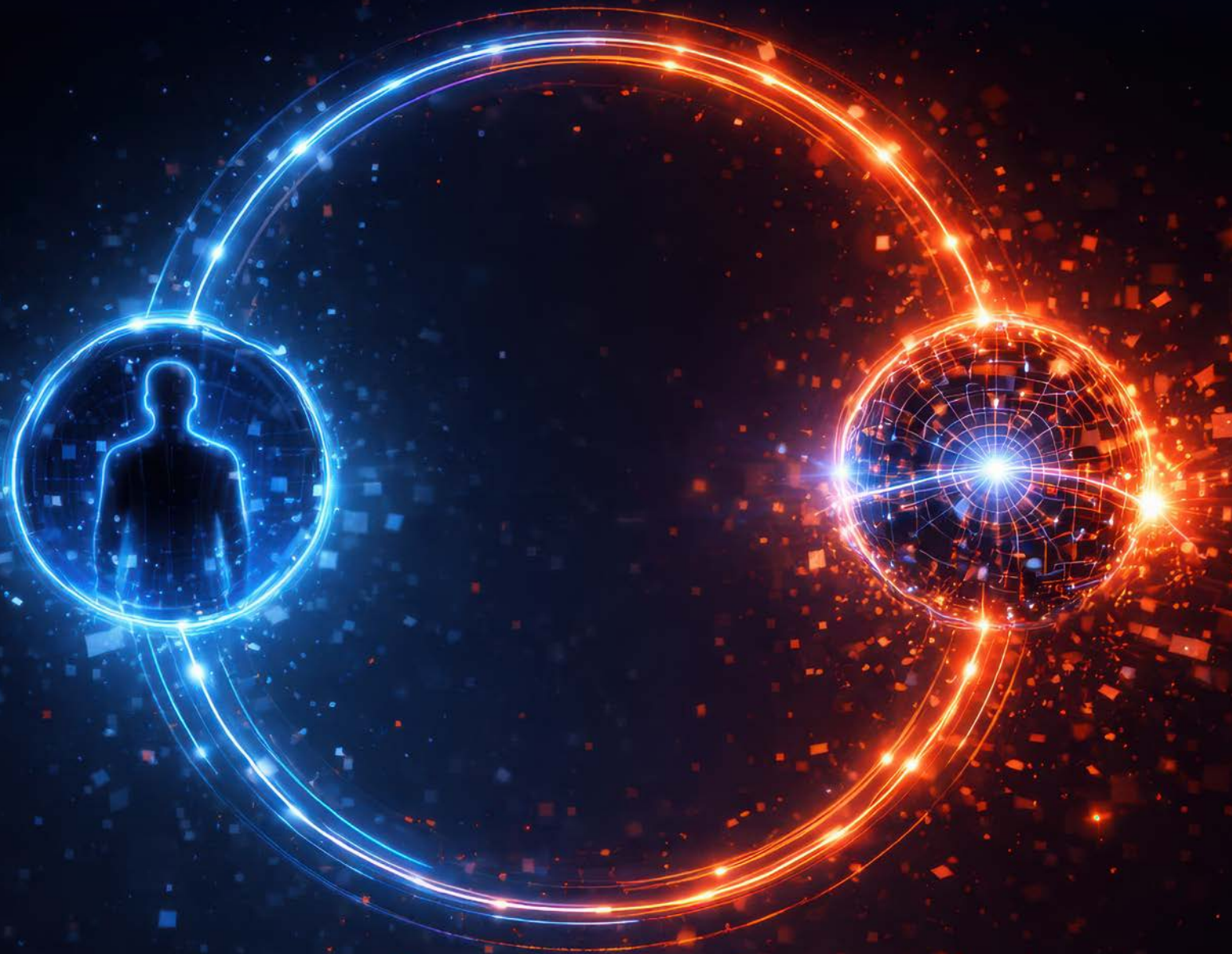


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Valuation of Care Coordination Services (Part II of II)

By Todd A. Zigrang and Jessica Bailey-Wheaton

Part I¹ of this series on the valuation of care coordination services examined the growing demand for these services, driven by the shift from volume-based to value-based care delivery, the aging U.S. population, and increasing chronic disease prevalence. It also explored the supply-side constraints—particularly the primary care shortage and the limited time physicians have for administrative tasks—that create significant market opportunities for dedicated care coordination providers. Part II builds on that foundation by examining the reimbursement and regulatory environments, as well as the technological innovations, that are transforming how care coordination services are delivered.

Reimbursement

The provision of care coordination services has increased in recent years, as payors have begun reimbursing these types of services through a combination of fee-for-service, bundled payment, and value-based care models.

The U.S. government is the largest payor of medical costs, through Medicare and Medicaid, and has a strong influence on physician reimbursement. The Centers for Medicare & Medicaid Services (CMS) have been a primary driver in establishing standardized reimbursement for care coordination (as with other healthcare services), largely through specific Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes in the Medicare Physician Fee Schedule (MPFS). Medicare and Medicaid, given their prevalence in the healthcare marketplace, often act as price and policy setters and are used as benchmarks for private reimbursement rates.

Medicare pays for physician services through its MPFS, which calculates payments according to Medicare's resource based relative value scales (RBRVS) system. This system

assigns relative value units (RVUs) to individual procedures based on the resources required to perform each procedure. Each procedure in the MPFS is assigned RVUs for three categories of resources:

1. Physician work (wRVUs), which 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.
2. Practice expense (PE RVUs), which 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.
3. Malpractice expense (MP RVUs), which corresponds to the relative malpractice expenses for medical procedures. These values are updated at least every five years and typically are the smallest component of a procedure's RVUs.²

¹ Todd Zigrang and Jessica Bailey-Wheaton, "Valuation of Care Coordination Services (Part I of II)," *The Value Examiner*, November/December 2025, 18–25.

² G.J. Verhovshek, "Understand How Medicare Payments Are Made by Learning How to Calculate Them," Knowledge Center, AAPC, November 1, 2011, <https://www.aapc.com/blog/23479-demystify-the-physician-fee-schedule/#:~:text=RVU%20Totals%20Are%20the%20Sum,least%20once%20every%20five%20years.>

Each procedure's RVUs are adjusted for local geographic differences using geographic practice cost indexes (GPCIs) for each RVU component. Once the 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 formula for calculating the Medicare physician reimbursement amount for a specific procedure and location is as follows:³

$$\text{Payment} = [(wRVU \times GPCI \text{ work}) + (RVU \text{ PE} \times GPCI \text{ PE}) + (RVU \text{ MP} \times GPCI \text{ MP})] \times CF$$

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.⁴ 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.⁵ There are currently 109 GPCI payment localities.⁶

The CF is a fixed monetary amount that is multiplied by the RVU from a locality to determine the payment amount for a given service.⁷ The CF is updated annually according to the predetermined update schedule set forth in the Medicare Access and CHIP Reauthorization Act (MACRA); while this update had been 0 percent from 2020 through 2025, it increased to 0.25 percent starting in 2026.⁸ MACRA also includes several provisions related to financial rewards for providers who furnish efficient, high quality healthcare services.⁹

For 2025, payment amounts were cut for the fifth straight year, with the MPFS conversion factor decreasing by 2.93 percent.¹⁰ However, in late 2025 CMS finalized an increase of over 3.25 percent to the MPFS for 2026.¹¹

The MPFS pays for several care coordination (also called care management) activities. These can largely be categorized into five types of activities:

1. Chronic care management (CCM), which includes monthly management of "a patient's multiple (two or more) chronic conditions."¹²
2. Transitional care management (TCM), which "begins when a physician discharges a Medicare patient from an inpatient stay and helps "patients transition back to a community setting after a stay at certain facility types."¹³
3. Remote patient monitoring (RPM), which allows providers to monitor and manage patients' acute and chronic conditions on an ongoing basis outside of the traditional clinical setting through the use of digital technologies.¹⁴
4. Principal care management (PCM), added in 2020, which focuses "on a single, high-risk chronic condition expected to last at least 3 months that places the patient at significant risk of hospitalization, acute exacerbation or decompensation, functional decline, or death."¹⁵
5. Advanced primary care management (APCM), added in 2025, which "includes the essential elements of advanced primary care," including PCM, TCM, and CCM, but may only be billed by primary care providers.¹⁶ Unlike other care coordination codes, APCM codes are not time-based, so as to reduce the administrative burden.

3 Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016; Final Rule, 80 Fed. Reg. 70890 (November 16, 2015).

4 "Documentation and Files: National Physician Fee Schedule and Relative Value Files," Centers for Medicare & Medicaid Services, last modified April 11, 2025, <https://www.cms.gov/medicare/physician-fee-schedule/search/documentation>.

5 Alan M. Scarrow, "Physician Reimbursement Under Medicare," *Neurosurgical Focus* 12, no. 4 (April 2002): 2.

6 "Medicare PFS Locality Configuration," Centers for Medicare & Medicaid Services, last modified September 10, 2024, <https://www.cms.gov/medicare/payment/fee-schedules/physician-locality-configuration>.

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

8 "Reforming Physician Fee Schedule Updates and Improving the Accuracy of Relative Payment Rates," chap. 1 in *June 2025 Report to the Congress: Medicare and the Health Care Delivery System*, Medicare Payment Advisory Commission, June 2025, 13, https://www.medpac.gov/wp-content/uploads/2025/06/Jun25_MedPAC_Report_To_Congress_SEC.pdf.

9 Ibid.

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

11 For more information, see Todd Zigrang and Jessica Bailey-Wheaton, "2026 MPFS Final Rule Increases Physician Payments," *Health Capital Topics* 18, no. 11 (November 2025), https://www.healthcapital.com/hcc/newsletter/11_25/HTML/MPFS/convert_mpfis_final_rule.php.

12 Such chronic conditions include Alzheimer's disease and related dementia; arthritis (osteoarthritis and rheumatoid arthritis); asthma; atrial fibrillation; autism spectrum disorders; cancer; cardiovascular disease; chronic obstructive pulmonary disease (COPD); depression; diabetes; glaucoma; HIV and AIDS; high blood pressure; and substance use disorders. Centers for Medicare & Medicaid Services, *Chronic Care Management Services* (Medicare Learning Network booklet) (CMS, June 2025), 3, 5, <https://www.cms.gov/files/document/chroniccaremanagement.pdf>.

13 Centers for Medicare & Medicaid Services, *Transitional Care Management Services* (Medicare Learning Network booklet) (CMS, August 2025), 3, <https://www.cms.gov/files/document/mlh908628-transitional-care-management-services.pdf>.

14 Also called remote physiologic monitoring. "Remote Patient Monitoring," Centers for Medicare & Medicaid Services, last modified May 5, 2025, <https://www.cms.gov/medicare/coverage/telehealth/remote-patient-monitoring#:~:text=Remote%20patient%20monitoring%20allows%20a,to%20make%20informed%20treatment%20decisions>.

15 Centers for Medicare & Medicaid Services, *Chronic Care Management Services*, 11; "CY 2020 Physician Fee Schedule Final Rule Summary," National Association of Epilepsy Centers, accessed November 12, 2025, 3, <https://naec-epilepsy.org/wp-content/uploads/2019/12/NAEC-2020-MPFS-Summary-and-Charts-FINAL.pdf>.

16 Centers for Medicare & Medicaid Services, *Chronic Care Management Services*, 11.

Research indicates that care coordination activities not only achieve the goals of coordinated patient care but also result in increased revenue for providers.

Importantly, despite the care coordination activities for which providers may be reimbursed,¹⁷ the specific tasks involved in the primary-to-specialty care referral that commences the coordination of specialty care are not reimbursed by Medicare (or other payors). These tasks include identifying an appropriate specialist; gathering pertinent information from insurance carriers or other staff to determine financial responsibility; obtaining referral authorization from insurance carriers and relaying such authorizations or denials to the patient and the provider; resolving pre-authorization, registration, or other referral-related issues prior to a patient's appointment).¹⁸ Research indicates that care coordination activities not only achieve the goals of coordinated patient care but also result in increased revenue for providers.¹⁹ This implies that increasing coverage of and reimbursement for care coordination activities are achieving payors' goals and raises the question of whether reimbursement may further expand in the near future.

Regulatory

Healthcare providers face federal and state legal and regulatory constraints that 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 law (the "Stark Law"), may have the greatest impact on the operations of healthcare organizations.

The AKS and Stark Law are generally concerned with the same issue: the financial motivation behind patient referrals. However, while the AKS broadly applies 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 referrals from physicians to entities with which they have a financial relationship for the provision of defined services paid for by the Medicare program.²⁰ While violation of the Stark Law carries only civil penalties, violation of the AKS carries both criminal and civil penalties.²¹

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,²² if one purpose of the arrangement in question is to offer remuneration deemed illegal under the AKS.²³ 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;²⁴ the person only needs to have an awareness that the conduct in question is "generally unlawful."²⁵ Further, a violation of the AKS is sufficient to state a claim under the False Claims Act (FCA).²⁶

17 Centers for Medicare & Medicaid Services, *Transitional Care Management Services*, 6–7; Centers for Medicare & Medicaid Services, *Chronic Care Management Services*, 3–5; "Principal Care Management," Rural Health Information Hub, last updated July 1, 2025, <https://www.ruralhealthinfo.org/care-management/principal-care-management>.

18 Rachel Zimlich, "Mastering care coordination," *Medical Economics Journal* 97, no. 9 (May 2020), <https://www.medicaleconomics.com/view/mastering-care-coordination>.

19 See, e.g., Mitchell Tang, et al., "Practices That Adopted Remote Physiologic Monitoring Increased Medicare Revenue and Outpatient Visits," *Health Affairs* 44, no. 11 (November 2025), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2025.00683>.

20 "Comparison of the Anti-Kickback Statute and Stark Law," Health Care Fraud Prevention and Enforcement Action Team (HEAT), Office of Inspector General (OIG), U.S. Department of Health & Human Services, accessed September 4, 2025, <https://oig.hhs.gov/documents/provider-compliance-training/939/StarkandAKSChartHandout508.pdf>.

21 *Ibid.*

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

23 "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).

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

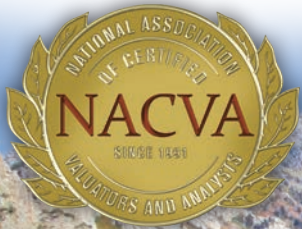
25 [Author's name redacted], "Health Care Fraud and Abuse Laws Affecting Medicare and Medicaid: An Overview," Congressional Research Service, September 8, 2014, 5, https://www.everycrsreport.com/files/20140908_RS22743_b01570c2edc4fc9853e88db6cfc54692842c17a.pdf.

26 "Health Care Reform: Substantial Fraud and Abuse and Program Integrity Measures Enacted" (newsletter, McDermott Will & Emery, April 12, 2010), 3; Patient Protection and Affordable Care Act.

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Criminal violations of the AKS are punishable by up to 10 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 (three times the illegal remuneration).²⁷ In addition to civil monetary penalties paid under the AKS, if the violation triggers liability under the FCA, defendants can incur additional civil monetary penalties of \$13,508 to \$27,018 per violation, plus treble damages.²⁸

Due to the broad nature of the AKS, legitimate business arrangements may appear to be prohibited.²⁹ In response to these concerns, Congress created a number of statutory exceptions and delegated authority to the U.S. Department of Health and Human Services (HHS) to protect certain business arrangements by promulgating several safe harbors.³⁰ 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.³¹ Failure to meet all of the requirements of a safe harbor does not necessarily render an arrangement illegal.³² Note: for a payment to meet the requirements of many AKS safe harbors, the compensation must not exceed the range of fair market value.

In December 2020, the HHS Office of Inspector General (OIG) released new revisions to the AKS regulations in a final rule, many of which are similar to revisions to the Stark Law proposed by CMS, discussed further below.³³ The changes contained in the final rule were part of a larger effort by HHS to modernize and clarify fraud and abuse laws as part of the Regulatory Sprint to Coordinated Care initiative. This initiative

aimed to reduce regulatory barriers and accelerate the transformation of the healthcare system into one that pays better for value and promotes care coordination.³⁴ In the revisions, the OIG established new rules, and rule changes, that are more consistent with emerging value-based healthcare delivery and payment models, and which may allow for better coordination of care. Among the more notable revisions are new safe harbors for value-based arrangements (the safe harbor requirements for these arrangements lessen as participants take on more financial risk).³⁵

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).³⁶ When a prohibited referral occurs, the entity may not bill for services resulting from that referral.³⁷ DHS include, but are not limited to, the following:

- Inpatient and outpatient hospital services
- Certain therapy services, such as physical therapy
- Radiology and certain other imaging services
- Radiation therapy services and supplies
- Durable medical equipment
- Outpatient prescription drugs³⁸

Under the Stark Law, financial relationships include ownership interests—through equity, debt, or other means—and ownership interests in entities that have

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

28 False Claims, 31 U.S.C. § 3729(a)(1)(G); Civil Monetary Penalties Inflation Adjustments for 2023, 88 Fed. Reg. 5776, 5777 (January 30, 2023).

29 "Re: OIG Advisory Opinion No. 15-10," 5.

30 *Ibid.*

31 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).

32 "Re: Malpractice Insurance Assistance," letter from Lewis Morris, Chief Counsel to the Inspector General, United States Department of Health and Human Services, to [Name redacted] (January 15, 2003), 1, <http://oig.hhs.gov/fraud/docs/alertsandbulletins/MalpracticeProgram.pdf>.

33 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, 85 Fed. Reg. 77814–77815 (December 2, 2020).

34 Centers for Medicare & Medicaid Services, "Modernizing and Clarifying the Physician Self-Referral Regulations Final Rule," fact sheet, November 20, 2020, <https://www.cms.gov/newsroom/fact-sheets/modernizing-and-clarifying-physician-self-referral-regulations-final-rule-cms-1720-f>.

35 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, 85 Fed. Reg. 77814–77815 (December 2, 2020).

36 Jennifer O'Sullivan, "CRS Report for Congress: Medicare: Physician Self-Referral ('Stark I and II')," Congressional Research Service, July 27, 2004, available at <https://www.policyarchive.org/handle/10207/2137>; Limitation on Certain Physician Referrals, 42 U.S.C. §1395nn.

37 Limitation on Certain Physician Referrals, 42 U.S.C. § 1395nn(a)(1)(A).

38 *Ibid.*, § 1395nn(a)(1)(B); Definitions, 42 C.F.R. § 411.351. Note the distinction in 42 C.F.R. § 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)."



ownership interests in DHS providers.³⁹ Additionally, financial relationships include compensation arrangements, defined as arrangements between physicians and entities involving any remuneration, directly or indirectly, in cash or in kind.⁴⁰

Civil penalties under the Stark Law include overpayment or refund obligations, potential civil monetary penalties of \$15,000 for each service, plus treble damages, and exclusion from Medicare and Medicaid programs.⁴¹ Similar to the AKS, violation of the Stark Law can also trigger a violation of the FCA.⁴²

Notably, the Stark Law contains many exceptions that describe ownership interests, compensation arrangements, and forms of remuneration to which it does not apply.⁴³ Similar to the AKS safe harbors, without these exceptions, the Stark Law may prohibit legitimate business arrangements. Note that 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.⁴⁴ Unlike the AKS safe harbors, an arrangement must fully fall within one of the exceptions to be shielded from enforcement of the Stark Law.⁴⁵

As noted above, in response to the Regulatory Sprint to Coordinated Care initiative, CMS also released several revisions to the Stark Law in a December 2020 final rule. They included:

- Revised definitions of fair market value, general market value, and commercial reasonableness
- New permanent exceptions for value-based arrangements⁴⁶

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

- Full financial risk arrangements: These include capitated payments and predetermined rates or a global budget.
- Value-based arrangements with meaningful downside financial risk: Under these arrangements, physicians who fail to meet predetermined benchmarks pay the entity no less than 10 percent of the value of the remuneration they receive.
- Value-based arrangements: This exception applies regardless of risk level to encourage physicians to enter value-based arrangements, even if they only assume upside risk.⁴⁷

39 Limitation on certain physician referrals, 42 U.S.C. § 1395nn (a)(2).

40 *Ibid.*, § 1395nn (h)(1).

41 *Ibid.*, § 1395nn (g).

42 "Comparison of the Anti-Kickback Statute and Stark Law," Health Care Fraud Prevention and Enforcement Action Team (HEAT), Office of Inspector General (OIG), U.S. Department of Health & Human Services, accessed September 4, 2025, <https://oig.hhs.gov/documents/provider-compliance-training/939/StarkandAKSChartHandout508.pdf>.

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

44 "Comparison of the Anti-Kickback Statute and Stark Law."

45 Linda A. Baumann, ed., *Health Care Fraud and Abuse: Practical Perspectives* (BNA Books, 2002), 106.

46 Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations, 85 Fed. Reg. 77492 (December 2, 2020).

47 *Ibid.*, 77510-77528.

Recent enforcement actions indicate that improper billing of CCM and RPM services remains a significant compliance risk.

Recent Enforcement Actions Related to Care Coordination Services

While the December 2020 regulatory revisions expanded protections for value-based arrangements, federal enforcement agencies have simultaneously increased scrutiny of billing practices related to care coordination services. Recent enforcement actions indicate that improper billing of CCM and RPM services remains a significant compliance risk.

In June 2024, the U.S. Department of Justice (DOJ) announced a settlement with Bluestone Physician Services, a primary care and chronic disease management provider operating in Florida, Minnesota, and Wisconsin.⁴⁸ The company agreed to pay over \$14.9 million to resolve allegations that it knowingly submitted false claims for CCM services and domiciliary rest home visits that did not support the level of service provided.⁴⁹ In connection with the settlement, Bluestone entered into a five-year corporate integrity agreement (CIA) with the OIG.⁵⁰ The Bluestone settlement is one of the first major FCA settlements involving CCM billing codes, signaling increased federal scrutiny of these services.

RPM services have also attracted significant regulatory attention. In November 2023, the OIG issued a consumer alert warning Medicare beneficiaries about fraudulent RPM enrollment schemes involving aggressive marketing, enrollment without clinical justification, and billing for

services not actually provided.⁵¹ In September 2024, the OIG published a report recommending additional oversight of RPM services, noting that the number of Medicare enrollees receiving RPM increased more than tenfold between 2019 and 2022, with Medicare and Medicare Advantage payments exceeding \$300 million in 2022.⁵² The report identified concerns that Medicare lacks key information for oversight, including who ordered the monitoring for enrollees, and found that approximately 43 percent of enrollees who received RPM did not receive all three components of the service, raising questions about whether monitoring was being used as intended.⁵³

In August 2025, OIG released a data snapshot analyzing 2024 Medicare billing for RPM services, revealing that Medicare payments had reached \$536 million (a 31 percent increase from 2023) and that nearly one million Medicare beneficiaries received RPM services during the year.⁵⁴ The snapshot identified five billing patterns warranting heightened scrutiny: abrupt spikes in patient enrollment, billing for high proportions of patients with no prior relationship to the practice, billing by multiple practices for RPM services furnished to the same patient, high billing for claims with no prior ordering visit, and billing for multiple monitoring devices per month for the same enrollee.⁵⁵ These enforcement trends underscore the importance of robust compliance programs for organizations engaging in care coordination arrangements, particularly those involving CCM or RPM services.

48 U.S. Department of Justice, "Chronic Disease Management Provider to Pay \$14.9M to Resolve Alleged False Claims," press release, June 5, 2024, <https://www.justice.gov/opa/pr/chronic-disease-management-provider-pay-149m-resolve-alleged-false-claims>.

49 Ibid.

50 Ibid.

51 U.S. Department of Health & Human Services, Office of Inspector General, "Consumer Alert: Remote Patient Monitoring," November 2023, <https://oig.hhs.gov/fraud/consumer-alerts/consumer-alert-remote-monitoring/>.

52 U.S. Department of Health & Human Services, Office of Inspector General, "Additional Oversight of Remote Patient Monitoring in Medicare Is Needed," September 2024, 5, <https://oig.hhs.gov/documents/evaluation/10001/OEI-02-23-00260.pdf>.

53 Ibid., 8.

54 U.S. Department of Health & Human Services, Office of Inspector General, "Billing for Remote Patient Monitoring in Medicare," August 25, 2025, <https://oig.hhs.gov/reports/all/2025/billing-for-remote-patient-monitoring/>.

55 Ibid.

Technology

In addition to regulatory compliance, technology is increasingly shaping how care coordination services are delivered and, consequently, how they are valued. Care coordination is undergoing a profound technological transformation. Driven by the shift to value-based care, digital innovations are breaking down traditional silos and creating interconnected health ecosystems focused on enhancing patient outcomes, reducing costs, and improving efficiency.

Care Coordination Software

Care coordination software, also known as care coordination information technology (CCIT), refers to software applications designed to facilitate a variety of functions related to managing patients' care. This software has been the focus of many digital healthcare companies. The U.S. care management solutions market—which encompasses care coordination software—reached \$6.63 billion in 2024 and is projected to grow 14.1 percent annually over the next five years.⁵⁶ The components and capabilities of such software vary widely, but it may perform tasks such as automating referral management; communicating to a patient's care team (e.g., automated email updates regarding patient status and hospital admission/discharge); delivery of discharge instructions and next steps to a patient's primary care provider; and reports that provide real-time utilization trends, outreach success rates, and no-show rates.⁵⁷ These technologies are also being aided by artificial intelligence and blockchain technology, "which support data interoperability and normalization within a defined clinical network."⁵⁸ Among other capabilities, these technologies allow for constant, two-way communication among providers in the acute, post-acute, and primary care spaces. This is significant as communication (or lack thereof) among providers in these spaces tends to be the root of many care coordination issues.

Care coordination software, as well as other data analytics, is needed by participants in value-based reimbursement models, which typically rely on preestablished benchmarks and require participants to report on patient outcomes.⁵⁹ Despite the potential benefits, adoption of these technologies poses significant administrative and cost burdens to small providers.⁶⁰

Artificial Intelligence (AI)

AI is becoming an increasingly essential element for modern care coordination. Some of its most popular applications include:

- **Predictive risk stratification:** AI and machine learning analyze big datasets to identify high-risk patients who may benefit from early, proactive intervention. For example, algorithms can predict patients who are at a high risk for hospital readmission, allowing care teams to intervene with preventative measures.
- **Workflow automation:** AI automates routine, administrative tasks, such as creating clinical summaries, prioritizing tasks, and managing patient discharge planning, which reduces the administrative burden on clinicians, freeing them to focus on patient care.
- **Clinical decision support:** AI augments clinical decision-making by analyzing patient data, enhancing care plans, and providing actionable insights and evidence-based recommendations at the point of care.⁶¹

While there remain privacy, security, and ethical concerns surrounding the use of AI, its use can drive cost savings and enhance revenue streams for healthcare organizations by automating administrative tasks, improving diagnostic accuracy, and enabling proactive interventions.⁶² In the future, AI's role will likely become even more sophisticated and integrated, creating a robust, intelligent ecosystem that promises not only to improve patient care, but to transform the economic and operational landscape of healthcare.

56 "Lumeon Wins Big in Frost & Sullivan's Latest Research on the US Care Coordination Market," Frost & Sullivan, December 5, 2019, <https://www.frost.com/frost-perspectives/lumeon-wins-big-in-frost-sullivans-latest-research-on-the-us-care-coordination-market/>; Frost & Sullivan, "AI-Powered Care Coordination Software Gives Vendors Competitive Edge in the Era of Personalized Healthcare," press release, April 10, 2019, <https://www.frost.com/news/press-releases/ai-powered-care-coordination-software-gives-vendors-competitive-edge-in-the-era-of-personalized-healthcare/>.

57 Greg Caressi & Kustav Chatterjee, "Care Management: It's More than Population Health" (white paper, Frost & Sullivan, 2017), 4, <https://www.experian.com/content/dam/marketing/na/healthcare/white-papers/frost-sullivan-care-management-population-health-outcomes.pdf>.

58 "AI-Powered Care Coordination."

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60 Miriam Reisman, "EHRs: The Challenge of Making Electronic Data Usable and Interoperable," *P&T* 42, no. 9 (September 2017), 574, available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5565131/pdf/ptj4209572.pdf>; David Squires and David Blumenthal, "Do Small Physician Practices Have a Future?," *To the Point* (blog), The Commonwealth Fund, May 26, 2016, <https://www.commonwealthfund.org/blog/2016/do-small-physician-practices-have-future>.

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Telehealth

Telehealth is revolutionizing care coordination by breaking down geographical barriers, enhancing communication, and enabling continuous patient monitoring. Specialists can consult remotely, promoting timely diagnoses and treatment decisions. As one source noted:

Research has shown that effective care coordination allows for earlier detection of problems, more precise intervention, and increased patient confidence in providers. When utilized properly, virtual care [such as telehealth] advances care coordination because it allows for:

- Fewer unreimbursed hospital readmissions,
- Improved capture of wellness screenings,
- Optimization of value-based indicators, such as timeliness of appointments and prompt answering of care-related questions, and
- New sources of revenue previously untapped through reimbursement for activities formerly considered to be simply the “work of the day.”⁶³

Notably, RPM—“the use of digital devices to monitor a patient’s health”⁶⁴—is becoming a more critical component of telehealth that elevates care coordination beyond episodic

visits to continuous, proactive management. For example, “with post-hospital discharge, telehealth enables remote monitoring of vital signs, allowing healthcare providers to track patients’ progress, identify potential complications early on and reduce readmissions. This proactive approach minimizes the risk of readmissions and improves patient outcomes.”⁶⁵ As RPM continues to evolve, it stands to significantly advance care coordination by enabling continuous oversight, early intervention, and improved patient outcomes throughout the continuum of care.

Conclusion

The convergence of evolving reimbursement structures, regulatory frameworks, and technological innovation is reshaping the care coordination landscape in ways that have significant implications for healthcare valuers. The growing recognition of care coordination’s role in achieving better patient outcomes at lower costs, combined with expanding reimbursement mechanisms and regulatory clarity around value-based arrangements, suggests that demand for fair market value opinions in this sector will continue to grow. Success in this emerging field will require a nuanced understanding of the competitive environment, reimbursement landscape, regulatory requirements, and technological capabilities that together define the value of care coordination services in the U.S. healthcare delivery system. **VE**



Todd A. Zigrang, MBA, MHA, FACHE, CVA, ASA, ABV, is president of Health Capital Consultants, where he focuses on the areas of valuation and financial analysis for hospitals and other healthcare enterprises. Mr. Zigrang has significant physician integration and financial analysis experience, and has participated in the development of a physician-owned, multispecialty management service organization and networks involving a wide range of specialties, physician-owned hospitals, as well as several limited liability companies for acquiring acute care and specialty hospitals, ASCs, and other ancillary facilities. Email: tzigrang@healthcapital.com.



Jessica L. Bailey-Wheaton, Esq., serves as senior vice president and general counsel of Health Capital Consultants. 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. Email: jbailey@healthcapital.com.

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