Healthcare Policy Pulse: Midyear Strategic Update

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Topics for today's discussion

1. HR 1: The One Big Beautiful Bill Act
2. Look Ahead: Congress' Rest-of-Year Priorities
3. Issues on the Radar: Inpatient Only List, Site-Neutral Payment, Certificate of need, and Physician Owned Hospital Moratorium
4. Closing Thoughts

HR 1: The Policy Driving Conversation Today

Overview Of Healthcare Provisions in HR 1
The One Big Beautiful Bill Act

1. **Changes to the Medicaid program that limit eligibility, impact program enrollment and change state financing structures.**

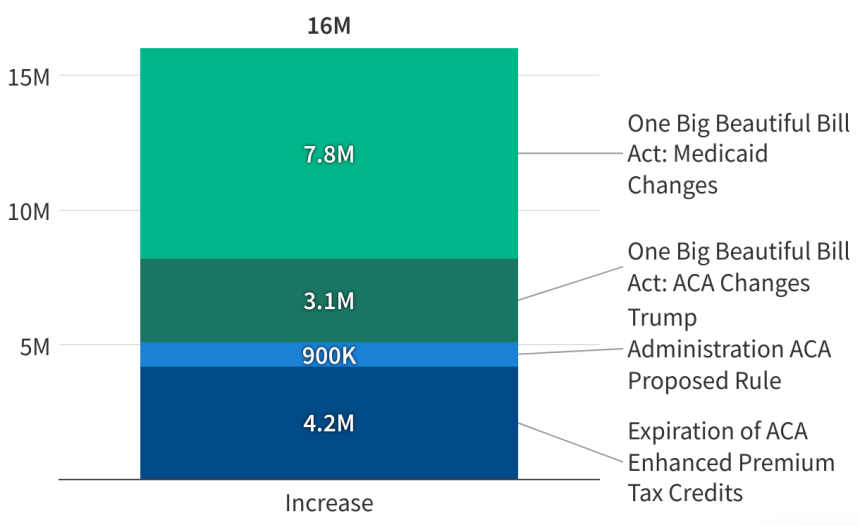
2. **Changes to ACA marketplace that limit eligibility and enrollment for subsidies.**

3. **Limited Medicare Updates including exactment of OPRHAN Cures Act and a 2.5% increase to the PFS conversion factor in CY2026.**

Mapping the Impact of HR1

Enrollment & Eligibility Changes: Shifts in Medicaid eligibility, new work requirements, and revised Marketplace enrollment rules will reshape program participation and provider/plan market share.

Kaiser Family Foundation estimates **16million more people would be uninsured in 2034** from combined impacts of HR 1, ACA Marketplace Changes, and expiration of enhanced tax credits



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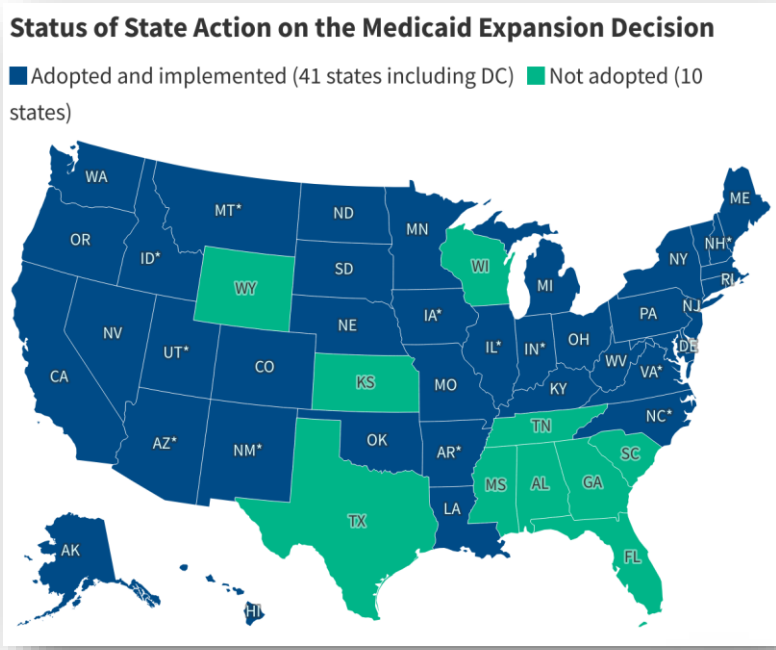

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State Financing Changes: Limits on provider taxes and changes to state-directed payment programs will shift payment responsibility to the states, and will force states to reduce coverage, limit services, and/or decrease reimbursements to hospitals resulting in a **$1.02 trillion decrease** in federal

The impact is state-specific. Non-expansion states will see a **6-11% reduction.** Expansion states: **10-21% reduction.**

States must balance their budgets. Federal spending decreases may cause states to cut optional benefits, reduce payments, or restrict coverage. These decisions will be state-specific.

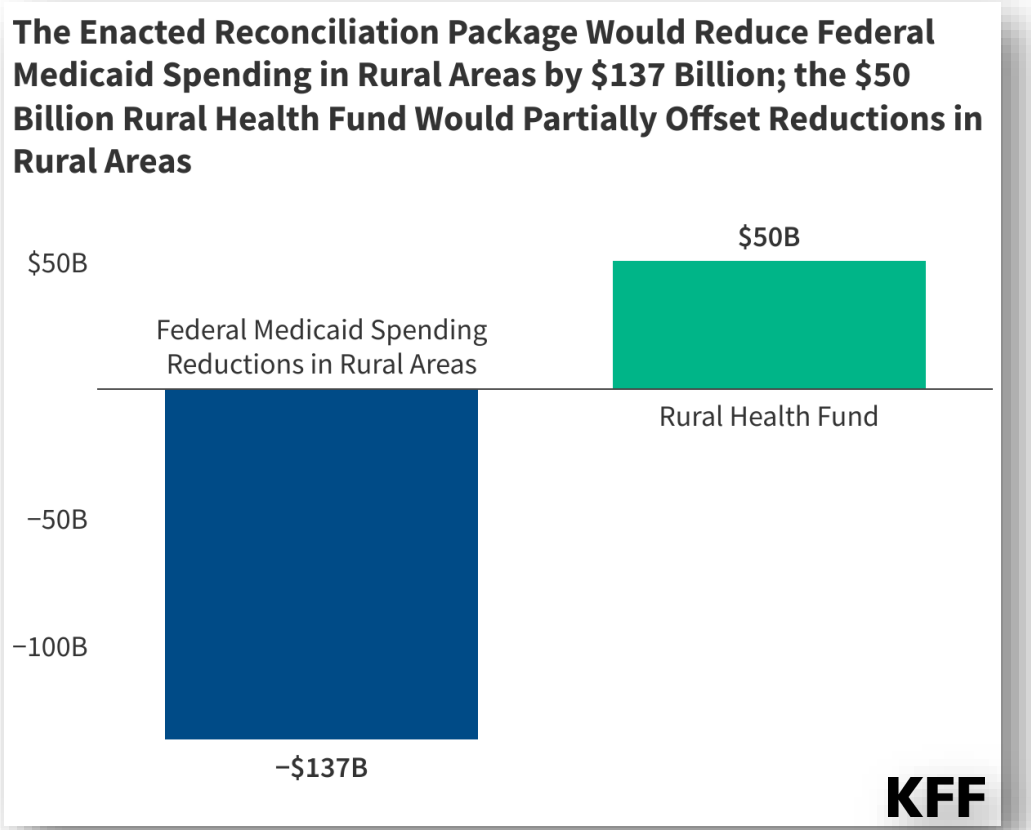
Rural Health Transformation Program

Summary: Provides **$50 billion over 5 years** for state grants to stabilize vulnerable hospitals and improve access in rural communities.

- To qualify for funding, states must submit a rural health transformation plan **by December 31, 2025**, outlining how the plan will improve:
  - Access to care,
  - Patient outcomes, and
  - The long-term success and financial viability of rural hospitals.
- **$25 billion** will be distributed equally among all states with an approved application.
- The **remaining $25 billion** will be allocated based on a rural formula *determined by the CMS Administrator*.

Key takeaways for health systems & physicians:

- **Federal Medicaid spending in rural areas is estimated to decline by $137 billion**, more than the $50 billion appropriated for the rural health fund.
- **CMS has virtually unlimited discretion** to withhold, reduce, or recover payments from states.



HR1 Cuts to Medicaid Program Grow Annually

Medicaid spending cuts from HR1 will be phased in over the 10-year budget window.

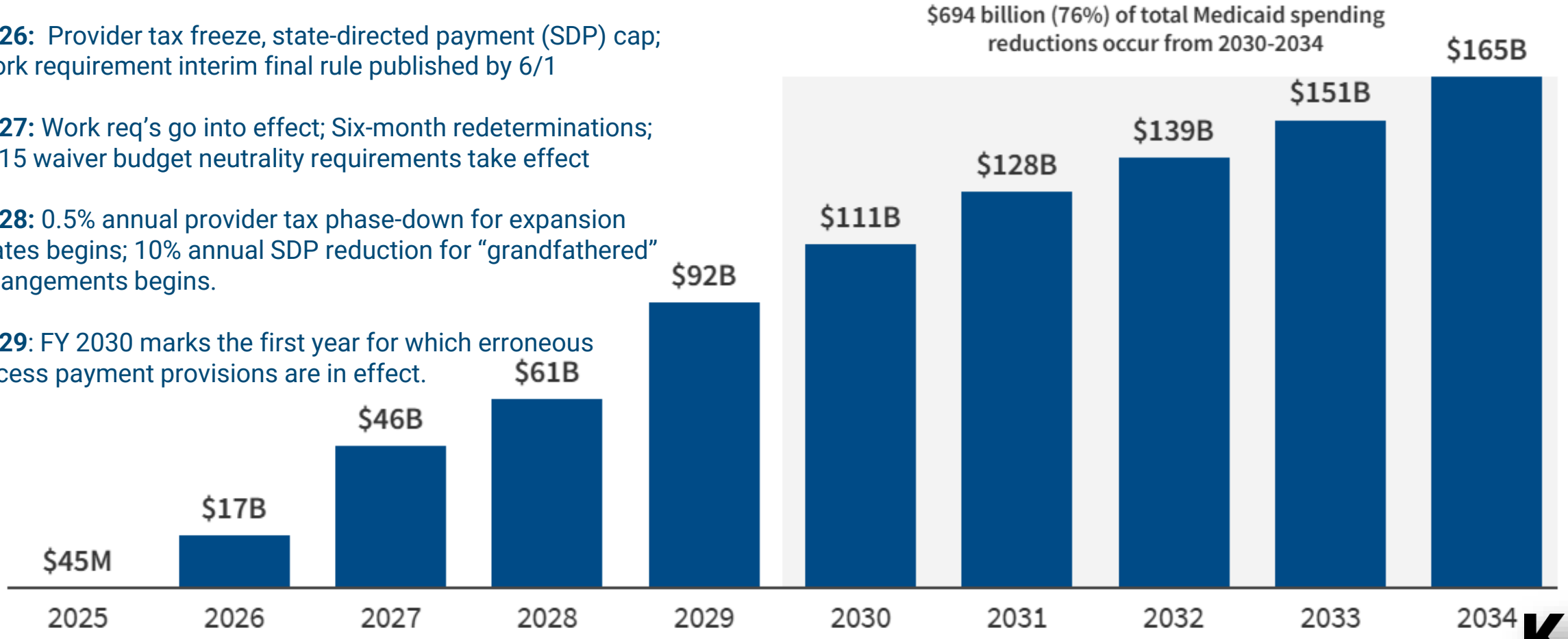
What's Right Around the Corner?

2026: Provider tax freeze, state-directed payment (SDP) cap; Work requirement interim final rule published by 6/1

2027: Work req's go into effect; Six-month redeterminations; 1115 waiver budget neutrality requirements take effect

2028: 0.5% annual provider tax phase-down for expansion states begins; 10% annual SDP reduction for "grandfathered" arrangements begins.

2029: FY 2030 marks the first year for which erroneous excess payment provisions are in effect.

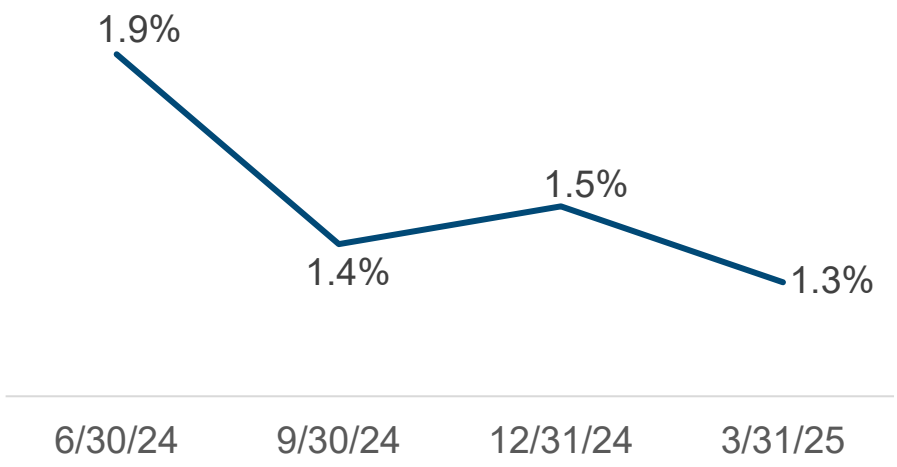


Macro context: financial improvements fading for many health systems

A familiar challenge: cost inflation outpacing revenue gains

Operating margins under pressure (again)

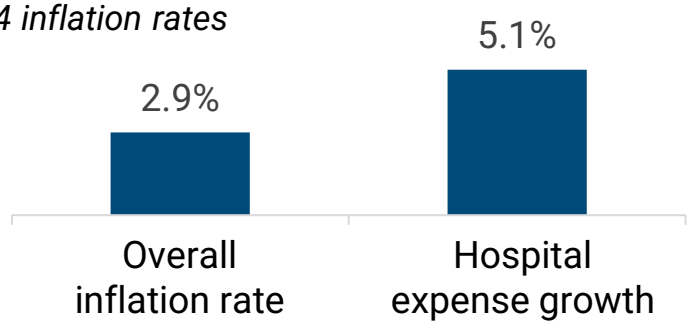
NFP health system average operating margins



Chronic cost-revenue imbalance

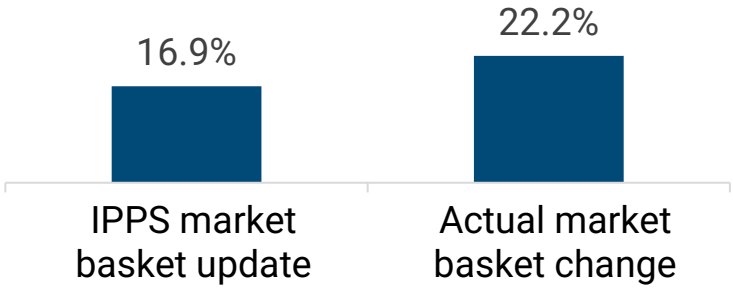
Hospital costs greatly outpace overall inflation

2024 inflation rates



Market basket forecasts underestimate actual growth

Medicare inpatient payment rules, cumulative FY 2021-2025



Source: Hospital and Health System Performance as of March 31, 2025; Bank of American, June 2025; Comment letter to CMS, IPPS Proposed Ruling; American Hospital Association, June 10, 2025; THMA research and analysis.

Translating policy into access, revenue, cost, & workforce impacts

Health systems must navigate the new reality to fortify access and economics of care

1 Access

- Increased uninsured patient load
- Increased ED crowding & wait time
- Reduced outpatient & preventive visits
- Closure or scaling back services
- Delayed or denied access to post acute care

2 Revenue

- Loss of Medicaid reimbursements
- Decline in supplemental payments (e.g., State Directed Payments and DSH payments)
- Reduced 340B eligibility or savings
- Greater bad debt and charity care

3 Cost

- Increased uncompensated care costs
- Higher case acuity and complexity
- Administrative burden (e.g., managing eligibility checks, charity care documentation, etc.)
- Capital & investment deferrals

4 Workforce

- Staffing strain & burnout (higher acuity care, complex care coordination, etc.)
- Higher admin overhead to process eligibility
- Reduction in force due to budget cuts generally (and service line reductions specifically)

Source: THMA research and analysis.

Response aims to balance economic resilience with patient care needs

Mix of active strategies and planned approaches

Internal Operations & Efficiency

- Divesting low performing service lines, sites
- Staff pruning strategies (e.g., conservative budgets, targeted RFIs)
- Ramping up access center, patient transfer systems
- Technology (AI) deployment for increased capacity from existing delivery assets

Revenue & Market Strategy

- Payer mix and service mix management strategies (e.g., selective service line investments, market placements, scheduling practices)
- Aggressive negotiations with commercial payers

Strategic Partnerships & Innovation

- Community clinic partnership
- Developing digitally-enabled, asset-light care models
- Developing ambulatory network, adjacent care sites (e.g., express clinics)

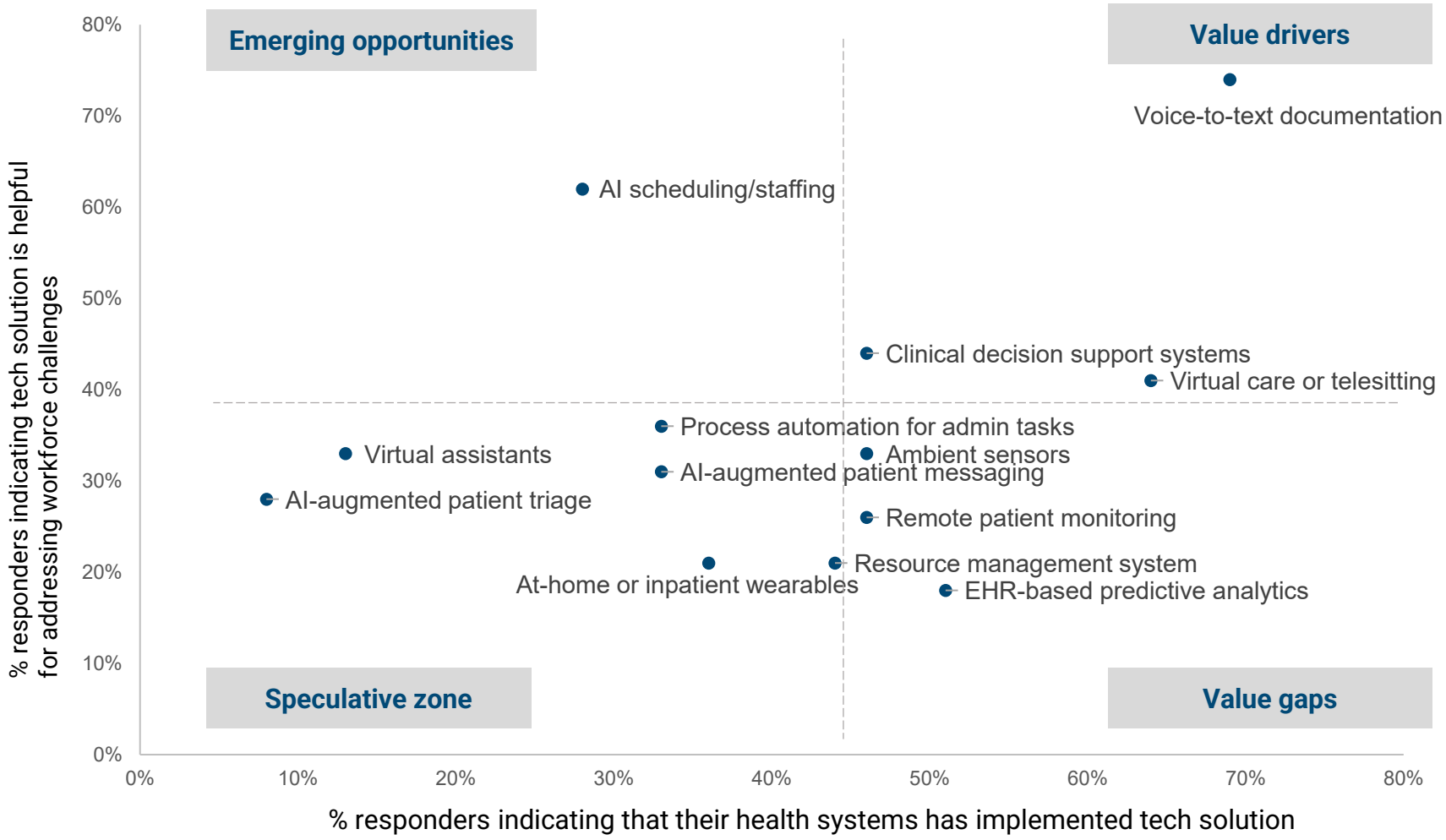
Default strategy hits a wall: commercial rate negotiation headwinds

- Payers caught between higher-than-expected costs and employer demands for cost control creates an unfavorable environment for hospital rate negotiations
- Health systems face indirect resistance from employers pushing back on payers
- Increase in high-deductible health plans (HDHP) may lead to more cost related barriers for patients
- Risk of insurers responding to rate increase demands by narrowing network, steerage to lower cost alternatives, shifting risk to hospitals
- Increasing price transparency regulations may put higher costs in spotlight leading to backlash from higher rates

Source: THMA research and analysis.

Spotlight on tech's role in expanding capacity and improving access

Technology adoption and perceived helpfulness in addressing care team and patient needs



Beyond hype: what's working and what gets in the way

- **Proven winners are rare**: Only voice-to-text documentation reaches the "value drivers" quadrant; suggesting most workforce tech investments haven't delivered on promises yet
- **Process automation shows promise**: Several automation tools sit near the middle, suggesting they're gaining traction and could advance with successful implementation
- **High expectations, low delivery:** Many technologies cluster in "value gaps," indicating pilot-to-production challenges that point to execution or concept problems
- **Integration-complexity trap**: Tech fails from two pitfalls – poor integration with existing systems or false tradeoffs between efficiency and cognitive load, when solutions must deliver both

Source: THMA research and analysis.

Making room for growth and patient care

AI-powered patient navigation at Montefiore

AI solution in brief Montefiore MyndYou

- MyEleanor is an AI-powered patient navigation system developed with MyndYou that addresses disparities in colorectal cancer screening for underserved communities
- AI virtual navigator contacts patients who missed their colonoscopy appointments (3,000 per year), assesses barriers to compliance, offers live transfers to reschedule, and provides preparation reminders

Key outcomes

57%	Patient engagement rate w/ MyEleanor
52	Hours/month saved per human patient navigator
36%	Increase in patient volume for colonoscopies (adding approx. 450 procedures)

OR scheduling and management at Geisinger

AI solution in brief Geisinger Opmed.ai

- Geissinger has integrated Opmed.ai as an intelligent, data-driven decision support system in its OR scheduling and management workflows.
- Users (OR schedulers, managers, and directors) interact with solution to access real-time schedule predictions, allocate shifts efficiently, and leverage insights for optimized block scheduling

Key outcomes

90%	Accuracy of Opmed.ai's suggested block release
185	Monthly block time hours opened compared to average hospital
96%	Of days for which AI solution was more accurate in predicting surgical durations than baseline

Source: THMA research and analysis.

Look Ahead: Congress' Rest-of-Year Health Policy Priorities

1

September 30 Expirations

- **Medicaid DSH payments** – $8B cut scheduled for FY 2026 unless Congress acts
- **Low-Volume Hospital Adjustment** & **Medicare-Dependent Hospital Program** – key rural supports
- **Medicare Telehealth Flexibilities** – pandemic-era waivers for site/geography/practitioner rules
- **Acute Hospital Care at Home Waiver** – authority for inpatient-level care at home
- **Children's Hospital GME funding** – pediatric workforce pipeline
- **Conrad 30 waivers** – J-1 physician immigration flexibility

Government Shutdown? The existing CR expires **Sept. 30, 2025**. Expect another short-term CR to avoid a shutdown, but longer-term funding fights remain unresolved.

2

End-Of-Year Deadlines

- **Enhanced ACA Subsidies (APTCs)** – expire **Dec. 31, 2025**; lapse could raise Marketplace premiums by 30-60% for millions of enrollees.
- **PAYGO -** Congress must either waive PAYGO or allow across-the-board Medicare cuts in early 2026
- **Medicare PFS** – ongoing push to avert physician payment cuts, with proposals to tie updates to inflation

Another Reconciliation Package? House leadership has signaled plans for two additional reconciliation bills targeting further tax reforms, spending reductions, and debt control measures.

Integrated, hybrid care models increase capacity, access, affordability

Representative use cases of digitally-enabled care

Direct patient care

- Telehealth visits
- E-visits
- E-consults
- Remote patient monitoring
- Digital therapeutics

Specialized care delivery

- Telestroke & ICU
- Telerehab
- Chronic care management

Diagnostic & monitoring

- Remote diagnostic testing
- Digital pathology
- Telepharmacy

Clinical workflow enhancement

- Virtual nursing
- Inboxology
- Virtual sitting
- Chatbot triage

Digital care implementation considerations

Current state

Which digital tools deliver strongest access ROI?

Patient fit

What % of visits could be supported by each use case?

Barriers

Technology, workflow, reimbursement, or adoption?

Quality balance

Balance of efficiency gain and clinical observation needs?

Community impact

Which are best opportunities for underserved populations?

Top priorities

Highest impact tools if reimbursement weren't a factor?

Source: THMA research and analysis.

Hospital at home: building viability beyond Medicare waivers

Medicare Hospital Care at Home program: Reimbursement path, implementation challenges

- Valuable framework but resource intensive
- Nurse visit twice per day
- Ongoing remote monitoring
- Nonmedical service requirements
- Nearly 400 waivers approved; not all hospitals have launched (cost and difficulty scaling)

Beyond the traditional Medicare framework: Insights from health system innovators

- Programs expanding care beyond waiver to meet more patient needs, potentially diversify revenue
- Some forgoing waivers altogether in interest of flexibility & innovation
- Greater urgency to work with private payers to mitigate CMS waiver risk
- Hospital capacity constraints and arbitrage can support ROI case for many systems, even without payer support for hospital at home
- Staffing remains growth limiter; advanced tech (e.g., AI-enhanced RPM) anticipated to drive greater efficiency, improved care delivery

Ochsner Health

Alterative path for hospital at home

- Acute Care at Home
- Not following CMS model
- Outsources part of program to myLaurel home healthcare company
- Key focus area is ACO population
- 250 patients per month

Los Angeles General Medical Center

Virtual care for acute illness

- All-virtual Safer@Home program established 2020
- Key strategy to free up hospital capacity
- Focus on uninsured or Medicaid patients
- Virtual clinic visits, remote vital sign monitoring, oral or inhaled medications rather than IV

Source: THMA research and analysis.

On the radar: Where else should health systems focus their attention?

Key Influencers

PARAGON HEALTH INSTITUTE

AFPI – America First Policy Institute

The Heritage Foundation

Project 2025 – Presidential Transition Project

Areas of focus YTD

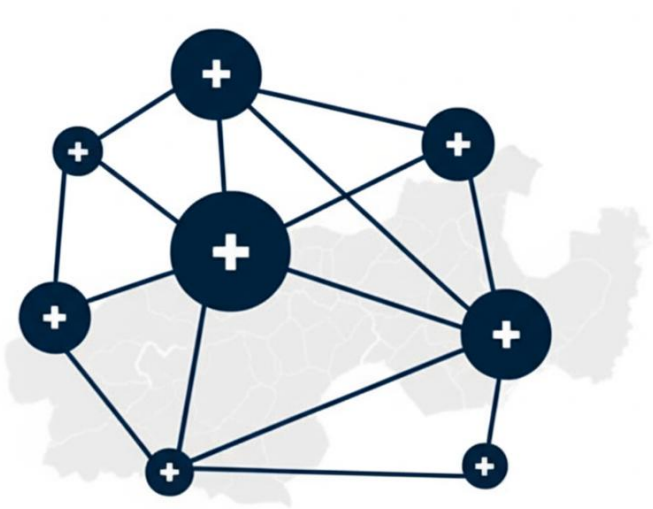
- Federal Medicaid spending reductions
- 340B program & reimbursement changes
- Price transparency
- Gender-affirming services
- NIH grant funding
- CDC re-organization and vaccine approval process changes
- Mandatory CMMI Models (TEAM, ASM)
- Prior authorization
- Health tech & interoperability

Focus Areas Ripe for Reform

1. **Site neutral payment**
2. **Elimination of the Inpatient Only (IPO) list**
3. **Repeal of POH moratorium**
4. **Push for CON repeal**

Six ways to lead with value

Site neutral policies create financial headwinds, but savvy systems can reposition as a catalyst, not a constraint



1. Differentiate on outcomes/cost to negotiate **carve-outs** or **narrow network** status
2. Leverage pricing & outcomes to **partner with employers** on services/bundles
3. Gain **share of wallet** & reduce leakage through improved access and better patient experience
4. Optimize **virtual care platforms** for lower-cost encounters and greater provider efficiency
5. Optimize **systemness protocols** to direct patients to most cost-effective sites
6. Bolster **physician alignment** through joint ventures (e.g., ASCs)

Source: THMA research and analysis.

ASC strategy enhances patient access, strengthens competitive position

5 ways ASCs drive access and competitive performance

1. Geographic reach: Strategic placement un underserved or priority markets

2. Capacity expansion without capital intensity: lower cost than hospital ORs

3. Scheduling flexibility: more convenient options and faster turnaround time

4. Care model innovation: specialized care pathways and streamlined workflows

5. Network resilience: distributed capacity offers backup to hospitals ORs

276 ASC additions in CMS outpatient proposed rule

Major procedure categories include (count of CPT codes):

- 35 Gastrourinary surgery
- 25 GI surgery
- 25 Spine surgery
- 21 Facial/cranial surgery
- 20 Cardiac device/EP
- 18 Vascular arterial repair
- 14 Pulmonary/thoracic procedures
- 12 ENT/sinus surgery
- 12 Hematopoietic/transplant procedures
- 9 Head/neck oncology

Source: THMA research and analysis.

ASCs are the top site-of-care growth priority

Some health systems are launching their first few sites, while others are pursuing aggressive expansion plans

Most health systems are here

- Few sites (median: 4); 80% own at least 1 ASC[2]
- Lack strategic clarity but developing more well-defined business strategy

Strategic expanders with clear growth goals

CommonSpirit
- 67 ASCs
- Goal: Enterprise-wide ASC vertical

Virtua Health
- 42 ASCs
- Goal: Targeted growth in ortho, general surgery, spine, cardiac, and vascular procedures

Banner Health
- 31 ASCs
- Goal: 30% portfolio growth

Corewell Health
- 8 ASCs
- Goal: Market share, physician alignment and retention, and address OR capacity

For-profit health system mega operators

Tenet Health *(USPI)*
- 518 ASCs (~55% independently owned without health system partners; ~45% co-owned with health system partners)
- 8.2% market share
- Goal of ~600 ASCs in 2025

HCA Healthcare
- 124 ASCs
- 2.3% market share
- Strategy driven by greenfield developments & targeted acquisitions

0 *50* *100+*

Number of ASCs per health system

1. Based on sample of THMA member health systems (n=20).
2. 6th Avanza Intelligence Hospital Leadership ASC Survey.

Sources: Avanza, Becker's ASC Review, Tenet Health, VMG Health, THMA research and analysis.

Site/care adjacent models picking up steam (again)

An asset-lite way to expand a health system's network and a hedge against future site neutrality mandates

Hybrid ED/urgent care facilities

HONOR HEALTH · UFHealth University of Florida Health · PRESBYTERIAN · ProMedica Your Health. Our Mission. · VHC Health · Baptist Health Care

Model

- Partner hospitals manage medical staff and billing, while **Intuitive Health** handles nonclinical staff and administrative functions
- Doctors triage patients based on facility appropriateness
- A flat $250 "all-inclusive" urgent care fee for cash-paying patients; patients who opt out of ED care are charged a triage fee

Strategic response

- Improving triage and ED overcrowding
- Expanding network especially for medically underserved areas
- Draw in patients from rival systems by strategically placing the hybrid facilities
- Operating at a lower cost than traditional EDs

Intuitive Health's state presence

Existing or planned ED/urgent care locations

Source: Company website • Created with Datawrapper

Source: Intuitive Health, THMA research and analysis.

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LHS Executive Relationships

450+
LHS C-suite Members

150+
Innovative Industry Members

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Convene exceptional peer groups that facilitate meaningful relationships and knowledge exchange

Create world-class leadership development programs designed to prepare next generation healthcare leaders

Produce original research leveraging member insights on healthcare's greatest challenges and opportunities

Deliver innovation surveillance and strategic roadmaps to help health systems navigate strategic transformation

Facilitate novel partnerships to address critical industry issues that demand collective action