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PULSE

North Carolina Medical Debt Relief Program Surpasses Goals

North Carolina has relieved more than $6.5 billion in medical debt for its residents in the last year through the North Carolina Medical Debt Relief Program.

The program was established in July 2024 and surpassed debt relief and financial projections by helping more than 2.5 million North Carolina residents to date, according to an announcement from Gov. Josh Stein's office.

North Carolina's program is a partnership between hospitals and Undue Medical Debt approved by the U.S. Center for Medicare and Medicaid Services.

Former Gov. Roy Cooper's office and the North Carolina Department of Health and Human Services crafted the plan to use the state's Medicaid program as an incentive for hospitals to relieve more than a decade of medical debt for eligible residents.

North Carolina residents started receiving letters from individual hospitals in mid-October and Undue Medical Debt also sent letters to thousands of residents announcing partial or complete relief of their medical debt, according to Gov. Stein's office.

CMS "approved using medical debt policies as a condition of eligibility for North Carolina hospitals to receive an enhanced level of payment under the Healthcare Access and Stabilization Program (HASP), a program that began at the same time as Medicaid expansion," according to the governor's office.

"Neither Medicaid expansion nor HASP required the use of state funds."

Hospitals eligible for HASP were required to relieve medical debt for certain low- and middle-income residents and implement more generous charity care policies.

They were also required to improve and streamline procedures to determine financial assistance/charity care eligibility and cease medical debt credit reporting.

Patients at hospitals that decide to participate will automatically benefit from the medical debt relief. They do not need to take any action to sign up.

Pennsylvania, Connecticut and New Jersey also have medical debt relief programs in place, all aiming to reduce the burden of medical debt for residents. These programs shed light on debt forgiveness processes for qualifying patients and how providers can tailor their own policies.

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The Affordable Care Act requires that nonprofit hospitals establish charity care — essentially financial assistance policies — for patients unable to cover their expenses. IRS Regulation 501(r) addresses extraordinary collection activities, such as credit reporting and legal remedies.

For providers in many states, 200% or 300% of the FPL is often the starting point before any copays or deductibles need to be paid to a nonprofit provider. Consistent with the Connecticut program, for example, patients who earn 400% or more of the FPL would be expected to pay their co-pays and deductibles in full while providers continue to offer charity care options for patients making less than that amount.

Oregon was the first state in the nation to mandate required charity care discounts for nonprofit providers. In Oregon, health care is free from nonprofit providers for patients living at 200% or below of the FPL, there are significant discounts for those living between 200% and 400% of the FPL, and there are no discounts required for patients living above 400% of the FPL.

Clarifications to California's Medical Debt Credit Reporting Law

Important clarifications on medical debt credit reporting in California are now in place thanks to over a year of efforts by the California Association of Collectors Inc. (CAC).

Gov. Gavin Newsom signed AB 1521, the judiciary omnibus bill, on Oct. 1, finalizing the updates to medical debt credit reporting requirements.

Those requirements were initially passed in California SB 1061 and signed into law by Newsom in September 2024.

Specifically, the omnibus bill clarifies that the notice requirements in SB 1061 required in a contract creating a medical debt only apply to a written agreement, according to Cliff Berg, CAC's lobbyist.

"This clarifies that the notice provisions do not apply when there is no written contract for medical services, such as when a patient is brought to a provider in an ambulance during an emergency," Berg said.

Overall, SB 1061 defines medical debt as "a debt owed by a consumer to a person whose primary business is providing medical services, products, or devices, or to the person's agent or assignee, for the provision of medical services, products, or devices. Medical debt includes, but is not limited to, medical bills that are not past due or that have been paid."

As a refresher, it also:

- Prohibits a consumer credit reporting agency or an investigative consumer reporting agency from making a consumer credit report or an investigative consumer report containing information about medical debt, as defined.
- Prohibits a person who uses a consumer credit report in connection with a credit transaction from using medical debt listed on the report as a negative factor when making a credit decision.
- Prohibits a person from furnishing information regarding a medical debt to a consumer credit reporting agency and makes a medical debt void and unenforceable if a person knowingly violates this provision by furnishing information regarding the medical debt to a consumer credit reporting agency.
- Requires a contract creating a medical debt entered into on or after July 1, 2025, to include a term describing these requirements, as specified, and makes a violation of these provisions by a person holding a license or permit issued by the state to be deemed to be a violation of the law governing that license or permit.

NEWS & NOTES

HBO Documentary Spotlights Physician's Fight to Preserve Rural Health Care

A new HBO documentary short chronicles the struggles of maintaining health care access in rural America as a community hospital faces bankruptcy, Becker's reports. The film follows James Graham, DO, a family physician in Fairfax, Oklahoma (population 1,263), over three years as he works to sustain care amid the local hospital's financial collapse. Dr. Graham divides his time between Fairfax Community Hospital, a nursing home, and three clinics — one located 60 miles away, serving patients from four counties.

The documentary captures Dr. Graham and his staff's efforts to preserve health care access as the hospital files for bankruptcy. It offers an intimate look at the challenges facing rural health care providers and communities as hospitals across America continue closing due to financial pressures.

Quality Metrics Declining in Physician Bonus Structures

Physician employment contracts are shifting away from quality-based bonuses toward productivity measures, according to new data from AMN Healthcare's Physician Solutions division. The findings, based on 1,420 physician searches conducted April 2024–March 2025, reflect broader compensation trends. Also, an AMA report shows combined salary-plus-bonus arrangements are increasingly common, with fewer physicians compensated by a single method.

AI Scribes Show Promise in Reducing Physician Burnout

A multicenter quality improvement study in JAMA Network Open demonstrates ambient AI scribes can significantly reduce administrative burden and burnout among health care providers. The study of physicians and nonphysician providers across six health systems found that after 30 days of using ambient AI scribes, burnout dropped from 51.9% to 38.8% — a 13.9 percentage-point reduction. Severe burnout decreased by 6.2 percentage points. Additional improvements included reduced cognitive task load, less after-hours documentation time, increased patient-focused attention, and better urgent care access. An accompanying JAMA Network Open commentary called physician burnout "a public health crisis."

Unlocking Physician Leadership

As health care organizations increasingly seek clinical experience at the top, understanding what drives and hinders physician leaders is critical. Currently, only 15% of CEOs at leading U.S. health care organizations are physicians, yet a recent McKinsey & Co. survey reveals significant untapped potential.

Purpose-Driven Leadership

Physician leaders pursue executive roles primarily to "make a broader impact on patient care" (51%) and "lead innovation and transformation" (42%), not for titles. Remarkably, 58% of surveyed physician leaders aspire to the CEO role, though most current physician CEOs never initially envisioned themselves in that position. This suggests organizations should proactively identify and develop high-potential physicians using data-driven approaches, even when individuals don't express CEO aspirations.

The Confidence-Competence Gap

A critical disconnect emerges between perception and reality. Surveyed physician leaders express strong confidence in business skills, yet CEO interviews reveal these same capabilities — leading large teams, driving strategy — frequently limit advancement. As one finding suggests: "skills and behaviors that may have helped physicians succeed in a prior role may not be sufficient for their next role."

Dual Barriers Demand Dual Solutions

Barriers exist at individual and institutional levels. Among respondents, 52% cite external perceptions as a top barrier, while others point to skill gaps and insufficient leadership training. Concerningly, organizations may inadvertently create "a cycle of exclusion — where physicians seen as unready for leadership are overlooked for mentorship [and] stretch opportunities."

Evolving Development Needs

Effective leadership development must adapt across career stages. Early-career physician leaders benefit most from on-the-job training and degree programs (70%+ effectiveness), while those approaching CEO roles prioritize informal mentorship, networking, peer coaching, and leadership fellowships.

Looking Ahead

Organizations must implement structured, meritocratic processes to identify high-potential physician leaders and deliberately cultivate them at scale. Success requires rethinking traditional CEO archetypes and investing in physician leadership development as rigorously as clinical training — treating it as "a discipline ... requiring in-depth study, on-the-job training, and apprenticeship."

DATAWATCH

Hospital M&A Activity Rebounds in Q3 2025 Amid Policy Clarity

Health care M&A activity showed renewed momentum in the third quarter of 2025, with 15 hospital and health system transactions announced — nearly double the eight deals closed in Q2, according to a recent Kaufman Hall analysis

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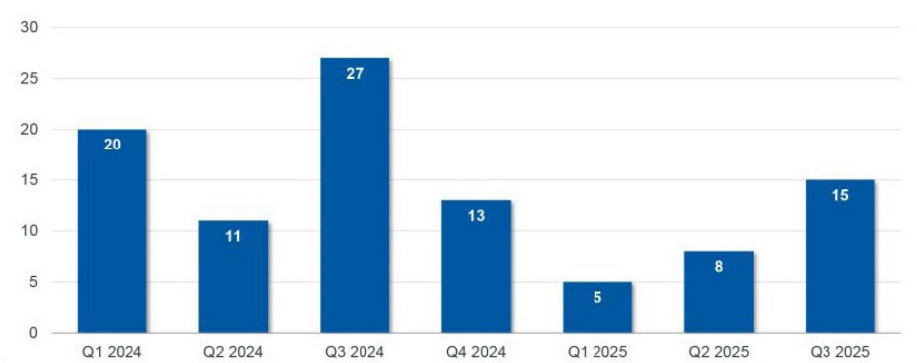
The uptick suggests that "policy clarity following passage of the One Big Beautiful Bill in July is beginning to [re] shape transaction strategy," according to the report. After uncertainty surrounding the new administration caused activity to slow in late 2024 and early 2025, reaching a low point of just five transactions in Q1, the market appears to be stabilizing.

Two trends dominated the quarter: over half (53%) of announced transactions involved either divestitures or financially distressed parties, reflecting ongoing operational and financial pressures across the industry. Kaufman Hall describes this as "an ongoing realignment in transitioning or relatively less attractive market models."

Deal size also rebounded significantly.

Number of Announced Transactions by Quarter, Q1 2024 – Q3 2025



Q3 marked the year's first two mega mergers, pushing average seller size to approximately $591million and total transacted revenue to $8.9 billion — more than six times Q2's $1.4 billion figure.

Notably, not-for-profit organizations served as acquirers in all 15 transactions, with five involving academically affiliated systems.

Looking ahead, Kaufman Hall expects continued partnership activity as organizations pursue "capability and competency-based affiliation models" and distressed systems seek sustainable partners. However, some volatility may persist as the health care sector adjusts to recent federal policy changes and their reimbursement impacts.

The resurgence suggests health care leaders are moving from uncertainty to strategic action in the evolving policy landscape.

Chart Source: *Kaufman Hall*

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is a monthly bulletin that contains information important to health care credit and collection personnel. Readers are invited to send comments and contributions to:

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