HEALTH LAW CONNECTIONS

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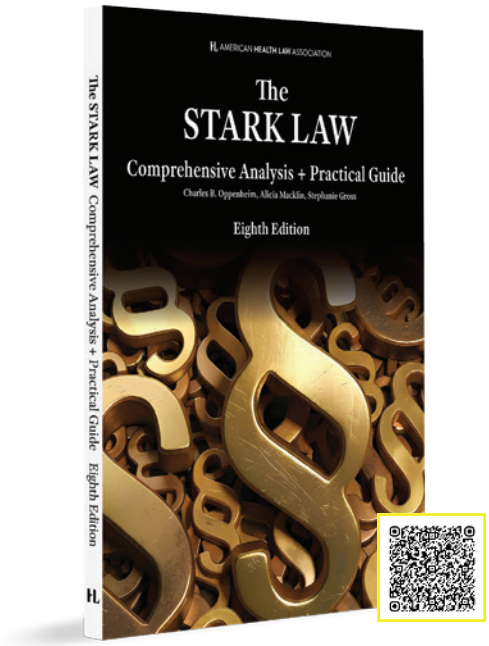

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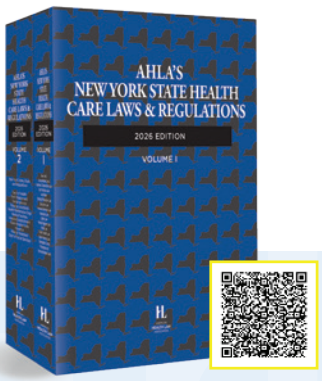

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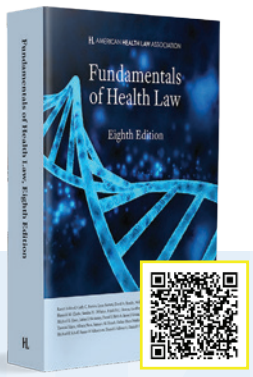

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Connection, Community, and the Year Ahead

Christine L. White
Westchester Medical Center

I still remember attending my first AHLA conference early in my career. As a staff attorney at the Federal Trade Commission, I was asked to present on recent merger enforcement activity. The audience was highly engaged, asking excellent, practical questions, and I found an equally warm reception at the networking events. Throughout the conference, I felt as though I had been adopted by a welcoming, inclusive community of colleagues—a group whose generosity and expertise have shaped my career ever since.

As I begin my term as president, I am deeply grateful for the trust this community has placed in me and energized by the opportunity to build on AHLA's extraordinary foundation. Like many of you, I have experienced AHLA as far more than a professional association. It is a community where health law professionals learn from one another, build lasting relationships, and find both mentorship and friendship.

I am grateful to assume this role at a time of strong momentum. My colleague and friend Mark Kopson has served AHLA with characteristic thoughtfulness and integrity, and I thank him for his steady leadership, the foundation he has helped build for the years ahead, and his continued engagement as Past President during the coming year. I also look forward to working alongside President-Elect Rob Gerberry and President-Elect Designate Carol Carden, each of whom brings personal and professional excellence to the Board's strategic and fiduciary oversight of the organization.

This July also marks a significant transition for our Board of Directors. We thank outgoing board members Saralisa Brau, Ari Markenson, Suzanne Scrutton, Matthew Wetzel, and Asha B. Scielzo, Past President, for their outstanding dedication and many contributions as they conclude their Board service. Joining the Board effective July 1 are Ryan S. Johnson of Fredrikson & Byron PA; Annie H. Shieh of Optum Health; Patrick D. Souter of Gray Reed; and Brian A. White of Wake Forest University. Jennifer Csik Hutchens and Mike Paulhus each begin a second term. I look forward to the strategic perspectives and insights each of them will bring.

As I reflect on my goals for this year, two themes rise to the surface: the enduring power of in-person connection and the expanding possibilities of artificial intelligence and digital innovation.

Health law is, at its core, a relationship profession. The advice we give, the advocacy we pursue, and the communities we build are all grounded in trust—and trust is built person to person. AHLA's in-person conferences are where that trust deepens: where colleagues become collaborators, where early career professionals find mentors, and where the health law community recognizes itself as exactly that—a community.

The fall conference season offers several opportunities to gather in person, including Tax Issues for Health Care Organizations in Washington, DC (September 10–11); the Fraud and Compliance Forum in Washington, DC (September 23–24); and Fundamentals of Health Law in Chicago (November 1–3). Whether you are joining us to deepen your own expertise or introducing a colleague, student, or early career attorney from your network to AHLA for the first time, I hope you will be part of these conversations.

At the same time, health law professionals are navigating rapid change driven by artificial intelligence and other emerging technologies. These developments are reshaping health care delivery, regulation, and the practice of law itself. AHLA has a responsibility to help our members understand these changes and use new tools thoughtfully, while continuing to provide accessible engagement and learning opportunities for members wherever they may be located.

These two themes may appear, at first glance, to be somewhat incompatible, but I firmly believe they are complementary. As professionals, we can achieve our greatest ambitions only by investing in both: the irreplaceable value of face-to-face engagement and the reach and innovation that digital platforms and AI make possible.

One of the greatest joys I have found in belonging to AHLA is that the organization has supported and facilitated every stage of my professional journey. From honing my skills as a young antitrust lawyer at the FTC, to moving into law firm life and partnership, and eventually transitioning into general counsel and in-house roles, I have always been able to draw on AHLA's educational programs, publications, and resources. Perhaps more importantly, at each stage I have found teachers, mentors, and friends—which truly makes AHLA my professional home. In the coming year, I encourage you to take advantage of the many opportunities to connect with one another at an AHLA event, whether in person or virtually; to write an article on a favorite legal topic or emerging AI issue; or to find other ways to engage with and support this community.

I look forward to a productive and connected year ahead. Please reach out and say hello at an AHLA event along the way. Your perspectives on what AHLA does well, where we can improve, and what you need from your professional home will help shape my work this year. I look forward to listening, learning, and serving alongside you.

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1099 Fourteenth Street NW
Suite 925,
Washington, DC 20005
202.833.1100
connections@americanhealthlaw.org
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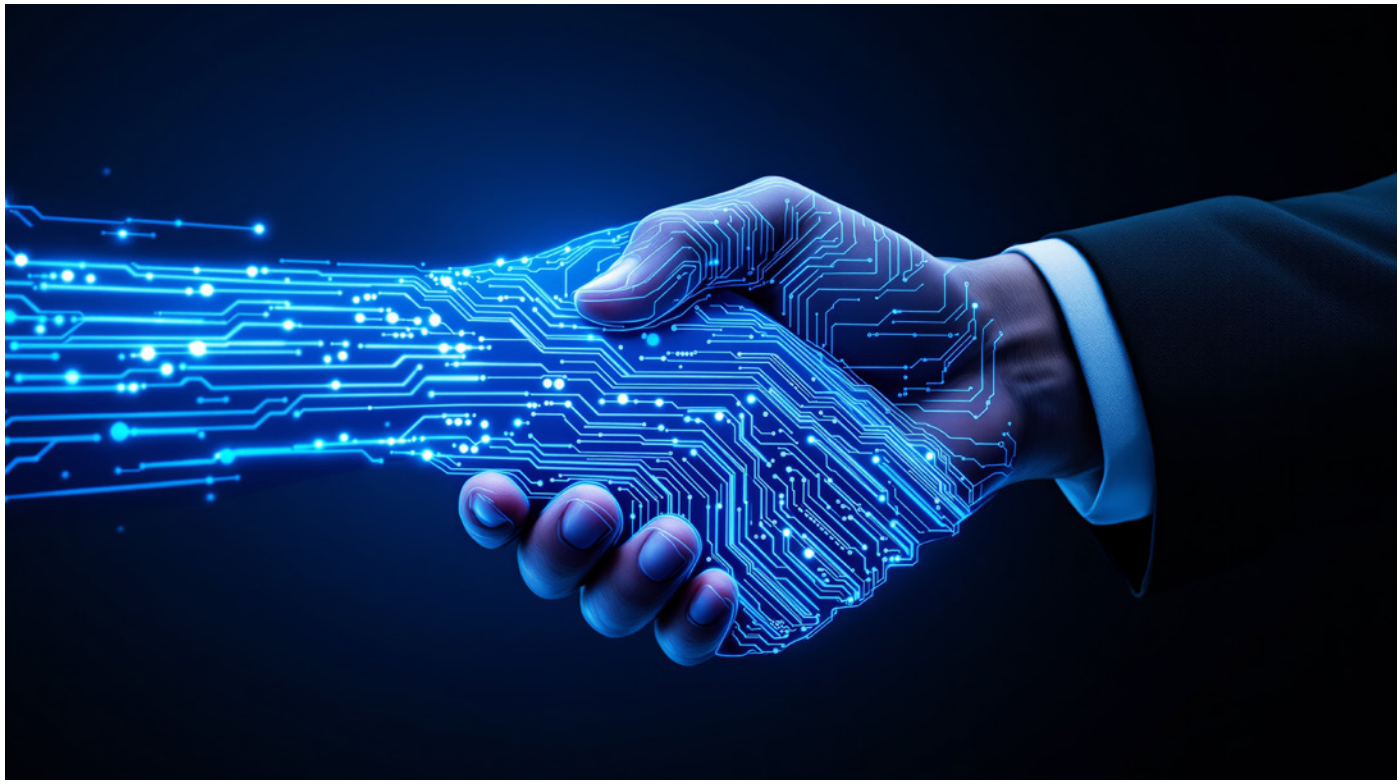
From Ad-Hoc to Enterprise-Wide: AI Vendor Contracting Through Governance



Sheela Ranganathan,
SCAN Health Plan
Arushi Pandya,
Sheppard Mullin Richter & Hampton LLP
Ava Dhakal,
Teacher Retirement System of Texas

A mid-sized health system procures a clinical decision support tool to assist with sepsis detection amidst enterprise-wide calls to quickly adopt new Artificial Intelligence (AI) tools. The tool demonstrated strong performance in vendor-provided validation studies; was evaluated by legal, privacy, and security; and went into implementation within 90 days. Over the next 18 months, the tool becomes embedded in clinical workflows, providing insights for triage and treatment decisions. But the health system lacks the information and processes needed to assess whether patient outcomes are improving as a result.

When a national headline reveals the model performs inconsistently across patient populations, the health system finds itself constrained. The contract contains no performance benchmarks, audit rights, or algorithm change notification requirements. The vendor has updated the model twice since implementation without notice to the system, and there is no basis to demand transparency or remediation.

This hypothetical illustrates the very real scenarios that health care entities are working diligently to prevent as they incorporate AI tools in a safe and responsible manner.

Since the AI boom began reshaping the health care industry, health care organizations have rushed to adapt their contracting practices for AI vendors. Early efforts to adopt AI oftentimes relied on traditional information technology (IT) procurement frameworks, such as evaluating AI tools on an ad-hoc basis, applying standard IT vendor diligence, and negotiating agreements with templates that were not designed to address AI-specific risks. In the initial years of AI adoption by health care organizations, governance was minimal and fragmented as individual reviewers determined the type of scrutiny to apply to each new tool, and cross-departmental stakeholder involvement was often activated as an escalation measure rather than a consistent review process.

At times, AI tools were trialed or adopted outside of the contracting process and legal review, especially as AI offered novel technologies that could be integrated into clinical care or administrative processes to reduce the burden on health care providers.[1]

As AI adoption accelerated and procurement cycles, in turn, compressed,[2] the vendor-by-vendor approach to AI procurement became both unsustainable and a source of enterprise-wide risk. Health care organizations began to experience a structural shift: The central question in AI vendor procurement was no longer "*should we adopt AI?*" but "*how should we govern our use of AI?*" Today, providers, payers, and other health care entities are moving from AI exploration to enterprise-wide deployment, and governance has emerged as a prerequisite to achieving responsible, scalable adoption of AI.[3]

Moreover, the focus on AI governance is now driving contracting itself. The most consequential AI contracting decisions are increasingly being made well before negotiations begin, with governance structures that classify tools, assign risk tiers, conduct diligence on vendors, and determine implementation expectations. These governance decisions dictate the contractual protections, oversight obligations, and accountability allocation between health care organizations and their vendors.[4] And in turn, contractual provisions provide enforcement mechanisms and data security obligations that allow governance to remain effective once the tools have been deployed.

This article examines how health care entities are structuring their governance functions, discusses how the evolving relationship between governance and contracting is reshaping AI vendor procurement, and offers practical takeaways for incorporating governance into agreement templates and playbooks.

Defining AI Governance

At a high level, "AI governance" refers to the organizational structures, policies, and processes that ensure responsible oversight of AI systems throughout their lifecycle, including the mechanisms used to identify, monitor, and mitigate risks associated with AI tools. Given the patchwork of federal and state AI guidance and regulations as well as the broad variances in organizational sizes, resources, and needs, AI governance models can vary significantly across the health care sector.

Emerging Frameworks

In the absence of standardized regulations on AI governance, a wide array of frameworks and guidance documents have emerged from regulators, professional associations, academic institutions, and health care systems themselves. While these frameworks vary in formality and scope, they are generally grounded in shared ethical principles such as patient safety, clinical accuracy, fairness and bias mitigation, transparency, accountability, and respect for patient autonomy.

The National Institute of Standards and Technology's (NIST's) Artificial Intelligence Risk Management Framework is one of the most influential examples.[5] Rather than prescribing specific technical controls, the NIST framework emphasizes organizational governance as the foundation of effective AI risk management. Its discussion of the "GOVERN" function focuses on establishing clear accountability structures, defined roles and responsibilities, documented policies, and escalation pathways that apply across the entire AI lifecycle—from design and procurement through deployment, monitoring, and retirement.

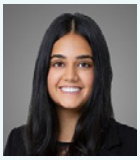
Health care-specific frameworks also provide operational insights. Guidance from major U.S. health systems, the American Medical Association, and the Joint Commission emphasizes centralized identification and registration of AI tools, standardized review of clinical validity and safety, bias and equity assessments, and ongoing post-deployment monitoring.[6] By tying AI governance to patient safety, clinical accuracy, and accreditation-adjacent quality standards, these frameworks converge on a common message: effective AI governance must be intentional, multidisciplinary, and continuous.

Regulatory Landscape

In the vacuum left by federal inaction to date, as well as changing priorities and approaches to AI regulations by different administrations, states have also moved aggressively to regulate AI, and health care has been a primary focus. While some state laws primarily focus on specific tools or use cases, others are requiring vendors—and the health care entities that work with them—to demonstrate that they have the capability to identify, assess, and manage AI-related risk. This medley of legal obligations creates a complicated regulatory landscape that is both constantly evolving and challenging to navigate for both health care organizations and vendors.

California's AI-related transparency and privacy requirements illustrate this trend. The California AI Transparency Act, which became effective on January 1, 2026, requires developers and deployers of high-risk AI systems to conduct impact assessments and disclose information about algorithmic

Sheela Ranganathan is Legal Counsel at SCAN, where she advises on contracting, regulatory, and operational matters to teams across information security, privacy, AI, compliance, pharmacy, and sales, as well as a street medicine provider group. She also serves as Adjunct Faculty at Georgetown University School of Health, where she teaches about health law, policy, and ethics at the undergraduate and graduate levels. Previously, Ranganathan was an associate at the O'Neill Institute's Center for Health Policy and Law and a health care regulatory associate at Sheppard. She holds a J.D. with honors from the University of Texas School of Law and a B.S. in Healthcare Management and Policy from Georgetown University.



Arushi Pandya is a health care and life sciences attorney at Sheppard, where she advises health care providers, digital health companies, pharmaceutical and medical device companies, hospitals and academic medical systems, and other health care and life sciences companies on a broad range of regulatory, operational, and compliance matters. In her privacy practice, she advises on issues related to AI adoption, governance, and contracting. She holds a J.D. and a B.S.A. in Biology from the University of Texas at Austin.

Ava Dhakal is a health care attorney at the Teacher Retirement System of Texas, where she advises on regulatory and transactional matters affecting a statewide public health-benefits system. Her practice focuses on a broad range of health care regulatory and transactional work, including health care and health-tech contracting, procurement matters, and regulatory compliance affecting the TRS-ActiveCare and TRS-Care plans, as well as health care governance and rulemaking matters. She holds a J.D. and a B.A. in English from the University of Texas at Austin. She is admitted to practice in Texas and is pending admission to the New York Bar.

decision making.[7] In parallel, recent amendments to the California Consumer Privacy Act impose additional obligations (also effective January 1, 2026 but with phased-in compliance obligations beginning in 2027) regarding automated decision-making technologies, risk assessments, and cybersecurity audits on businesses that use, retain, or share consumer data, which can include certain health care organizations.[8]

Highlighting the rapidly evolving regulatory landscape, Colorado recently repealed its landmark AI Act before it took effect, which established requirements for developers and deployers of "high-risk artificial intelligence systems" to conduct risk assessments, implement risk management programs, and disclose AI use to affected individuals. The AI Act has been replaced with the less expansive Automated Decision-Making Technology Act, which focuses instead on transparency and disclosures about adverse outcomes affected by automated decision-making technology.[9] Health care organizations operating in states with AI-regulating laws should align their governance programs with these requirements and ensure that vendor contracts reflect them.

This growing patchwork of state AI laws creates particular complexity for health care organizations that operate across multiple jurisdictions or deploy AI tools developed by vendors serving customers nationwide. Establishing mechanisms to monitor AI legislative developments enables an organization's AI governance function to identify emerging regulatory expectations and ensure they are adequately considered during contract negotiations.

Building a Committee

Although each AI governance model may be different, most models coalesce around the AI governance committee. The core functions of these committees are broad and often include:

- Guardrails and use-policy recommendations that define appropriate use cases, required monitoring, and limits on autonomous decision making.
- Compliance and ethics review, ensuring adherence to regulatory expectations, ethical standards, and organizational values.
- Oversight of employee use of AI, including monitoring for use of unapproved or high-risk tools, enforcing internal AI-use policies, and verifying that tools are used consistent with approved workflows.
- Training and informed consent requirements, ensuring individuals who use AI tools receive appropriate, role-specific training and provide appropriate consents.
- Risk tiering of AI tools based on clinical impact, patient-facing components, data sensitivity, and operational risk.
- Clinical oversight, including review of clinical validation evidence, safety risks, and workflow implications.
- Privacy and security review, ensuring compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), data-use limitations, cybersecurity requirements, and access controls.
- Bias and fairness review, including assessment of model training data, demographic performance variation, and mitigation plans.
- Approval of new tools and vendors, including alignment with organizational priorities and risk appetite.

The composition of a governance committee is driven by the size and type of the health care organization, but generally includes multidisciplinary representation such as:

- AI leads or a Chief AI Officer, who provide strategic direction and technical expertise.
- Legal counsel, who translate governance decisions into contractual requirements and manage regulatory risk.
- Compliance officers, who ensure alignment with applicable law and accreditation standards.
- IT and cybersecurity professionals, who assess technical integration and security risk.
- Privacy officers, who evaluate data use and HIPAA compliance implications.
- Clinical leads—e.g., physicians, nurses, and clinical informaticists—who evaluate clinical validity, quality, and patient safety implications.
- Business owners, who represent the operational unit seeking to deploy the tool and can articulate the intended use case and workflow.
- Data scientists, who assess model performance, training data quality, and statistical validity.
- Human resources representatives, particularly where AI tools affect workforce management or employee-facing functions.
- Government affairs representatives, who track legislative and policy developments, engage with policymakers as appropriate, and provide insight into emerging regulatory requirements.

Governance committees can serve a variety of purposes and are often tailored to the needs of a particular organization, but are generally interdisciplinary and address matters such as:

- Risk management and safety, such as identifying potential harms and ensuring patient safety.
- Validation and monitoring, such as evaluating AI tool performance pre- and post-deployment.
- Inventory and control, such as tracking the AI tools that are used by the organization.
- Policy and ethics formulation, such as developing guidelines for AI deployment.
- Regulatory compliance, such as ensuring compliance with state laws.
- Cross-functional oversight, such as involving interdisciplinary (clinical, technical, business, legal, and operational) departments to provide comprehensive governance.

Balancing Oversight with Innovation

Building an AI governance function from the ground up is inherently complex, and coordinating input from a broad set of stakeholders—each already managing substantial operational demands—can lead to business concerns about potential delays in the contracting process through additional

Establishing mechanisms to monitor AI legislative developments enables an organization's AI governance function to identify emerging regulatory expectations and ensure they are adequately considered during contract negotiations.

diligence on vendor stability, algorithms, data handling, and security practices. These operational challenges are further compounded by the pace of AI itself: vendors evolve quickly, models change frequently, and new use cases emerge before governance processes have been fully implemented or refined. As AI use cases evolve, reviewers may broaden their assessments to address emerging risks. However, additional review layers can unintentionally create bottlenecks for procurement and implementation.

At the same time, health care organizations cannot always afford to slow AI procurement timelines. While they may need the ability to pause or intensify review where warranted, organizations are also focused on providing timely, practical pathways to approved solutions when appropriate, so that business units are not driven to adopt readily available but unvetted tools without fully understanding the associated privacy, security, or operational risks. Effective governance therefore requires a calibrated approach: one that provides clear guardrails and timely guidance, aligns oversight with the organization's actual risk tolerance, ensures business owners and leadership understand and take responsibility for risk acceptance decisions, and enables legal and contracting teams to incorporate governance expectations into agreements that support ongoing monitoring and accountability.

Aligning Governance and Contracting Review

Strong, consistent alignment between governance and contracting is essential because governance decisions shape contractual protections an organization needs, and the contract then determines whether governance can operate effectively after deployment of an AI tool. An effective governance function continuously integrates into the contracting process and drives both the before and after of contract execution.

Pre-Procurement

As health care organizations continue to face significant financial and cost pressures, the ability of an AI tool or software to deliver on promises becomes increasingly important. Consequently, many deployers of AI are trying to ensure that the AI tool is not only effective but also provides a return on investment. The governance structure is crucial in evaluating the tool and building in the proper contractual controls to avoid the situation described in the hypothetical at the beginning of this article and provide sufficient protection for the deployer. For example, before contract execution, a tool classified as high-risk through the governance committee's risk-tiering process may require enhanced contractual protections, such as stricter performance specifications and more frequent review cycles.

Strong, consistent alignment between governance and contracting is essential because governance decisions shape contractual protections an organization needs, and the contract then determines whether governance can operate effectively after deployment of an AI tool.

The governance committee's risk assessment and tool classification inform what the organization will require of a vendor before negotiations begin. As the sheer number of AI tools proliferate the health care market and many are offered by emerging companies, vendor due diligence is key in understanding the risks and obligations that are necessary to build into the contract. For clinical or other patient-facing tools, this stage may include questionnaires to validate that the tool is appropriate for the organization's patient population, assess potential performance gaps, and understand what education, resources, and consents the organization will need to use the tool. Additionally, organizations might think of the pre-procurement process as essential in developing a relationship with the vendor—which is ultimately crucial in negotiating a contract to execution and building in flexibilities for change management in light of the constantly shifting AI health care landscape.

After a health care organization decides to use a particular AI tool or enter into a contractual relationship with a vendor, governance priorities can impact, and ideally quicken, contract negotiations. The negotiation process can also ensure that terms that support governance are finalized as certain provisions can constrain or enable governance.

To support this process, many health care organizations are modernizing their templates and negotiation playbooks. Rather than treating AI tools as one-off exceptions, organizations are increasingly incorporating baseline AI provisions into their standard IT agreements or incorporating AI addendums. These provisions commonly address issues such as model documentation, algorithm-change notifications, bias testing representations, data-use restrictions, and performance monitoring frameworks, creating a consistent contractual foundation that can be scaled across AI deployments regardless of risk tier. Terms such as audit rights give governance committees ongoing visibility into vendor performance, reporting obligations create post-deployment monitoring data, and escalation triggers ensure that changes in model behavior are elevated to the appropriate reviewers rather than going unnoticed.

In parallel, organizations are developing pre-approved model language and practical evaluation tools to support more consistent AI vendor negotiations. This often includes use-case-specific model provisions—for example, for clinical, administrative, or diagnostic AI—to reduce ad-hoc drafting and improve alignment across deals. Many organizations also equip business owners and operational leads with structured checklists to guide early vendor diligence, prompting collection of key information related to cyber-insurance coverage, contractual performance guarantees, liability caps relative to the tool's risk profile, and vendor sophistication, size, and financial stability. Together, these tools help shift AI contracting from an improvised exercise to a more repeatable, enterprise-wide, and governance-aligned process that supports ongoing oversight, accountability, and enforcement.

Health care entities are also structuring their AI vendor agreements to accommodate the evolving AI regulatory landscape through a combination of contractual and operational mechanisms. Contracts increasingly include change-management provisions that allocate responsibility for compliance with new or amended AI laws and establish processes for revisiting affected terms as regulatory requirements evolve. Health care organizations are also requiring vendors to provide ongoing regulatory compliance representations and

warranties across all jurisdictions where the AI tool is deployed, coupled with affirmative notification obligations if a vendor's compliance status changes. To ensure these obligations remain effective after contract execution, compliance functions are often integrated into ongoing contract management rather than limited to pre-signature review. In multi-state deployments, health care entities may further require vendors to manage jurisdiction-specific compliance obligations, including documenting how conflicting state requirements are addressed and which legal regimes apply in particular contexts.

Ongoing Vendor Management

Governance does not end at contract signature. One of the most common failures in health care AI governance programs is the absence of robust post-contract oversight. Only a few years ago, as the AI boom began, health care organizations began entering into many contractual relationships partially to remain at the forefront of innovation and partially because the AI tools offered by vendors were fragmented. Now, health care organizations are left to manage the operational impacts of monitoring a large number of contracts. Effective ongoing vendor management typically includes:

- Algorithm and subcontractor update monitoring, which may include contractual requirements for vendors to notify the health care organization of material updates to their AI models or changes in their subcontractor relationships that could affect the tool's performance or security profile
- Performance monitoring, which often includes cadences for reviewing vendor-provided performance data, including disaggregated performance metrics across patient subpopulations, and defined processes for escalating performance concerns to the governance committee
- Incident response protocols, which establish clear protocols for AI-related safety incidents, including notification timelines, evidence preservation obligations, cooperation requirements, and escalation to the governance committee and, where applicable, to regulators
- Periodic reassessment of existing vendor relationships, which might incorporate a regular review cycle—at minimum annually—for existing AI vendor relationships, during which the tool is reassessed against current governance standards, regulatory requirements, and organizational risk tolerance. Where tools no longer align with these expectations, organizations may revisit contractual terms, engage remediation plans, or initiate exit strategies.

Looking Forward

The health care organizations that will navigate the AI era most successfully are not those that treat AI governance as a compliance obligation to be checked off. They are those that recognize AI governance as a competitive advantage—a strategic capability that enables responsible innovation, builds trust with patients and regulators, and creates a durable foundation for AI adoption at scale.

Effective AI governance, and the contracting frameworks it produces, requires the sustained integration of clinical, legal, technical, and ethical expertise from the earliest stages of procurement through deployment and beyond. No single function—not legal, not compliance, not IT, not clinical leadership—can do this work alone. The organizations that build genuinely cross-functional governance programs, and that invest in aligning those programs with their contracting processes, will be better positioned to adopt AI responsibly, manage the inevitable challenges that arise, and demonstrate to patients, regulators, and the public that their use of AI is worthy of trust.

The contract remains an essential instrument. But in 2026 and beyond, it is governance that gives the contract its direction—and governance that will define what responsible AI adoption in health care actually looks like.

*This Feature Article is brought to you by the **Health Information and Technology Practice Group: Adam Greene**, Davis Wright Tremaine LLP (Chair); **Andria Adigwe**, Buchanan Ingersoll & Rooney PC (Vice Chair); **Aastha Farr**, Health Plan of San Joaquin (Vice Chair); **Amy Joseph**, Orrick Herrington & Sutcliffe LLP (Vice Chair); **Jody Erdfarb**, Wiggin and Dana LLP (Vice Chair); and **Jennifer Kreick**, Haynes and Boone LLP (Vice Chair).*

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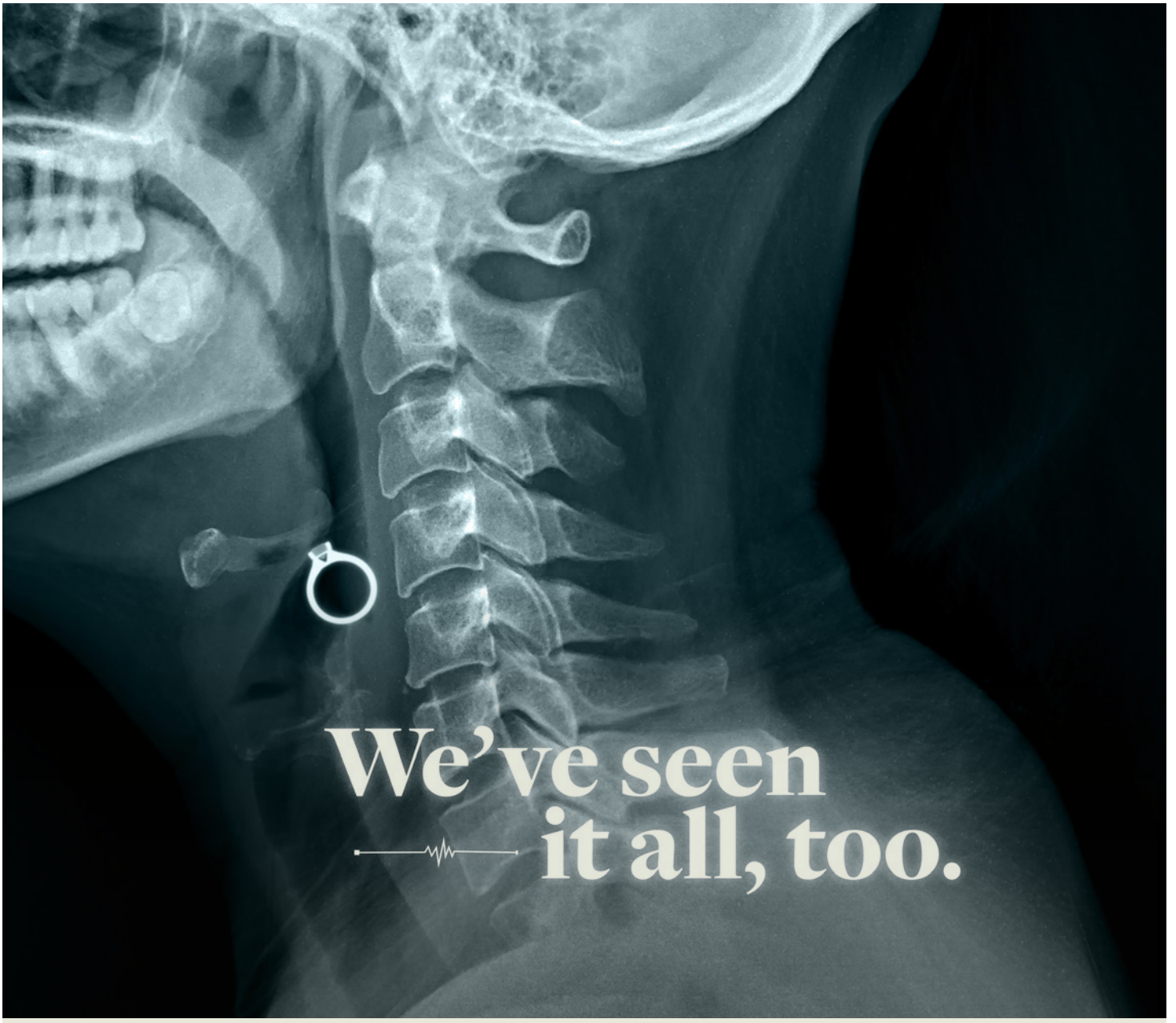
6 Parker *supra* note 5; Lozovatsky *supra* note 5; Joint Commission & Coalition for Health AI, *supra* note 5.

7 *See* California SB 942 ("California AI Transparency Act") (2023-2024).

8 California Consumer Privacy Act of 2018, Cal Civ. Code § 1798.100 et seq.

9 Colo. Rev. Stat. (C.R.S.) § 6-1-1701 et seq.; Automated Decision-Making Technology, S.B. 189, 75th Gen. Assemb., 2nd Reg. Sess. (Colo. 2026).



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Feature

Trends in Payor Disputes for Behavioral Health Providers

***Sandra L. Heller**, Holland & Knight LLP*
***Dan M. Silverboard**, Holland & Knight LLP*
***Tyler Gilbert**, Holland & Knight LLP*

Behavioral health care providers operate in one of the most heavily scrutinized segments of the health care industry. Over the past decade, payors—including commercial health plans, Medicaid Managed Care Organizations, Medicare Advantage Organizations, and other governmental payors, along with federal and state enforcement authorities—have intensified their focus on behavioral health. This scrutiny reflects several converging forces: rapid industry growth; expanded telehealth utilization; evolving mental health treatment modalities; increasing public funding for substance use disorder (SUD) treatment; as well as the fallout from bad actors in the SUD treatment space during the opioid crisis. The issues that have received significant attention included high-profile fraud prosecutions involving patient brokering, laboratory schemes, and other kickback arrangements.

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Across behavioral health, including outpatient psychiatry, SUD treatment, autism therapy, and eating disorder treatment, audits are no longer episodic anomalies or part of a routine review process. Payor Special Investigation Units (SIUs) and government contractors rely on data mining and comparative analytics to identify outliers, and the consequences of adverse findings range from indeterminately long prepayment holds and denials and post-payment extrapolated recoupment demands to contract termination and referrals to law enforcement. This article examines the audit landscape confronting behavioral health care providers, the enforcement statutes that

underpin and inform payor audits and other enforcement activity, and practical strategies for response and risk mitigation.

Types of Audits and Reviews

Behavioral health care providers encounter audits in several forms, each carrying distinct procedural requirements and practical consequences. Audits may originate from data-driven sweeps flagging statistical outliers, spikes in cost, industry or payor-wide initiatives targeting specific service lines, member complaints, or internal whistleblower concerns. The nature of the triggering event often determines the type of audit and the resulting outcomes.

Prepayment Reviews

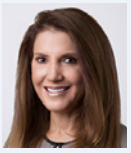
Prepayment reviews are typically grounded in contractual audit rights within network participation agreements but also apply to out of network providers. These audits are often the first visible sign that a provider has attracted payor scrutiny. Upon claim submission, providers will receive an initial "soft" denial, requiring the submission of records to support the codes billed within a relatively short timeframe. This audit status can be administratively overwhelming, as the provider is required to submit extensive documentation reflecting all aspects of the treatment, demonstrating medical necessity, proper coding, and appropriate clinician credentials as a condition precedent to payment on submitted claims. The financial strain on the provider can be significant since cash flow is disrupted while the payor reviews the submitted information. Other challenges that providers encounter during a prepayment review include:

- Prepayment reviews are often indeterminate. The provider will have no clear idea as to how long they will be under prepayment review status or what "pass rate" or percentage of claims that must be determined to be "appropriately documented" to warrant payment and be taken off prepayment review status.
- These reviews are typically documentation sufficiency reviews, so the payor's reviewer is not a behavioral health provider or anyone with any experience as a health care practitioner. They are typically "coders."
- Payors may not provide any rubric of other clear "scoring" protocol for the documentation sufficiency review. The way patient records are reviewed can be a "black box" to a provider.
- To the extent there is a medical necessity component to the review, the provider will not know the qualifications of the individual performing the review.
- The provider may be given nondescript or inconsistent justifications for claim denials.
- In terms of the "standards" applied for these reviews, payors may point to a myriad of sources, authorities, and guidelines for the claim failing audit. These include the payor's medical policies and billing guidelines, Centers for Medicare & Medicaid Services billing and coding guidelines (even for commercial claims), clinical guidelines developed by national provider associations (e.g., ASAM Criteria), state or federal statutes, and various studies and white papers. A provider may not always know what specific source the payor is relying on for a claim determination absent further inquiry.
- For each denial, payors require providers to exhaust internal/administrative remedies, including requests for reconsideration and appeals, to preserve the right to advance these disputes to pursue payment for these claims.

Providers seldom know the impetus for the prepayment review, which can be troubling. As discussed in greater detail below, it is critical for providers to have mechanisms in place to both respond to and strategically deal with prepayment audits.

Post-Payment Reviews

Post-payment reviews occur with respect to claims for which a provider has already received reimbursement. A provider may receive an innocuous looking letter informing them that records are being requested for a discrete list of patients. It may be a relatively small sample, even as few as ten to 30 patients. If the letter is innocently missed, it can result in the complete "fail" of the audit and require the payor to agree to extend the due date, which is not guaranteed. The provider will be advised that the review is to identify any payments that were made "in error."



Sandra Heller leads Holland & Knight's Payer Dispute and Managed Care Litigation Team and focuses her national practice on managed care litigation and reimbursement disputes between providers and both private and governmental payers. Ms. Heller works closely with behavioral health care facilities, hospitals and health systems, physician groups, dental service organizations, medical service organizations, laboratories, pharmacies, home care providers, billing companies, and other provider and provider-adjacent organizations to resolve reimbursement disputes efficiently and without disrupting provider–payer relationships.

Dan Silverboard is a health care attorney in Holland & Knight's Atlanta office who focuses his practice on regulatory compliance and business transactions. With more than 20 years of experience, Mr. Silverboard provides legal counsel to businesses across the provider spectrum, including hospitals, physician practices, clinical laboratories, pharmacies, drug/device manufacturers, diagnostic imaging centers and ambulatory surgery centers.

Tyler Gilbert is an attorney in Holland & Knight's Nashville office where he assists clients with regulatory compliance issues related to transactional matters and changes of ownership and provides advice on day-to-day operational concerns.

The permissible lookback period for post-payment reviews varies depending on the applicable contract terms and governing law. Commercial payor audits are typically governed by provider agreement provisions, while federal health care programs impose specific regulatory lookback limits. Allegations of fraud may permit longer recovery periods in certain circumstances.

Like a prepayment review, non-clinicians will typically perform any coding review. For these reviews, should the payor find "errors" in the reviewed claims—which can include the use of an "unsupported code," a provider whose credentials are not identified properly, or even a missing signature—the payor may calculate an "error rate" and extrapolate that rate across

the entire population of claims.[1] Such data sampling and extrapolation techniques may result in recoupment demands that can reach millions of dollars.

SIU Involvement in Audits

Both prepayment and post-payment audits can be initiated by a payor's SIU, which can represent a different level of scrutiny. SIUs primarily serve to detect potential fraud, waste, and abuse. However, SIUs may investigate providers who are compliant and have every belief they have submitted clean claims. SIU audits may precede (and sometimes trigger) recoupment actions, network termination, False Claims Act (FCA) suits, criminal charges, and/or professional disciplinary actions. Although SIUs are not government prosecutors, their findings, in the most extreme circumstances, can form the predicate for referrals to the Department of Justice.

SIU reviews can differ from routine medical necessity audits in tone and scope. They may involve broad document requests functioning as quasi-subpoenas (enforcing audit provisions in the provider agreement), staff interviews, review of marketing relationships and patient acquisition channels, requests for referral source contracts, and close examination of ownership and compensation structures. An SIU investigation may begin with a discrete billing anomaly but rapidly expand to encompass the provider's entire business model if initial findings suggest systemic irregularities.

Understanding the different audit types is only part of the picture. Equally important is understanding the events and patterns that cause payors to initiate these reviews in the first place.

Precipitating Events for Audits

Data Analytics and Outlier Detection

Many audits are data driven. Payors may compare providers against peer benchmarks across variables such as average units billed per visit, trends in levels of care, session duration patterns, testing utilization, anomalous billing and coding patterns such as outlier ratios of group to individual therapy, or spikes in costs. Based on this analysis, payors may identify outliers against whom they will initiate audits.

> *Across all service lines, documentation must support medical necessity, session duration, treatment modality, and the credentials of the rendering provider. In addition, the documentation must indicate that pertinent regulatory requirements are met.*

Certain CPT and Revenue codes attract heightened payor scrutiny due to their higher reimbursement rates and susceptibility to misuse, and understanding the documentation and billing requirements for each is essential to mitigating audit and enforcement risk. Coding and billing irregularities remain a principal area of SIU investigation. Common issues include upcoding, "unbundling" of bundled codes, and billing for services not rendered. In addition, SIUs will scrutinize billing for compliance with regulatory requirements, such as billing by unlicensed staff to ensure applicable supervision requirements are met. Additionally, SIUs will scrutinize whether a facility complies with applicable group size requirements, as well as other licensure requirements, discussed in more detail below. Across all service lines, documentation must support medical necessity, session duration, treatment modality, and the credentials of the rendering provider. In addition, the documentation must indicate that pertinent regulatory requirements are met.

Support for these codes are found in the documentation. A non-exhaustive list of issues that tend to attract payor scrutiny in supporting the level and degree of billing include:

- Sufficiency of Record Documentation (even beyond regulatory requirements);
- Missing Provider Signatures;
- Missing Provider Credentials;
- Lack of Provider Credentialing;
- Number of Hours Reflected Relative to Level of Care;
- Therapy Note Sufficiency and Patient Specific Engagement Information;
- Propriety of Activities Included in Group Therapy Encounters;
- Standing Orders Around Urine Drug Testing; and
- Out of Network Referrals (discussed in more detail below).

It is wise for providers to have a system in place for providing these records and ensuring that the records submitted are fully complete. It is also advisable that providers are well positioned to respond to the overpayment demands that typically ensue from these audits. As discussed below, it should be expected that some degree of error rate, extrapolation, and overpayment demand will flow from these efforts.

Member Complaints

Data anomalies are not the only catalyst for audits. In addition to data outlier analytics, a single member complaint alleging billing for services not received, inflated session durations, or unnecessary testing can also prompt a targeted review. Payors are required to investigate grievances, and an investigation corroborating even a portion of a complaint may expand into a broader audit.

Federal and State Enforcement Actions and Qui Tam Suits

The risk of audit escalation increases further when government enforcement enters the picture. Federal and state enforcement actions, including qui tam suits under the FCA, can trigger or intensify payor audits. When a provider is publicly identified as a government target, commercial payors may initiate parallel reviews. Qui tam actions are particularly consequential because they may remain under seal while the government investigates without the provider's knowledge. Upon unsealing, the provider may face simultaneous government and commercial payor scrutiny.

SIU Hot-Button Issues

AKS and EKRA: Prohibited Referral Arrangements

Although numerous statutes inform behavioral health care enforcement, SIUs may anchor their investigations in the federal Anti-Kickback Statute (AKS),[2] the Eliminating Kickbacks in Recovery Act (EKRA),[3] and their state counterparts.

The AKS prohibits the knowing and willful solicitation, receipt, offer, or payment of any remuneration—directly or indirectly, in cash or in kind—to induce or reward patient referrals or the generation of business involving any item or service reimbursable by a federal health care program.[4] The AKS has long served as the primary federal kickback prohibition, though its application is limited to services reimbursable under federal health care programs. Recognizing this gap, particularly as the opioid epidemic exposed pervasive fraud in the addiction treatment industry, Congress enacted EKRA as part of the SUPPORT for Patients and Communities Act of 2018 to combat fraud and abuse in the addiction treatment industry.[5] Unlike the AKS, EKRA is not limited to services reimbursable under a government health care program, but is an "all payor" statute.[6]

At its core, EKRA targets remuneration in exchange for patient referrals to recovery homes, clinical treatment facilities, and laboratories.[7] Each conviction under EKRA is punishable by a fine of up to $200,000, imprisonment for up to ten years, or both.[8] The statute's penalties are more severe than those under the AKS, reflecting Congress' particular concern with fraud in the SUD treatment industry.

Based on the AKS and EKRA, SIUs increasingly review provider referral patterns and practices as an area of focus. Steering patients to affiliated toxicology labs for high-frequency, high-cost testing has been a hallmark of behavioral health fraud schemes.[9] In addition, marketing practices by SUD programs have been the subject of intense scrutiny. SIUs routinely monitor referral concentration and volume as indicators of potential kickback arrangements.

SIUs are also closely attuned to practices that constitute patient inducements. Routine waiver of patient copayments, coinsurance, and deductibles is a significant area of SIU focus. While occasional, documented financial hardship waivers may be permissible, waiving cost-sharing amounts as a matter of course may constitute an improper inducement. Accordingly, providers should implement robust compliance programs with written policies addressing cost-sharing waiver practices, including documentation requirements for financial hardship determinations and collection efforts.

SIUs have also taken a specific interest in housing, food, and transportation programs offered by clinical treatment/SUD facilities to patients. Often, a facility will offer below market or even free housing as an inducement for a patient to enroll at the facility. SUD facility offers of free transportation have also been common. Such inducements could be seen by an SIU to violate fraud, waste, and abuse laws where the rental payment is below fair market value.

Telehealth Compliance

The expansion of telehealth in behavioral health has also introduced new compliance dimensions that warrant careful attention. Providers delivering services across state lines should ensure the rendering clinician's license permits practice where the patient is located (e.g. through an applicable interstate compact or temporary waiver). In addition, commercial payor requirements often mirror Medicare's requirements for telehealth services and cover such services only "when furnished by

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Overall, in the audit context, providers that demonstrate a functioning compliance program are better positioned to negotiate favorable resolutions and argue against extrapolated penalties.

an interactive telecommunications system" that includes "at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner."[10] Medicaid requirements and opportunities for tele-behavioral health services vary considerably by state. At a minimum, payors expect documentation reflecting the platform used, patient consent, and evidence that the encounter met in-person clinical standards.

Licensure and Accreditation

Licensure and accreditation issues round out the major categories of SIU concern and often intersect with the coding and telehealth issues discussed above. Each state has its own licensing boards and criteria for behavioral health providers and facilities. Operating without proper state licensure, failing to maintain accreditation (e.g., Joint Commission or Commission on Accreditation of Rehabilitation Facilities), or billing under expired provider numbers can invalidate claims and trigger repayment demands spanning the entire noncompliance period. If an SIU identifies fraud or abuse, it may report findings to state licensing boards, potentially triggering disciplinary proceedings. In behavioral health, where clinicians frequently bill under their own credentials, individual exposure is meaningful and distinct from entity-level risk.

Strategies for Avoiding, Anticipating, and Responding to Audits

Preparation for the Eventual Audit; Appeals and the Dispute Resolution Process

The question is "when," not "if," an audit will come. Having processes in place to identify and flag an audit notice is key. Internal RCM staff or an external vendor ready to gather records for timely submission is also critical. Regardless of audit type, providers should examine several threshold issues upon receiving notice: whether the notice satisfies contractual requirements; applicable timelines for production and response; documentation standards; appeal rights; and provisions governing retroactive application of revised payor policies.

It is advisable to have readily available health care regulatory and litigation counsel to assist in these efforts, including for communicating with the payor, preparing for appeals, and escalating the matter to arbitration or litigation if necessary. Appeals should include careful analysis of any regulatory, statutory or contractual issues raised by the payor. Experienced health care counsel can assist with best positioning providers for success in this effort.

It is also critical that providers understand the dispute resolution provisions in their payor contracts before an audit arises. Network participation agreements usually outline steps for challenging adverse decisions, such as internal appeals, external reviews, or binding arbitration. Knowing these procedures in advance helps behavioral health care counsel protect rights and plan escalation strategies. Providers should also review provisions governing the payor's attempts to offset recoupment amounts against future claims, as these can compound the financial impact of adverse findings. Providers should be wary of attempts at cross-plan offsetting and consider whether any attempts by the payor to offset the recoupment amount against amounts owed to the provider under other plans or lines of business are permissible under the terms of the contract and applicable law.

Providers should exhaust all available administrative appeal rights. Appeals need to cover not only the actual reasons behind audit findings but also any procedural issues, such as questions about how extrapolation was used, whether proper notice was provided, and if all contractual deadlines were met. Failure to adhere to strict appeal deadlines may waive challenge rights entirely. However, providers should also ensure that payors do not attempt to impose appeal processes or deadlines that are more stringent than applicable federal or state law, particularly in the context of audits or investigations that cross multiple lines of business.

Compliance Programs and Periodic Auditing

A robust compliance program is the single most important structural defense against audit exposure. The U.S. Department of Health and Human Services Office of Inspector General (OIG) recommends that health care providers and suppliers put in place a voluntary compliance plan focusing on the following elements: (i) conducting internal monitoring and auditing; (ii) implementing compliance and practice standards; (iii) designating a compliance officer or contact; (iv) conducting appropriate training and education; (v) responding appropriately to detected offenses and developing corrective action; (vi) developing open lines of communication; and (vii) enforcing disciplinary standards through well-publicized guidelines.[11] Effective compliance programs should further include regular coding accuracy reviews, documentation assessments, and billing pattern analyses benchmarked against publicly available data.

Overall, in the audit context, providers that demonstrate a functioning compliance program are better positioned to negotiate favorable resolutions and argue against extrapolated penalties.

Internal Risk Assessments

With a solid compliance base, providers should perform focused internal risk assessments. Internal risk assessments should encompass all areas of heightened regulatory risk: referral source relationships, compensation arrangements, cost-sharing practices, telehealth compliance, and licensure status. Identified deficiencies should be addressed through corrective action plans with defined timelines. When conducted under the direction of legal counsel, risk assessments may be protected by attorney-client privilege and the work product doctrine, providing an additional layer of protection in subsequent litigation or government investigation.

Key Practical Takeaways for Providers

- Maintain organized medical records for rapid audit response
- Review provider agreements for audit and recoupment provisions
- Monitor coding patterns and outlier utilization
- Implement cost-sharing collection policies
- Conduct privileged internal compliance audits
- Consider consulting experienced managed care dispute counsel to assist in related responses and appeals, along with ensuring all steps are taken to ensure the ability to escalate any disputes that may arise from an overpayment demand.

Conclusion

As capital continues to flow into behavioral health and industry consolidation accelerates, enforcement authorities and commercial payors alike will intensify oversight. The convergence of expanded telehealth utilization, heightened public investment in SUD treatment, and a growing body of enforcement precedent means that the current audit environment does not appear to be a temporary phenomenon. Behavioral health care providers who anticipate payor audit methodologies, maintain strong documentation and compliance programs, and respond strategically to audit findings will be better positioned to mitigate financial exposure and regulatory risk.

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*This Feature Article is brought to you by the **Behavioral Health Practice Group: Kirti Reddy** (Chair); **Alicia Macklin**, Hooper Lundy & Bookman PC (Vice Chair); **Michaela Poizner**, Baker Donelson Bearman Caldwell & Berkowitz PC (Vice Chair); **David Shillcutt**, Epstein Becker & Green PC (Vice Chair); **Shalyn Watkins**, Holland & Knight LLP (Vice Chair); and **Christianna Finnern**, Winthrop & Weinstine PA (Vice Chair).*

1 Different types of governmental plans may have regulations around how payors may extrapolate error rates and determine overpayments. They may also have regulations impacting how error rates are calculated. Although commercial payors often apply similar techniques, the contractual basis for extrapolation may vary. It is important to be aware of the requirements that apply to the specific type of plan or coverage.

2 42 U.S.C. § 1320a-7b(b).

3 18 U.S.C.§ 220.

4 42 U.S.C. § 1320a-7b(b).

5 *See* 164 Cong. Rec. S6467-02, S6473 (Senator Amy Klobuchar: "Our bill targets unscrupulous actors who prey on patients seeking treatment to exploit their health insurance by making it illegal to provide or receive kickbacks for referring patients to recovery homes and treatment facilities. These kickbacks are already illegal under Federal healthcare plans like Medicare, but there is no Federal law to prohibit them in private health insurance plans.").

6 EKRA applies to a "health care benefit program," which means any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract. 18 U.S.C. § 220(e); 18 U.S.C. § 24(b).

7 *See* 18 U.S.C.A. § 220(a).

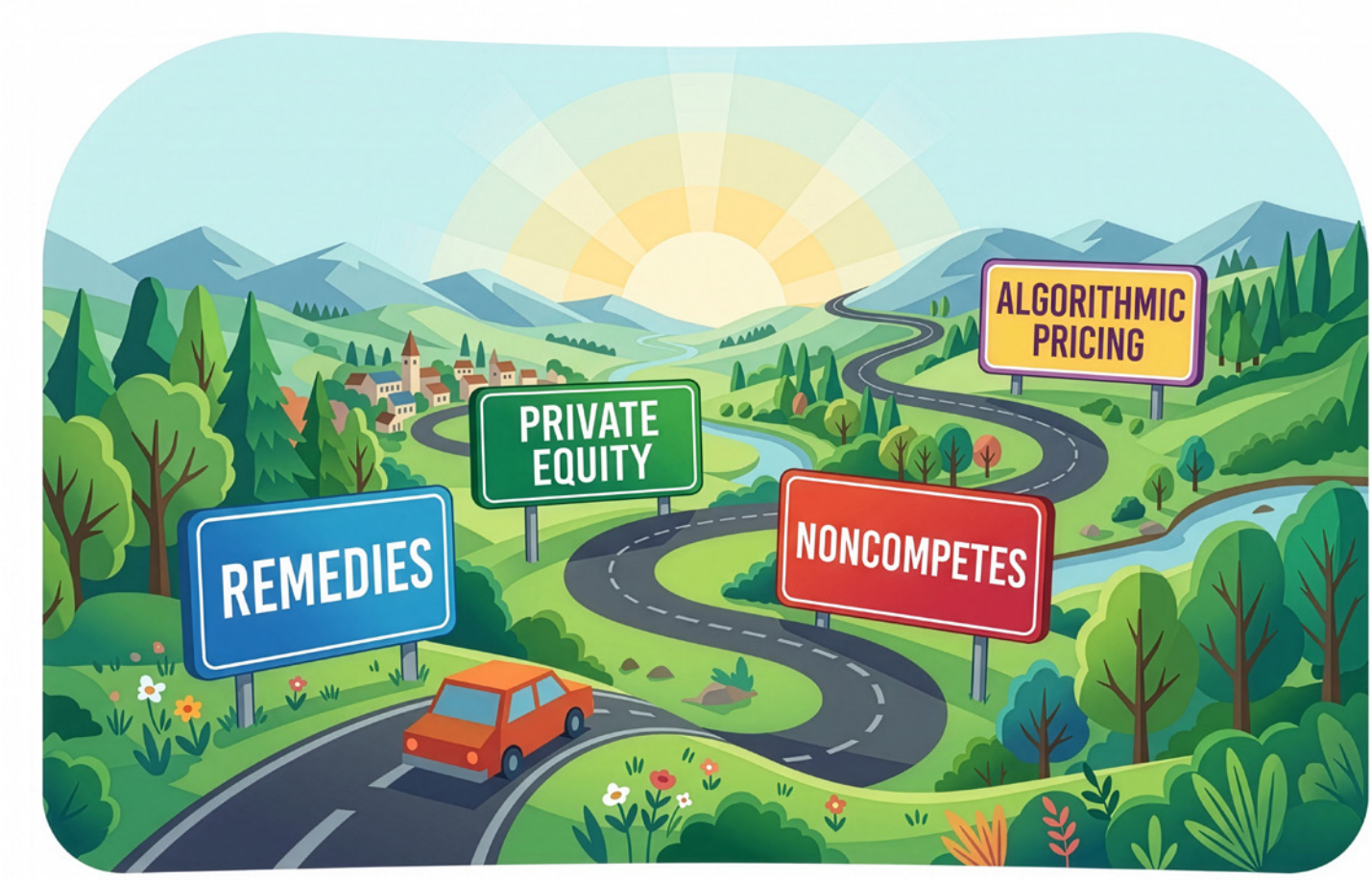
8 18 U.S.C.A. § 220.

9 *See* U.S. Dep't of Justice, Press Release, *Precision Toxicology Agrees to Pay $27 Million to Resolve Allegations of Unnecessary Drug Testing and Illegal Remuneration to Physicians* (Oct. 2, 2024) (settlement with corporate integrity agreement with Department of Health and Human Services Office of Inspector General); U.S. Att'y's Off., W.D. Mich., Press Release, *Physicians Toxicology Laboratory and Its Owners to Pay $4.425 Million to Settle Allegations of Unnecessary Drug Testing* (Jan. 3, 2025).

10 42 C.F.R. § 410.78.

11 U.S. Dep't of Health & Hum. Servs., Off. of Inspector Gen., *General Compliance Program Guidance* 10 (2023), https://oig.hhs.gov/compliance/general-compliance-program-guidance/.

Markets and Medicine:
Health Care Antitrust Enforcement Under Trump's Second Term and the Road Ahead



***Karla M. Doe**, Alston & Bird LLP*
***Andrew J. Liebler**, Alston & Bird LLP*

> *In the opening phase of the Trump administration's second term, health care remains squarely at the center of federal competition policy.*

Predictions that health care antitrust enforcement would recede under President Trump's second term have thus far not materialized. In the opening phase of the Trump administration's second term, health care remains squarely at the center of federal competition policy. Instead, the administration has taken an enforcement posture that favors disciplined case selection, reliance on traditional antitrust doctrine, and closer alignment between legal theories and how modern health care markets actually operate—through complex provider networks, intermediaries, data-driven pricing tools, and evolving technology platforms.

Three themes have emerged in the opening phase of Trump's second term:

- **Continuity in focus:** Sustained scrutiny of provider consolidation, medical devices, life sciences, and health care intermediaries (e.g., specialty physician practice roll-ups, reimbursement platforms, and other data-driven health care intermediaries).
- **Recalibration in approach:** Preference for traditional Section 7 of the Clayton Act and Section 1 of the Sherman Act frameworks and a renewed receptivity to credible, competition-preserving remedies in appropriate cases.
- **Emerging focus on technology-driven competition issues:** Heightened focus on how pricing tools, platforms, and artificial intelligence (AI) shape competitive outcomes.

Across these areas, affordability and consumer impact have become the dominant lens through which enforcement decisions are framed.

This article examines how health care antitrust enforcement is taking shape in the second Trump administration, focusing on recent enforcement actions targeting providers, specialty practices, algorithmic pricing, and labor restraints in health care employment agreements.

Reversion to Trump's First-Term Antitrust Enforcement with Modernized Tools

Early enforcement activity in Trump's second term marks a departure from the Biden administration's approach and a reversion to Trump's first-term antitrust approaches with modernized tools.

During Trump's first term, health care enforcement was widely characterized as "business as usual" in core areas like hospital mergers, which were handled case-by-case, were fact-driven, and were largely bipartisan in their emphasis on local market power and payer leverage. The Biden years, by contrast, were defined by policy moves that narrowed or eliminated prior health care safe harbors. Most notably, the U.S. Department of Justice (DOJ) and the U.S. Federal Trade Commission (FTC) withdrew the long-standing health care enforcement policy statements, reflecting heightened skepticism toward information sharing and other coordination-adjacent practices.[1]

In Trump's second term, the agencies are keeping health care at the top of the priority list but emphasizing litigation-resilient theories and a more operational, coordinated enforcement model rather than leading with sweeping policy pronouncements.

Traditional Antitrust Doctrine, Modern Health Care Markets

DOJ's and FTC's health care focus in Trump's second term is best described as traditional doctrine with modern fact patterns. The FTC and the DOJ have leaned into familiar frameworks like horizontal overlaps, entry barriers, contracting restraints, and innovation competition, while building cases that reflect how health care markets operate

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today: through intermediaries, platforms, complex reimbursement formulas, and algorithmic tools.

This recalibration is apparent in the agencies' messaging and organization. In March 2026, the FTC launched a multi-bureau Healthcare Task Force to coordinate enforcement and advocacy across the Bureaus of Competition, Consumer Protection, and Economics, along with the Office of Policy Planning and the Office of Technology.[2] The Task Force has four focus areas: coordinated investigations, targeted initiatives, amicus opportunities, and "horizon-scanning" for emerging issues.[3] Substantively, the FTC has positioned the Task Force to pursue an integrated agenda spanning both competition and consumer-protection problems in health care—meaning it is likely to focus not only on mergers but also on consumer-facing issues and technology-enabled practices that affect costs and access. The FTC's "recent wins" highlighted alongside the Task Force—device merger challenges, labor-market initiatives, and consumer-protection matters involving health-insurance marketing—underscore that the Task Force is intended to operate across sectors and theories rather than within a single enforcement silo.[4]

In short, enforcement agencies are operationalizing health care enforcement through coordinated pipelines, economically grounded theories, and fact patterns that increasingly incorporate technology, data, and platform dynamics.

Two Deals, One Message: Protecting Innovation in Health Care Device Markets

Health care merger enforcement has remained active in Trump's second term, especially in medical devices, where innovation competition can be the central theory of harm. A particularly instructive case is the FTC's challenge to Edwards Lifesciences' proposed acquisition of JenaValve, a deal involving pipeline transcatheter aortic valve replacement devices for aortic regurgitation.[5] The FTC brought both an administrative action and a federal court case and, after a six-day trial, the U.S. District Court for the District of Columbia granted a preliminary injunction on January 9, 2026, temporarily preventing the acquisition.[6] That same day, Edwards publicly announced that it would not proceed with the acquisition of JenaValve in light of the court's ruling.

What makes Edwards/JenaValve significant is how it illustrates a "traditional" Section 7 theory applied to a modern innovation market. The relevant competitive constraint was not current sales but future head-to-head rivalry between two leading pipeline technologies. The FTC's public case summary reflects concern that the transaction would limit access to devices used to treat a potentially fatal heart condition, underscoring that innovation and future competition can be the protected interest even where commercialization is not yet complete.[7]

Karla M. Doe, a Senior Associate in Alston & Bird LLP's Atlanta office, is a seasoned litigator representing clients in high-stakes antitrust and health care–related litigation and government investigations. Her practice spans the full lifecycle of complex litigation, from early strategic planning through trial and appeal.

Andrew J. Liebler is a Partner in Alston & Bird LLP's Litigation & Trial Practice Group. Andrew focuses his practice on health care, government and internal investigations, qui tam litigation, cybersecurity, and complex commercial litigation. Andrew routinely defends clients in the health care, insurance, and higher education industries against investigations and qui tam litigation brought by the Department of Justice, U.S. Attorney's Offices, and state and federal regulators. Andrew often represents health care clients in payer–provider disputes and other complex business disputes.

A second device example is the abandonment of Alcon's proposed acquisition of LENSAR. In March 2026, the FTC publicly stated that the transaction would have combined the "two most significant players" in the market for femtosecond laser-assisted cataract surgery systems. The FTC described the parties as locked in a "price war" that benefited doctors and patients and said the merger threatened to reduce both price competition and innovation, prompting the companies to "thr[o]w up a white flag rather than risk facing the FTC in court."[8]

Together, Edwards/JenaValve and Alcon/LENSAR show the administration's enforcement posture: the DOJ and the FTC will pursue classic horizontal and innovation theories with modern health care applications, particularly where competitive impact is clear.

Remedies Are Possible, If Credible and Administrable

A key point of antitrust enforcement under Trump's second term is the renewed role of remedies. The agencies have resisted the posture that every problematic deal must be litigated to the end; rather, the agencies appear more willing to consider negotiated outcomes, especially structural relief, when the remedy is credible and administrable. The difficulty is that the agencies' remedy expectations are more demanding in practice, particularly for health care and device markets with regulatory and operational constraints. For dealmakers, the best lesson from the current environment is to treat remedy design as a core workstream rather than a late-stage contingency. For example, if companies are considering divestiture, the divestiture package must resemble a functioning competitor, not an abstract concept. Three considerations are paramount. First, viability: the divested assets must be able to operate and compete effectively post-deal. Second, regulatory and supply realities: approvals, manufacturing, and distribution pathways must be preserved. Third, transitional support: limited, time-bound behavioral commitments may be necessary to make the structural fix work.

Conduct Enforcement in Provider Markets: A Return to Contracting Restraints

On the conduct side, the administration's focus on affordability concerns is reflected by the DOJ's February 2026 lawsuit against OhioHealth. The DOJ and the Ohio Attorney General sued OhioHealth over contractual restrictions that allegedly prevent insurers from offering "budget-conscious" plans and impede access to price information.[9] The government alleges that OhioHealth uses its market power to require insurers to include OhioHealth in all networks for the commercial products they offer, foreclosing narrower or tiered networks that could steer patients to lower-cost providers.[10] That theory has already advanced beyond the pleadings stage. In June 2026, the DOJ and the Ohio Attorney General reached a proposed settlement requiring OhioHealth to abandon the challenged contracting practices, void existing anti-steering and plan-design restrictions, and refrain from imposing similar terms going forward—reinforcing the agencies' willingness to pursue and resolve provider-contracting cases through targeted, administrable relief.[11]

That enforcement line expanded in late March 2026 with the DOJ's suit against New York-Presbyterian Hospital.[12] The DOJ likewise challenges contracting restrictions alleged to block "budget-conscious" plan designs and insulate a dominant system from price competition. The DOJ alleges New York-Presbyterian's contracts operate as "all-or-nothing" restraints that force broad inclusion of the system's facilities and limit insurers' ability to use differential cost-sharing or other benefit-design features to steer patients toward lower-priced rivals. The DOJ further alleges these restrictions reduce plan choice, impede competition between hospitals, and allow New York-Presbyterian to maintain higher prices by insulating it from the competitive pressure that budget-conscious plan designs would otherwise create.

Notably, the DOJ proceeded under Section 1 restraint-of-trade theories for both cases, rather than a monopolization claim, emphasizing contract restraints as standalone rule-of-reason violations. That is a useful marker for health care players: even absent a classic "single-firm dominance" story, aggressive contracting practices that restrict plan design can draw enforcement when they plausibly suppress insurer competition and raise costs.

OhioHealth and *New York-Presbyterian* are also instructive because they dovetail with broader policy priorities. The government's public statement on *OhioHealth* framed the lawsuit as enabling consumers, employers, and insurers to choose lower-cost options as well as improving access to meaningful price information.[13] That framing suggests a road ahead in which provider contracting cases may be selected and narrated through affordability and transparency impacts, while relying on familiar legal tests.

OhioHealth also fits within a longer-running enforcement line that predates both the Biden and second Trump administrations: provider contracting restraints that limit steering and hinder price transparency. That enforcement line predates Trump's first term. The DOJ filed and resolved the Atrium Health anti-steering case in 2016, but the resulting consent decree governed Atrium's contracting practices well into the Trump administration, reflecting continuity in the government's approach to provider steering restraints.[14] That case has an enforcement theory that looks similar to the plan-design and transparency story the DOJ is advancing in *OhioHealth* and *New York-Presbyterian* today.

Private Equity and Specialty Practices

Federal rhetoric has shifted away from treating private equity as a categorical antitrust target. Nevertheless, Trump's enforcement playbook still includes roll-up and consolidation theories in specialty services where market power can be built through acquisition and contracting leverage. The FTC's ongoing litigation against U.S. Anesthesia Partners (USAP) is a prominent example.[15]

The *USAP* litigation centers on allegations that a private-equity-backed roll-up strategy allowed the company to amass significant market power in several Texas anesthesiology markets through serial acquisitions, exclusive contracting, and employment restrictions.[16] The FTC's complaint alleges

> *A key point of antitrust enforcement under Trump's second term is the renewed role of remedies.*

that this consolidation reduced competition for hospital anesthesia services and weakened insurers' negotiating leverage, ultimately leading to higher prices and reduced choice.[17] After the case was filed in 2023, the defendants moved to dismiss, focusing on market definition, the plausibility of exclusionary conduct, and whether aggregation in specialty physician services can give rise to durable horizontal power.[18] The case nonetheless proceeded past the motion to dismiss stage and the parties are now briefing summary judgment. The case's ultimate resolution is likely to shape how aggressively the agencies pursue consolidation theories in physician-practice markets going forward.

The *USAP* case illustrates that the Trump administration shares the Biden administration's focus on specialty-practice consolidation and serves as a reminder that antitrust enforcement can continue across administrations despite broader policy disagreements. This is particularly true where the government can tell a story about reduced insurer leverage, network dynamics, and downstream price effects.

Health Care Intermediaries and Algorithmic Pricing: The MultiPlan MDL

Perhaps the most prominent bridge between traditional antitrust and emerging technology concerns is the wave of private (i.e., non-government) cases challenging algorithmic tools across a variety of industries, including rental housing, agriculture, and others. In health care, there is the *MultiPlan* multidistrict litigation where plaintiffs allege that MultiPlan, a vendor of out-of-network pricing and repricing tools, acted as a hub coordinating reimbursement practices among insurers in a way that allegedly suppressed payments to out-of-network providers.[19] The core claim is a modern "hub-and-spoke" theory. A hub-and-spoke conspiracy is an arrangement in which competitors do not deal directly with one another but instead coordinate their conduct through a common intermediary—the "hub"—that facilitates alignment among the "spokes."

In June 2025, Judge Matthew Kennelly in the Northern District of Illinois largely denied motions to dismiss in the MDL, allowing federal and state antitrust claims and consumer protection claims to proceed to discovery (while dismissing unjust enrichment claims).[20] The decision was purely procedural; no liability has been found on the part of MultiPlan.

This case signals a key theme for health care antitrust under Trump: agencies and private plaintiffs do not need new statutes or theories to challenge allegedly anticompetitive conduct through AI-enabled pricing or reimbursement tools. Traditional Section 1 concepts—agreement, coordination, information exchange—can be mapped onto platform conduct where the algorithm becomes the alleged mechanism of alignment.

Labor as an Enforcement Priority: Noncompetes in Health Care

A parallel focus area in the early second term is labor, particularly restrictions that limit clinician mobility and patient access. In September 2025, FTC Chairman Andrew N. Ferguson issued warning letters to major health care employers and staffing companies urging a comprehensive review of employment agreements—including noncompetes and other restrictive covenants—to ensure they are appropriately tailored and lawful.[21] The FTC framed overbroad noncompetes as a competition problem with direct patient-care consequences, especially in rural markets where provider shortages heighten the impact of mobility restraints.

For health care employers, the takeaway is practical: noncompetes are not off the table. The agency is signaling case-by-case enforcement under Section 5 of the FTC Act and encouraging compliance review now.

That labor sensitivity is not limited to restrictive covenants. In December 2025, Aya Healthcare abandoned its proposed acquisition of Cross Country Healthcare after FTC staff identified "significant competitive concerns," concluding that the transaction would eliminate head-to-head competition between two of the largest firms providing services used to recruit, manage, and deploy traveling nurses and other temporary health care workers. The FTC explicitly tied those concerns to reduced labor-market options for clinicians, higher staffing costs for hospitals, and downstream effects that risk increasing health care costs for patients.[22]

What the Early Phase of Trump's Second Term Suggests About the Road Ahead

The common thread through these examples is that health care enforcement is evolving in method more than in mission. Traditional theories remain the backbone, but agencies are increasingly attentive to the institutional and technological realities of health care markets.

Several practical predictions follow from Trump's second term so far:

1. **Local provider power and contracting restraints will remain a focus.** Provider market cases remain attractive to enforcers because markets are local, entry barriers are high, and the harms can be communicated in plain terms. As *OhioHealth* illustrates, plan-design restraints, including anti-steering, all-or-nothing contracting, and gag clauses that impede price information, may be a particularly salient lane where enforcers can frame cases as affordability actions.

2. **Device and life sciences deals will see sustained innovation scrutiny**. As *Edwards/JenaValve* demonstrates, innovation markets, especially where there are only a few plausible pipeline rivals, remain prime enforcement territory. The story is a simple one: prices and innovation improve when rivals fight; they worsen when one buys the other.

3. **AI and algorithmic pricing issues will increasingly appear inside routine investigations**. The *MultiPlan* MDL illustrates how algorithmic tools can become the factual mechanism for coordination allegations. The practical point is that scrutiny of AI-enabled pricing tools is likely to show up in routine merger review and civil conduct investigations, through questions about what data is used, what outputs are generated, and whether the tool effectively aligns competitor behavior.

4. **The FTC's Task Force signals increased coordination**. The March 2026 Task Force does not signal a wholesale reinvention of health care antitrust, but it does signal a more coordinated way to prosecute familiar cases and to identify emerging issues early, especially those involving

technology and consumer-facing transparency concerns.

5. **Labor restraints will remain in view.** The FTC's health care noncompete warning letters and merger scrutiny in health care staffing markets signal that labor-market conduct will be treated as a competition issue tied to cost, access, and patient choice.

Conclusion

Health care antitrust enforcement under Trump's second term reflects refinement rather than retrenchment. The agencies are prioritizing cases that translate familiar legal frameworks into fact patterns that resonate with contemporary health care markets—where competition is shaped by contracting leverage, labor dynamics, intermediaries, and technology-enabled tools. The forward signal is less about doctrinal reinvention and more about disciplined deployment: selecting cases that foreground affordability, access, and patient impact, and prosecuting them through economically grounded theories that courts are receptive to adjudicating. For health care stakeholders, the road ahead is one in which traditional antitrust rules will continue to govern, but their application will be increasingly informed by how health care is actually delivered, priced, and staffed today.

This Feature Article is brought to you by the ***Health Care Liability and Litigation Practice Group: Oren Rosenthal****, SCAN Health Plan (Chair);* ***Rachel Freyman****, MultiCare Health System (Vice Chair);* ***Michelle Meloche****, BJC Health System (Vice Chair);* ***David O'Neal****, Parker Hudson Rainer & Dobbs LLP (Vice Chair);* ***Jennifer Smith****, Wright Lindsey & Jennings LLP (Vice Chair); and* ***Danica Sun****, Cleveland Clinic (Vice Chair).*

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These ten firms share what drives their commitment to AHLA, how membership shapes their practice, and why the relationships forged through this community continue to matter year after year.

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3	**Polsinelli PC**	299
4	**King & Spalding LLP**	263
5	**Holland & Knight LLP**	231
6	**Baker Donelson Bearman Caldwell & Berkowitz PC**	228
7	**Epstein Becker & Green PC**	172
8	**Hall Render Killian Heath & Lyman PC**	166
9	**Mintz Levin Cohn Ferris Glovsky & Popeo PC**	134
10	**Crowell & Moring LLP**	130

1 HUSCH BLACKWELL LLP

HUSCH BLACKWELL

"Husch Blackwell's commitment to AHLA is grounded in the firm's industry-focused approach and dedication to advancing the health law profession. AHLA's emphasis on educating and connecting the health law community aligns closely with the firm's values of collaboration, practical insight, and delivering uncommon solutions for clients. Engagement with AHLA is viewed as both an investment in attorney development and a meaningful way to enhance the value delivered to clients across the health care industry.

At its core, AHLA provides a unique national platform for engaging with highly skilled and respected health care attorneys from across the country. While AHLA's formal programming is invaluable, it is often the informal conversations—at lunch, in the hallway, or between sessions—that create the greatest impact. These moments allow attorneys to discuss the latest national issues in real time and bring those insights directly to client work. Relationship-building is central to the firm's involvement: AHLA creates an environment where meaningful, lasting connections extend well beyond individual events, providing trusted peer perspectives when navigating complex client matters.

AHLA also provides a valuable platform for stepping into leadership roles and actively contributing to the profession. Husch Blackwell supports its attorneys in pursuing leadership opportunities within AHLA's practice groups, councils, and governance structures—roles that allow professionals to shape programming, contribute to thought leadership, and stay closely connected to the issues that matter most to health care organizations. Combined with AHLA's robust educational offerings through conferences, publications, and speaking engagements, these experiences ensure that client counsel remains informed, relevant, and actionable. Ultimately, Husch Blackwell's continued support of AHLA reflects a belief in the power of connection, leadership, and education to advance health law in ways that directly benefit the health care organizations the firm serves."

— Curt Chase, Partner, Healthcare, Life Science and Education Team Lead, Husch Blackwell

2 BASS, BERRY & SIMS PLC

BASS BERRY + SIMS

Bass, Berry & Sims has been a long-time supporter of AHLA, with a commitment that spans speaking, writing, mentoring, attending conferences, and serving in leadership positions across Practice Groups, Councils, and the Board of Directors. Partner Cindy Reisz served as President of the Board and was selected as a Fellow in 2025. Founded in 1922, the firm has grown into an integrated health care practice of more than 325 attorneys, and AHLA has been a consistent resource in delivering exceptional client service—uniquely bringing together government representatives, attorneys, consultants, and others for thoughtful collaboration. The connections formed through AHLA are equally central to the firm's culture: it is difficult to attend a conference without meeting a dozen or more peers whose introductions quickly become lasting partnerships. Bass, Berry & Sims was recognized by Law360 as Healthcare Practice Group of the Year in 2025 and Chambers USA 2025 named it among the nationally ranked elite health care practices, adding to 22 consecutive years of inclusion. The firm recently expanded into the Chicago market, where AHLA relationships have already contributed meaningfully to early success.

3 POLSINELLI PC

POLSINELLI

Polsinelli continues to support AHLA because it fosters the kind of collaboration, professional development, and community that is essential in health law. AHLA creates meaningful opportunities for the firm's attorneys to stay connected to emerging

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legal and regulatory developments while building relationships with peers across the industry. As one of the nation's largest health care practices, Polsinelli values AHLA's role in helping its attorneys remain informed, connected, and engaged—drawing on AHLA's educational programming, publications, and collaborative network to deliver practical, forward-looking counsel to clients across the health care sector.

AHLA has played an important role in helping Polsinelli attorneys grow both professionally and personally throughout their careers. Through conferences, webinars, practice groups, speaking opportunities, and leadership roles, attorneys deepen their subject matter knowledge while building strong professional networks. AHLA also provides valuable opportunities for newer attorneys to become engaged early in their careers and learn directly from experienced practitioners across the country. The organization reinforces the firm's focus on thought leadership, professional development, and active participation in shaping conversations within health law.

4 KING & SPALDING LLP

King & Spalding's ongoing support of AHLA is rooted in the value it delivers to both their lawyers and their clients. AHLA functions as a central connection point across private practice, government, and in-house counsel—a cross-constituency forum that King & Spalding views as essential in a sector as complex and highly regulated as health care. Its programs and materials are consistently substantive and practical, helping attorneys stay current on legal and regulatory developments in their day-to-day practice. AHLA also creates meaningful opportunities for leadership and visibility: King & Spalding lawyers contribute as authors and speakers, participate on committees, help lead initiatives, and serve in board and other leadership roles—expanding and deepening their professional networks in the process. Those networks come to life most vividly at AHLA's in-person conferences and events, where attorneys engage with government lawyers, in-house counsel, consultants, and private-practice peers from across the country, building relationships that are genuine, lasting, and professionally valuable.

5 HOLLAND & KNIGHT LLP

With more than 500 attorneys working on health law–related matters, Holland & Knight depends on lawyers who are true thought leaders in their specialties. AHLA places those attorneys at the center of important conversations with other specialists and gives them a platform to share their expertise with client teams tracking industry trends—an ongoing exchange that strengthens the firm's internal capabilities and the value it brings to clients navigating a rapidly evolving landscape. Professional development is another area where AHLA's impact is wide and lasting: from writing opportunities for young associates to leadership roles for more senior lawyers, the organization supports attorneys at every stage of their career. Beyond development, AHLA proves its value in day-to-day practice through educational content, toolkits, and its Communities platform—a collaborative space where attorneys connect with peers, gather perspective, and find referrals when faced with novel or complex challenges.

6 BAKER DONELSON BEARMAN CALDWELL & BERKOWITZ PC

What draws Baker Donelson to AHLA year after year is how closely its mission aligns with the firm's own. Health care is constantly changing, and the stakes are high for the organizations and communities they serve. AHLA plays an important role in helping the industry function more effectively—bringing people together, sharing timely information, and creating space for thoughtful conversation around the legal and business issues shaping health care. Through AHLA's programs, publications, and day-to-day insights, the firm's attorneys have access to current information and practical perspectives that help them spot issues early and respond in a meaningful way. AHLA also suports the growth of individual attorneys—sharpening their thinking, deepening peer engagement, and building relationships that extend well beyond a single issue or matter. At the end of the day, AHLA strengthens how Baker Donelson works, supporting a commitment to thoughtful, practical advice and reinforcing a culture of learning and collaboration across the health law team.

7 EPSTEIN BECKER & GREEN PC

Epstein Becker Green's relationship with AHLA predates the organization in its current form—long enough that the association's growth and the firm's growth in health law

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have, in many respects, run in parallel. What sustains that commitment is straightforward: AHLA is where the field thinks out loud, bringing together outside counsel, in-house attorneys, government lawyers, and academics in the same committees and forums, year after year. That kind of sustained, cross-constituency conversation produces something genuinely useful—a shared vocabulary and a professional community that holds up under the weight of real problems. The connections built through AHLA reflect the same logic: a relationship formed by co-authoring an article or serving on a committee alongside a government attorney is different in character from a conference introduction, and those relationships surface at critical moments in ways that are difficult to predict and impossible to manufacture. Epstein Becker Green was recognized by Best Lawyers® as its Law Firm of the Year in Health Care Law for 2026. Long-term engagement with AHLA has been part of building the practice that earned it.

8 HALL RENDER KILLIAN HEATH & LYMAN PC

HALL RENDER

As a law firm exclusively dedicated to the health care industry, Hall Render views its participation in AHLA not simply as a membership, but as an essential extension of its mission to serve health care clients with integrity, practical solutions, and innovation. AHLA's value to the firm shows up most clearly in how it sharpens attorneys at every stage of their careers—from early-career lawyers building foundational knowledge and confidence, to experienced attorneys contributing as speakers, authors, and organizational leaders. Through educational programming, publications, and speaking opportunities, Hall Render lawyers stay at the forefront of emerging legal and regulatory developments. AHLA's collaborative environment brings together health care leaders from across the country, allowing attorneys to deepen their understanding and deliver more informed, strategic counsel. The relationships formed through that engagement are among the most enduring benefits—a network of trusted colleagues and collaborators that extends well beyond individual engagements and contributes to a broader, forward-thinking health law community.

9 MINTZ LEVIN COHN FERRIS GLOVSKY & POPEO PC

MINTZ

Mintz Levin Cohn Ferris Glovsky & Popeo PC did not submit a response for this feature.

10 CROWELL & MORING LLP

Crowell

For Crowell & Moring, an active and engaged presence within AHLA sends a clear signal to clients, peers, and the broader market: the firm's commitment to health care legal excellence is both substantive and enduring. Three strategic priorities guide the firm's health law practice—earning client trust, demonstrating genuine depth of specialization, and giving talented attorneys opportunities to shine. AHLA actively cultivates the two things both depend on: industry-leading thought leadership and lasting professional relationships. In health care law, credibility is earned through practice, not biography. By contributing to AHLA publications, events, and programming, attorneys demonstrate their expertise and reinforce the firm's standing. AHLA also convenes a genuinely diverse cross-section of health care legal professionals—inside and outside counsel, regulators, executives, and policy thinkers—whose conversations matter enormously to the industry and to many of the firm's clients. Crowell & Moring views its AHLA membership not as an institutional affiliation, but as an active investment in the relationships, visibility, and credibility that sustain a thriving health care law practice.

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10 BRG (tied)
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Top Sponsors

AHLA would like to thank our sponsors for their generous support of the Association's programs and products. This lists the top 10 companies that provided the highest level of financial support in fiscal year 2025 (June 1, 2025–May 31, 2026).

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2 Stout
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Relive the moments

ANNUAL MEETING

& In-House Counsel Program

June 28-July 1, 2026 | New York, NY

The 2026 In-House Counsel Program and Annual Meeting exceeded expectations, providing attendees with intellectual exchanges in a collaborative atmosphere, transforming mere conversations into dynamic collaborations. Read the recap of the conferences and stay tuned for exciting developments on the horizon.

Creating Professional Connections

Celebrating our Health Law Community

The First AHLA Leadership & Career Development Program

The new AHLA Leadership & Career Development Program contained two days of focused sessions, peer exchange, and connection across career stages. Spanning tracks for emerging professionals and experienced leaders—plus joint sessions open to both—the program covered topics including strategic networking, conflict resolution, mentoring and sponsorship, governance, and career pathways.

Participants also joined AHLA Board members for lunch on Saturday, June 27, sponsored by Consillo, offering direct engagement with AHLA's leadership and insight into the organization's direction. Saturday evening's Awards Dinner brought the broader community together to celebrate excellence across health law.

In-House Counsel Program Networking Highlights

The In-House Counsel Program luncheon featured a conversation with Christina Farr, Editor-in-Chief and CEO of Second Opinion Media, on the power of storytelling in professional practice. The conversation with Ms. Farr, an author whose career spans health care journalism, venture capital, and media, and moderator Julia Michael, Deputy General Counsel, K Health focused on why storytelling has evolved from a nice-to-have into an essential leadership skill, particularly in a health care industry often seen as risk-averse and compliance-heavy. We extend a special thank you to Stout for sponsoring the lunch.

Monday Night at the Museum of Modern Art

Monday evening, June 29, nearly 1,000 attendees and their guests gathered at the Museum of Modern Art for the off-property reception sponsored by AHLA's Members' Law Firms—a memorable night of networking among some of New York City's most iconic collections. We would like to thank our generous sponsors whose support made this special occasion and destination possible *(see sponsors on page 34)*.

Tuesday Networking in Full Swing

Tuesday, June 30 brought a full social calendar. Early risers joined the Exercise Class and Fun Run through Central Park, both sponsored by Simpliphy and hosted by AHLA's Early Career Professionals Council. The Conference Breakfast, sponsored by Pivotal Mobile eDiscovery Inc., welcomed attendees, speakers, and registered guests to start the day. Arnold & Porter Kaye Scholer hosted a Lunch and Learn, offering a policy report from Washington and a midterm preview. The day closed with the Networking Reception sponsored by LawVu, open to all attendees, speakers, and registered guests.

Recognizing AHLA Changemakers

AHLA was honored to present the following awards during the Annual Meeting:

- **David J. Greenburg Founders Award |** AHLA proudly announced Lisa Diehl Vandecaveye as the 2026 recipient of the David J. Greenburg Founders Award, the Association's highest honor. This distinguished recognition acknowledges Vandecaveye's exceptional career-long contributions to both the Association and the broader health law community *(see more on page 44)*.
- **2026 Fellows Class |** AHLA honored the 2026 class of Fellows for their career-long achievements, contributions, and tenure with AHLA, and their continuing service and leadership in the legal profession. Congratulations to Kirk Dobbins, James (Jim) Flynn, Charles B. Oppenheim, and Thomas (Tom) Shorter *(see more on page 36)*.

Passing on the Gavel

During the Board of Directors meeting, Mark Kopson passed the presidential gavel to Christine White, who serves as AHLA's president for 2026-2027.

In-House Counsel eProgram

Earn credits on demand.

The In-House Counsel eProgram is designed specifically for health care in-house lawyers who want practical tools they can use immediately. The agenda blends timely substance with professional development, starting with real-world guidance on managing emerging risk—from AI vendor contracting and effective AI prompting for lawyers to a candid fireside chat with DOJ and OIG leaders on current health care fraud enforcement priorities. Together, these sessions give in-house counsel a clear view of how regulatory expectations are evolving and how to position their organizations to respond strategically.

The program also emphasizes the skills required to lead high-performing legal departments. Sessions explore how in-house counsel can strengthen their leadership presence, build a personal brand, and transition from legal advisor to strategic catalyst within their organizations.

educate.americanhealthlaw.org

In-House Counsel Session Highlights

Unlocking Critical Strategies and Solutions

In-House Counsel Opening Session Explores AI Implementation

AHLA's In-House Counsel Program kicked off June 28 with an engaging general session: *It's Not Just a SaaS Deal: Contracting for AI in Health Care,* presented by Jane Elphick, Deputy General Counsel, Maven Clinic; Carolyn V. Metnick, Sheppard Mullin Richter & Hampton LLP; and Lauren Willens, Henry Ford Health.

The session provided important insight into AI contracting issues, including what to do when AI systems underperform or produce harmful outcomes and contractual mechanisms to address algorithmic bias and ensure equitable outcomes. The speakers also discussed liability, transparency, and data governance, and provided a look ahead at evolving AI governance.

Break Out Sessions Provide Regulatory Insights

Attendees then had several break-out sessions to choose from, including a *Fireside Chat with DOJ Health Care Fraud and Health and Safety Leadership: Current Enforcement Priorities and Compliance Takeaways* with Sandra Moser, Morgan, Lewis & Bockius LLP; Jacob Foster, Acting Chief, Health Care Fraud Unit, U.S. Department of Justice, Criminal Division; and Kate Payerle, Acting Chief, Health & Safety Unit, U.S. Department of Justice, Criminal Division. At this interactive session, attendees got an inside look at DOJ enforcement priorities and what to expect in the future from the agency, along with practical guidance for strengthening compliance programs.

Afternoon sessions included many more topics pertinent to in-house counsel, including leadership hacks to close the gap between lawyer and legal executives, a guide to creating win/win outside counsel engagements and compensation arrangements, approaches for achieving excellence in delivering in-house legal services, how the right KPIs drive performance and demonstrate value, and building and maintaining an effective in-house legal team, along with moderated group breakouts tailored to the size of your legal department.

Annual Meeting Session Highlights

Unforgettable Moments from AHLA's Premier Program

Keynote Highlights Health Law's Next Chapter

AHLA's New York Annual Meeting commenced Monday morning with a Keynote address by Dr. Mark McClellan, Director, Duke-Margolis Center for Health Policy, moderated by John E. Kelly, Barnes & Thornburg LLP and sponsored by FTI Consulting. Dr. McClellan shared insight into how AI may impact health care in the future, including making health care more accessible, lowering costs by using AI to replace mundane administrative tasks, and lowering costs of preventive medicine.

Dr. McClellan also discussed how to advise clients about new payment models and noted that auditable, actionable monitoring of outcomes and risks is needed. Affordability has overtaken coverage as the number one driver for health agencies, which squeezes employers and state governments simultaneously, especially as CMS implements HR1, which tightens coverage availability and payments to states. He noted that CMS is trying to bring down costs through innovation: efficiency gains from AI, faster/more personalized access to information, plus continued focus on fraud, waste, and improper payments; however, there is no easy fix.

Year in Review Panel Serves Entertaining Take on Key Health Law Developments

The keynote was followed by the much-anticipated annual *Year in Review,* sponsored by Greater New York Hospital Association, and presented by Robert G. Homchick, Davis Wright Tremaine LLP, Kim Harvey Looney, Epstein Becker & Green PC, and Cynthia F. Wisner, Trinity Health (Ret.). This humorous and enlightening look at the year in health law covered public health developments, fraud and abuse, reimbursement changes, No Suprises Act updates, drug pricing, health information, transaction trends, life sciences developments, and everything you always wanted to know about AI but were afraid to ask, among many others.

Government Health Care Agencies Embracing AI on Enforcement Front

The last day of the Annual Meeting started with an informative keynote from government regulators, *Straight from the Source: DOJ, OIG and CMS Fraud and Abuse Prevention and Enforcement Efforts in 2026 and Beyond,* sponsored by BDO. AHLA CEO David Cade spoke to Kim Brandt, Deputy Administrator and Chief Operating Officer, Centers for Medicare and Medicaid Services; Susan Gillin, acting Chief Counsel to the Inspector General, Office of Inspector General; and Brenna Jenny, Deputy Assistant Attorney General, Commercial Litigation Branch – Civil Division, Department of Justice.

The government representatives emphasized the agencies are employing an unprecedented whole-of-government approach to implement the administration's war on fraud. According to Brandt, CMS' new approach is "detect and prevent" as opposed to the old pay and chase model.

The agencies have transformative new tools such as AI and EFT to help look at claims data. CMS has "fully embraced" AI, Brandt said. The agency is implementing AI tools at the front end to prevent erroneous payments from going out and has also built AI tools into the enrollment process.

OIG and DOJ will coordinate more with CMS and earlier in the process on the enforcement side. Jenny noted DOJ is experiencing record breaking increases in qui tams, which are being driven in large part by data miners. More than 45% of new qui tams are being filed by data miners, she said. DOJ will work with the data miners that have been able to make the connection between data outliers and actual fraud taking place. The agency's FOCUS initiative is expected to contribute to that effort.

The regulators addressed many other pressing issues as well including CMS' prior authorization rule, OIG's focus on managed care marketing fraud, and the agencies' numerous Medicaid initiatives.

Thank You to Our **In-House Counsel Program Planning Committee**

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AMERICAN **HEALTH LAW** ASSOCIATION

SAVE THE DATE

June 27–30

2027 CHICAGO

ANNUAL MEETING

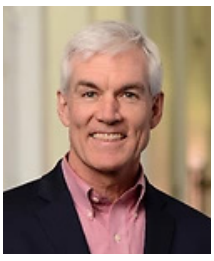
& In-House Counsel Program

AHLA Welcomes Four Distinguished Leaders to the 2026 Fellows Class

AHLA is proud to announce the induction of Kirk Dobbins, James (Jim) Flynn, Charles B. Oppenheim, and Thomas (Tom) Shorter into the prestigious 2026 Fellows class. This honor recognizes their exceptional contributions to both the health law profession and the Association.

Kirk Dobbins

Kirk Dobbins serves as Vice President, Regional Counsel, and Assistant Corporate Secretary at Kaiser Foundation Health Plan and Kaiser Foundation in Portland, Oregon, where he leads legal, compliance, and regulatory matters while championing diversity, equity, and inclusion across the legal department. Drawing on a career that spans private practice, government, and in-house corporate roles, Kirk brings a broad and distinctive lens to health law. Kirk joined AHLA in 2006 and served on the Board of Directors from 2017–2023. As a member of the Diversity + Inclusion Council (2015–2019), he helped develop the D+I Toolkit and Assessment Tool and advanced the IDEA Action Plan's focus on communications, culture, the volunteer and leadership pipeline, and community. In a gesture emblematic of his commitment to the next generation, Kirk partnered with AHLA and his alma mater to establish an annual scholarship for two students to attend AHLA's Fundamentals of Health Law conference.



Jim Flynn

Jim Flynn is a health law attorney at Bricker Graydon Wyatt LLP in Columbus, Ohio, with 35 years of experience advising clients on regulatory, accreditation, and payment matters. A recognized thought leader in Ohio and nationally, Jim has built expertise in Medicare and Medicaid and is known for his rare ability to make complex regulatory topics clear and accessible. He speaks regularly at the Ohio Hospital Association's Annual Meeting and at regional and private education forums, earning a reputation as a trusted and engaging educator. Jim joined AHLA in 2000 and served on the AHLA Board of Directors from 2015–2021. A founding member of the task force that established the Board Governance Committee, he played a key role in modernizing and strengthening the Board's governance practices. Before his Board service, Jim served as Vice Chair and Chair of AHLA's Regulation, Accreditation, and Payment Practice Group from 2006–2015.

Charles B. Oppenheim

Charles B. Oppenheim is a partner at Hooper Lundy & Bookman PC in Los Angeles, where he has built one of the country's preeminent practices in health care regulatory law. Recognized by Chambers USA as an outstanding California health law attorney, Charles is widely regarded as a premier authority on the Stark Law and Anti-Kickback Statute, having guided major health care organizations through some of the most complex fraud and abuse compliance challenges of the past three decades. He has served his firm as both a Board of Directors member and Chair of the Business Department for six years and extends his expertise as a guest lecturer at multiple law schools and schools of public health. Charles joined AHLA in 2001 and has left a profound mark on the Association's educational resources. He is the author of *The Stark Law: Comprehensive Analysis and Practical Guide*, one of AHLA's bestselling publications of all time, now in its eighth edition, and a treatise so influential that it was cited by the Fourth Circuit Court of Appeals in *United States ex rel. Drakeford v. Tuomey* (2015).

Tom Shorter

Tom Shorter is a partner at Husch Blackwell in Madison, Wisconsin, where he has developed a distinguished health law practice focused on labor and employment matters and health care transactions. A recognized leader in Wisconsin's health law community, Tom has served as President of the Wisconsin Health Law Section and holds leadership roles in the American College of Healthcare Executives and the National Association of Latino Healthcare Executives. Tom joined AHLA in 1996 and has dedicated nearly three decades of service to the Association. He served six years on the AHLA Board of Directors and held the distinction of serving as AHLA President during the 2022–2023 fiscal year, where he championed the Association's collegial culture as a defining element of its strategic direction. Prior to his Board service, Tom chaired AHLA's Labor and Employment Practice Group.

A Legacy of Shared Excellence

What unites these four exceptional leaders is an unwavering commitment to health law excellence and to AHLA's mission. Each has given generously of their time and expertise through decades of Association membership, Board service, committee leadership, and educational programming—and each has helped AHLA grow stronger and more effective through their contributions. The 2026 Fellows designation recognizes these leaders not only for what they have accomplished individually, but for how their collective efforts have elevated the profession and the American Health Law Association to new heights of excellence.

AHLA's 2026 Presidential Citations

Mark Kopson

***Mark Kopson**, Plunkett Cooney*

During AHLA's 2026 Annual Meeting, I had the honor and privilege of bestowing upon several individuals the Association's Presidential Citations. Through these Citations, the President may publicly recognize individuals who have played an important role during his or her tenure. Through their mentorship, support, insight, and guidance, these individuals helped me accomplish my presidential goals and serve AHLA to the best of my ability.

The individuals receiving Presidential Citations are as follows:

Terrie Kopson: For her unconditional love, never-ending support, and constant encouragement. From nursing sick fur babies while I was at conferences, to postponing vacation activities while I participated in AHLA meetings, to serving as Chief Imposter Syndrome Slayer, my beloved wife of 43 years has been by my side every step of my AHLA journey, has attended more Annual Meetings than many AHLA members, and has unequivocally demonstrated you cannot keep a good woman down.

Lisa Hathaway: For her mentorship, encouragement, and infectious enthusiasm. Lisa invited me to not only participate in an HMOs and Health Plans (now Payers, Plans, and Managed Care – "PPMC") Practice Group leadership meeting but to also offer my suggestions for the PG's name change, despite me lacking a formal leadership posi tion and knowing none of its actual leaders. Not content with that initial involvement, Lisa insisted that I co-present with her for my first ever AHLA speaking engagement, become the Managed Care Contracting Affinity Group leader, and follow in her footsteps as PPMC Membership Vice Chair. She has been a constant mentor and champion and instilled in me my sincere desire to pay it forward to newer health law professionals.

Through their mentorship, support, insight, and guidance, these individuals helped me accomplish my presidential goals and serve AHLA to the best of my ability.

Avery Schumacher: For her incredible service as the Early Career Professional Board Delegate and confirmation that our Association will be in good hands with the coming generation of leaders. I have had the honor of working with Avery during her two-year Board Delegate term and seeing first-hand the exuberance and dedication she brings to every task, all while demonstrating confidence and professional maturity beyond her years. Her contributions to the inaugural Leadership and Career Development Program have been both invaluable and impressive.

S. Craig Holden: For his sage advice and demonstrating by his words and actions what true leadership looks like. As a young government lawyer on the dais at the fraud and abuse conference his mastery of substantive law was readily apparent. Fast forward three decades and Craig led us through the initial chaos of COVID-19 with a steady hand and admirable gravitas. Throughout the entire time I have known him, Craig has always been willing to listen without judgement and—only if requested—to offer perspective and encouragement.

I also extend my sincere thanks and appreciation to the Directors with whom I've served on the Board over the past eight years; AHLA's many leaders, volunteers, and members who have shared their time, talent, and treasure so selflessly; and to the incredibly talented, hardworking, and dedicated AHLA staff—both public facing and behind the scenes—whose efforts, advice, encouragement, and support have made AHLA my welcoming and nurturing professional home for nearly 39 years. Thank you all!

A Challenging Six Years Since COVID-19… But I'm Optimistic and Determined

Jenny Nelson Carney,
Epstein Becker Green

It is an understatement that the last six years have been challenging for providers of health care, not only with frontline workers experiencing the most visceral consequences but also with significant downstream effects on the attorneys and other professionals who support and defend them. But as trying as the last six years have been for those who touch health care, there is still reason for celebration and hope.

COVID-19 was officially labeled a pandemic in March 2020, and readers of this article will remember the chaos that followed. While clinicians and researchers confronted a novel virus, insufficient personal protective equipment, and rising patient volumes, communities battled over mandatory lockdowns, masking, and cancelled elective procedures. The initial support for health care workers waned as portions of the public became suspicious of recommended treatments, enthusiastic about unconventional (and sometimes risky) treatments, and skeptical of a brand-new vaccine.[1] The physical and emotional exhaustion that hit health care workers led many to early retirement, leaving behind an understaffed industry with plenty of burnout.

Two years later (but still in the thick of COVID-19 variant surges), the 2022 Supreme Court decision in *Dobbs v. Jackson Women's Health Organization* returned the authority to regulate abortion to individual states, resulting in a drastically varying (and often confusing) landscape of reproductive health care laws across the country.[2] OBGYNs and emergency medicine clinicians looked to attorneys to help them appropriately treat patients, with each party expressing concerns about increased legal involvement in patient care. While experienced clinicians were unsettled about the uncertain new boundaries for their clinical practices, medical students and residents also experienced a change in their education, with the American College of Obstetricians and Gynecologists reporting that almost half of medical students were encountering barriers in their education resulting from their state's restricted access to certain reproductive health care.[3]

Jenny Nelson Carney is an attorney with Epstein Becker Green, where she advises hospitals, health systems, and other health care entities on their regulatory and business law needs. Jenny counsels clients on all aspects of provider operations with a focus on patient care; health information; and provider licensure, certification, and accreditation. Contact Jenny at JNelsonCarney@ebglaw.com.

Across the profession, health care attorneys have helped health care providers navigate a pandemic by monitoring and interpreting the flood of changing emergency regulations and agency guidance…

2025 brought federal government attempts to rollback access to gender affirming care for minors through a variety of means—executive orders, subpoenas, cessation of funding, and proposed changes to federal laws governing hospitals participating in Medicare. As a result, some clinicians who provide specialized care to trans patients face conflicting state and federal laws as well as profound professional and ethical conflicts—and these clinicians, too, have looked to attorneys for direction.

Now the health care system is bracing for impending and substantial cuts to Medicaid. The combination of decreased funding, increased federal regulation of specific types of clinical care, increasing vaccine uncertainty from the American public,[4] and a growing shortage of health care workers means the health care environment is stressed.

What does that mean for the lawyers and other professionals who support these providers? Certainly, we absorb some of that stress and uncertainty for our clients—especially in an emergent patient situation or when you learn a government agency is knocking on their door *right now*—but as to the future of health care and health law, I'm (still) optimistic.

Across the profession, health care attorneys have helped health care providers navigate a pandemic by monitoring and interpreting the flood of changing emergency regulations and agency guidance, and we helped them stand up telehealth services and understand the parameters of provider relief funds. With the recent pressures on certain types of care, we are helping health care providers

understand new clinical restrictions and navigate the resulting patient care issues. And with the impending funding decreases and uncertainties, we are helping think through creative affiliations and other cost-saving ventures. Meanwhile, our life sciences colleagues are supporting providers and researchers who are making important advancements in health care. A recent article headline proclaimed, "After Decades of Misunderstanding, Menopause is Finally Having Its Moment,"[5] and there have been exciting reports of a landmark pancreatic cancer treatment.[6] And that painful shingles vaccine I just received promises not only to prevent shingles but to lower my risk of dementia.[7] Medicine continues to inspire.

I'm determined that as our health care clients and colleagues continue to innovate amongst these many challenges, our health law industry will continue to provide thoughtful and diligent support. And we are well suited to do this because of AHLA. AHLA creates opportunities for connection for all of us in health law. Readers who attended the 2022 Annual Meeting will remember AHLA responding quickly to the just announced *Dobbs* decision by coordinating a time for us to gather and discuss the SCOTUS opinion and its implications. It was amazing to have so many smart legal minds in one room.

I'm determined that as our health care clients and colleagues continue to innovate amongst these many challenges, our health law industry will continue to provide thoughtful and diligent support.

Importantly, AHLA provides training, education, and mentoring for our earliest career colleagues all the way to our latest career Fellows, whether through the Fundamentals of Health Law conference, the "Top Ten" issue of *Health Law Connections* magazine, or the beloved "Year in Review" at the Annual Meeting. And AHLA continues to recognize the importance of creating welcoming and accessible professional environments and building a health law community that supports opportunities for all.

I have been fortunate to have had a courtside seat to see the impact of AHLA during my 20+ years in the Association, but especially during my last seven years on AHLA's Women's Leadership Council. Year after year, I watched busy, smart, hardworking women volunteer their time to plan, write, speak, and mentor for AHLA publications, conferences, and virtual forums. We dove into all aspects of health law and what it means to be part of this important profession, and we proudly partnered with early career professionals who inspire and ensure the future in our profession is bright.

There is much to do about the complex issues affecting health care in our country. But AHLA and its membership will continue to educate, collaborate, and support the advancement of the health law industry.

1 https://www.pewresearch.org/politics/2025/02/12/5-years-later-america-looks-back-at-the-impact-of-covid-19/

2 https://www.guttmacher.org/2024/05/clear-and-growing-evidence-dobbs-harming-reproductive-health-and-freedom

3 https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2025/abortion-training-and-education-in-a-post-dobbs-landscape

4 https://www.pewresearch.org/science/2025/11/18/how-do-americans-view-childhood-vaccines-vaccine-research-and-policy/

5 https://medicine.yale.edu/news-article/after-decades-of-misunderstanding-menopause-is-finally-having-its-moment/

6 https://hms.harvard.edu/news/experimental-drug-doubles-median-survival-patients-metastatic-pancreatic-cancer

7 https://med.stanford.edu/news/all-news/2025/03/shingles-vaccination-dementia.html

Three Settings in Health Law as an Early Career Attorney

***Sheela Ranganathan**, SCAN Health Plan*

Sheela Ranganathan is Legal Counsel at SCAN, where she advises on contracting, regulatory, and operational matters to teams across information security, privacy, AI, compliance, pharmacy, and sales, as well as a street medicine provider group. She also serves as Adjunct Faculty at Georgetown University School of Health, where she teaches about health law, policy, and ethics at the undergraduate and graduate levels. Previously, Ranganathan was an associate at the O'Neill Institute's Center for Health Policy and Law and a health care regulatory associate at Sheppard. She holds a J.D. with honors from the University of Texas School of Law and a B.S. in Healthcare Management and Policy from Georgetown University.

I went to law school to become a health care regulatory attorney, a goal shaped by my major in Healthcare Management and Policy and internships shadowing policy attorneys at boutique consulting firms. I chose my law school for its culture and a scholarship offer rather than an established health law pipeline, which meant I had to seek out exposure to health law through electives, internships, coffee chats, and Zoom calls.

As a 1L, I noticed that students were often advised to choose between transactional work and litigation—regulatory practice was rarely discussed as a distinct path. As the first lawyer in my family, I did not have a built-in network to guide me, so after conversations with my career center and former professors, I decided to recruit for big law, find a firm with a broad health care practice, and build a foundation that would leave room to grow. Since then, I've worked across a few settings and learned that the role of a health care lawyer is often defined as much by environment as by subject matter.

Big Law

I approached big law recruiting by casting a wide net and trying to identify firms with meaningful health care practices through partner bios, firm websites, and health law blogs. Ultimately, I chose my firm because of the people. The partners seemed genuinely interested in training me, and the firm let me sit between the antitrust and regulatory teams while also working across the broader health care group.

As a first-year associate, I benefited from the formal infrastructure of big law: access to seasoned partners and senior associates, training programs and retreats, strong research tools, and support teams who could help with administrative tasks. I worked with a wide range of clients, including health plans, hospitals, physician groups, community health centers, nursing homes, and health tech companies. My work ranged from contract review and antitrust filings

to drafting administrative appeals briefs for regulator hearings, conducting state-by-state compliance reviews, leading the regulatory diligence for a health plan acquisition, and helping develop legal strategies for litigation against federal agencies.

Many regulatory questions did not have a clear answer in the statutes, agency guidance, or case law, which meant my job was often to determine whether the issue had been addressed at all and to be confident that I had looked carefully enough to say so. That kind of work sharpened my research habits, reinforced the importance of accuracy, and taught me how much care it takes to be the subject matter expert providing legal advice when the law is incomplete.

Think Tank

A year into practice, I took a risk and moved into academia, joining a health law think tank I had followed for years. There, I studied how litigation, policy, agencies, legislators, advocacy organizations, and public messaging interact. I researched private equity's role in physician group consolidation, tracked reproductive health litigation, followed Inflation Reduction Act challenges, and wrote about these issues for both academic and public audiences. I had the chance to teach, designing undergraduate and master's courses on health law, ethics, and reproductive health. I also learned how to communicate about contentious issues with care and clarity, whether that meant speaking with reporters, collaborating with funders and partners, or writing about complicated topics without legal jargon.

That work taught me how to study fast-moving legal developments and explain them clearly to non-lawyers, but it also gave me a broader view of the health care system itself. I saw how stakeholders perceived one another, where their interests aligned or diverged, and how litigation could shape public conversation and push for change. Over time, and after many conversations with mentors (many that I'd found through AHLA), I came to understand that I wanted to work closer to the actual decision making and problem solving within an organization. That realization led me in-house.

Looking back, I am grateful I gave myself the room to take a few risks, follow my curiosity, and meet the people who helped me find my way.

In-House

For the past year and a half, I have worked in-house at a nonprofit health plan focused on older adults. I was initially brought in to support our IT team, including negotiating vendor agreements for technology and artificial intelligence (AI) tools, calibrating risk with our information security and privacy teams, and helping build an enterprise-wide AI governance function. Since then, my role has expanded to support compliance, pharmacy, a street medicine provider group affiliate, and a range of strategic partnerships.

In-house work has required me to get comfortable with a fast pace and a high level of ownership. A wide range of questions come my way each day, the facts are often still developing, and legal analysis is often just a small part of what clients actually seek from Legal. And while I've learned a great deal from working with a small, close-knit legal team, much of my growth has also come from trial by fire: negotiating for my clients on the spot, issue spotting in real time, asking better questions, and giving advice that is operationally useful to the client. While I still rely heavily on the research habits I developed in my prior roles, my role now is less about identifying the most thorough legal answer and more about helping clients quickly assess risk and move a project forward. I really enjoy the process of translating legal concepts into practical guidance, staying close enough to the business to see how that advice plays out, and working with colleagues who have a shared goal of improving the health care system for our members.

What I've Learned

Each of these roles has taught me something different and valuable. For example, big law taught me to hold my work to a high standard, the think tank gave me a wider view of the health care system and the stakeholders shaping it, and in-house work showed me how much I enjoy practical problem-solving and being close to clients and decisions as they are made. Looking back, I am grateful I gave myself the room to take a few risks, follow my curiosity, and meet the people who helped me find my way.

Now in Washington, DC

2026 AHLA In-Person & Virtual Conference

A Capital Move

The Fraud and Compliance Forum heads to Washington, DC for 2026—putting attendees close to the federal agencies and enforcement activity they'll spend two days discussing.

Start Planning Today!

americanhealthlaw.org/Fraud/Schedule

Fraud and Compliance Forum

September 23–24, 2026 | Washington, DC & Virtual

For the first time, the AHLA Fraud and Compliance Forum comes to the nation's capital. The conference is designed to serve as both a crash-course for advisors just entering the health care industry and a deep dive for experienced advocates seeking new strategies. This conference features sessions led by fraud and compliance specialists who work with a wide variety of health care providers, as well as presenters in federal agency roles.

Programming Excellence

Two days of thoughtfully developed presentations encompass the full spectrum of fraud and compliance challenges confronting health care advisors today:

- **Foundational Knowledge:** Introductions to critical areas including coding and billing, false claims, Physician Self-Referral Law, the Anti-Kickback Statute, and civil monetary penalties
- **Emerging Risk Analysis:** Strategies for evolving areas such as artificial intelligence, data analytics in enforcement, and advanced practice provider utilization
- **Enforcement Intelligence:** Lessons from federal investigations, False Claims Act litigation, drug diversion enforcement, and Medicare Advantage activity
- **Practical Implementation:** Strategies for compliance program design, self-disclosure decisions, and responding to government inquiries
- **Current Legal Developments:** Sessions incorporating the latest legislation, regulation, case law, and agency activity as they apply to comprehensive health care activities

Washington, DC: Where the Conversation Happens

Being in Washington, DC means being where health care fraud policy and enforcement decisions take shape—close to the agencies and personnel shaping the rules attendees navigate every day. All conference events, including sessions, the luncheon, and evening receptions, will take place at **The Westin DC Downtown**, 999 9th Street, NW, Washington, DC. Check the AHLA website for continued updates on the in-person agenda and virtual session accessibility details.

Session Spotlights

Both attendance formats deliver interactive sessions, expert insights, and real-time engagement opportunities designed to advance your health law practice. AHLA's conferences feature diverse speaker perspectives and collegial learning through breakout sessions focused on specialized topics, including:

- Big Data, Big Consequences: Enforcement and the Integration of Data Analytics and AI
- The Algorithm as Accomplice: AI-Driven Documentation, Coding, and the Emerging FCA Risk Landscape
- Cyber-Fraud Is Health Care Fraud
- Is Every Case a Part C Case Now? Why the Newest Waves of Medicare Advantage Enforcement Need to Be on Everyone's Radars
- Closing the Loop: Preventing and Addressing Drug Diversion in Clinical Settings

Don't Wait, Register Today!

Save **$200** when you **register by August 31**

americanhealthlaw.org/Fraud

Flexible Attendance Options for Maximum Professional Impact

This conference spans two days in Washington, DC, offering both in-person and virtual attendance options. Attendees will benefit from valuable networking opportunities in the nation's capital, while virtual participants can access sessions remotely with full engagement capabilities.

Founders Award

Lisa Diehl Vandecaveye Named 2026 Recipient of the David J. Greenburg Founders Award

The American Health Law Association proudly celebrates Lisa Diehl Vandecaveye as the 2026 recipient of the David J. Greenburg Founders Award, the highest and most prestigious honor bestowed by AHLA. This distinguished recognition acknowledges Vandecaveye's exceptional career-long contributions to both the Association and the broader health law community.

Vandecaveye brings more than 35 years of experience as a chief legal officer and health care executive, with a career defined by business-minded legal guidance in governance, compliance, licensing, risk management, and leadership transitions. She most recently served as Executive Vice President, Chief Legal Officer, and Board Secretary of The Joint Commission, where she provided strategic leadership on legal, compliance, and governance matters.

Her practical, business-savvy approach to health law is rooted in senior leadership roles within Michigan health care systems, where she oversaw compliance, privacy, and accreditation efforts for an eight-hospital system with 5,000 physicians and 33,000 employees, and managed corporate legal affairs and risk management programs for a 330-bed hospital and trauma center. Earlier in her career, she served as Associate General Counsel for a major academic health care system and as Senior Attorney for a multi-hospital and mental health system in Detroit. She holds a J.D. from the University of Toledo and an M.B.A. with a specialization in health care administration, and she has served as an adjunct faculty member teaching health care law at the University of Toledo College of Law.

Vandecaveye's service to AHLA spans nearly four decades. She served on the AHLA Board of Directors from 2006 to 2012, holding roles on the Executive, Finance, Membership, Program, and Nominating Committees, and serving as Board Secretary. She chaired the Academic Medical Centers and Teaching Hospitals Practice Group, the Public Interest Committee, the Alternative Dispute Resolution (ADR) Task Force, and the In-House Counsel Program Planning Committee. Elected an AHLA Fellow in 2014, she went on to chair the Fellows Coordinating Committee from 2019 to 2022. She has also served as a mediator through AHLA's ADR Service and has presented at more than 40 AHLA programs and teleconferences over the course of her career.

Throughout her career, Vandecaveye has advanced the health law profession at the local, state, and federal levels. Her impact has been informed by her expertise, her analytical approach to complex issues, her optimistic outlook, and her warm personality. Colleagues consistently point to her mentorship and collaborative spirit as transformative influences on their own careers — qualities that reflect the very values the Greenburg Founders Award was created to celebrate.

> Watch the video honoring Lisa Vandecaveye's achievements at https://www.americanhealthlaw.org/greenburgfoundersaward

Member Updates

Loyola University Chicago Hosts 15th Annual National Health Law Transactional Competition

The Beazley Institute for Health Law and Policy at Loyola University Chicago School of Law hosted the 15th Annual L. Edward Bryant, Jr. National Health Law Transactional Competition in 2026. The event once again brought together talented law students from schools across the country to demonstrate their expertise in corporate and regulatory health law.

Student teams were tasked with drafting a legal memorandum providing strategic legal and business counsel to a hypothetical health care client—a rigorous exercise designed to sharpen transactional lawyering skills and deepen regulatory knowledge.

AHLA congratulates all participants on their outstanding dedication and commitment to the field of health law. The top three teams each received complimentary registration to either the AHLA Annual Meeting or the AHLA Fundamentals of Health Law conference, along with a complimentary copy of AHLA's *Fundamentals of Health Law* ebook. All participants received complimentary student memberships to AHLA.

The following teams earned top honors at this year's competition:

Champion: Nova Southeastern University Shepard Broad College of Law

- Averie Bischoff
- Kassidy Caride
- Lidia Menbaeva

Second Place: Baylor Law School

- Justin Garber
- Luke Tyler
- Chris Weber

Third Place: Loyola University Chicago School of Law

- Faye O'Connell
- Christina Ramesh
- Gurujjal Roopra

Now in its fifteenth year, the competition remains a standout opportunity for the next generation of health law professionals to develop their legal skills and build lasting connections within the field.

Member Spotlight

Andria Adigwe

Andria Adigwe
Buchanan Ingersoll & Rooney PC
New York, NY
andria.adigwe@bipc.com

What is the biggest risk you ever took?

Moving from the Netherlands to the United States by myself. I had always been interested in comparing the Dutch legal system to the U.S. legal system, and I decided to take that interest to the next level by actually moving here and immersing myself in it. Entrenching myself in a new country and learning the language, customs, and culture has been an ongoing adventure filled with moments of shock, awe, and discovery. It's been a bold step, but one that has profoundly enriched my perspective and growth.

Where is the coolest place you traveled?

Curacao. There's something truly magical about visiting a sun-drenched country where the vibrant culture, stunning nature, delicious food, and lively music come together in perfect harmony. Being able to communicate with people in Dutch, English, and Papiamentu adds an extra layer of connection and authenticity—it's simply unparalleled. Curacao's unique blend of beauty and cultural richness makes it a place I'll always hold close to my heart.

What is your go-to karaoke song?

My go-to karaoke song is "Life" by Des'ree. I love the song for its soothing low tones and the whimsical nature of its lyrics. The words resonate deeply with me, especially the lines:

"So after all is said and done
I know I'm not the only one
Life indeed can be fun
If you really want to..."

They remind me that life is uplifting, focused on embracing joy and chasing dreams, even when it's not as easy as it seems; it always puts a smile on my face.

What is one thing that instantly makes your day better?

Sunshine. When I wake up and see the sun shining, it feels like the day has already started the right way—like a gentle nudge from the universe saying, "Today is going to be good." It's a simple reminder that every new day is a blank canvas, ready to be painted with light, laughter, and a touch of whimsy. But, of course, sometimes the universe can be wrong and cynical, and life can hit you with challenges as overwhelming as biblical plagues. Yet, even in those moments, that single ray of sunshine offers a glimmer of hope—a reminder that no matter how tough things get, there's always the possibility of a better day ahead.

Do you have a favorite or funny story about how AHLA affected your career?

AHLA has been critical to the development of my career. I started as a baby health care lawyer, just learning the space, and over time, I shifted my focus to regulatory health care work, eventually honing in on HIPAA, privacy, cyber, AI, and everything in between. The organization has provided invaluable resources, connections, and opportunities that have helped me grow and refine my skills. I'm especially grateful for my journey from being part of the Women Leadership Council to now serving as Vice Chair of the Health Information and Technology Practice Group. I am forever thankful to AHLA for its role in shaping my professional path.

Would you like to be featured in our Member Spotlight section? Please contact agreene@americanhealthlaw.org. We'd love to hear from you!

Thank You to Our April and May 2026 Donors

We are grateful to the following donors whose contributions in April and May 2026 support AHLA's mission and help develop the next generation of health law professionals. Your generosity strengthens our community and advances the field of health law.

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Subscribe to AHLA's **Speaking of Health Law** Wherever You Get Your Podcasts

For more information on all AHLA events and to register, go to www.americanhealthlaw.org/education-events or call (202) 833-1100, prompt #2.

August

15

Thought Leader Webinar: Where the Risk Hides: AI Across the Health Care Contract Lifecycle

Brought to you by Legalon.

17-20

Health Care Arbitration Training 2026
Virtual

19

AHLA Virtual Forum – What I Wish Someone Had Told Me: Hard-Won Lessons from the Profession
Virtual

September

2

Women's Leadership Council Virtual Roundtable
Virtual

10-11

Tax Issues for Health Care Organizations
Washington, DC

23-24

Fraud and Compliance Forum
Washington, DC & Virtual

October

7-8

Antitrust in Health Care
Virtual

November

1-3

Fundamentals of Health Law
Chicago, IL

December

7-10

Health Care Arbitration Training 2026
Virtual

AHLA's Online Career Center will allow you to:

Manage Your Career:

- Search and apply to more health law jobs than in any other job bank.
- Upload your anonymous resume and allow employers to contact you through the AHLA Career Center's messaging system.
- Set up Job Alerts specifying your workplace type, job type, core interest (job function) and location(s) to receive email notifications when a job is posted that matches your criteria.
- Access career resources and job searching tips and tools.
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Recruit for Open Positions:

- Post your job in front of the most qualified group of health law professionals in the industry.
- Promote your jobs directly to candidates via the exclusive Job Flash email.
- Search the anonymous resume database to find qualified candidates.
- Manage your posted jobs and applicant activity easily on this user-friendly site.

For more information and to start the journey to enhance your career or organization, please visit the AHLA Career Center at **careercenter.americanhealthlaw.org**.

VISION
A diverse health law community working to advance health care

MISSION
To deliver authoritative educational content and serve as a professional home for all who engage with health law

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AMERICAN HEALTH LAW ASSOCIATION

Shape the Future of Health Law: AHLA's Call for Leaders

Applications open July 1st for 2027–2028 leadership positions!

LEADERSHIP OPPORTUNITIES

AHLA seeks volunteer leaders to advance health law excellence through education, information, and dialogue. Learn more: **americanhealthlaw.org/GovernanceLeadership**

- **Board of Directors**
- **Nominating Committee—Member-At-Large**
- **Council Leaders**
- **Conference Planning Leaders**
- **Practice Group Leaders**
- **Review Board Leaders**

BENEFITS OF LEADERSHIP

- Build professional skills and reputation
- Expand your health law network
- Shape the future of health law
- Create valuable educational content
- Enhance your career while giving back

OUR COMMITMENT TO INCLUSION

AHLA values diverse, equitable, inclusive, and accessible participation for all members.

KEY DATES

Applications Open: **July 1, 2026**

Deadline: **October 31, 2026**

Terms Begin: **July 1, 2027**

Apply July 1st!

Learn More:
americanhealthlaw.org/VolunteerResourceCenter

Questions? Contact volunteer@americanhealthlaw.org or call (202) 833-1100, prompt #2.