Academic Medical Centers in a Shifting Policy Era

Implications for Competition, Cost and Care

Academic medical centers ("AMCs") represent a small fraction of U.S. hospitals, yet play an outsized role in delivering highly specialized care, training physicians through Graduate Medical Education programs and advancing medical research.[1] In recent years, AMCs operate in an environment of increasing cost pressure, reimbursement uncertainty and shifts in the locations of care delivery outside of hospital walls.

These trends increase incentives to scale through affiliations, acquisitions and joint ventures and to invest in supporting capital-intensive services. In addition, AMCs are often called upon to make investments to expand capacity and address gaps in care, or to stabilize and rescue distressed facilities through transactions or other forms of affiliation. Given their size, brand recognition and unique role in providing highly specialized care delivery and education, often as one of a few specialized providers in a given geography, both expansion efforts and affiliation strategies by AMCs often encounter heightened regulatory scrutiny and state oversight (*e.g.*, Certificate of Need ("CON") or Determination of Need ("DON") requirements, attorney general reviews and health care affordability and cost-growth oversight regimes).[2]

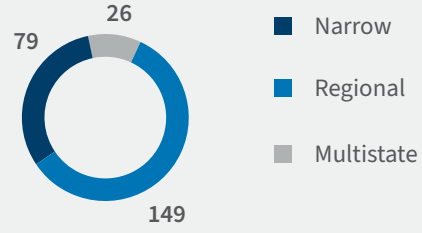
This article highlights unique attributes that distinguish AMCs from other hospitals and the diversity of AMC operating models. It examines ongoing challenges facing AMCs and the policy and competitive landscape shaping their strategic responses. AMCs often serve as sole providers of advanced and tertiary care in their regions while simultaneously facing increased financial pressures driven by payer mix, cost structure and policy uncertainty. Regulatory review of transactions and investments involving AMCs often explicitly consider their unique role in providing essential services and highly specialized care, and the implications for access to care and system sustainability.

Understanding AMCs

While there is no standardized AMC definition, the term is commonly defined using a combination of educational affiliation and teaching intensity criteria. The Association of American Medical Colleges ("AAMC") definition, often used in academic literature, identifies AMCs as hospitals having a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education.[3]

To analyze the characteristics of AMCs, we applied this definition to a matched dataset constructed from the August 2025 release of the 2023 calendar-year hospital data derived from Research and Development ("RAND") Hospital Data and survey data from the American Hospital Association.[4] Of the 6,075 U.S. hospitals included in the available data, 257 meet the AAMC definition of an AMC. These AMCs are typically located in urban areas[5] (about 98%), and the vast majority are affiliated with or part of a health system.[6] Of the 254 AMCs affiliated with a health system, 149 (59%) are part of a regional health system, 79 (31%) are in a narrow health system and 26 (10%) are in a larger multistate health system[7] (see Figure 1).

Figure 1: Classification of AMCs by Health System Type

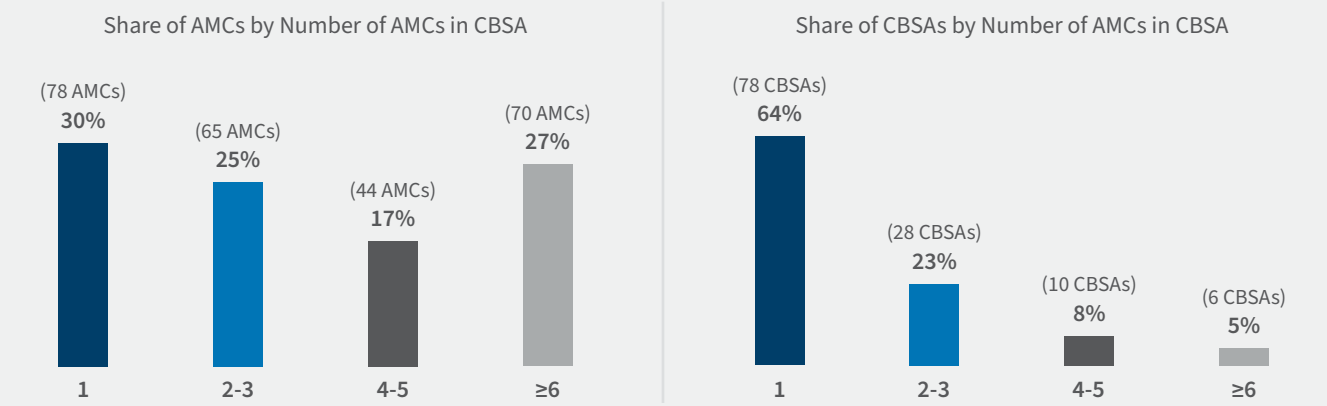


This diverse group of AMCs shares several characteristics, including the provision of advanced tertiary services, large and specialized physician and medical staff, substantial infrastructure and technological capabilities, and treatment of complex and high-acuity patients, many of whom often travel significant distances to receive care at AMCs. At the same time, AMCs vary substantially in size, system affiliations and geographic locations across a wide array of cities in the United States. To better understand the role and characteristics of AMCs, we conducted two complementary analyses. The first analysis compared AMCs to non-AMC hospitals across key operational and patient care dimensions.[8] Generally, AMCs are larger than non-AMCs (total beds: 608 vs. 251) and, by definition, operate larger residency programs (average residents and interns: 335 vs. 51). Beyond size, AMCs serve a distinct patient population characterized by greater clinical complexity and higher acuity (case-mix index: 2.23 vs. 1.79). They also disproportionately care for vulnerable populations, treating a higher share of Medicaid patients (Medicaid discharge share: 27% vs. 22%) and providing substantially more care for uninsured populations (charity care per bed: $62,291 vs. $41,061) relative to non-AMC hospitals.

Variation Across AMCs: Heterogeneity in Structure and Performance

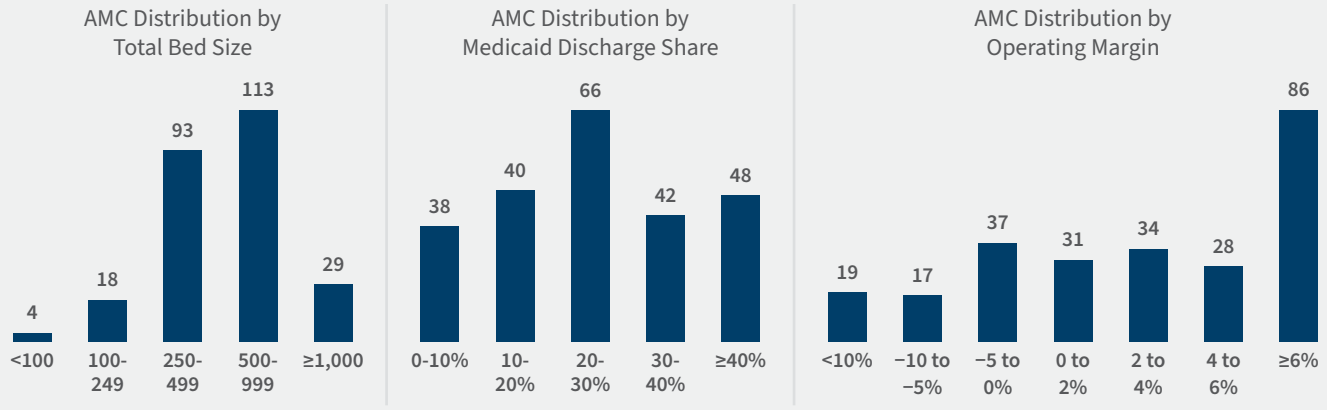
To evaluate structural and financial variations across AMCs, we also examined their geographic distribution and key financial characteristics. First, AMCs are often the sole or primary providers of advanced and tertiary care within their regions. As shown in Figure 2, approximately 30% of AMCs are the only AMC in their core-based statistical area ("CBSA"), and nearly 90% of CBSAs with an AMC have only one to three such institutions. In contrast, some larger CBSAs (*e.g.*, Chicago, Boston, New York, Los Angeles) have four or more AMCs. The substantial populations in areas with a single AMC are at risk if their sole AMC faces significant financial pressures, reduced reimbursements or inability to fund major new investments.

Figure 2: AMC and CBSA Distribution by Number of AMCs in CBSA[9]



Second, AMCs exhibit variation in size, payer mix and financial performance. Figure 3 shows that while AMCs span a wide range of sizes — from smaller facilities to very large institutions — approximately 80% have between 250 and 999 beds. Figure 3 shows that while AMCs are not uniform in margin or financial pressures under current conditions, many could face increased pressure from policy changes such as Medicaid cuts. Specifically, 35% (90 out of 255 with available Medicaid data) of AMCs have Medicaid discharge shares exceeding 30%, making these AMCs particularly vulnerable to upcoming reimbursement reductions. Even at current reimbursement levels, 29% (73 out of 252 reporting operating margin) of AMCs already face negative operating margins. These patterns reflect the dual pressures AMCs face: disproportionately serving vulnerable populations while maintaining high-cost, resource-intensive clinical and academic missions.

Figure 3: AMC Distribution by Total Bed Size, Medicaid Discharge, Operating Margin[10]



Importantly, these two dimensions intersect. Tables 1 and 2 illustrate that a subset of AMCs that are the sole or primary AMC within their region also exhibit elevated financial risk — characterized by higher Medicaid exposure and weaker operating margins. This combination raises potential risks regarding continuity of access to advanced care, as financial pressures on these institutions may have outsized regional implications.[11]

Table 1: AMC Distribution by Number of AMCs in CBSA and Share of Medicaid Discharges

Number of AMCs in the CBSA	0-10%	10-20%	20-30%	30-40%	≥40%
1	12	12	36	12	6
2-3	10	12	21	10	11
4-5	7	11	8	5	13
6+	9	15	12	15	18

Table 2: AMC Distribution by Number of AMCs in CBSA and Operating Margin

Number of AMCs in the CBSA	<−10%	−10 to −5%	−5 to 0%	0 to 2%	2 to 4%	4 to 6%	≥6%
1	4	4	13	7	9	11	27
2-3	4	6	10	7	11	3	23
4-5	4	2	5	8	3	5	16
6+	7	5	9	9	11	9	20

Variation in Strategic Position and Organizational Forms

AMCs are also differentiated in their organizational forms. Building on strategic archetypes described in prior AAMC work, we use a descriptive typology to illustrate common operating models observed among AMCs today. The AAMC framework informs the categories below (see Table 3) yet has been adapted to reflect contemporary organizational structures and marketplace relationships.[12]

Table 3: AMC Archetypes

Type	Description
AMCs affiliated with large non-academic systems	AMCs affiliated or combined with large, predominantly non-academic health systems. These AMCs retain academic missions while leveraging system scale, capital access and operational infrastructure. Academic functions may be concentrated at a flagship campus while clinical delivery is integrated across the broader healthcare delivery system.
Specialized complex-care leaders	Research-intensive AMCs serving as regional or national referral centers for highly specialized, tertiary and quaternary care (e.g., oncology, pediatrics, transplants). These institutions often are embedded in or affiliated with large systems, have strong brand presence and lead in clinical innovation and research funded by the National Institute of Health ("NIH"), and may be the sole or primary provider of certain complex services.
High-performance regional systems	Large, integrated academic health systems with one or multiple AMCs in an attractive geography. They typically hold a leading position in their primary service areas and are widely viewed by payers and patients as important referral centers for tertiary and quaternary care.
Public entity statewide hubs	Public or state-affiliated AMCs that function as central providers of essential and highly specialized services to large populations within and across a state. These institutions often disproportionately serve Medicaid and uninsured populations, are main providers of specialized services, operate as safety-net providers and are called upon by states to preserve access to care through affiliations or acquisitions.
Population health managers	AMCs that emphasize population health, value-based care and risk management, often with advanced care coordination infrastructure and sometimes affiliation with or ownership of a health plan. This model reflects a strategic orientation toward managing total cost of care for enrolled population.

Challenges and Trends Affecting AMCs

Across all typologies, AMCs face structural cost pressures, policy uncertainty and intensifying regulatory scrutiny. These pressures shape both strategic behavior and the regulatory lens through which AMC actions can be evaluated. Some unique challenges affect one or a few types of AMCs, while others are common across multiple types.

— AMCs affiliated with large non-academic systems must navigate complex governance and mission alignment issues. When academic missions (education and research) and operational priorities (clinical efficiency and system financial performance) pull an institution in different directions, this can contribute to ongoing organizational and financial tensions.[13] This may be particularly challenging as systems expand, e.g., doing so to support broader goals rather than explicitly in pursuit of the system's academic mission.[14]

— Safety-net–anchored AMCs, which rely heavily on Medicaid reimbursement and supplemental funding, face outsized risk from policy changes and funding delays. The Congressional Budget Office estimated that the budget reconciliation package passed in 2025 (commonly referred to as the One Big Beautiful Bill) will reduce federal Medicaid spending by approximately $910 billion over the next ten years. In addition, the federal Disproportional Share Hospital ("DSH") program, which provides states with federal allotments that help support hospitals serving large numbers of Medicaid and uninsured patients, faced considerable uncertainty in recent years. Substantial cuts enacted under the Affordable Care Act have been delayed multiple times, most recently by the Consolidated Appropriations Act of 2026, but are currently scheduled to go into effect in fiscal year 2028.[15] For safety-net AMCs highly dependent on Medicaid reimbursements and DSH payments, these reductions will directly impact margins.[16] In addition to reductions in supplemental funding, high uncompensated-care burdens and limited commercial cross-subsidization can constrain financial flexibility.[17]

— High-performance regional systems may face challenges related to higher cost structures, given their mission of providing specialized care to high-acuity patients and the associated resources needed to treat these complex cases.[18] Teaching hospitals also receive a disproportionate share of transfer patients. A recent report on academic medicine found that transfer cases had a 19% higher case severity rating and were disproportionately represented among complex Diagnosis-Related Groups ("DRGs"). Moreover, transfer cases cost 51% more per case, largely due to a longer length of stay. Transfer patients add to the additional costs associated with complex cases, affecting the financial margins of major teaching hospitals.[19] Non-transfer patients at AMCs are also reported to be more complex compared to patients treated at non-teaching hospitals.[20]

— Both high-performance regional systems and AMCs that are specialized complex-care leaders may face high fixed costs driven by research intensity, specialized workforce and the need to invest in advanced technologies and infrastructure. Therefore, sustaining mission activities often depends on continued research funding, philanthropic support and cross-subsidization from commercial payers. Research funding may be at risk; for example, the President's proposed fiscal year 2027 NIH budget would cut funding to $41.2 billion, the lowest budget since 2020.[21] The AAMC reported that NIH has canceled approximately $1.9 billion in grants across hundreds of awards in recent months.[22] Fewer new awards and less renewal funding implies labs may shrink, fewer clinical trials may be conducted (which often generate revenue for AMCs) and overhead cost recovery could decline, risking reduced margins.

— AMCs that focus on specialty care may face tension between their mission to provide equitable access and the operational and financial constraints associated with delivering highly specialized care. Research indicates that while pediatric specialty clinics affiliated with AMCs were more likely to provide appointments to children covered by Medicaid or the Children's Health Insurance Program ("CHIP") than those not affiliated with AMCs, these patients nonetheless experienced significant wait times to access care, indicating capacity and resource limitations.[23] Lower Medicaid reimbursement rates for complex specialty services may further intensify these pressures by limiting the resources available to expand capacity.

— AMCs engaged in population health and risk-based models face challenges in aligning risk-bearing care delivery models with their academic and research missions. Literature on integrated academic health systems highlights that the integration of clinical care, teaching and research — when combined with risk-bearing payment models — requires sophisticated infrastructure, data systems and management capacity, which can strain resources and expose institutions to financial variability.[24]

Strategic Responses: Transactions and Investments

AMCs face structural cost pressures, capacity constraints and mission obligations that often cannot be addressed through growth within their existing model of care. As a result, AMCs increasingly rely on two distinct but related strategic responses: transactions, including mergers, acquisitions, affiliations and joint ventures, and capital and infrastructure investments, including expansions of facilities and service lines. These strategies may be employed differently across AMC archetypes.

AMCs are often called upon to participate in affiliations, joint ventures or acquisitions to preserve access to care, particularly when smaller or rural hospitals face financial distress.[25] Recent reports on deal activity show AMCs are actively involved in transactions with community hospitals, with trade reporting that over 20 academic health systems acquired hospitals in 2025.[26] Acquirors are more often large multi-hospital academic systems or state-anchored AMCs expanding regional networks, while their partners tend to be financially distressed community or rural hospitals or non-academic facilities seeking capital and specialty affiliation. A smaller subset of acquiring AMCs operate within vertically integrated delivery systems that include affiliated health plans. In these contexts, AMC acquisitions or affiliations are often framed as preserving local access and achieving system-level efficiencies, including shifting lower-acuity care to lower-cost sites, freeing tertiary-campus capacity for complex care, spreading quality-improvement infrastructure and strengthening physician-training pipelines.[27]

As a recent research emphasizes, the nature of regulatory review varies significantly depending on whether the arrangement is a full acquisition, an affiliation or a joint venture.[28] Full mergers or acquisitions typically trigger federal antitrust review and state transaction oversight. Federal antitrust review primarily assesses whether a transaction may substantially lessen competition (including effects on price, output, quality or innovation) rather than conducting a broader public-interest balancing of access or community benefit.[29] In contrast, state-level oversight may vary in scope and intensity, with some states requiring advance notice or approval of hospital transactions, cost-impact analyses or reviews and decisions imposing conditions related to access, governance or preservation of charitable assets.[30] Where an AMC is affiliated with a state-created university or public entity, certain transactions may implicate the "state-action immunity" doctrine, a judicially created principle that can shield political subdivisions from federal antitrust liability when the challenged conduct is clearly articulated and affirmatively expressed as state policy and is actively supervised by the state.[31] Affiliations or joint ventures short of acquisition are also subject to antitrust scrutiny as described above, with some differences. Where the AMC and community hospital remain separate economic entities, these arrangements may involve ongoing antitrust compliance guardrails governing information sharing, joint contracting with payers, physician recruitment and compensation, and clinical integration.

Policymakers and stakeholders have commented that AMC transactions can be reviewed as responses to mission-driven capacity needs and financial constraints.[32] To the extent that transactions involving AMCs can generate pro-competitive and pro-patient benefits, such as access, quality and clinical integration, these factors may be considered during both the federal and state regulatory review processes. These benefits are often closely tied to the AMC's unique ability to maintain regional access to primary and specialized care and sustain workforce training pipelines. In the broader policy landscape, some observers have called for a more "dynamic" approach to antitrust enforcement, one that focuses less on static measures of market concentration and more on how market forces evolve over time and foster innovation.[33] Applied to healthcare, this school of thought argues that large providers, especially AMCs, may serve as engines of progress by advancing research, technology and clinical innovation.[34]

In addition to acquisitions, AMCs may utilize investments and expansions to build capacity. For instance, public entity statewide hubs may expand capacity when they are the sole or primary providers of highly specialized and core services and cannot meet patient needs with the existing capacity.[35] On the other hand, specialty-focused AMCs may invest in specialty-specific facilities to maintain national leadership, or in care models aligned with broader shifts toward delivering care in less intensive settings (*e.g.*, ambulatory and outpatient facilities) to preserve highly specialized inpatient capacity where clinically necessary.[36] High-performing regional systems build tertiary/quaternary or specialty capacity to meet demand and sustain research programs.[37]

Implementing these expansions and investments often involves specialized regulatory review. Currently, 35 states operate CON or DON programs, which require state approval for new facilities or expanded services and often involve assessment of community need and potential risks of duplication.[38] Additionally, eight states[39] have launched cost-growth target programs to track and manage spending, sometimes integrating oversight into broader health policy.[40] From a regulatory perspective, review of AMC expansions and investments also involves whether existing providers have the capacity and clinical expertise to meet current and projected demand, particularly for complex or specialized care. Public approval decisions emphasize evidence that alternative providers lack comparable capability, that the AMC serves as a sole or primary provider of advanced services, or that the AMC is already operating near or above capacity in ways that may affect access, wait times or quality of care. In some recent CON/DON approvals involving major AMCs,[41] state regulators relied on findings that (i) demand for specialized services exceeded existing capacity, (ii) comparable services were not readily available elsewhere in the region and (iii) expansion was necessary to preserve timely access to high-acuity care. These illustrate that a CON or DON review is often a capacity and expertise-based inquiry requiring detailed assessment of current and projected demand.

AMCs are key providers of both core and highly specialized care and play a unique role in the healthcare ecosystem, often called upon to participate in efforts to ensure appropriate access in their local, regional or state communities. As AMCs and community providers adapt to the current challenging environment, regulatory review of transactions and investments involving AMCs are highly likely to involve extensive inquiry into potential impacts on access to care, quality of care and benefit to the community, requiring comprehensive and fact-based assessments of the expected future state and plausible alternatives.

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Endnotes

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2 Jaromin, Sarah, *"The Evolving Landscape of State Health Care Transaction Laws,"* National Conference of State Legislatures (August 19, 2024).

3 *"Academic Health System & Teaching Hospital Membership,"* Association of American Medical Colleges (2026). An alternative definition, used by the Medicare Payment Advisory Commission ("MACPAC"), identifies "high-teaching hospitals" as those that have an Intern-and-Resident-to-Bed ratio of 0.25 or greater, a threshold commonly used in Medicare payment policy. Applying this criterion to the Medicare Cost Report data identifies 481 hospitals (8% of all hospitals) as major teaching hospitals. *"Chapter 3: Annual Analysis of Medicaid Disproportionate Share Hospital Allotments to States,"* MACPAC (March 2024).

4 RAND Hospital Data are a longitudinal, facility-level dataset that compiles information from Medicare Cost Reports and other Center for Medicare and Medicaid Services ("CMS") public use files. The Medicare Cost Report data contain detailed information on hospital characteristics, utilization, revenues, expenses and charges, among other operational and financial metrics, from Medicare-certified facilities. CMS uses Medicare Cost Reports to calculate and update key components of Medicare reimbursement, including cost-based payments and other payment adjustments. The RAND dataset harmonizes variable definitions over time, constructs consistent hospital identifiers and produces cleaned, research-ready files designed to facilitate longitudinal and cross-sectional analyses of hospital finances and utilization. *"RAND Hospital Data,"* RAND Corporation (2023).

5 Defined in a metropolitan statistical area, a geographic region defined by the U.S. Office of Management and Budget to represent a single, integrated labor and housing market centered around a large population core. *"2020 Standards for Delineating Core Based Statistical Areas,"* Fed'l. Register (July 16, 2021).

6 Based on author calculations using 2023 RAND Hospital Data, supra, note 4. Health system is defined by the Agency for Healthcare Research and Quality ("AHRQ") as "at least one hospital and at least one group of physicians that provides comprehensive care… [with] common ownership or joint management." Jones, David, et al. *"Comparative Health System Performance Initiative: Compendium of U.S. Health Systems, 2022, Technical Documentation,"* Agency for Healthcare Research and Quality (2024).

7 For this article, we classify health systems into three categories: A regional health system includes more than three hospitals operating in three or fewer states; a narrow system includes fewer than three hospitals operating in three or fewer states; and a multistate system includes more than three hospitals operating in more than three state. In addition to sources in footnote 6, the analysis uses *"American Hospital Association (AHA) Annual Survey Database – 2023,"* American Hospital Association (2023).

8 To identify comparable non-AMC hospitals, we identified non-federal, non-critical access, short-term and acute care hospitals with 100 or more beds, resulting in 1,758 non-AMC hospitals using 2023 RAND Hospital Data.

9 Author analysis of 2023 RAND Hospital Data, *supra*, note 4; N=122 CBSAs, 257 AMCs.

10 In Figure 3 and Tables 1-2, the number of AMCs does not add to 257 due to missing data.

11 FTI Consulting's Center for Healthcare Economics and Policy has developed a model that incorporates operating margin and payer mix and other financial and operational indicators into a comprehensive forward-looking assessment of financial position across all hospitals in the US, including AMCs. The model's risk scores aim to measure potential current financial distress as well as constraints on capital access and long-term sustainability. Examining risk scores at the community level allows for targeted evaluation of AMCs in the context of other hospitals within a region and assessment of potential implications of financial distress, service reductions or strategic investments or transactions on access to care.

12 The AAMC identified several options for AMCs with regard to health system organization, formation and transformational change: Merge/affiliate with a mega system; serve as a specialized complex care leader; act as a high performance regional system; act as a public entity statewide hub; or act as a population health manager. *Supra*, note 1.

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26 *"22 academic health systems acquiring hospitals,"* Becker's Hospital Review (Dec. 17, 2025).

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29 *"2023 Merger Guidelines,"* U.S. Dep't of Justice Antitrust Division (2023).

30 Montague, A., et al. *"Considerations for state-imposed conditions on healthcare provider transactions,"* Frontiers in Public Health 11 (Aug. 15, 2023): 1220624; *supra*, note 2.

31 *Supra*, note 28.

32 *Ibid*.

33 *"Merger Control in Dynamic Markets,"* OECD (2020).

34 Abbott, A., *"Nobel Prize Winners' Work Supports Dynamic Antitrust Enforcement,"* Forbes (Oct. 23, 2025).

35 Justice, B., "A statewide push to deliver top cancer care to rural Iowans," American Medical Association (July 28, 2025); *"UAB Hospital Emergency Department to expand with state support,"* The University of Alabama at Birmingham (July 10, 2023).

36 For example, the Dana-Farber Cancer Institute's recently approved cancer hospital project is designed to knit together inpatient services with integrated outpatient and collaborative care settings to meet patients' full continuum of needs. *"Following State and City Approvals, New Cancer Hospital and Clinical Collaboration Enters Next Phase,"* Dana Farber Cancer Institute (July 7, 2025).

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