

Harnessing the Policy Horizon: How NCQA's Recommendations to the Trump Administration Could Reshape the Healthcare Technology and Venture Capital Landscape

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The NCQA's recent 4/9/25 recommendations to the Trump administration arrive at a critical inflection point for U.S. healthcare. The systemic fragmentation, legacy IT burdens, and mental health crises that plague care delivery are not new phenomena, but the velocity of innovation, regulatory momentum, and capital alignment poised to confront them has never been greater. As the NCQA articulates a vision that is equal parts reform and reinvention—placing artificial intelligence, interoperability, and behavioral health integration at the center—it subtly constructs a blueprint for the future of digitally mediated, value-driven healthcare.

The implications for the healthcare technology ecosystem are profound. Where government payment reform intersects with emerging interoperability standards and AI-enabled clinical infrastructure, new regulatory tailwinds are likely to catalyze a wave of healthtech business model innovation. Venture capital, which has often operated at the edge of regulatory awareness rather than in lockstep with policy, may find at this moment a rare opportunity to finance not just companies, but compliance-as-a-category creation.

Value-Based Care as a Platform Shift: The Emergence of Payment-Integrated Care Infrastructure

The NCQA's call to aggressively transition all Medicare beneficiaries into value-based arrangements by 2030 represents more than just an evolution in reimbursement.

signals a potential shift toward treating value-based care not as a payment mechanism but as a core infrastructure layer—akin to a national platform for operationalizing outcomes.

If realized, this platformization would incentivize vertically integrated care coordination infrastructure, wherein AI-driven clinical orchestration engines, integrated quality measurement, and interoperable care plans form the basis for time reimbursement. Future payment models are envisioned not simply as bundled ACOs but as adaptive, context-sensitive contracts that respond dynamically to patient risk, care delivery modality, and provider behavior.

This opens a path for care orchestration technology—platforms capable of generalizing, adjusting, and aligning care plans across longitudinal timelines based on real-world data inputs—to become de facto operating systems for provider networks. Companies in this space could derive revenue from care plan optimization analytics, API-access fees for health plans, or shared savings tied to modular risk contracts. Over time, they could position such platforms as regulated intermediaries between CMS and providers, mirroring the role of clearinghouses in claims administration today.

FHIR as Economic Infrastructure: The Unbundling of EHRs and the Rise of Health Data Liquidity Markets

The NCQA's renewed urgency around FHIR standardization—and particularly its push for incentives to expand FHIR-based quality reporting and data sharing—hints at an impending unbundling of the EHR as the singular clinical data container. With growing signaling support for machine-readable HEDIS measures and industry-led FHIR implementations, an interoperable digital health substrate is being quietly built beneath the existing reimbursement scaffolding.

This substrate, once matured, will enable secondary health data liquidity—creating markets where patient-generated, payer-contributed, and system-extracted data become a tradable commodity, not in a transactional sense, but in terms of access-as-a-service. Companies that can abstract FHIR and USCDI+ compliance into middleware platforms may become the new B2B health data layer, selling standardized

compliant integration, data normalization, and privacy-preserving analytics infrastructure to both startups and incumbents.

Expect to see business models emerge around “compliance-as-a-service” for FHI quality measure reporting, enabling smaller provider networks and emerging virtual first plans to offload regulatory complexity while retaining data ownership. These platforms will likely monetize via per-member-per-month SaaS licensing or usage-based APIs, analogous to Plaid’s role in fintech.

The Future of Digital Quality: Measurement as Real-Time Feedback Loops

If NCQA’s recommendations are adopted, digital quality measurement may undergo structural transformation—from retrospective accountability metrics to proactive care optimization systems. This reimagining positions quality metrics as feedback loops, dynamically calibrated through machine learning to adjust provider behavior in real time rather than merely auditing it post hoc.

This reframing presents a compelling opportunity: intelligent quality orchestration engines that act as quality improvement co-pilots for clinicians. These systems could dynamically present quality flags, stratify patients by improvement opportunity, simulate the impact of care interventions on performance metrics. In this model, quality is no longer measured—it is operationalized.

Startups building real-time, FHIR-native quality dashboards with predictive capability could anchor this shift, offering subscription-based tools that plug directly into health plans’ digital measure frameworks. As Medicare Advantage Star Ratings potentially incorporate digital exchange metrics, these tools may become essential for plans to maintain ratings competitiveness—creating predictable ARR models for investors and massive defensibility through payer entrenchment.

Behavioral Health as an Anchor Tenant: The Next Layer of Clinical Integration

The NCQA’s behavioral health integration proposals are far more than catch-up modernization—they represent a reimagining of behavioral health as a foundational component of chronic disease management infrastructure. If behavioral care becomes

integrated with EHR, quality metrics, and value-based contracts, it will be replatformed from episodic intervention to a permanent clinical pillar.

We anticipate the rise of vertically integrated Behavioral-Primary Integration Platforms (BPIPs) that unify teletherapy, e-prescribing, measurement-based care, and virtual collaboration into shared infrastructure. These platforms could monetize through hybrid arrangements: licensing fees from FQHCs, PMPM contracts from Medicaid MCOs, and value-based performance bonuses tied to depression remission or substance use engagement metrics.

Simultaneously, expect modular behavioral APIs to proliferate—enabling integration of behavioral screening tools, referral routing engines, and therapist availability calendars into existing primary care systems. These modules will likely emerge as a top priority investment area as behavioral adequacy metrics are introduced into Star Ratings and CCBHC oversight becomes standardized through third-party accreditation, as recommended.

The Return of Risk-Based Contracting: Embedded Actuarial Intelligence and Care Model Design

As the NCQA pushes CMS and CMMI to reframe care models around high-risk conditions and procedures—especially those suitable for AI-enabled stratification—we will likely see a rebirth of condition-specific risk contracting, but with radically enhanced precision. Embedded actuarial intelligence, leveraging both historical claims and real-time SDOH and clinical data, will become the linchpin of this transformation.

Companies offering risk stratification models tailored to bundled payments or procedural carve-outs (e.g., orthopedic episodes, cardiovascular events) will become essential partners to payers and providers redesigning contracts. These models will be licensed on a per-condition basis, with actuaries embedded into virtual clinical care teams. Over time, a cottage industry of risk contracting orchestration may emerge, integrating actuarial tools, episode definitions, and care model blueprints into digital contracting marketplaces.

These marketplaces may serve as SaaS-enabled service exchanges, where payers and ACOs can discover, test, and deploy new contracting models with pre-built clinical pathways, analytics, and regulatory guardrails.

Capital Flows and Emerging Investment Archetypes

Venture capital will need to align to this increasingly sophisticated, compliance-heavy environment. The archetype of the healthtech investment will shift from consumer-facing apps and feature-oriented tools to deeply embedded, infrastructure-level platforms that facilitate compliance, coordination, and care orchestration. We expect three dominant investment theses to emerge:

1. **Interoperability as Horizontal Infrastructure:** Investing in middleware that unifies EHR, payer, and consumer data layers through FHIR, NLP, and real-time normalization. This thesis underpins platforms like Redox, Health Gorilla, and newer API-first entrants that abstract away complexity in connecting systems.
2. **Behavioral Health Infrastructure-as-a-Service:** Platforms enabling PCMHs, CCBHCs, and virtual-first models to add behavioral capacity—delivering virtual networks, integrated EHRs, and measurement tools as turnkey capabilities. These platforms will be well-positioned to serve Medicaid MCOs under value-based behavioral contracts.
3. **AI-Enabled Clinical Operations:** Not diagnostics, but systems that manage care pathways, predict admissions, suggest treatment plans, and optimize staffing. Investors will target companies embedding clinical AI into workflows in a way that survives future regulation, especially those aligning with PROMs, digital quality measures, and USCDI+ expansions.

Future Policy Scenarios and Their Commercial Implications

If the Trump administration takes NCQA's recommendations seriously, several long-term regulatory moves seem likely. These include:

- **Mandatory FHIR quality reporting by 2028:** Driving acceleration of digital measurement platforms and deprecation of legacy chart abstraction services

- **AI-based shared care plan pilot programs at CMMI:** Leading to the growth of clinical intelligence platforms offering explainable AI to support VBC contract performance.
- **Integration of behavioral metrics into Medicaid 1115 waivers:** Requiring MCOs to demonstrate behavioral outcomes in SUD treatment, stimulating demand for digital therapeutic integration and care coordination tools.
- **Inclusion of network adequacy metrics in Star Ratings:** Forcing payers to pay for behavioral provider network analytics, routing, and availability monitoring solutions.
- **Expansion of PCMH and CCBHC accreditation requirements:** Creating a regulatory moat for tech platforms that manage compliance workflows, outcome measurement, and operational enablement for smaller provider networks.

Conclusion: Aligning Innovation with Inevitable Regulation

The NCQA's policy vision is not merely a response to healthcare inefficiencies; it is a latent operating manual for the next generation of care delivery infrastructure. It portends a world where digital quality measures, AI-supported chronic care, and integrated behavioral health are not optional differentiators but table stakes for participation in the healthcare economy.

For technologists, this is a call to build with regulation in mind. For investors, it is an invitation to finance companies that don't just scale—they comply, coordinate, and catalyze the shift toward a more intelligent, less fragmented care model.

The coming regulatory tide will not lift all boats. But those designed to float atop structured data, value-based contracts, and digital quality metrics may find themselves sailing into an unprecedented era of scalable, sustainable healthcare transformation.



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