2025 TRENDS REPORT

Strategy is (finally) back in the driver's seat

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2025 Trends

1

Accelerate bigger, bolder opportunities for better access

A loyal patient generates more than three times the revenue of an uncommitted one.

2

Fuel success through pharmacy innovation

Outpatient pharmacy spend is growing 52% faster than total outpatient spend.

3

Greenlight advanced analytics and AI investment

82% of healthcare organizations consider clinical decision support tools as their top AI priority over the next three years.

4

Map new approaches to Medicare Advantage

The average length of stay for Medicare Advantage patients is .6 days longer than Fee-For-Service Medicare patients.

Introduction

Healthcare organizations have turned the corner on pandemic recovery and are now strongly focused on strategy and investment.

Day-to-day operations have stabilized for most. The August 2024 Kaufman Hall Flash Report shows that when adjusted for volume, expenses — while still elevated — have declined, and the patient volume growth rate has slowed.[1]

But the industry's competitive landscape has irrevocably shifted, and the performance gap between the best and worst has widened. Health systems must chart this new territory with less capital, which makes strategy — from both a financial and operational lens — essential.

So, what's key heading into 2025? For one, a deep understanding about the value health systems bring to the communities they serve, as well as contemplating how scale, scope and system alignment contribute to this value proposition. For another, the foresight to determine where to differentiate, deselect or disrupt to steer incremental growth and quickly yield sustainable growth.

While economic recovery varies among systems, those recovering fastest are expanding ambulatory care and igniting revenue engines in areas that are traditionally seen as inpatient cost centers (including pharmacy, lab, imaging and diagnostics). And with increased labor expenses accounting for 83.9% of total expenses, higher-performing organizations are carefully reviewing their employed physician portfolios with a focus on improving access and capturing downstream services. They also are more effective at deploying advanced practice providers (APPs).[2,3,4]

With lower interest rates anticipated this coming year, accessing external capital to fund strategic projects should be easier. Compressed margins will require a disciplined approach to quantify opportunities and a transparent process to evaluate and choose the best options for the enterprise. Alignment among the C-suite and internal teams — particularly strategy, financial and operational — to prioritize investments is crucial. Additionally, establishing an enterprise roadmap for the next 10 years and developing a three-year plan tying strategic priorities to financial and capital plans ensures organizations can make holistic decisions.

To guide that journey, we'll explore four trends in this report that will drive strategy in the year ahead: improved patient access, pharmacy innovation, data and technology integration and new approaches to Medicare Advantage.

"Now, more than ever, healthcare leaders need to determine what's going to differentiate them in their market: Is it clinical specialization, being the lowest cost or the easiest to access? You can't be all three. Decide what you're going to go after and build a model that enables you to do so successfully — and sustainably."

Amanda Steele
Managing Director and Practice Co-Lead, Strategy and Business Transformation, Kaufman Hall, a Vizient Company

TREND 1

Accelerate bigger, bolder opportunities for better access

Access is one of healthcare's biggest roadblocks, and care will become increasingly more complex due to an aging population, rising chronic disease and health disparities. Hospitals will continue to grow busier. According to the 2024 Impact of Change® forecast by Sg2, a Vizient company, utilization is expected to rise with a 9% spike in inpatient (IP) days and 15% overall outpatient (OP) volumes over the coming decade. While this growth represents a significant opportunity for health systems, the inability to meet the demand on consumers' terms poses signficant risk to create frustration, erode trust and jeopardize loyalty and long-term growth.[5]

"The key to maximizing access and care is to look at your overall lifetime relationship with the patient and prioritize what interactions and populations you should target to create the highest impact and value possible for them — and then steer away from those interactions that fall short."

Yelena Bouaziz
Principal, Intelligence, Vizient

To harness these trends as opportunities, healthcare leaders must look deeper and shift from transactional growth to creating access that delivers a compelling, value-driven experience for patients. This means developing access points that prioritize convenience, meet the needs of different segments in an individualized way, encourage engagement and build lasting trust.

The financial potential in loyalty is substantial. A typical health system currently captures less than 50% of its patients' total healthcare spend (as measured by share of wallet — the proportion of a patient's healthcare dollars spent within a single system over a longitudinal period of time). A loyal patient (whose share of wallet with the health system is 75% or more) generates more than three times the revenue of an uncommitted one, and a 1% increase in loyal patients can yield a $40 million revenue lift for a $2 billion health system.[6]

Patient behavioral segmentation grounded in tying patient interactions to share of wallet and usage frequency is critical to achieving this shift. Understanding the patterns and preferences that drive patient loyalty (or defection) allows health systems to invest in access points that not only serve immediate needs but also deepen patient commitment. Access should not be defined solely by physical location but by the integration of virtual care, non-acute partnerships and digital tools that allow patients to engage with the health system on their terms.

52.8%

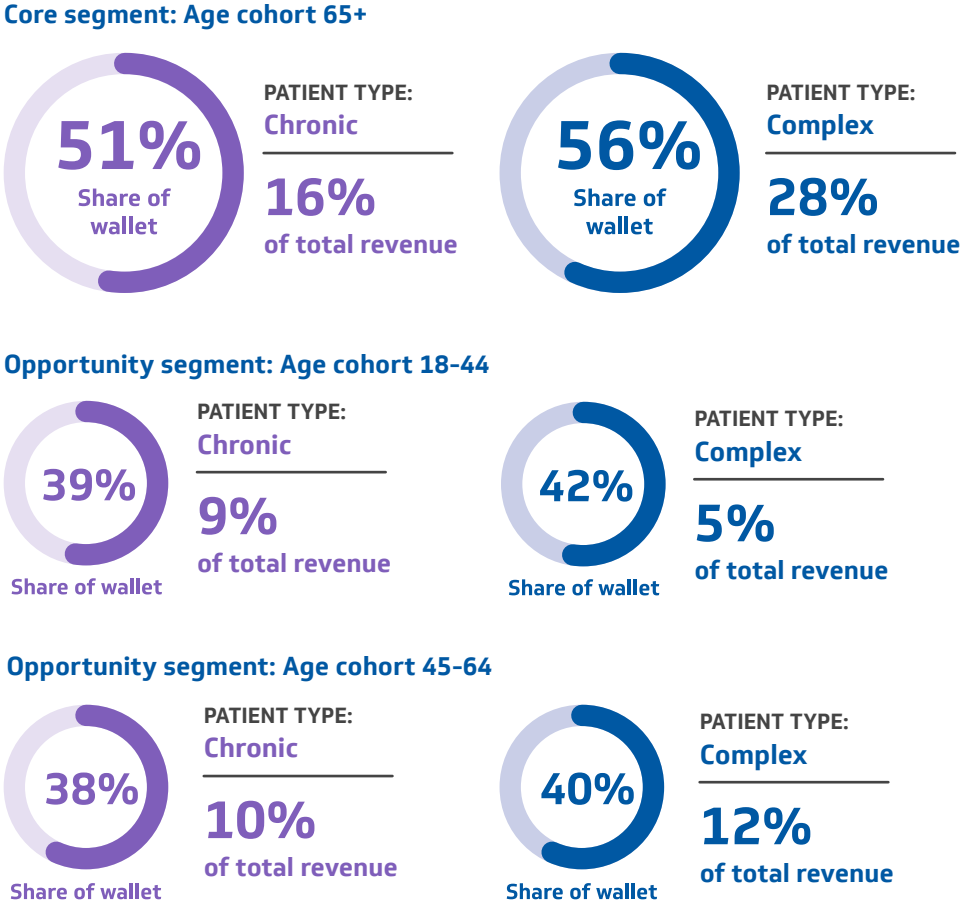
See patient access, throughput and capacity as their top area of focus for 2025, according to our annual survey of hospital and health system leaders.

Figure 1: Wide variation in loyalty, reflected in share of wallet, underscores the need for a segment-specific strategy to focus growth

Age	Patient type	Share of wallet
0-17	**Chronic**	**54%**
	Complex	**65%**
	Episodic	66%
	Surgical	68%
18-44	**Chronic**	**39%**
	Complex	**42%**
	Episodic	50%
	Surgical	52%
45-64	**Chronic**	**38%**
	Complex	**40%**
	Episodic	45%
	Surgical	43%
65+	**Chronic**	**51%**
	Complex	**56%**
	Episodic	50%
	Surgical	53%

*Share of wallet is Revenue vs Total Customer Spend exclusively for customers to whom sample hospitals have provided as least 5% of all care (as measured in $$).

Source: Proprietary Sg2 All-Payer Claims Data



Earning just an additional **5%** of these existing Chronic and Complex patients' healthcare spend would result in **8%** overall growth and **$200M+** in revenue.

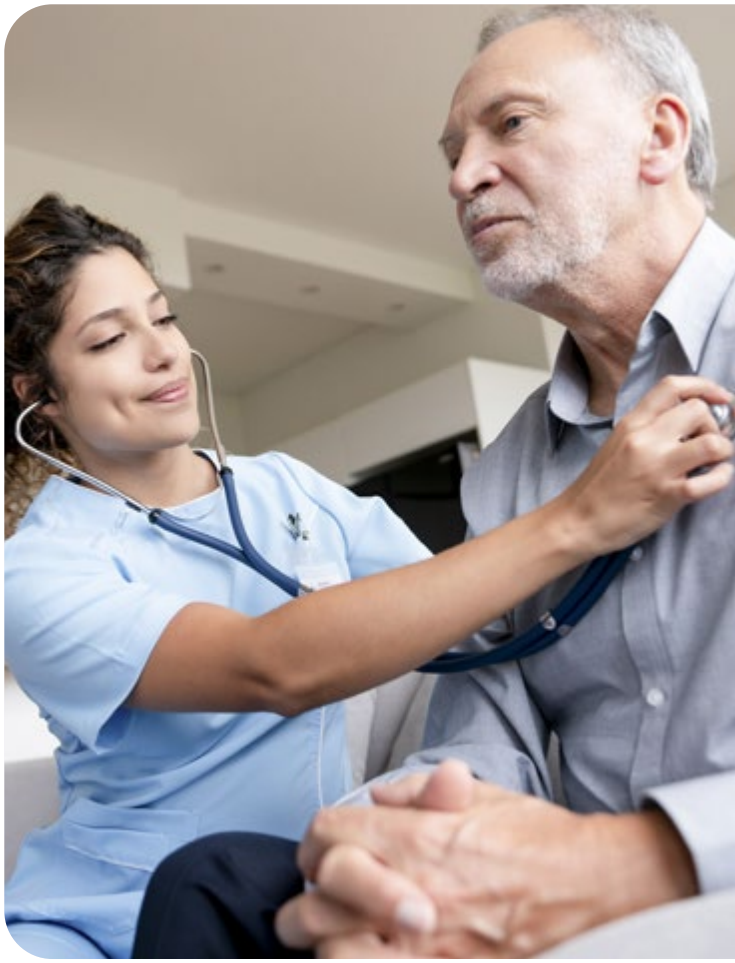
CASE STUDY

Loyalty-based segmentation in action

To determine what kind of healthcare consumer it appealed to most, a health system in the Midwest segmented its patient base by share of wallet (SOW), grouping patients into: loyal (SOW above 75%), splitter (SOW between 25% and 75%) and uncommitted (SOW below 25%). It then looked at utilization patterns within these three segments to understand the differences among them.

This process revealed that highly loyal patients tended to overuse inpatient and emergency department services and underuse ambulatory care. In contrast, splitter and uncommitted patients were more likely to engage with ambulatory care and were less reliant on avoidable inpatient or ED services. This insight revealed a crucial gap in the health system's appeal — it attracted a broad patient base but struggled to retain those who proactively manage their health. Follow-up voice-of-customer research confirmed that the splitter community did not see the organization as offering whole-person, comprehensive care.

The organization launched a rebranding initiative to emphasize its capabilities in disease management, wellness and prevention. The goal was to better meet the needs of splitter patients, particularly high-value, complex, commercially insured individuals aged 45 to 64. Simultaneously, the system leveraged its relationship with its loyal patients to identify opportunities to better support their health needs, such as encouraging greater participation in disease management and preventive care.



How leaders should respond

- **Connect data on consumers' economic loyalty.** Tie share of wallet to factors that influence it, including qualitative consumer experience, operations, quality and physician referrals.
- **Make patient experiences more convenient.** Incorporate virtual and other sites of care, as well as digital solutions for easier appointment scheduling and provider interactions.
- **Incorporate social determinants of health (SDOH) into access planning.** Identify barriers that may prevent patients from seeking care, such as transportation or financial constraints, and develop targeted solutions.
- **Look at longitudinal care.** For example, launching a congestive heart failure program in your cardiac service line could reduce avoidable ED visits and hospitalizations, delivering continuity of care over time and reinforcing the system's role as a reliable partner in health.
- **Leverage nonacute partnerships.** Specialty providers in areas including urgent care, home health and hospice, inpatient rehab, behavioral health and others can provide access to capital and specialized expertise where your organization has identified gaps. They ensure a comprehensive, connected network of care that encourages loyalty through choice and convenience.
- **Tailor care redesign models.** Align with the patient population's unmet needs. For example, leverage APPs in a system of ICUs with virtual central physician oversight to provide support that improves physician workforce demand and burnout while maintaining high-quality care and capacity positively impacting both access and patient satisfaction.
- **Implement a merger and acquisition smart growth plan.** Assess if access points across service lines are still relevant and make bold decisions where needed. This may mean exiting certain access points and services or acquiring others to meet the evolving needs of your consumer base.

TREND 2

Fuel success through pharmacy innovation

Specialty pharmacy has grown to 54% of health systems' total drug spend. Leaders are looking beyond oncology to emerging service lines that are heavy utilizers of specialty pharmaceuticals. Coincidently, "ultra-specialty" medicines, which include emerging cell and gene therapies, are certain to grow. Of the 2,588 drugs in late-stage trials, over half are biologics — and nearly 300 of those are cell and gene therapies — which puts pharmacy in a favorable position to expand its already sizeable revenue-generating growth opportunity.[7,8]

"Systems with multidisciplinary teams — physician champions, pharmacy leaders and finance teams — working together can more successfully enhance programs and provide equitable patient access to these expensive drug therapies from a systemwide approach."

Steven Lucio
Senior Principal, Spend Management Insights and Intelligence, Vizient

Clear direction on how you want to evolve your pharmacy strategy is important — which also means bringing the right people to the table. Organizations experiencing the greatest success in this area are those who include chief pharmacy officers and other pharmacy leaders in their decision-making. In service line planning, they can offer perspective on capital investments and program execution as treatment modalities shift due to drops in bariatric surgery volumes. Other factors include subcutaneous drugs moving to outpatient settings, payers exerting increased influence on site of care administration and new specialty drugs and their associated distribution becoming more complex in terms of management and storage.

Additionally, embedding a pharmacist in ambulatory care not only aids physicians and nurses as a workforce solution, but can help ensure prior authorizations and patient satisfaction. For example, through weight loss clinics, pharmacists can help adjust patient doses and ensure outcomes, which ultimately saves organizations and payers money — an important strategy considering one in eight Americans use GLP-1s to date.[9] Adoption of expensive cell and gene therapy drugs — in some instances, single-dose treatments that cure rare diseases — is transforming the care pathway for patients. As the industry evolves, these treatments will often be administered in nonacute settings. Maximizing the revenue capture of specialty pharmacy and cell and gene therapy by enhancing system efficiencies now can help organizations deliver on the future promise of this innovative pipeline.

54%

The percentage of a health system's total drug spend devoted to specialty pharmacy

Figure 2: Outpatient pharmacy costs surge, growing 52% faster than total outpatient spend, with cancer drug costs up 50% in past three years

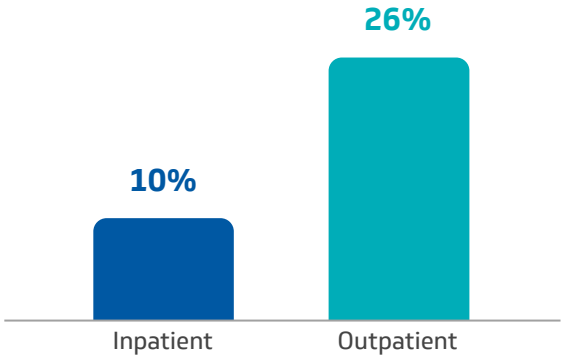
Outpatient pharmacy spend grows led by cancer and neurosciences

Service line	Average annual pharmacy costs/ hospital	Pharmacy % of total service line costs*	3-Year % increase in pharmacy costs**
Cancer	19.4M	61%	50%
Neurosciences	3.1M	37%	42%
Gastroenterology	1.5M	28%	13%
Rheumatology	1.4M	64%	38%
Hematology	1.3M	50%	41%
General Medicine	1.1M	8%	35%
Orthopedics	1.1M	7%	71%
Allergy and Immunology	0.7M	47%	50%
Cardiovascular	0.6M	4%	18%

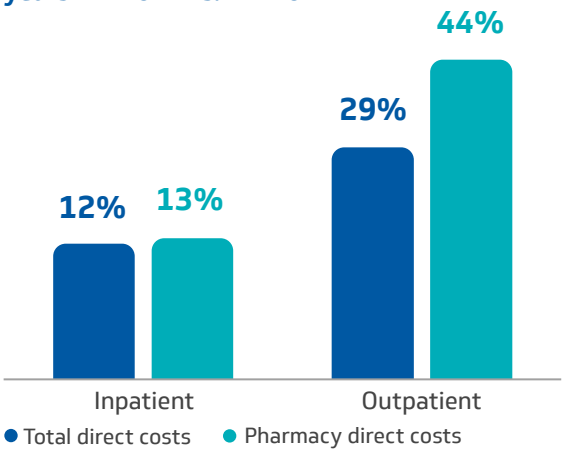
Notes: Service Lines defined by Sg2 CARE Grouper v2024; *Total Service Line Costs represents hospital outpatient total direct costs**

Source: Vizient Clinical Data Base represents Q42021 to Q32024.

Pharmacy share of hospital direct costs FFY2024



Growth in hospital costs over last three years FFY2024 vs. FFY2021



Notes: FFY 2024= Federal Fiscal Year Q42023-Q32024

CASE STUDY

Streamlining system pharmacy prior authorizations

Utilization management has become increasingly important for specialty pharmacy. An AMC on the East coast and an AMC in the South have both created central benefits investigation programs that streamline prior authorization throughout the system. They employ teams of 15-plus prior authorization specialists to reduce the administrative paperwork burden on providers, patients and pharmacists. These teams communicate new payer dynamics that could hinder timely treatment and reimbursement:

- Change the formulary in the electronic health record (EHR) if there are new categorical exclusions, if biosimilars become preferred or if generics are available or in shortage.
- Coordinate physician-to-physician interactions, often with the payer.
- File appeals with proper documentation.

How leaders should respond

- **Include pharmacy throughout the continuum of care.** Align with finance and other C-suite teams to assist with quality, cost and reimbursement, especially for high-cost medications and in ambulatory settings, which is one of the top spends for medications. Currently, outpatient (OP) pharmacy spend is growing 52% faster than total OP spend (see figure 2).[10]
- **Recognize potential intrasystem turf wars.** For instance, there may be disagreement between more conventional bone marrow transplant teams, CAR T-cell therapy teams and bispecific prescribers. Preempt issues with system processes that prioritize patient needs.
- **Ensure optimal oversight and support of organization's use of 340B program.** Successful management of the value within the 340B program requires the expertise and attention to detail to enable enduring patient care access. In addition, the 340B program is subject to rapid changes in terms of supplier behavior and the ongoing potential for legislative and/or regulatory actions. Executive leadership must ensure pharmacy leaders are resourced appropriately to guarantee program integrity that will sustain patient services.
- **Create a high-cost drug committee.** For drugs costing more than $500,000, develop an interdisciplinary team that will evaluate the appropriateness of use, ensure equitable access and navigate supply chain and reimbursement issues for treatments.
- **Contend with disruptors.** While direct-to-customer and pharma companies may cut health system pharmacy revenue potential, regulate (e.g., advocate government to increase accountability of compounding pharmacies that cut quality corners) or replicate (e.g., build compounding pharmacies and sell directly to customers) to compete.

TREND 3

Greenlight advanced analytics and AI investment

Advanced analytics, including artificial intelligence (AI), is not optional in the future of healthcare.

As healthcare organization data sets and patient complexities continue to increase, it's important that leaders leverage technology. While some organizations have taken a wait-and-see approach to incorporating AI or an advanced analytics strategy — due to perceived barriers including lack of clear return on investment, operationalizing and organizational buy-in — it's time to accelerate from general exploration to deliberate testing and integration.

"Organizations are often data rich and information poor, and so these tools can reveal important interconnections. They are a sorting mechanism to determine what is most important to focus on, which you can then use to create objectives and action plans around those KPIs."

Erik Swanson
Senior Vice President, Data Science and Analytics, Kaufman Hall

According to a recent Vizient Member Networks survey, regardless of a healthcare organization's AI and analytics strategy, operational efficiency and quality outcomes are providers' top two drivers for development — 88% and 82%, respectively. And clinical decision support tools are becoming a top priority (see figure 3).[11]

Advanced analytics or AI can allow clinicians to work at top of license through augmenting decision-making and patient care. They can more efficiently evaluate a patient's condition by optimizing the analysis of medical imaging data and synthesizing medical history and family history. Advanced analytics can help optimize patient care by summarizing complex EHRs and identifying care gaps earlier, screening for high risks, reducing unnecessary testing, monitoring remotely and tracking missed appointments and medication refills. There is broad consensus that clinicians will not be replaced by advanced analytics or AI, but those who do use it to augment their work will replace those who do not.

Additionally, the use of AI or advanced analytics for operational gaps — to ensure correct coding and billing, track and reduce patient no shows and improve compliance with payment bundles — supports efficiency and bolsters bottom lines. Through volume and competitive analyses, prescriptive analytics serves as a GPS for systems in site of care optimization, alignment and identification of service lines to pursue.

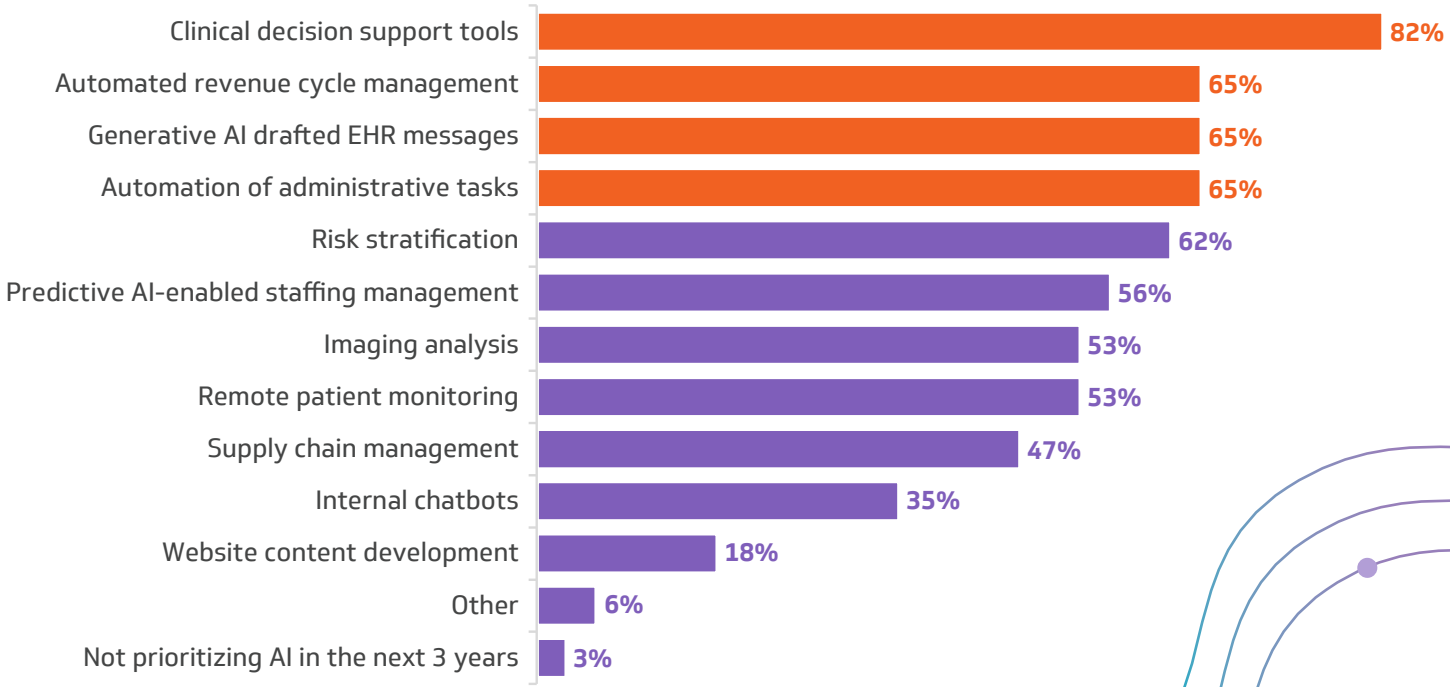
Lastly, implementing advanced analytics through workforce optimization — both predictive and prescriptive that best aligns staff with demand — leads to improved patient outcomes and employee satisfaction and decreased employee turnover and labor costs.

82%

The percentage of providers who see clinical decision support tools as their top AI priority

Figure 3: Three-year AI application priorities

Clinical decision support tools are the top priority for the majority of organizations over the next three years followed by **automated revenue cycle management, generative AI drafted EHR messages and automation of administrative tasks.**



Source: Vizient Member Networks AI Survey 2023

CASE STUDY

Strategic planning with complex modeling based on multiple success factors

Goal: A health system in the Southeast sought optimization for ambulatory planning to maximize their financial outcomes within a variety of constraints, including 340B eligibility, as well as to minimize patient and physician turnover, ensure affordability, maximize the value of construction, renovation costs and their existing footprint, and position themselves strategically with the payers in the market on a long-term basis.

Solutions:

- In combination with the financial planning and physician enterprise teams, the data and analytics team built a tailored tool using a machine learning algorithm that could analyze the system's financial and strategic plans and allow for modifications of all inputs. These inputs included clinic type (hospital outpatient department versus standalone), costs for conversion, patient affordability metrics, forward projections over the next several years and assumptions for payer dynamics.
- A constraint optimization process ensured that all the objectives — some competing — were held within acceptable ranges while maximizing financial outcome.
- Hundreds of millions of "scenarios" were generated and analyzed using the tool to not only determine the best solution, but also the influence of each input, assumption and constraint on the resulting financial and strategic outcomes.

Results:

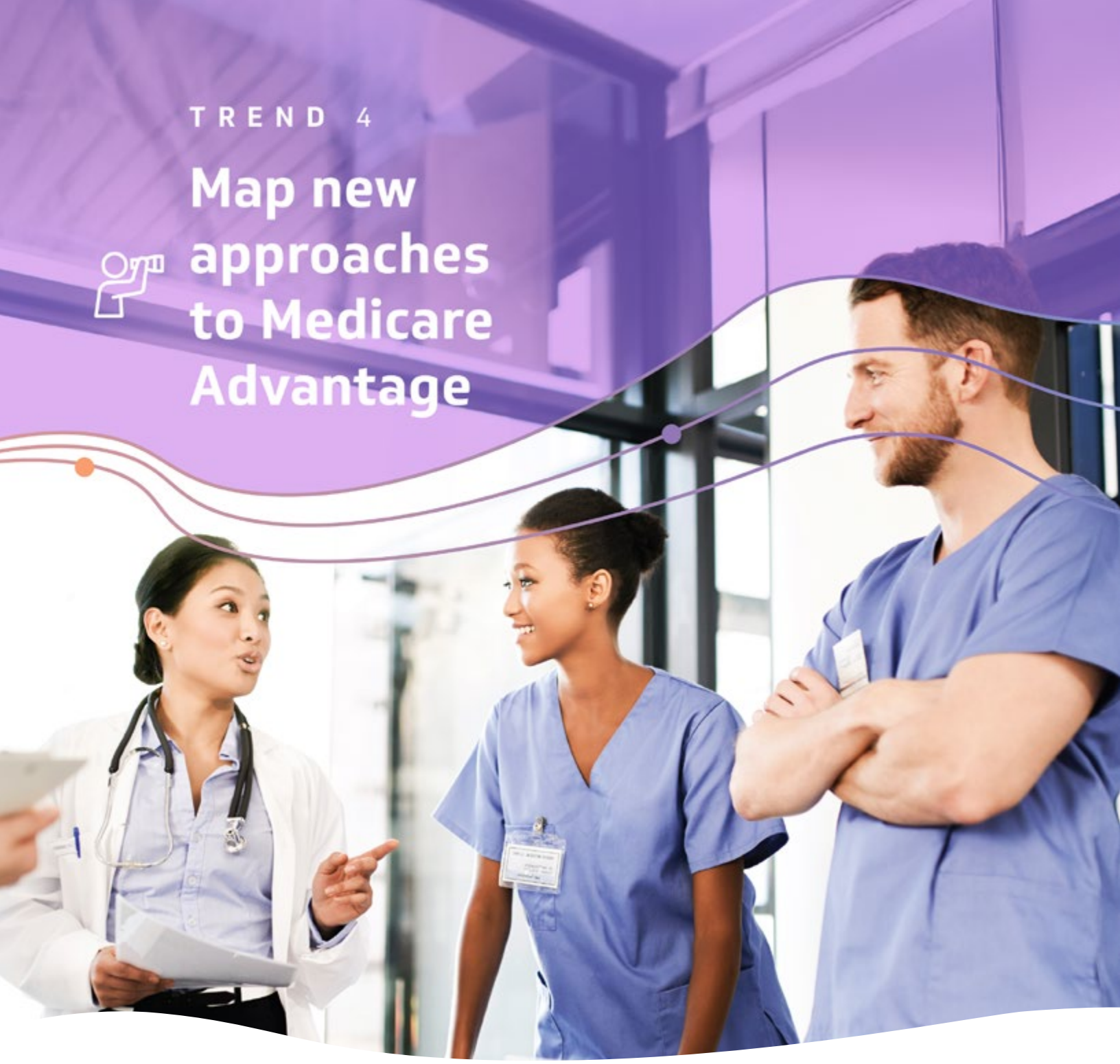
- An integrated strategic and financial plan based on the recommended optimization of their ambulatory footprint.
- The plan provided roughly $170 million in net margin opportunity if executed fully, reduced patient and physician turnover and loss, protected against commercial payer changes and ensured that 340B status was retained.

How leaders should respond

- **Define your need and vision.** Start by identifying your most important business problems and opportunities. Capture cross-functional input and set up accountability frameworks, metrics of value, budgets and timelines.
- **Build C-suite and staff analytics literacy.** This is essential for informed strategic planning.
- **Find champions.** Combine a startup core group of staff and providers who are excited by, and will objectively test, new approaches with a tech-centric few who implement and manage.
- **Prioritize governance and security.** Data ownership, alongside human oversight, is crucial to ensure safety and security.
- **Be mindful of data quality.** Focus on model drift, include data auditors and identify the sources of potential bias early on before it's introduced into algorithms.
- **Build change management.** It's vital to hire leaders for hybrid roles that oversee innovation and operations.

TREND 4

Map new approaches to Medicare Advantage



Providers have hit many challenges with Medicare Advantage in the past year, including payer contractual yield decreases, restrictive authorizations for care and impacts related to risk adjustment methodology changes.[12] According to a recent Vizient Member Networks survey, payer behaviors most costly to healthcare organizations are utilization management, diagnosis related group downgrades and discharge delays.[13]

"Most metrics for Medicare Advantage payers are provider driven. So, whether it's risk adjustment, coding for accurate diagnosis, CMS star ratings improvement or total cost of care management, providers are in the driver's seat more than ever if they're willing to change their business and care models."

Joyjit Saha Choudhury
Managing Director, Strategy and Business Transformation,Kaufman Hall

And there are significant differences in length of stay and conversion to inpatient admission for observation patients covered by Medicare Advantage versus Fee-for-Service (see figure 4). For example, Medicare Advantage observation patients are 50% less likely to be converted to inpatient admission. However, their length of stay in observation is significantly longer — 41% higher for those discharged home and 35% higher for those converted to inpatient. These variations necessitate provider input.

Despite continued headwinds, and a slower growth rate of 1.7 million beneficiaries (+5.4%) from the previous year's record growth of 2.7 million (+9.4%), healthcare organizations must prepare for the reality of ongoing enrollment — expected to reach 60% of total Medicare enrollment by 2030.[14,15]

While there is no single solution for health systems to right-size Medicare Advantage contracts, providers need tailored contracting strategies. Comprehensive, multipronged, data-oriented arguments are the best way to establish a toehold in negotiations, which are expected to remain tense for the foreseeable future.[16]

Collection and aggregation of financial, clinical and consumer data from across the organization in partnership with internal stakeholders is critical. Additionally, negotiators must prepare the enterprise for negotiations that fail — and for the possibility of payment and care interruptions resulting from the termination of payers — by involving strategy, physician enterprise and marketing stakeholders across the organization.

It's also imperative that health systems educate teams about how value is created, and their role in creating that value. Teams who are aligned to the mission will negotiate more successfully with payers in acquiring a fair share of their contribution.

The long game for organizations is to develop a business model that includes quality care, as well as to foster better partnerships with payers. A continuous, collaborative effort can improve cost structures on both sides.

60%

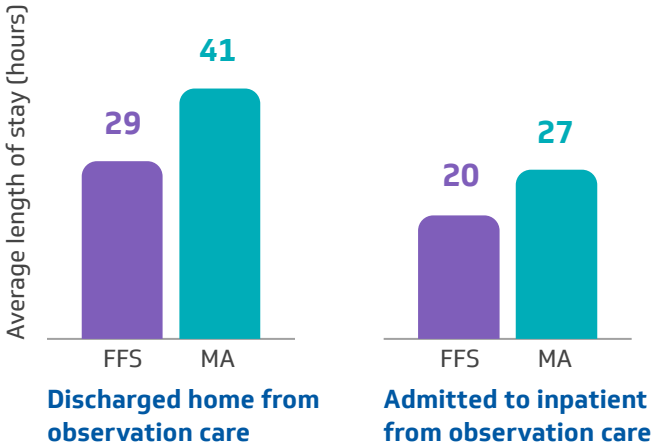
Medicare Advantage will comprise more than half of total Medicare enrollment by 2030

Figure 4: Average hours in observation care for patients, 2023

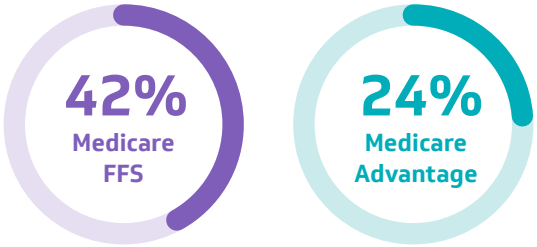
Medicare Fee-For-Service (FFS) vs. Medicare Advantage (MA)

Key takeaways:

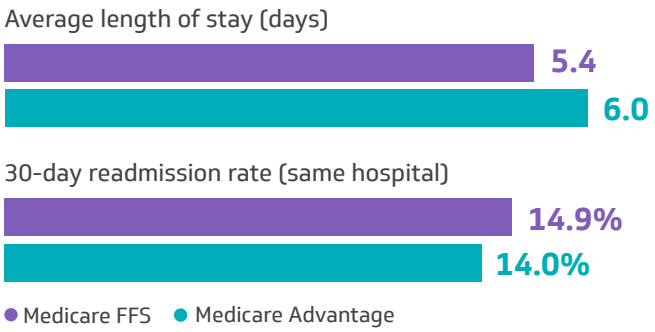
- ~50% fewer MA observation patients are admitted to the hospital as an inpatient than FFS patients.
- MA patients spend 12 hours more in observation care before being discharged home than FFS patients.
- While inpatient 30-day readmits are lower for MA patients than FFS patients, the average LOS for MA patients is .6 days longer than FFS.



Patients with observation care admitted to inpatient



Hospital utilization by payer group for inpatient medical admissions, 2023



Source: Vizient Clinical Data Base, 2023. Results limited to patients who came through the emergency department and had a length of stay of ≤ 168 hours.

CASE STUDY

Key partners: proactively managing Medicare Advantage

A disruptor focused on total care management in risk-based payment environments, particularly Medicare Advantage, has created a physician-oriented platform that accelerates the transition towards value. By targeting care gaps and brokering advanced payer partnerships this disruptor accelerates growth for participating clinics.

A health system in the Northeast has embraced the disruptor platform and a risk-bearing entity was created with a 50/50 shared governance structure. The disruptor assumes complete downside risk while the provider entity and disruptor share net surplus (50/50). Payers, physicians, the health system, disruptor and patients all are connected through the Total Care Model, a clinical and financial platform. Results have included:

- Long-term contracts with provider partners that typically last 20 years to actualize the effects of care management.
- Value-based care contracts help to, at minimum, equalize net patient yields to cost of delivery; often, they generate a positive margin. The highest-performing disruptor's primary care providers make 1.5 to 2.5 times their earnings prior to the partnership.
- Alignment of quality outcomes and care decision-making allows healthcare organizations to stay engaged. Better patient outcomes are proven through lower readmission rates, admits per thousand and ED visits (compared with Medicare Fee-For-Service benchmarks).

How leaders should respond

- **Drive star ratings.** It not only helps with Centers for Medicare & Medicaid Services bonus payments but can build a more persuasive narrative for payers on why you deserve better rates and/or a better value-based care program.
- **Maximize physician advisors.** Collaborations can ensure utilization review in the ED to guide attending physicians on proper placement of patients to appropriate levels of care and discuss Medicare Advantage cases with medical directors regularly.
- **Build out a comprehensive care management function.** Include dedicated resources for programs like transitional care management and chronic care management.
- **Determine cost and contractual language variation in contracts.** Building a data-driven story — tracking yield, cost of business, regulatory compliance and value incentives over time — is crucial.
- **Tailor negotiation tactics toward payer needs.** Create better partnerships by discussing administrative costs associated with plans, such as preauthorizations that impact both providers' and payers' bottom lines.
- **Use data to plan your strategy.** There's no "one size fits all" approach. Instead, strategically select optimal partners and determine which to terminate while considering the best time to do so.
- **Coordinate contract terminations.** Collaborate with strategy, physician enterprise and marketing teams to proactively address contract terminations with a robust communication plan inclusive of marketing campaigns targeted to affected beneficiaries.

To sum it up

System leaders have difficult decisions to make to compete in the ever-changing healthcare landscape. Strategic planning is key as systems set their sights on accelerating growth opportunities: tackling access through patient consumerism, optimizing Medicare Advantage contracts, leaning into pharmacy opportunities, and leveraging the power of advanced analytics and AI to change the way care is delivered.

Vizient is committed to helping you take the wheel to navigate these opportunities. Reach out to discuss where your journey can take you.

METHODOLOGY

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Internal data sources

The following Vizient, Sg2 and Kaufman Hall data sources were used to create and inform this report:

- Kaufman Hall National Hospital Flash Report: August 2024 Metrics (based on data provided by Strata)
- Kaufman Hall Physician Flash Report: Q2 2024 Metrics (based on data provided by Strata)
- Proprietary Sg2 All-Payer Claims Data Set; IQVIA; Sg2 Analysis, 2024
- Sg2 2024 Executive Briefing: Refining the Outpatient Portfolio
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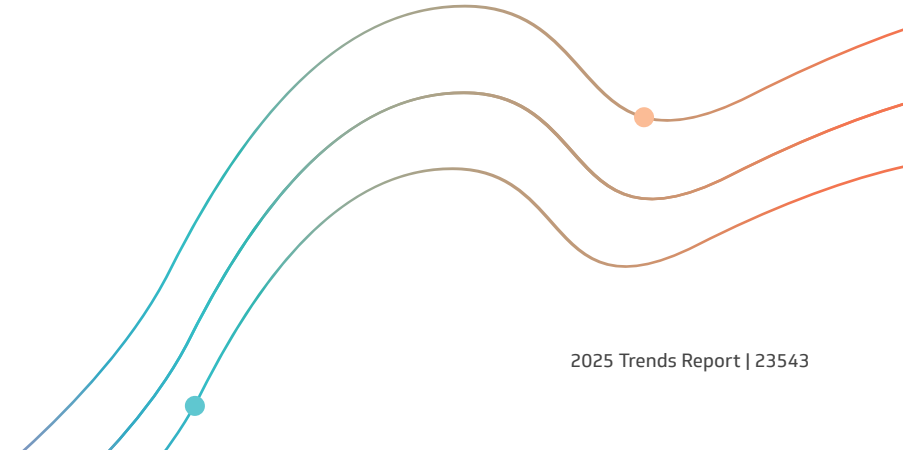
- Vizient Clinical Data Base
- Vizient Summer 2024 Pharmacy Market Outlook
- Vizient's The Great Medicare Divide: Bridging the Gap and Finding Success
- Vizient Member Networks 2023 Artificial Intelligence Survey
- Vizient Member Networks 2024 Medicare Advantage Survey



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