STATE OF THE INDUSTRY REPORT 2025

The State of the Industry: Senior Leaders Face the Challenges of This Moment in Healthcare

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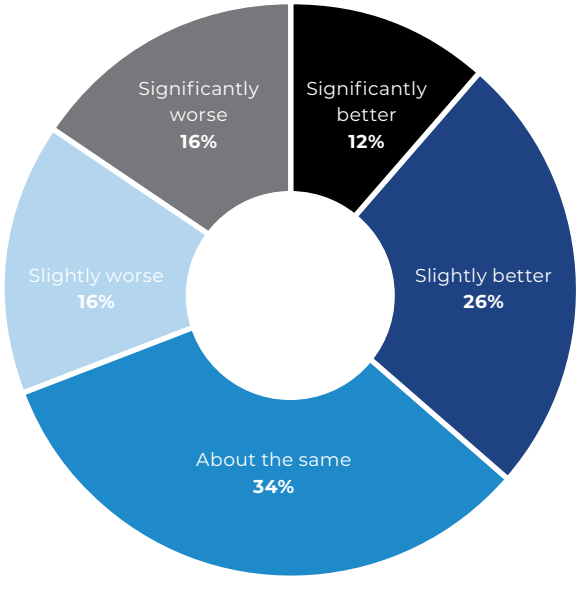
The editors of *Healthcare Innovation* have once again polled our readers to find out about their biggest challenges and concerns and their most important strategies in the moment in a rapidly changing policy, payment, and operational landscape. Below are some of the top findings of our survey, and experts' perspectives on those findings.

Finances and other challenges

First, we asked our readers how they would describe their financial position relative to one a year ago. Here's what they said:



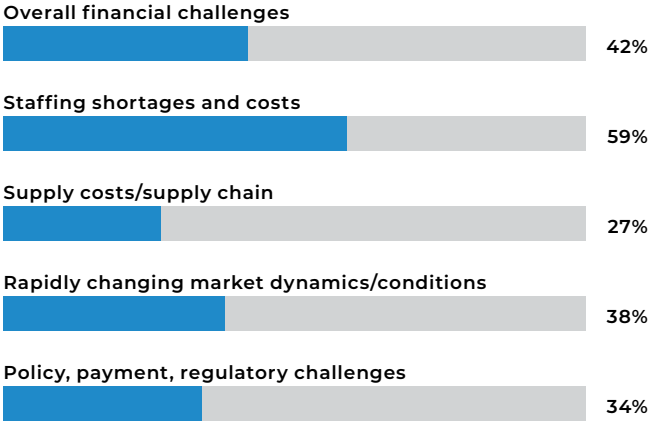
Per those results, John Klare, a managing partner at the Chicago-based Impact Advisors consulting firm, says that, "Honestly, those results make a lot of sense. And, per more than one-third citing better finances, that accords with what I'm seeing across the industry. In terms of broad trends, while there are continued pressures attracting and retaining the workforce, and while it's still very competitive, it's slightly less intense than last year. Labor expenses are a little bit more than half of your expense base, and as that factor eases, that makes a difference."

When asked about our reporting that is uncovering a widening gap between the "haves" and "have-nots" of hospital-based organizations—meaning the highly resourced health systems, versus those that are poorly or only moderated resourced—he says, "I think that it's correct that the gap is widening; but even among the 'haves,' the pro-action-oriented, decisive teams are doing better, particularly among the academics. Still, claims denials, a huge issue, affect the smaller, standalone hospitals much more."

Richard Gundling, senior vice president at the Healthcare Financial Management Association (HFMA), says that, in discussions with chief financial officers (CFOs) and other senior leaders focused on finance in hospital-based organizations, "They're cautiously optimistic. They're still concerned with declining

payment rates, high denial rates, staffing and cost issues. There are a lot of challenges, but there's also a lot of hope. We're seeing financial stabilization."

Adding to the picture, we asked survey respondents what their biggest challenges are in this moment. Here's what we found:



Per staffing-related issues, Klare says that "The pressure compounds on the smaller, rural hospitals. They don't have the preferential rates to begin with. And because you're rural and smaller, sometimes your labor force senses your instability. And I think that in the past, larger healthcare systems might have been less rigorous in how they evaluate potential partners, whereas today, if a larger health system looks at a potential acquisition, they have to ask, should I acquire, or let it fall apart?" Even the decision on the part of a large, better-resourced health system as to whether to acquire a standalone hospital that is not in great financial shape, becomes complicated, he notes.

Angela Littrell, CEO of the 60-bed Fitzgibbon Hospital in the town of Marshall in rural central Missouri, confirms Klare's perceptions. Operating with a payer mix that is 60-percent Medicare, 12-percent Medicaid or self-pay, and less than 25-percent commercial, the payer situation is dire for her organization. "There's not a lot of leverage if you're a small, independent rural hospital in negotiating with payers," Littrell says. "And even larger hospitals are struggling in terms of reimbursement from payers like UnitedHealthcare and battling all the denials. The time to get paid by them is becoming exponentially longer. And the denials feel egregious. So it becomes a serious challenge for all facilities, particularly rural ones."

Per staffing, Littrell shares that Fitzgibbon hospital two years ago had to close its intensive care unit (ICU): "We had a seven-bed ICU, which requires specialized staff and training; and we were experiencing a 2-to-1 staff to patient ratio in the ICU, and made the decision to close that unit. We took a big hit in terms of our public relations as a result, but we had no choice." Staffing, in fact, weighs strongly on all the key financial decisions the hospital is having to make these days.

Per all of that, 67 percent of survey respondents reported ongoing shortages of bedside nurses; 43 percent reported shortages of nurse managers; 48 percent are seeing shortages of revenue cycle management professionals; 47 percent are experiencing shortages of information technology staffers; and fully 77 percent are reporting overall clinician staffing shortages.

One factor that had been weighing heavily on hospital leaders during the COVID-19 pandemic and in the two years following it, was a heavy dependence on traveling/agency nurses. "That," says Erik Swanson, senior vice president and data analytics group leader at the Chicago-based Kaufman Hall consulting and advisory firm, "was an absolute killer." The good news? "The data are very clear, and our discussions with clients are clear, that that reliance on contract labor has diminished substantially. It's still higher than in the past, but it's been reduced substantially since its peak in 2022. And because the demand has gone down, the rates that agencies could charge, have decreased as well. So we're seeing reductions both in the volume of agency nursing and in the rates charged. Now, for a number of months, we've seen a reduction of FTEs per actively occupied bed. So some of those nurses from agencies are becoming reemployed by the hospitals. And on an overall basis, that has lowered or at least attenuated the growth in labor expense. Still, overall FTEs per AOB is still extremely lean. So we're still operating in a mode of staffing shortage. So there is certainly some relief on that contract employment side, but still a very lean operation from at least a nursing perspective."

Mary Sirois, managing director, transformation and innovation, at the Madison, Wis.-based Nordic Consulting, makes the point that, "When you think about the perspective of staffing shortages, first and foremost, you need to consider the human resource—people—as an asset, and make an investment and plan for that asset. And sometimes, that's a little bit different from how people have been thinking about the issue."

All of that said, some types of hospital organizations will continue to be challenged by basic factors, going into the future; children's hospitals are among the most obvious examples, with nearly all children's hospitals heavily dependent on Medicaid reimbursement, and with Medicaid being a notorious under-payer. Per that, R. Lawrence "Larry" Moss, M.D., president and CEO of the Wilmington, Del.- and Jacksonville, Fla-based Nemours


R. Lawrence Moss, M.D.

Children's Health, puts it this way: "There are a variety of challenges that we all face. I'll say that fundamentally in the United States, all children's hospitals are fundamentally reimbursed and live on a shoestring all the time, and to the extent that I can play a role and continue to advocate for sustainability facing the Medicaid challenges we face, I'll do so."

And, per that, Dr. Moss emphasizes that "I think it's important for the American people to understand—a lot of people don't realize this—over half of all children in the US get their healthcare funded by Medicaid, and Medicaid in the vast majority of cases, underfunds care. We have a big challenge with underinsurance of kids through the Medicaid program, and that's an important thing to discuss."

Value-based contracting: holding steady, but not expanding rapidly

We asked our readers about their involvement in value-based contracting. Just 12 percent said that they had significantly increased their proportion of value-based contracts relative to discounted fee-for-service contracts, though 28 percent had slightly increased that proportion; fully 60 percent told us that that proportion remains the same as a year ago.

Still, there are signs that patient care organizations' involvement in value-based contracting is showing lasting results. Back in October, when the federal Centers for Medicare and Medicaid Services (CMS) announced the 2023 results from the Medicare Shared Savings Program (MSSP), the agency found that the MSSP had yielded more than $2.1 billion in net savings in 2023—"the largest savings in the Shared Savings Program's history."

On that same date, Farzad Mostashari, M.D., the CEO and co-founder of the Bethesda, Md.-based Aledade, a physician enablement company, tweeted this: "Is Value-Based Care working? After a decade, we know this: The latest results for the largest such program just dropped. Giving primary care accountability for total cost and quality of care is good for patients, good for practices, and good for society." Further, he wrote, "As the press release says, 480 ACOs providing care to nearly 11 million people with Medicare saved the gov't $5B dollars while improving quality of care. The gov't kept $2B. Providers earned an extra $3B. Beneficiaries saved on lower out-of-pocket spending-AND LESS SUFFERING."

And in a subsequent interview with Healthcare Innovation in early November, Dr. Mostashari said that "The MSSP is the largest value-based program in the country, and it is now clear, the most successful. What has made that program successful, and how can the lessons be expanded upon? And I think it's an interesting contrast to the results that are frequently talked about when people are talking about the 50 or so experiments run out of the Innovation Center. Many of those experiments did not bear fruit; and the four or five that saved money and improved quality drove more participation in the MSSP and more success."

And, he added, "The single biggest learning in the program has been that the most important thing we can do is to give access to primary care. It's getting harder and harder to get an appointment with one's primary care physician. It turns out that that's huge: when you're sick, being able to see the person who knows you best, is huge."

Meanwhile, one leader in the trenches says that organizational size and scope really matter when it comes to value-based contracting. John Farley, M.D., is the chief medical officer at the Birmingham, Ala.-based Complete Health, an organization that describes itself as "a physician-driven, privately owned, technology-enabled primary care group delivering excellent quality support services and patient health outcomes." Complete Health now encompasses 185 physicians and nurse practitioners across 28 care sites in Colorado, Florida, Alabama, and Virginia. Care sites: 28 care sites. "The bigger we get, the more impact we can have with the big national payers," Dr. Farley says. "They've actually in some cases approached us, saying, we need a risk-bearing entity that does a good job. That's some of it. But we've also significantly been able to expand our back-office medical economics department." Importantly, he adds, "We know, using information technology, which patients to focus on. So size allows for scale, which helps create efficiency. Through risk stratification, we're able to identify the high-volume patients. Often, they're lonely and don't have social support, and the more we're able to interact with them, the less likely they are to go to the ED, etc. So that's been successful."

Artificial intelligence: surging

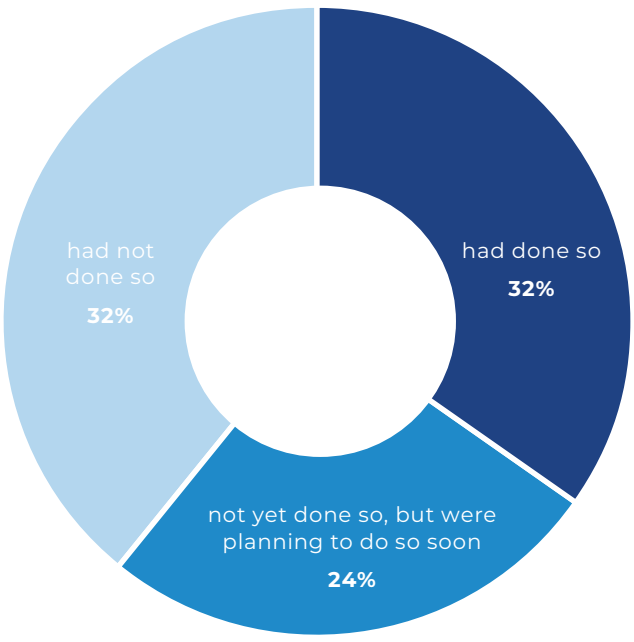
In a moment in U.S. healthcare in which everyone is at least talking about artificial intelligence (AI), adoption of AI technologies is growing—if more gradually than some might have expected. We asked our readers whether they had made significant progress in their adoption of AI technologies; 32 percent said they had done so; 24 percent said they had not yet done so, but were planning to do so soon; 36 percent said they had not done so.

Per that, Liam Bouchier, managing director, data and AI practice, at Impact Advisors, noted that, "From November 2022 when ChatGPT was introduced and became the fastest-growing technology adoption in history, there's been a significant investment in generative AI in all industries, including HC. And AI isn't new. But the generative AI is new, and that's what's different and is driving a lot of the unknowns. And in the past year, we've moved into this experimentation phase where organizations are figuring out what to do with it. And I think a lot of people are looking at the production phase, to prove the concept and the value. And that's where you lead to innovation and expand capabilities. And once you get to that second phase of innovation, that's where you really get to growth."

Indeed, Bouchier emphasizes, "We're really just in the first phase of exploration and experimentation. There's a huge potential and there are many use cases. But they haven't been able to scale their work." Not surprisingly, note-starting/message-starting is one of the technologies being most quickly and widely implemented right now. That doesn't surprise Bouchier either, though he notes that "Those are very rudimentary and basic uses. There's more value actually sitting outside the platforms," he stresses.

One leader in trenches whose organization is moving ahead with alacrity is Brian Patterson, M.D., physician administrative director for clinical AI at UW Health in Madison, Wis. Dr. Patterson, who continues to practice as an emergency physician, reports that "We're still excited about using LLMs to improve patient care and reduce clinician burden. We're already using AI LLMs to draft responses to patient questions in the chart. We're piloting ambient technology, which has been going well. And we're getting into summarization, which is going to be one of the next big waves, but these documentation reduction tasks—it's clear that LLMs are able to generate a great deal of text. As we develop summarization for clinicians, that represents a big step up in terms of how much trust you need in the tool. If a summarization isn't good even once a while, clinicians will learn not to trust it."

Adoption of AI Technologies



Responding to our survey results, Patterson says that "The key in your survey question was the word 'significant.' I think we're teetering over the edge of inflated expectations, and the pit of disillusionment, before we get to the plane of productivity. And the talk for a few years has been, this is going to change medicine, are you implementing this in clinical care? But a lot more people are adopting these things, but it's not going to magically change things. Improving the lives of the workforce or the outcomes for patients, that's different from just using things."

In the end, Patterson says, "Like a lot of things that are hyped up, it's going to be a little trickier to get clear value propositions—where these things work right out of the box and not, and where organizations are going. When I talk to other colleagues, the shine of newness has worn off. Hopefully, these technologies will be huge value-creators, but it will take a lot of work."

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