MARCH 2026

The Status Quo Has a Cost:

Ten Trends Rewriting the Rules of Healthcare

StatusGo

STRATEGY IN MOTION

Scale, care, and technology are all being redesigned at once. Speed is the differentiator.

▶ BUSINESS TRENDS

The Business of Care

01 Pursuit of Survival

Providers are leveraging M&A and strategic alliances to build the essential capital, data, and geographic reach required for survival.

02 Margin Challenges

Healthcare margins remain severely compressed, driven by a perfect storm of Medicaid contraction, stubborn inflation, supply chain volatility, and escalating labor costs of clinical, operational and technology resources

03 Care without Walls

Traditional acute care model is decentralizing. Fueled by advanced remote monitoring technology & favorable reimbursement tailwinds, health systems are shifting complex, high-acuity care out of the hospital walls and directly into the patient's home

04 ASC Migration

Spurred by evolving reimbursement models and the expansion of approved outpatient codes, providers are proactively migrating high-acuity surgeries (advanced orthopedics, cardiac interventions, and complex spine procedures) to the ambulatory space.

05 Expanded Clinical Trial Access

By deploying technologies to operationalize decentralized trials, health systems are reinventing precise patient matching. This strategic shift seamlessly connects complex patients to nationwide research, drastically shrinking enrollment timelines and expanding access

▶ TECHNOLOGY TRENDS

The Innovation Frontier

06 The Agentic Evolution

AI is ascending the capability ladder from simple chatbots into reasoning, task-oriented agents. Organizations can now deploy these agentic AI systems to execute complex, long-duration, and multi-modal workflows

07 Precision & Digital Twin

The continued rise of digital twins and multimodal models is transforming specialty care, enabling simulation-based decision-making and unprecedented clinical precision

08 Reimagining Workforce

Technology teams confront a dual mandate: aggressively upskilling to integrate AI into their own workflows, while simultaneously managing a wave of non-technical staff rapidly "vibe coding" custom solutions.

09 Zero-Trust Security

Threat landscape has fundamentally shifted as bad actors weaponize AI to expose systemic vulnerabilities and execute breaches at machine speed. Deploying an impenetrable, proactive defense architecture is critical.

10 Infrastructure Optimization

Facing higher compute costs and zero-latency clinical demands, providers are adopting hybrid-by-design architectures, intelligently routing workloads across public cloud, on-premise servers, and the clinical edge

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01. Scale as Survival: The Rise of the National Health Platform

Provider consolidation is accelerating as health systems seek scale to fund digital infrastructure, strengthen negotiating leverage, and compete across larger geographies. The standalone regional system is becoming harder to sustain.

WHAT'S DRIVING IT

1. **Capital intensity**
   AI, data, and platform investments now exceed what standalone systems can fund alone
2. **Geographic reach**
   Multi-market presence diversifies revenue and reduces single-region exposure
3. **Data at scale**
   Larger patient pools strengthen analytics, AI models, and value-based care execution
4. **Integrated competition**
   Vertically integrated payer-provider platforms are raising the bar on every dimension

RECENT CONSOLIDATION MOVES

Five transactions redefining the competitive map

Risant Health (Kaiser) + Geisinger / Cone Health — Building the National Platform
Mid-Atlantic & Southeast
Acquiring top-tier value-based systems to compete with national payers at scale

Sutter Health + Allina Health — Cross-Market Digital Synergy
West (CA) & Midwest (MN)
Shared digital infrastructure and AI deployment across non-contiguous geographies

Advocate Aurora + Atrium Health — The Megasystem Play
Midwest & Southeast
$27B combination — capital reserves to fund Innovation-First clinical technology

UnityPoint + Presbyterian Healthcare — Geographic Risk Diversification
Midwest (IA) & Southwest (NM)
Insulating against local Medicaid contraction while scaling administrative back-offices

Michigan Medicine + Sparrow Health — Securing the Referral Moat
Midwest (MI)
Academic giant absorbs regional system to create a dedicated quaternary care funnel

Scale is foundational
next-gen tech requires platform capital

Larger = more resilient
absorbs reimbursement & rate volatility

Smaller = more vulnerable
margin compression or loss of independence

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02. Margin Challenges: The Perfect Storm of Structural Pressure

01
Medicaid Contraction

$800B+

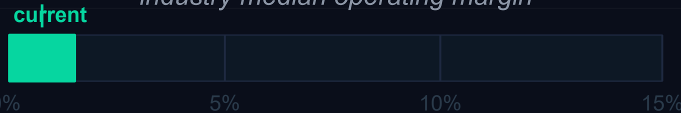
federal reimbursement at risk

Coverage rollbacks from redeterminations and new federal legislation are removing hundreds of billions in Medicaid funding. Safety-net systems and Medicaid-heavy providers face direct revenue reduction with no offsets available

THE PRESSURE POINT

1–2%

industry median operating margin



OPERATING MARGIN vs. REPORTED NET MARGIN · FY 2025

System	Op. Margin	Net Margin	Gap
CommonSpirit	-0.6%	+4.0%	+4.6 pts
Ascension	-1.9%	+3.6%	+5.5 pts
Sutter Health	+2.6%	+9.6%	+7.0 pts
Cleveland Clinic	+5.0%	+12.6%	+7.6 pts

Investment income masking operational reality

02
Labor Cost Escalation

+11.8%

physician investment per FTE, early 2026

Clinical, operational, and technology workforce costs remain elevated even as contract labor has stabilized. Investment per physician FTE rose sharply while productivity declined, compressing the labor cost ratio systemwide

03
Supply Chain and Drug Costs

+6.8%

drug expense growth YOY, 2026

Pharmaceutical costs are the fastest-growing non-labor expense category. Supply chain inflation across devices, implants, and consumables continues to outpace revenue growth, squeezing every dollar of operating income

04
Reimbursement Pressure

<1%

Medicare rate increases vs. cost inflation

Medicare rate updates are running below the true cost of care. Payers are simultaneously intensifying prior authorization scrutiny, downcoding, and denial activity, compressing the realized revenue per patient encounter

Capital Constraint
Thin margins block every AI, infrastructure, and workforce investment that recovery requires

Hidden Fragility
Investment income masks operational losses, the gap between reported and real performance is widening

Existential Risk
Smaller systems without endowments face the operational reality undiluted, threatening independence

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03. Care Without Walls: Hospital Is No Longer the Default Site of Care

HOSPITAL AT HOME

Acute care moves into the home, backed by a five-year policy runway and proven by outcomes at scale

Sep 2030
Waiver expiration

Consolidated Appropriations Act, 2026 (P.L. 119-75) — the longest authorization since the program launched in 2020. Passed the House unanimously. Congress has signaled this model is heading toward permanence.

366
Programs operating today

Across 139 health systems in 37 states, approved to deliver inpatient-equivalent acute care in patients' homes. Coverage now includes 300+ DRG-equivalent conditions — from cardiac monitoring to post-surgical recovery.

44%
Readmission reduction

Marshfield Clinic Health System: 44% fewer readmissions, 35% shorter average stays, 90%+ patient satisfaction. Ochsner Health: 1,000+ bed-days saved in year one by diverting eligible ED patients directly to home.

INFUSION AT HOME

A payer-driven shift, already accelerating across oncology and specialty therapy

30–40%
Lower drug cost outside HOPD

Commercial payers are mandating or incentivizing infusion site-of-care shifts. Health systems that don't build home infusion capability will see that revenue migrate to third-party providers.

0.16%
Home infusion reaction rate

vs. 0.19% in hospital outpatient departments — statistically equivalent. 2025 NHIA study across 39,000+ infusions. Fewer respiratory infections at home. The safety argument against home infusion no longer holds for appropriate patients.

$100B+
The oncology case

Routine supportive infusions at home — iron, IVIG, IV hydration, maintenance biologics — free scarce oncology chair time for CAR-T, high-dose chemotherapy, and clinical trials that can only happen on-site.

SYSTEMS MOVING NOW

Mass General Brigham — H@H
Home Hospital Program

Readmission rates below 7%, comparable to inpatient. Scaling to a permanent care line.

Mayo Clinic — H@H
Medically Home

44% readmission reduction, 35% shorter stays. Expanding to cover cardiology and post-surgical recovery.

Ochsner Health — H@H
Acute Care at Home

1,000+ bed-days saved in year one. ED diversion to home; direct capacity relief, no capital investment.

City of Hope — Infusion
Hope Infusions — Home Extension

9+ outpatient infusion centers. Extending routine supportive infusions to home frees chair time for CAR-T and high-dose protocols.

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04. ASC Migration: Complex Surgery Is Leaving the Hospital

THE CATALYST

560

new procedures added to the ASC Covered Procedures List

CMS CY 2026 Final Rule

Newly approved for ASC settings:

- Cardiac ablation
- Lumbar spinal fusion
- Vascular embolization
- Complex spine procedures
- Pacemaker implantation

CMS is also phasing out the Inpatient-Only list over three years — ending decades of policy that kept complex procedures hospital-bound.

PROCEDURES MIGRATING TO ASC

Cardiovascular

▶ Cardiology's data-driven safety record opened the ASC door — now one of the fastest-growing categories

- Cardiac ablation
- Pacemaker implantation
- Coronary stenting
- Vascular embolization

Spine & Neuro

▶ Lumbar fusion codes added to ASC CPL for 2026 — procedures previously restricted to inpatient settings

- Lumbar spinal fusion
- Cervical disc replacement
- Complex spine decompression
- Pain management

Orthopedics

▶ Most mature migration — TJR has been moving to ASCs for a decade and continues to accelerate

- Total joint replacement
- Rotator cuff repair
- Unicompartmental knee
- Foot & ankle surgery

Urology & GI

▶ Robotics are the key enabler — USPI expanding urology and spine robotics across its 533-center network

- Robotic prostatectomy
- Kidney stone treatment
- Complex colonoscopy
- Advanced endoscopy

WHY IT MATTERS

Physicians follow the procedures

As high-acuity surgeries move to ASCs, specialists gain access to lower-overhead, higher-autonomy environments. Systems that don't build or partner on ASC infrastructure lose not just the procedure volume — they lose the surgeons who perform them. ASC strategy and physician retention strategy are the same strategy.

Orthopedic, cardiac, and spine specialists are most at risk

High-margin revenue is leaving permanently

Tenet's USPI operates 533 ASCs and invested $350M in 2025 to add 35 facilities. Surgery Partners, HCA Surgery Ventures, and private equity platforms are systematically building ASC networks in high-volume markets. Health systems without a competing footprint are ceding their highest-margin surgical lines to operators who move faster.

ASC market valued to grow $29.8B through 2030 — CAGR 6.3%

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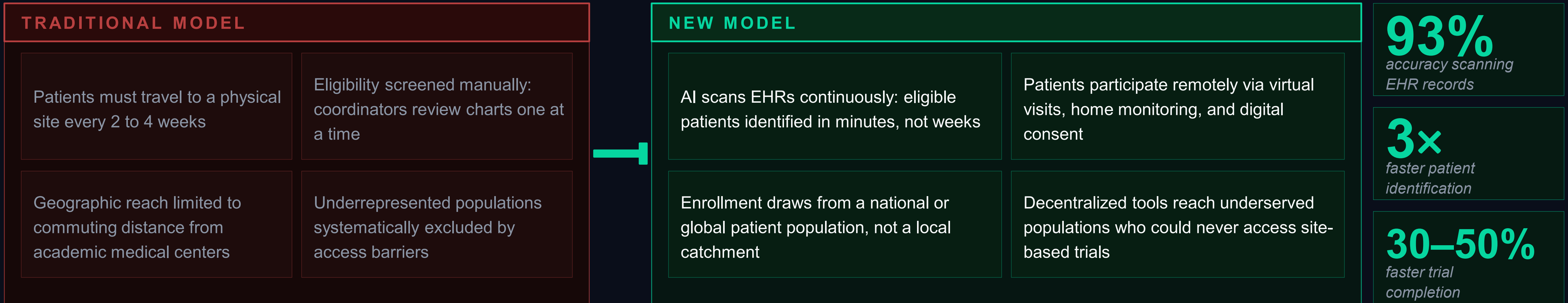
05. Expanded Clinical Trial Access, Built Around the Patient

AI patient matching and decentralized participation tools are transforming trial access from a bottleneck into a competitive advantage for sponsors, for health systems, and for patients who have no other treatment options.



WHY IT MATTERS

Specialists choosing employers based on research access

Academic medical centers building AI matching infrastructure are becoming more attractive employers. Research capability is now a physician recruitment argument, not just an academic one.

Faster enrollment is a revenue line: systems that perform get re-selected

A single Phase III oncology or cardiology trial generates $500K to $2M+ in site revenue, plus indirect cost recovery. Sponsors track time-to-first-patient and time-to-full-enrollment by site, and they re-select the sites that consistently hit timelines. Health systems that deploy AI matching and decentralized tools build a compounding advantage.

For the hardest cases, the system that can offer a trial becomes irreplaceable

The health system that can identify that patient through AI matching and enroll them, regardless of where they live, becomes irreplaceable to that patient, their family, and their referring physician. This is not a research argument. It is a mission argument, a patient loyalty argument, and a referral network argument simultaneously.

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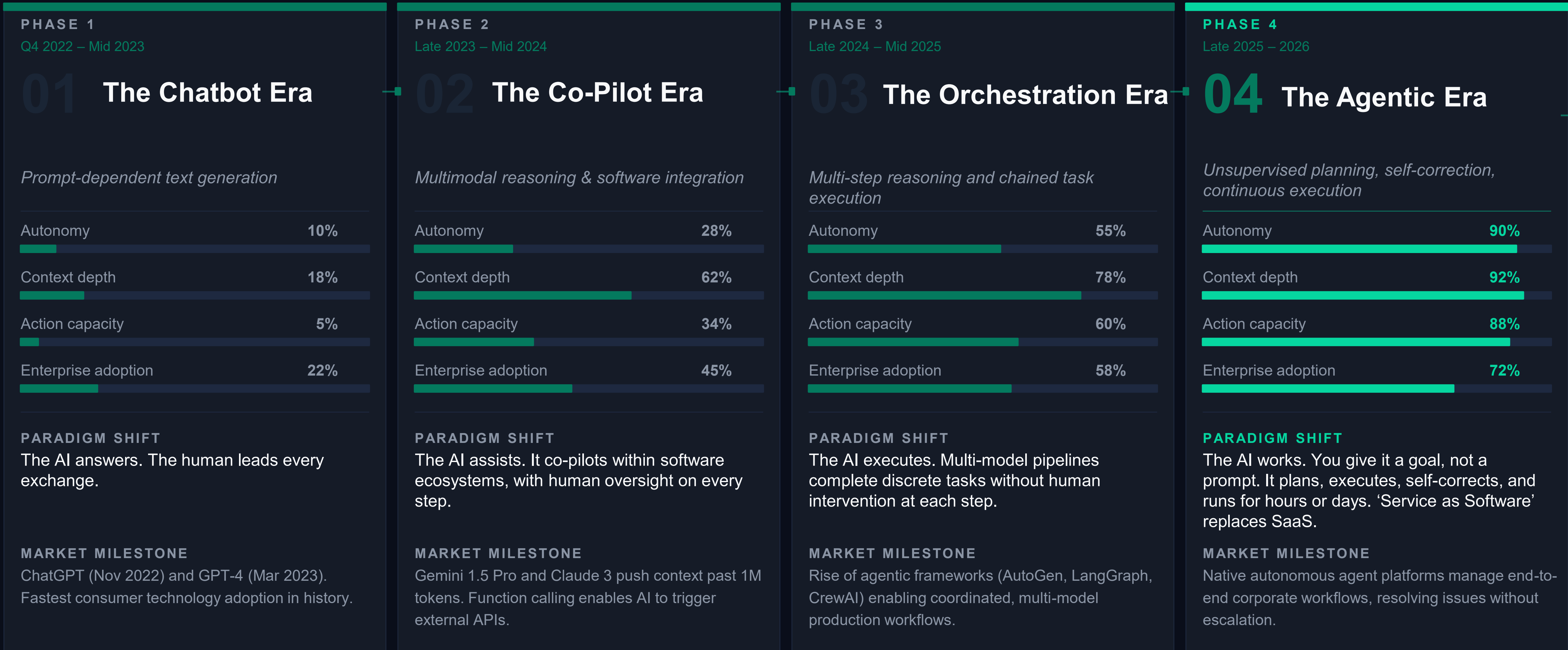
06. Autonomous Execution: The Transition to Agentic AI



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07. Precision and Digital Twin: Moving to Patient-Specific Simulation

As AI enables real-time digital twins of individual patients, the standard of care is shifting from "what works for most" to "what's right for this person“, fundamentally redefining what personalized medicine means.

WHERE IT'S ALREADY WORKING

Cardiology

74–86% *accuracy predicting cardiac resynchronization therapy outcomes*

Digital twin models of cardiac anatomy and electrical activity now guide antiarrhythmic drug selection and device therapy planning. Johns Hopkins is advancing patient-specific digital twin hearts for individualized cardiology decisions. Studies show significantly lower arrhythmia recurrence when treatment is guided by virtual testing vs. standard of care.

Oncology

25% *reduction in hospital readmissions through digital twin monitoring*

Tumor digital twins integrate genomic, imaging, and treatment response data to predict which therapies will work for an individual patient's cancer biology. Siemens Healthineers launched AI-enabled radiology services supporting scenario planning. Virtual drug trials test efficacy across diverse patient profiles without physical enrollment.

Surgical Planning

15% *reduction in postoperative complications through digital twin surgical rehearsal*

Surgeons rehearse procedures on patient-specific anatomical models, anticipate complications, and optimize technique before operating. Digital hearts have transformed ventricular tachycardia ablation by incorporating tissue characteristics into 3D models. Personalized implant sizing and positioning are validated virtually before placement.

Health System Operations

using digital twins to simulate staffing, service distribution, and care delivery across hospital networks

Digital twins extend beyond individual patients to model entire care delivery systems. Predictive patient flow, equipment utilization, and staffing requirements reduce operational inefficiency. Organizations that build this modeling capability gain a material advantage in capacity planning, capital allocation, and network optimization.

WHY IT MATTERS

Precision becomes a clinical quality differentiator

Health systems that can offer simulation-guided treatment planning for complex cardiology, oncology, and surgical cases attract the patients and specialists that drive disproportionate revenue and reputation.

Data infrastructure built today sets the ceiling for precision tomorrow

Digital twins require seamless integration of imaging, genomic, physiologic, and longitudinal EHR data. Organizations that have not invested in interoperable data architecture will not be able to deploy patient-specific models when the technology reaches mainstream clinical use.

The competitive moat is infrastructure, not software

Digital twin platforms (Siemens, GE, Philips, emerging startups) are commoditizing. The differentiator will be the quality and depth of the underlying patient data each system has accumulated.

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08. Reimagining Workforce: Every Role Is Being Rewritten

Technology teams face a dual mandate: aggressively upskilling to integrate AI into their own workflows, while simultaneously governing a wave of non-technical staff building unsanctioned AI tools. The old model of build-buy-maintain is over.

THE OLD MODEL

Build · Buy · Maintain

CIO
Vendor management, budget, IT strategy

IT Engineering
Build systems, maintain integrations

Analyst
Query databases, generate reports

Clinician
Document care, follow workflows

WHAT'S DRIVING IT

AI democratizes coding
Non-engineers build tools

Shadow AI is here
Ungoverned PHI exposure

Skills gap widening
~70% of CIOs cite it

Roles restructuring
Execution gives way to oversight

THE NEW MODEL

Govern · Prompt · Enable

CDTO
AI strategy, governance framework, board reporting

AI Engineer
Build, evaluate and deploy AI systems safely

AI Governance Lead
Audit shadow AI, enforce policy, manage risk

AI-Enabled Clinician
Review AI outputs, validate recommendations

Role	Old mandate	New mandate	Risk if not addressed
IT / Engineering	Build systems, maintain integrations	**Build + govern AI pipelines**	Shadow AI expands unchecked; PHI exposed in unreviewed tools
Data / Analytics	Query databases, generate reports	**Prompt, validate, and govern AI outputs**	Biased or incorrect AI outputs treated as ground truth
Clinical Informatics	EHR optimization, workflow design	**AI safety review, clinical AI governance**	AI clinical recommendations deployed without safety validation
CIO / CDTO	Vendor management, IT budget	**AI strategy, ethics, board reporting**	No governance framework; regulatory exposure and board liability

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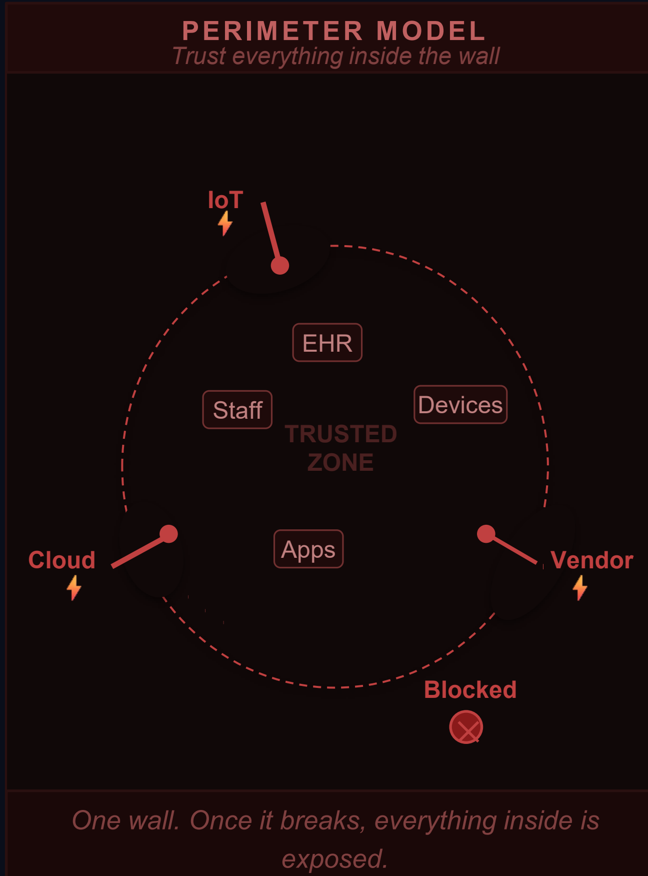
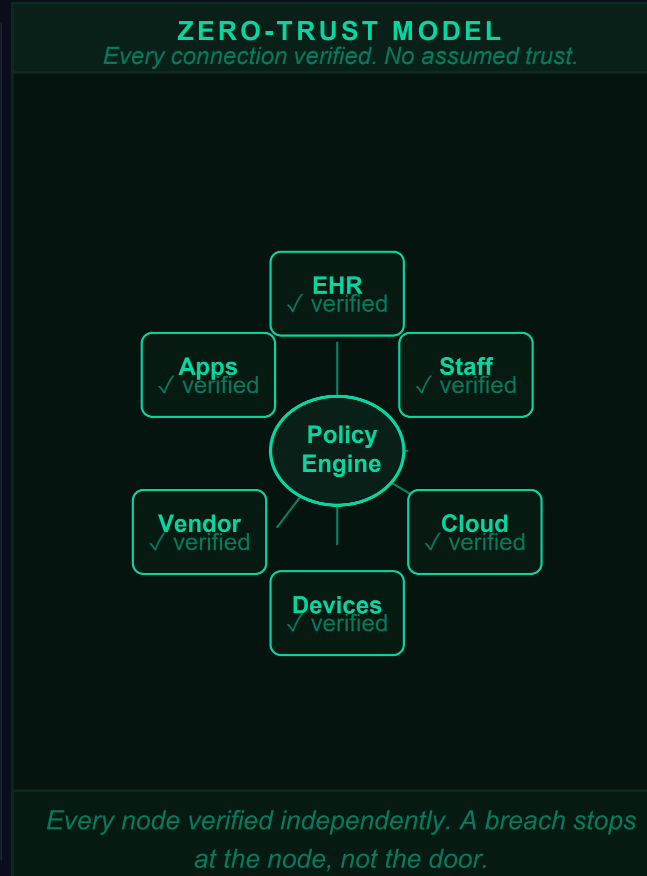
09. Zero-Trust Security: Build for Resilience Before the Breach

Resilience is not a response. It is an architectural decision made years before the breach.

THE REFRAME





WHAT LEADERS MUST DECIDE

Treat cyber resilience as operational infrastructure, not IT spend

Zero-trust architecture, identity management, and immutable backups are not optional security enhancements. They are the prerequisites for staying operational during an attack.

Map and govern your third-party attack surface

Every vendor, clearinghouse, technology partner, and connected device is a potential entry point. The Change Healthcare breach demonstrated that a single upstream vendor can disable care delivery across hundreds of organizations simultaneously. Boards need visibility into third-party risk, not just internal systems.

Prepare for when, not if: continuity planning is the real test

48% of healthcare organizations experienced a security incident requiring dedicated response in the past 12 months. The measure of cyber maturity is not whether an attack was prevented. It is how quickly the organization can maintain clinical operations during an active attack. Tabletop exercises, incident response playbooks, and clinical downtime procedures are board-level obligations.

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10. Infrastructure Optimization: The Architecture Default Is Breaking Down

WHAT'S DRIVING IT

01

AI compute costs are rising fast

3–5× *cost increase running AI workloads on public cloud at scale*

As health systems scale LLM inference, ambient scribing, and predictive analytics, cloud-only architectures face deteriorating unit economics. On-premise GPU infrastructure becomes more cost-effective at sustained AI volume, forcing a build-vs-rent analysis most systems have not yet done.

02

Clinical AI can't tolerate cloud latency

<50ms *required response time for real-time clinical AI at point of care*

Ambient scribes, ICU deterioration alerts, and real-time drug checking require sub-50ms response times. A cloud round-trip takes 80–200ms on a good day. These applications are driving a new infrastructure category: clinical edge compute that sits inside or adjacent to the care environment.

HOW SYSTEMS ARE RESPONDING

PUBLIC CLOUD — *Elastic scale at variable cost — ideal for workloads that burst*

- LLM inference and AI model training
- Population health analytics
- Data archival and backup
- Research and clinical trial platforms

▶ *Systems are expanding cloud use for analytics and AI training — where scale matters more than latency*

ON-PREMISE — *PHI compliance and data gravity anchor sensitive workloads on-site*

- Core EHR and Epic environments
- PHI-sensitive analytics
- Financial and billing systems
- Compliance and audit logging

▶ *On-premise is not going away — it is being optimized for the workloads that cannot leave the building*

CLINICAL EDGE — *Sub-50ms latency requirements make cloud round-trips unsafe for clinical use*

- Ambient AI and clinical scribing
- Real-time patient monitoring
- ICU deterioration alerts
- Point-of-care drug checking

▶ *Clinical edge is the fastest-growing infrastructure layer — driven entirely by real-time AI at the bedside*

WHY IT MATTERS

- **Cloud-Only is Non-Viable:** Legacy EHR constraints and data sovereignty require more than just a cloud connection.
- **The 3x Cost Penalty:** Cloud costs scale linearly; sustained AI workloads are 2–3x more expensive in the cloud than on-premise.
- **Edge is the Requirement:** Zero-latency clinical apps cannot afford cloud round-trips. Edge inference is now a necessity.
- **A Decade-Long Lock-in:** Today's infrastructure choices dictate your cost structure and AI capability for the next 10 years.
- **The Hybrid Advantage:** Leaders are moving toward Hybrid-by-Design to balance cost, compliance, and speed.

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Strategy in Motion

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