A Hospitalogy Report

in collaboration with innovaccer

Autonomous Healthcare is Here: The 2026 Health System Paradigm Shift

The New Strategic and Capital Reality Facing Health Systems

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Table of Contents

Introduction

1

Section Contents

The Automation Era is Here: Adapt or Die

You are running a health system during the most significant technological discontinuity since the internet. Maybe since electricity. The only question that matters is whether you recognize it.

History is littered with executives who didn't understand the urgency to disrupt themselves.

In 1975, Kodak engineer Steve Sasson invented the digital camera. His bosses buried it. They were a film company, after all, and film was a $10B annual business with gorgeous margins. Why cannibalize the golden goose? Twenty years later, digital photography began its inexorable march. By 2012, Kodak filed for bankruptcy. How ironic that the company that invented the killer technology couldn't bring itself to deploy it.

Everyone has heard of the Blockbuster example. Blockbuster had the chance to buy Netflix for $50M in 2000 and laughed Neflix's founders out of the room. Why would anyone want DVDs mailed to their house when they could drive to a store? What a ridiculous business concept.

Of course, Blockbuster is dead today while Netflix is worth $400 billion. They may even buy HBO. What a world!

The newspaper industry watched classifieds migrate to Craigslist and advertising dollars flow to Google. They formed committees. They launched "digital initiatives." They hired consultants. They did everything except change. And now, half of all newspaper jobs have vanished while journalists build their own brands, monetizing their voice and talent. The survivors have consolidated into a handful of national brands – adopting new consumer-forward technological advances – while local news became a shell of itself.

The pattern is always the same. Incumbents see the threat. They intellectually understand the disruption. And yet, inertia holds them back. Humans love routine and they despise true behavior change. Why do you think GLP-1s are so popular? And this effect is exacerbated in healthcare, with large incumbency, regulatory capture, and an oligopoly of firmly entrenched stakeholders with longstanding leaders. We move too slowly, protect legacy revenue too fiercely, and delegate transformation to people three levels removed from actual power. By the time urgency arrives, it's too late. To those still building MOBs, employing physicians, setting committee meetings with bloated administrative teams or optimizing their HOPDs, it's exactly the trap they're in.

Your sense of urgency needed to have started yesterday. You don't have as much time as you think. The AI adoption timeline is compressed from past industrial revolutions as society quickens the pace of innovation. The vinyl-to-streaming transition took 15 years. The shift from CDs to Spotify took five. Tik Tok took a mere four years to overtake Instagram, Snapchat, and YouTube in downloads, and it recently surpassed YouTube in total user minutes per session. Child screen time addiction nightmares aside, the pace of change is alarming. And, I think, healthcare is finally waking up to the technological reality around it. We as an industry are not immune to capitalism and consumerism. But look at how far we've tried to defer its effects. What once required a decade of organizational change now demands 24 months of decisive action. So it's time to lead. Even in an industry where everyone is safe to follow and collect their rent.

And yet: most health systems are still treating generative AI as an administrative efficiency play. A nicer way to draft letters. A faster prior authorization workflow. Summarization tools for clinicians who are already drowning. This is not wrong, but it is insufficient. The real transformation is unlocked, enterprise-wide thinking rather than service line or department optimization. Clinical, operational, strategic cohesion. It's AI co-pilots in the ED. It's predictive models that reshape capacity planning. It's workforce redesign that treats technology as a labor substitute, not just a labor augment. It's rethinking your entire health system structure to emerge from your silos, and unlock true, enterprise-wide strategic thinking, enabled by new AI orchestration platforms and systems of intelligence with the ability to supercharge multidisciplinary teams.

The Automation Era is Here: Adapt or Die

Suddenly, clinical field teams, operators, and corporate finance teams can be on the same page. The great AI unlock is NOT enabling individuals to work at the top of their license. Rather, it is the convergence of incumbent organizations into one, cohesive unit. And the health systems that forge forward boldly and move aggressively will compound advantages. Lower cost structures. Better clinician retention. Superior patient experience. Faster iteration cycles. The laggards will watch their best people leave for organizations that don't make them fight the technology every day. They will see their margins erode as payors and competitors adopt tools they couldn't muster the courage to deploy.

This is Darwinian selection dressed in digital clothing.

"How did you go bankrupt?" Bill asked.

"Two ways," Mike said. "Gradually and then suddenly." *– Ernest Hemingway, 'The Sun Also Rises'*

This new paradigm shift won't play out overnight. Behavior change is required for true business model transformation. And behavior change requires bold leadership, which unfortunately there is an alarming dearth of in healthcare.

Here's the thing about inflection points: they reward the bold. Kodak's failure was not inevitable. Blockbuster could have pivoted. Newspapers could have owned the digital transition instead of ceding it to platform companies.

The technology wasn't the problem. Leadership was.

You have the opportunity others have squandered. Do not sit idle, waiting to be disrupted or die by slow market share attrition. AI is not a threat to health systems that embrace it. It is the single greatest tool for consumerism and growth, cost transformation, quality improvement, and workforce sustainability this industry has ever seen. The organizations that treat this moment with the seriousness it deserves will not just survive. They will define the next era of American healthcare.

The Shrike is here, and his name is artificial intelligence.

(For my non-sci-fi fans, this is a Hyperion reference. Great series.)

The Automation Era is Here: Adapt or Die

Don't be the next Blockbuster. Lead with humility. Apple, Best Buy, and Microsoft all have reinvented themselves over the past decades with shrewd strategy and visionary leadership. It's high time we had that in healthcare.

So with these thoughts in mind, in this report, my goal is to leave hospital leadership and those involved in legitimate health system transformation with unfettered thoughts and valuable intel on the actual current state of things. I've researched and chatted with leading health systems across the country to draw in examples of meaningful health system transformation, how you should be thinking about AI, the current state of the healthcare industry as it sits today, margin expansion opportunities, where you stack up financially and strategically against your large nonprofit peers (below), and what to expect in 2026.

Let's dive in.

(Some of these logos are bigger than others. If I had to cram your health system's logo in, I am sorry. Deal with it.)

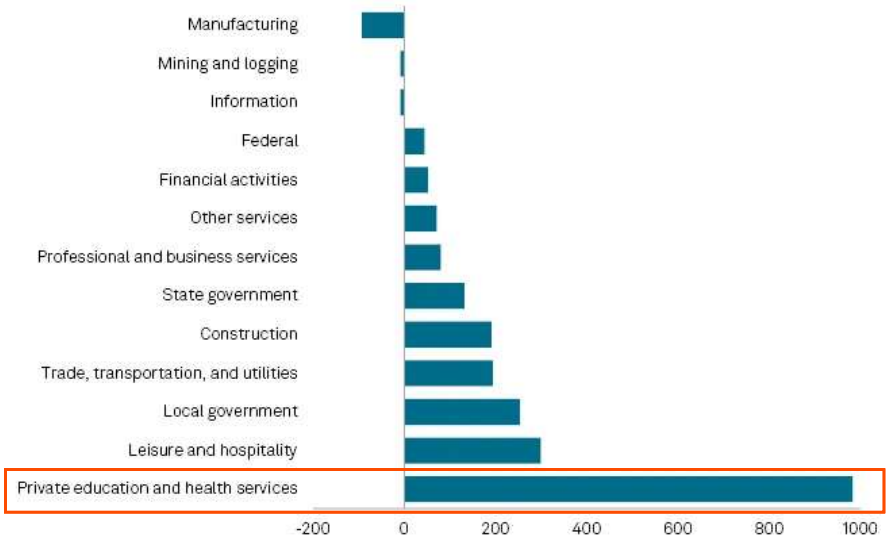
A Challenge to Health Systems: Overcome the Healthcare AI Paradox

Thesis: *AI and technology will not fix healthcare until leaders redesign the work it touches and align culture, technology, and workflows so savings come from substitution, not addition. The path is to target routine administrative volume, remove low value tasks, redeploy people to patient-facing or other productive roles in other industries, and return verified savings to reinvest in needed initiatives, or return to purchasers. Incentives are not enough. Real, true behavior change is needed, and this change trickles down first from leadership and gets infused into organizational culture.*

Healthcare is 2025's blue collar job economy. It's an uncomfortable truth of our industry. The benefits costs employers see to the tune of 8-10% per year nationwide go straight to things like lower and middle management job creation in healthcare…or government (and, of course, the brokers).

Two-thirds of jobs created in 2024 were in healthcare and government

Change in total employment from December 2023 to December 2024 (000s of jobs)



Data accessed Jan. 10, 2025.
Source: US Bureau of Labor Statistics.

Adding to this point, hospitals anchor local economies. Boards and mayors expect and prefer stability and growth. Leaders attend the same fundraisers as their employees. That reality pushes tech adoption toward addition, not substitution. You know what doesn't win over local communities? Headlines that hit KFF or Stat News with items like "hospital makes draconian cuts to staff after placing bets on AI rather than people." Couple this with local political pressures and longstanding mission statements and you have a recipe for stagnation or added costs rather than efficiency and productivity. I know all you health systems care fiercely for your brands. No need to ruffle feathers further.

But when incentives collide, the path of least resistance wins. **And that path is almost always minimal change**. Administrative spend and roles have grown for decades. Some of that growth was the price of complexity. Much of it was duplication, defensive documentation, and a belief that more oversight solves everything. The result is an odd dissonance.

A Challenge to Health Systems: Overcome the Healthcare AI Paradox

The organizations with the most to gain from AI are the least capable of deploying it. Systems drowning in administrative bloat, wage inflation, and margin compression are the same systems whose boards, mayors, and mission statements make meaningful technology substitution politically radioactive.

This paradox is not a technology problem (for once). It's a leadership issue. I've seen the innovation paradox play out even in the past couple of years with the emergence of AI. A health system buys an AI solution. Maybe it's an automated procurement platform for purchasing supplies. Leadership models out the potential impact, sees the ROI opportunity, and is thrilled to announce the initiative at a town hall meeting (could've been an e-mail, by the way). Then, a committee forms (unnecessary). The vendor runs a pilot with the procurement team. But then the human element gets involved. Somewhere in middle management, someone sees the capabilities of the new solution. What was once a full day's worth of work compiling pricing spreadsheets compresses down to 30 minutes. Their job is threatened, and innate feelings of career security stalls any further adoption. This roadblock is the human condition, and I empathize with the outcome. But this culture and behavior is what gets in the way of innovation in healthcare.

A smooth 18 months later, the CFO asks what happened to the promising project. In reality, the ROI never materialized because the flame was snuffed out by the administrative state. Nobody was allowed to change anything, and nobody took responsibility of the problem or felt a compelling incentive to make processes better at their organization when they're collecting a stable paycheck for their family as a middle manager.

This dynamic is all a sequencing failure and a result of toxic conservatism combined with job anxiety. The psychology is simple, even if the politics are not. What if you saw AI do what you do in half the time? You'd feel fear. Revenue cycle staff see ambient AI or CDI automation and know what it means for headcount. Supply chain analysts watch procurement platforms demo real-time cost benchmarking and realize their Rolodex just became a liability. And the consequences are predictable within organizations without real incentive to change or 'disrupt' themselves. ***Suboptimal deployment***. Slow or incremental adoption. "Technical issues" that are human issues in disguise.

The people closest to the work understand the implications faster than the people buying the software. And their rational response is to protect themselves. Now layer on the political reality and local market pressures we talked about earlier. The path of least resistance is almost always minimal change. And so the paradox deepens. The systems that most need productivity gains are the ones least equipped to capture them.

"Leaders set the pace. People sometimes ask to get back to me in a week, and I ask, why not tomorrow or the next day? Start compressing cycle times. We can move so much quicker if we just change the mindset. Once the cadence changes, everybody moves quicker, and new energy and urgency will be everywhere. Good performers crave a culture of energy…Apply pressure. Be impatient. Patience may be a virtue, but in business it can signal a lack of leadership. Nobody wants to swim in glue or struggle to get things done. Some organizations slow things down by design. Change that – ASAP." – *Frank Slootman, former Snowflake CEO and current Chairman*

A Challenge to Health Systems: Overcome the Healthcare AI Paradox

The administrative state keeps growing at these backwards organizations, eating up more costs faster than Joey Chestnut on the 4th of July.

But despite it all, capitalism and the fierce human spirit to make our industry a better place marches on. Our tools keep getting better. And the gap between what is possible and what is permitted widens every quarter, but the organizations who are unafraid find their problems shrinking and their margins expanding.

Other industries solved this.

- Banking deployed ATMs and did not fire every teller overnight. They shifted the workforce toward service and sales, opened more branches for a period, and let the operating model evolve as the channel mix evolved.
- Retail rebuilt around e-commerce not by bolting a shopping cart onto a tired floor plan, but by redesigning fulfillment, inventory, and customer support from scratch.

The common thread is sequencing. Technology delivered value, not just cost, when leaders redesigned process, redefined roles, and realigned incentives simultaneously. Yes, there was attrition. Yes, some banks closed and Sears failed. But the winners did not pretend they could adopt transformative technology while promising nothing would change. Healthcare keeps making that promise. And then wondering why the cost curve never bends.

The way out is not comfortable. It requires leaders to stop keeping every stakeholder equally happy. It requires moving people to work that matters and acknowledging there are some roles the system no longer needs. It requires reinvesting savings in patient-facing capacity or, God forbid, returning dollars to employers so they can reinvest in their own businesses. We are not talking about creating the next depression. We are talking about reskilling, optimizing administrative bloat, building sustainable business models, and ***developing an actual sense of urgency***. The alternative is to keep doing the same thing, knowing the result will be the same, and doing it anyway.

There is a word for that. It is not "prudent." It is not "measured." It is insane.

Key Macro Themes

2

Section Contents

Emergence of the Tech Enabled Health System: The Autonomy Era Begins

The Commoditization of Healthcare Technology: AI is Increasingly Fungible

The AI gold rush is over. The picks-and-shovels phase is ending. What comes next will determine which health systems actually capture value from their AI investments and which ones just rented expensive science projects for three years.

Welcome to the Autonomy Era.

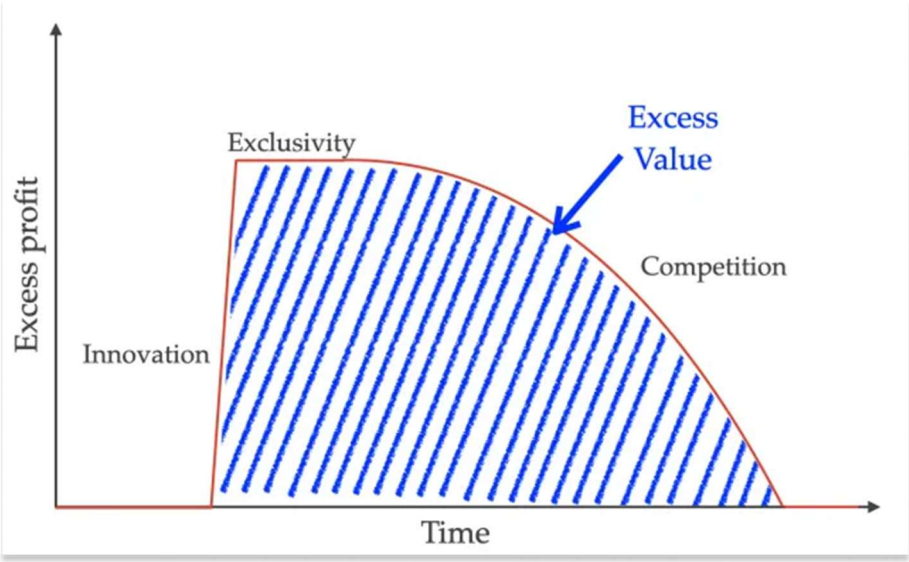
My core thesis is simple, even if the implications are not. **AI is commoditizing**. The models are increasingly fungible. GPT-4, Claude, Gemini, Llama, and a dozen others can all summarize a clinical note, draft a denial appeal, or extract structured data from unstructured text. And the delta between frontier models shrinks every quarter. Your competitive advantage is no longer "we have AI." Everyone has AI. Look at every health tech pitch deck getting shoved across your innovation team's desk. No – the advantage is rapidly moving to ***how you orchestrate AI*** across your enterprise AND how you ***indoctrinate actual behavior change*** around organizational transformation.

Today, most health systems are not orchestrating anything. They are accumulating.

Take stock of what the average system has deployed. Ambient documentation from one vendor. Revenue cycle automation from another. A clinical decision support tool over here, a patient communication platform over there, a predictive analytics suite that IT bought three years ago and nobody fully implemented. Each tool has its own data model, its own integration pattern, its own login, its own support contract, and its own promised ROI that nobody can actually verify because the data lives in silos.

There are even vendors of vendors, managing point solutions on behalf of large enterprises. That's actually psychotic if you think about it.

So as AI commoditizes, you have an unprecedented level of technology and new autonomous capabilities available to you and your organization, and cost will continue to drop as models grow more efficient and venture dollars flood the space, creating hyper competition to serve YOU. Compelling opportunities exist – and will emerge – to materially expand bottom lines, boost patient access, drive better patient experiences, and keep your physicians and workforce happy.



Source: Stratechery

Emergence of the Tech Enabled Health System: The Autonomy Era Begins

The market is shifting beneath these deployments. Healthcare buyers are moving from siloed, best-of-breed point solutions to enterprise orchestration layers that span clinical, operational, and financial workflows. The new architecture is systems of intelligence sitting on top of systems of record. One integration layer. One data fabric. One place where AI agents can access the context they need to actually do useful work across domains.

The implications for vendor selection are profound.

Build versus buy is bifurcating the market along predictable lines. The capitalized, talent-rich organizations (think Kaiser, Mayo, Cleveland Clinic, a handful of large academic medical centers) are building internal AI capabilities. They have the engineering depth, the data infrastructure, and the strategic patience to create proprietary orchestration layers tuned to their specific workflows and competitive positioning.

Everyone else is converging on a small set of enterprise AI partners offering three things: platform breadth, healthcare domain depth, and serious data infrastructure. The market cannot support 400 point solution vendors when five platform players can do 80% of what each of them does.

Vendor consolidation pressure is peaking. Orchestration players and engineer-forward organizations are moving aggressively into healthcare, positioning themselves as the intelligence layer that sits above your EHR. Hyperscalers (Microsoft, Google, AWS) are bundling AI capabilities into their cloud offerings, making standalone AI tools feel redundant. And the EHR incumbents are not standing still.

Which brings us to the EHR.

EHRs CANNOT Be Your Enterprise AI Strategy

Having a single instance of an EHR is now a competitive advantage. Not because any particular EHR is a great AI company (absolutely none are, despite what they may tell you), but because a unified data environment is a prerequisite for enterprise orchestration. If your data is fragmented across three EHRs and a dozen legacy systems, no orchestration layer can save you. You are still fighting data plumbing while your competitors are training models. But here is where health system leaders get comfortable and complacent. Raise your hand if you've heard this line before over coffee or drinks:

"Nobody ever got fired for waiting on (insert your EHR of choice here)."

The phrase echoes in boardrooms and IT steering committees across the country. It is the healthcare version of "nobody ever got fired for choosing IBM for IT" or "nobody ever got fired for picking UnitedHealthcare for health insurance." It is safe. It is defensible. But it is a recipe for mediocrity.

As we speak, EHRs are building AI features as fast as they can. Ambient documentation is coming natively. In-basket management is improving. The AI assist features will get better every release cycle. For many workflows, EHR-native capabilities will be "good enough." But as my father always used to tell me, "don't ever let good enough, be good enough."

Good enough is not a strategy. Good enough is a ceiling.

Emergence of the Tech Enabled Health System: The Autonomy Era Begins

EHRs typically solve for the median. They build features that work across 700 health systems with wildly different workflows, patient populations, and strategic priorities. Their incentive is broad applicability, NOT competitive differentiation for your specific organization.

The health systems that treat EHRs as their primary AI strategy will get exactly what that implies: the same capabilities as everyone else running generic, lagging tech, deployed on someone else's timeline, optimized for the lowest common denominator use cases. You will not be worse than your peers. You will be identical to them.

For some organizations, that is fine. If you are a community hospital with constrained capital and limited IT sophistication, riding EHR roadmaps is a rational choice. You will benefit from the R&D spend of a larger software company without having to fund your own innovation.

But if you are a regional or national system with ambitions beyond survival, relying on your EHR vendor for AI innovation is like relying on your electricity provider for competitive strategy. Epic, Cerner, Meditech, and others are infrastructure. Critical infrastructure. But infrastructure does not differentiate.

The organizations pulling ahead are doing something different. They are treating EHRs as their systems of record and building (or buying) a system of intelligence on top of it. They are partnering with orchestration vendors or building internal teams that can move faster than an EHR's release cycle, solving for pain points acute to their specific operations, and creating proprietary capabilities that competitors cannot replicate easily given the nuance involved for clinical and administrative workflows.

This new paradigm requires investment. It requires talent. It requires executive sponsorship that treats AI as a strategic capability, not an IT procurement decision. It requires accepting that the "safe" choice is no longer safe if it means ceding differentiation to organizations willing to take more risk. And for health systems currently benefiting from status quo, it requires recognizing your own inertia and having a sense of urgency to change without a perceived need.

Ambient documentation vendors should be paying attention. The category that barely existed three years ago is now facing existential pressure from both directions. EHRs are ingraining ambient capabilities into their platforms natively while orchestration platforms (you'll be hearing plenty about these in 2026) are subsuming documentation into broader clinical AI offerings. The standalone ambient company that raised $50M in 2023 is now competing against features, not products. AI is growing increasingly fungible, and health systems ought to take notice.

Some will get acquired. Some will pivot to orchestration themselves. Some will discover that their "moat" was really just a head start, and head starts expire.

Ask yourselves. Amid everything happening in healthcare, where do you want to be in 36 months? Running the same AI capabilities as every other EHR shop, deployed when and where your EHR decides to deploy them? Or operating a differentiated intelligence layer that compounds advantages in cost structure, clinical quality, and operational throughput?

The Autonomy Era rewards systems ready for the orchestration layer. Systems who treat AI as a strategic asset worthy of dedicated investment and executive attention with a culture of collaboration and desire for change. And over the coming years, this new paradigm will disproportionately punish systems that outsource their AI strategy to their EHR vendor and hope for the best. You need to understand TODAY what readiness for autonomy looks like. Hope is not a strategy. Neither is waiting on your EHR.

System Transformation: Assessing Recent Ambulatory Strategies

Ascension's Big Bet with AmSurg: the Dominant Health System Transformation Playbook in 2026

Ascension is the poster child for nonprofit health system transformation, and for good reason. The large nonprofit presented updates to its strategy to a hushed room full of nonprofit leaders with bated breath during the Jefferies Not for Profit Conference in October.

In 2025 Ascension has executed one of the most aggressive portfolio and operating model resets among large nonprofit health systems, shifting from acute-heavy sprawl to an ambulatory-scaled, capital-disciplined platform built for margin recovery and long-term relevance. The last 24 months reflect a deliberate unwind of underperforming assets, paired with a decisive bet on outpatient growth and national scale.

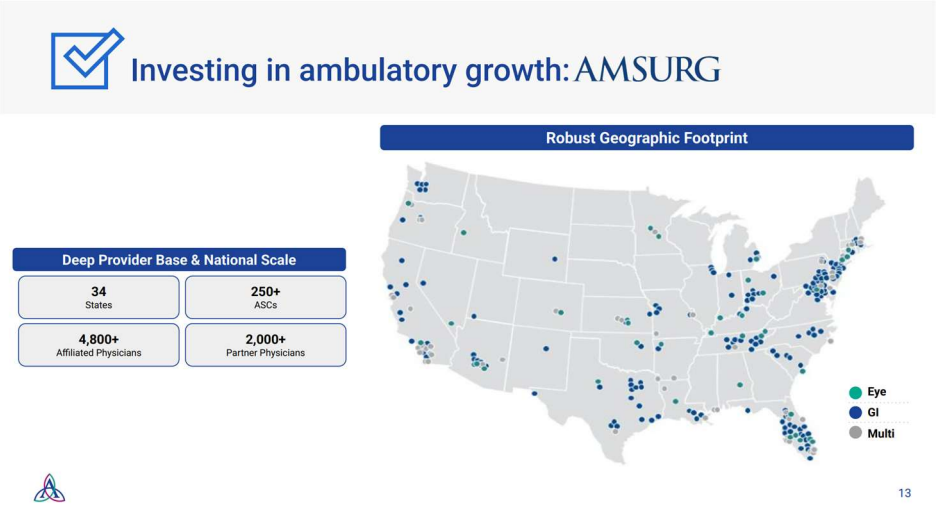
At the core is a financial turnaround mandate. Following a ~$3B operating loss in FY2023, Ascension delivered a ~$2.6B improvement over two years, returning to profitability in FY2025 with ~$900M in net income and materially improved liquidity and leverage. This recovery was driven by labor normalization, expense discipline, rate optimization, and decisive portfolio pruning. Ascension framed this phase as restoring "operational rigor" to re-earn the right to grow.

Growth is now explicitly ambulatory-led. Ascension has reduced hospital count from ~120 to ~95, dropping its revenue base significantly while expanding outpatient density across imaging, rehab, pharmacy, urgent care, and surgery.

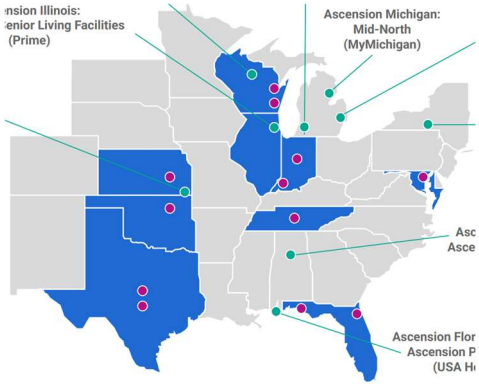
System Transformation: Assessing Recent Ambulatory Strategies

The AmSurg acquisition is the capstone of healthcare services deals and system transformation in 2025. All eyes are on Ascension to see if the nonprofit can complete its so-far successful journey down Tenet's playbook. At ~$3.9B, the deal instantly transforms Ascension into one of the largest ASC owners in the country, adding 250+ centers across 34 states and tripling its surgical footprint. Strategically, this move is less about incremental volume and more about control of site-of-care economics, physician alignment, and market entry optionality. The ASC sits at a convergence point of patient convenience, payor preference, and volume influx as outpatient migration from hospital procedures continues. Therefore, Ascension through AmSurg and its reimagined hospital portfolio is positioning itself for both optimizing core-market density and existing service lines while holding a powerful growth ASC vector with a more asset-light expansion into adjacent geographies.

AmSurg's platform provides three levers Ascension previously lacked at scale: national physician joint-venture infrastructure, predictable outpatient cash flow, and a repeatable growth engine decoupled from hospital capex. Near-term priorities will include funneling low-acuity surgical volume out of hospitals, standardizing perioperative operations, tightening payor strategies around outpatient pricing (i.e., "we're doing you a favor by shifting these out of the hospital so give us the rate"), and layering adjacent services (imaging, ***pharmacy***, infusion, post-acute care).



AmSurg acquisition presents compelling opportunities for density and physician alignment in existing markets while providing attractive, capital light entry points into new markets



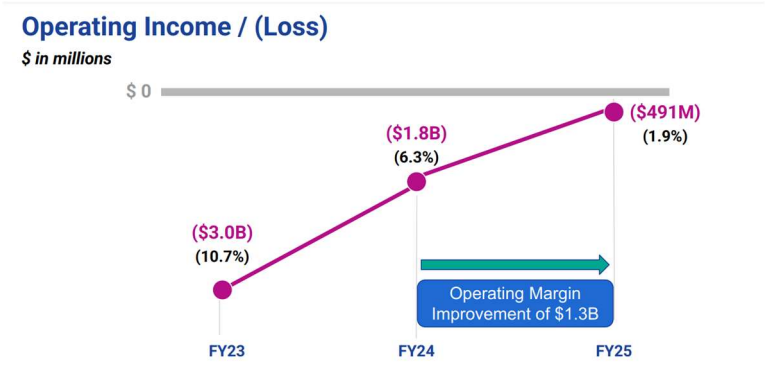
For the sector, what can we learn from Ascension's Grand Plan? Their move and strategic reset signals the maturation of a new nonprofit playbook: ***more thoughtful hospital portfolios, and density where it matters***. A focus on assembling the right subspecialists and associated facilities to maximize for acuity and throughput in the inpatient setting, then a surrounding critical mass, dense network of consumer-oriented ambulatory assets around those hospitals to create smart, local market nodes. ***Fewer*** hospitals, ***more*** ambulatory assets, consumer-friendly digital front door experiences for patient acquisition, and more efficient capital allocation. Ascension is following Tenet's playbook, which will be the dominant health system transformation strategy over the coming years: a focus on high acuity service lines and offering, both on an inpatient and outpatient basis, and which are most insulated from competitive external threats. This puts pressure on peers still anchored to acute-centric models and accelerates the industry-wide arms race for outpatient scale. And it also introduces some uncomfortable strategic decisions, like HOPD conversion or building new ASC management capabilities. Ascension has moved from retrenchment to offense, with ambulatory care as the primary growth vector.

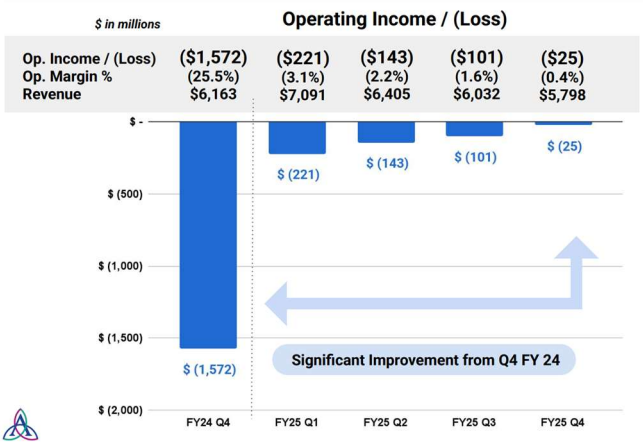
System Transformation: Assessing Recent Ambulatory Strategies

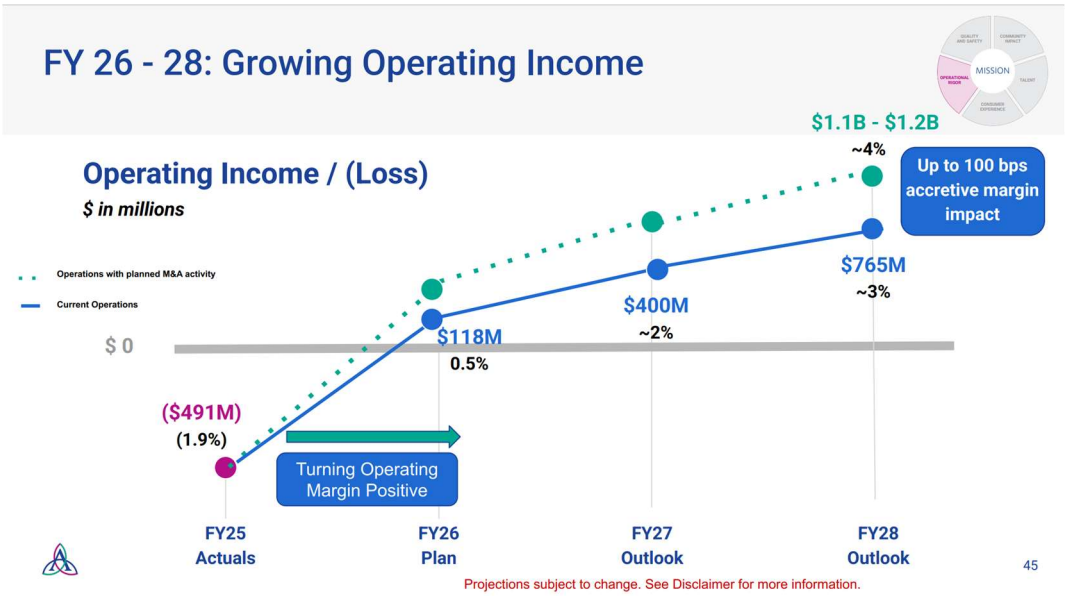
Ascension's Transformation: by the Numbers

In 2025 and now entering 2026, Ascension is bringing hope to nonprofit health system transformation. The nonprofit health system has put on a financially transformative light show for other nonprofit health systems to learn from, like moths to a flame. For one, its operating margin is improving sequentially, and I expect them to breakeven in fiscal 2026 to continue their impressive recovery journey.

This year Ascension's operating income sits just under break even as it steadily right-sizes its operations after M&A and some major portfolio realignment. The turnaround numbers are impressive: through fiscal 2025, Ascension's days cash on hand increased 34 days to 228, operating income improved by $1.3B year over year, and net income improved $2B year over year driven by investment returns. Ascension also significantly de-levered Tenet-style through cash proceeds from divestitures over the past 18 months, dropping its debt to cap to 22%. Better collections resulted in a $1.4B drop in A/R, reducing net days in A/R to 51, from 78 in fiscal 2024.





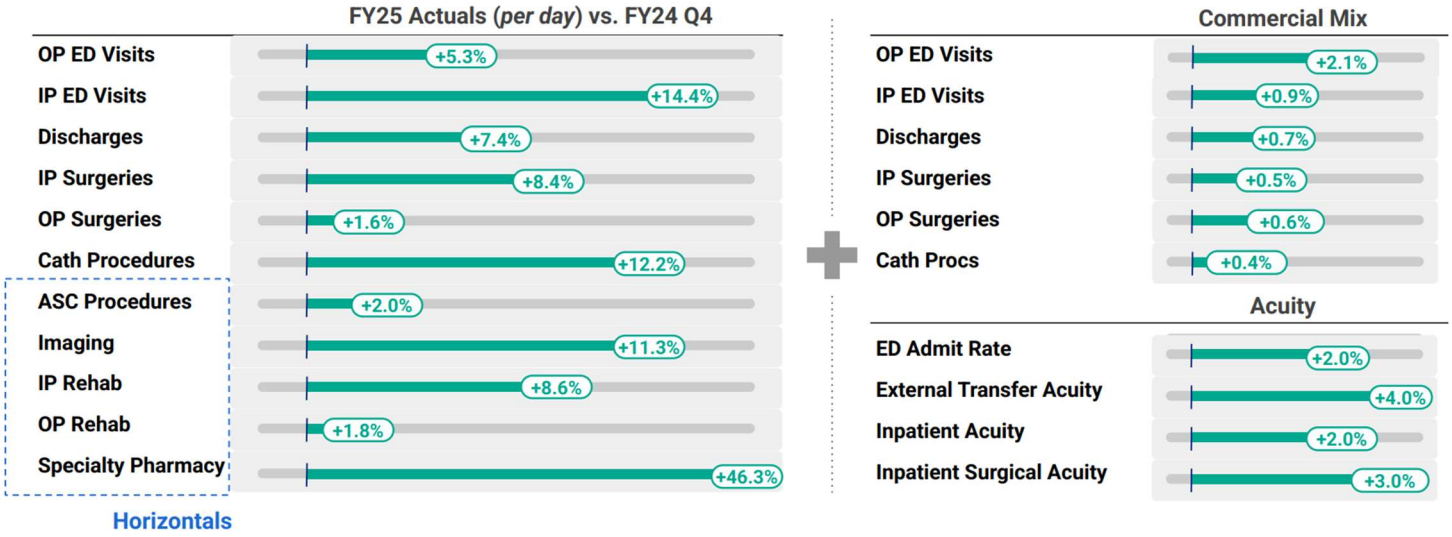


Through Fiscal 2028 Ascension expects to generate $1.1B – $1.2B in operating income on its upside case, while its base case plans to achieve ~$765M in operating income, or 3% operating margin through a mix of portfolio restructuring, service line horizontal expansion, and initiatives including length of stay management, optimized staffing ratios, OR turnover rates, and more.

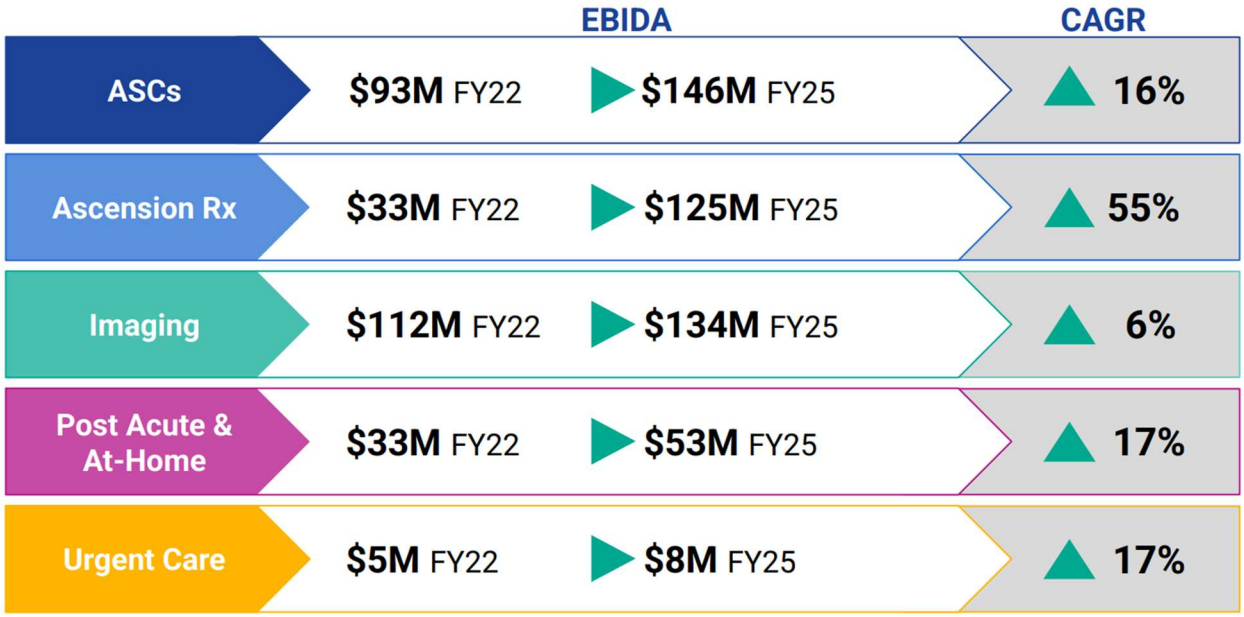
System Transformation: Assessing Recent Ambulatory Strategies

Ascension's Transformation: by the Numbers

Diving into a more granular service line breakdown, given its national footprint and recovery from cyber attacks, Ascension has experience broad-based growth across its key service lines. Maybe one of these service lines sticks out a bit more to you than most – look at that specialty pharmacy spike, and acuity mix is strong:



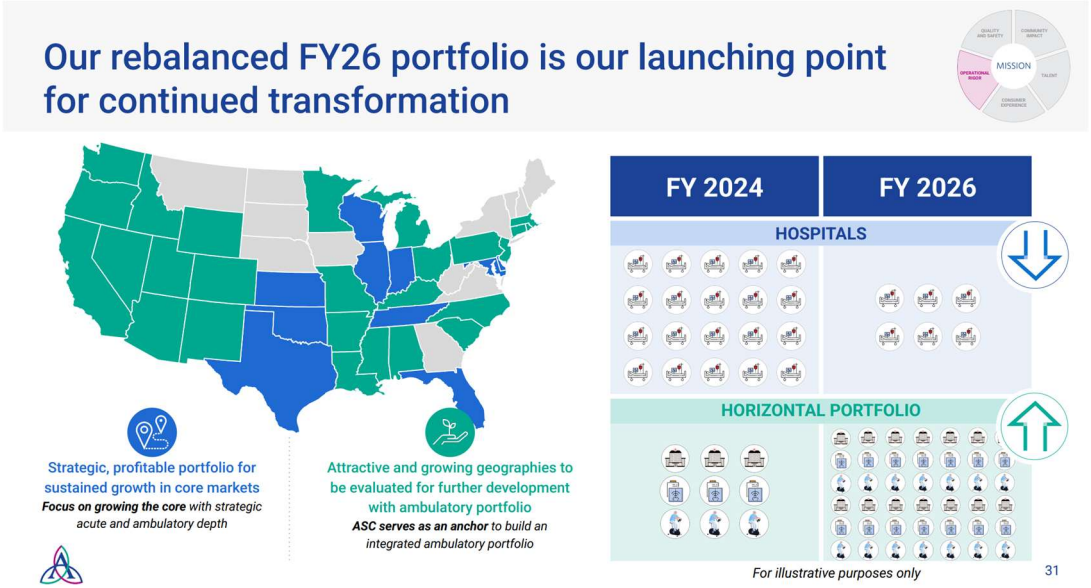
The Ascension Rx growth has led to significant boosts to profitability in the service line, and the pharmacy growth phenomenon is not isolated to Ascension. Many health system 'turnarounds' can be boiled down to simple facts: facts like specialty drug utilization growth and downstream effects on infusion and associated ancillaries.

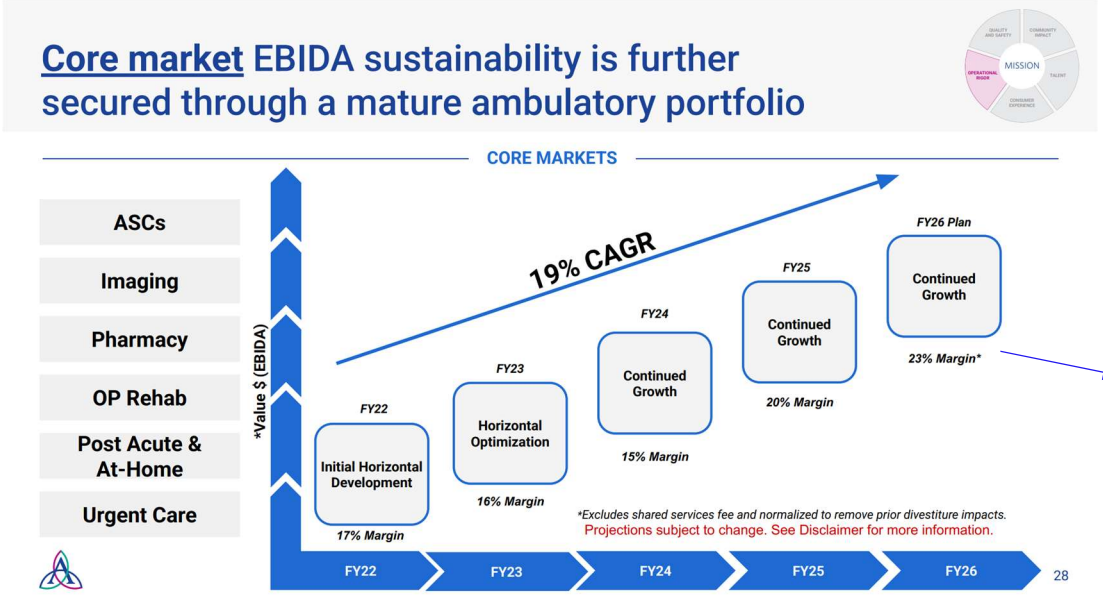


System Transformation: Assessing Recent Ambulatory Strategies

AmSurg as the Launch Point for Ascension's Next Phase of Growth

The cake is baked. But now with a scaled, nationwide platform from coast to coast, Ascension has quite a bit to manage on their plates. From this point forward and with significant de-leveraging and a relatively attractive cost of capital entering 2026, Ascension has the pick of the litter as far as new asset development (de-novo or inorganic M&A) across various markets, building density in more attractive regions in a newly reformed commercial footprint:





Ascension's 3-step framework for transformation is straightforward:

1. Drive efficiency improvements where you can (procurement, patient acquisition, retention efforts, staffing models, vendor consolidation).
2. Reconfigure your portfolio to solve for high acuity subspecialist care to feed the mother ship. Divest non-core and unattractive assets or outsource their functions to key partners.
3. Reposition capital into more efficient, patient-friendly transformative business efforts and M&A targeted at key growth vectors

The health system is targeting 23% EBIDA margins in core, mature markets with scaled ambulatory portfolios in FYE 2026.

Source for all slides: Ascension investor presentation, Jefferies Nonprofit Conference, October 2025

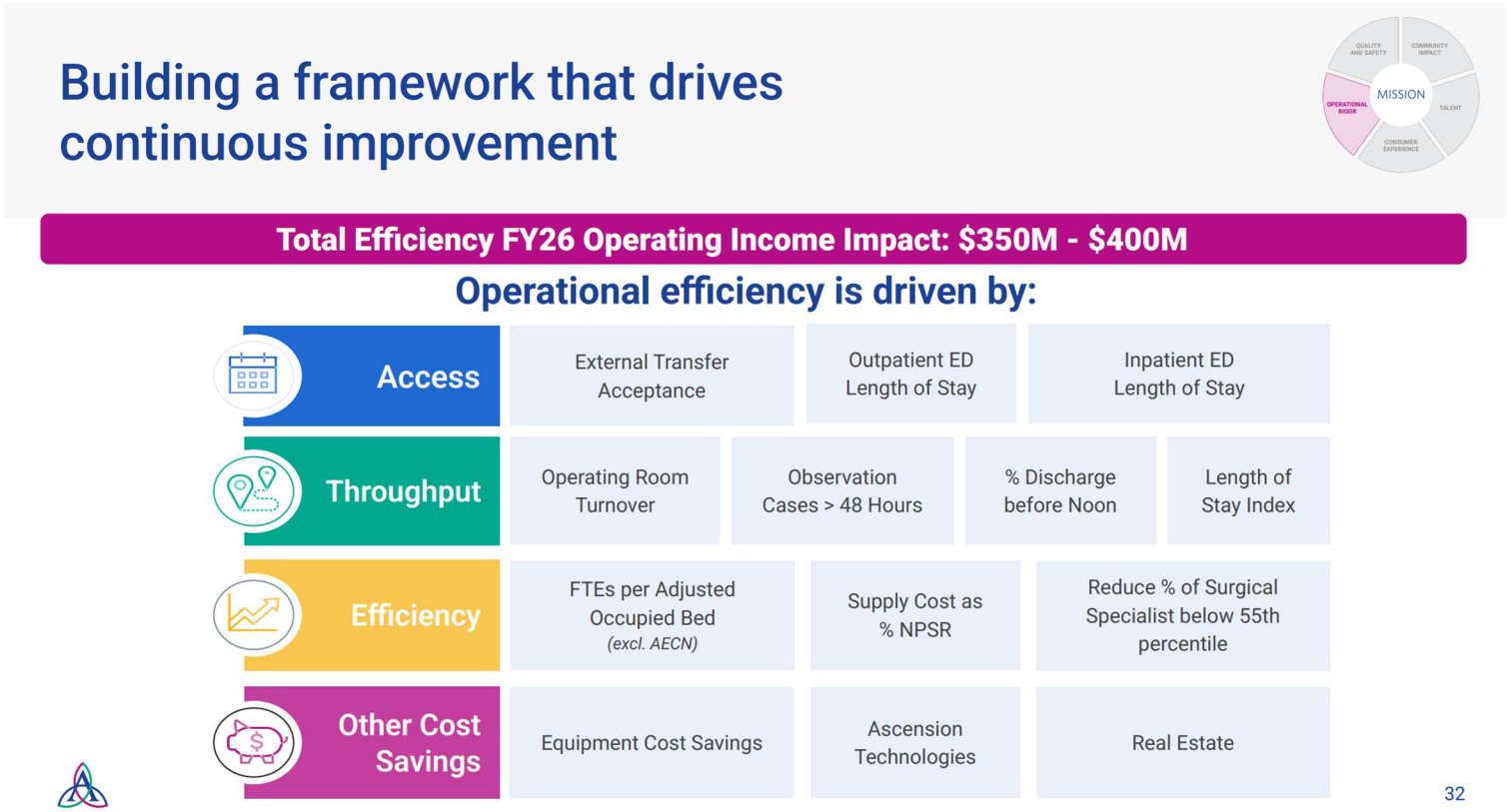
System Transformation: Assessing Recent Ambulatory Strategies

There's one final point I'd like to note about Ascension. The first thing I'd like to say is…give credit where credit is due. Even though the turnaround story isn't yet complete, the building blocks are there to create the nonprofit version of Tenet. They've successfully de-levered their operation and are moving toward investments in high growth, capital light assets.

The other thing that isn't being discussed broadly is the simple fact that Ascension did not change – and had no interest in evolving its operations – until it was facing existential pressure. Until it was forced to.

What Ascension is calling resiliency and growth boils down to something else entirely. Ascension is too big to fail, holds a huge balance sheet and asset base to weather storms, and eventually figured it out.

Too often – perhaps all the time – incumbent players are reactive and resistant to change. The opportunities are already there to revamp your cost structure, maximize throughput, increase efficiencies, and put capital in better places while recognizing and responding to new paradigm shifts. Develop a sense of urgency and move through the inertia that healthcare places all of us so comfortably within. Ascension did, and so can you.



Consumerism is Here. Get Ready.

Healthcare cannot handle a profound lack of consumerism much longer. Gen Z wants instant gratification. Gen Z'ers are now almost 30. Now think about a generation of youths beyond Gen Z who have been raised during the limitless era of on-demand everything. It terrifies me for my 2 year old son. Gone are the days of being bored. Choose whichever show you want. Click on the Spotify song. Doordash anything, and it arrives in 30 minutes. If you don't think healthcare will follow these trends, you're dead wrong. **Consumerism in healthcare is here, and from this point forward, it will only accelerate.**

AI, Consumerism, and the Stratification of Primary Care

The most profound entrance to consumerism is playing out before our eyes in primary care. Everyone's favorite punching bag in healthcare is primary care. PCPs do the most profound, saint-like work in healthcare, and yet they're the lowest physicians on the totem pole in terms of compensation. The appetite to invest in and fix primary care has never declined. But because of the historical economics of primary care, new models are emerging, and the schism is here. **Primary care is fragmenting.**

And the fragmentation is happening along economic fault lines that we insiders are not talking about loudly enough. The unified model of primary care, where a single PCP manages a heterogeneous panel of commercially insured, Medicare, and Medicaid patients with roughly the same service model, is dying. That subsidized model is being replaced with a stratified landscape where care delivery, access, and amenities diverge sharply based on ability to pay. This is not a prediction. It is already happening.

Look at the market segmentation that now exists.

- Medicare Advantage beneficiaries are being siphoned into purpose-built senior primary care clinics (Oak Street, ChenMed) where the unit economics depend on capitation and risk adjustment, not visit volume. They also receive NP-heavy care, the fastest growing job in America, but is also objectively worse care to PCPs.
- Seniors with more disposable income have the highest demand for high touch services, fleeing to concierge medicine and longevity clinics, paying $10K-$30K annually for 24/7 access, 60-minute appointments, and proactive health optimization.
- Aging men and women raised on "Outlive" by Peter Attia are increasingly interested in hormone replacement therapy, and other anti-aging regiments. They seek out direct primary care, or concierge care for more direct access to practitioners and care on their terms.
- The commercially insured middle class gets whatever is left of traditional primary care: 15-minute appointments, six-week wait times, and an annual physical, with urgent care and telehealth visits to solve for low acuity illnesses.
- The biohacker class, along with worried well among Gen Z and Millennials are paying for longevity subscriptions left and right, mainstreaming peptides, preventive imaging, DEXA scans, and full-body MRIs that once cost $2,500 and took an hour to administer, but can now be accessed for $500 in 15 minutes.
- Medicaid patients, lost in all of this chaos, get sent to overburdened clinics with razor thin margins.

The classist bifurcation will only stand to get worse as policy like the One Big Beautiful Bill makes its way through healthcare.

Consumerism is Here. Get Ready.

Now add the policy accelerants.

ACA premium subsidies are on the chopping block. If they expire (which appear highly likely), relatively well-off individuals currently buying subsidized exchange plans will face a choice: pay absurd premiums for insurance that quite literally does not cover anything, that comes with narrow networks and $8,000 deductibles, or…take a chance on catastrophe and self-fund the preventive components. Many will choose Door B, which leads to…shopping for primary care ***as a consumer***.

Adding to this dynamic, Congress keeps expanding tax-advantaged health spending accounts. Tax-advantaged employer benefits like dependent care accounts (a type of FSA) contribution ceilings are rising – from $5,000 to $7,500 in 2026 alone. HSA expansion is a perennial talking point with bipartisan appeal. Talk of ICHRA and QSEHRA expansion gained major steam before folding out of OBBBA. Throw in some price transparency, some longevity startups, some wearables and AI-enabled navigators, and all of a sudden, you have a bit of a Petri dish full of the right ingredients to create a cash-pay, consumer centric part of the healthcare industry.

Then, of course, there's the whole MAHA ELEVATE thing, and the small $50 billion earmarked for rural health transformation, the beginnings of which will be distributed by the time this write-up releases.

No matter what, policy direction is clear: push more healthcare costs onto consumers, but give them pre-tax dollars to spend, and do what is possible to increase competition. The new administration is not a fan of payors or PBMs. They've said as much publicly. Behind closed doors is a different thing entirely, but the public and policymaker sentiment can be leveraged to your advantage as the new, parallel cash-pay centric healthcare system emerges.

Healthcare AI's 'Self-Driving Car' Problem

One final note on AI in healthcare. Healthcare AI has inherited the same cognitive bias that has plagued autonomous vehicles for a decade: algorithmic errors are treated as scandals while human errors remain invisible background noise. A radiologist misses a lung nodule, and it is a tragic but accepted feature of medical practice. An AI model misses the same nodule, and it is a Congressional hearing, a class action lawsuit, and a thousand op-eds about the hubris of Silicon Valley (see the recent Prenuvo news). This asymmetry is not rational. But it is real, and oh so human.

The sensationalism slows down technology deployment that could materially improve care. Think about it this way. If an AI diagnostic tool is right 95% of the time and the human baseline is 88%, the AI will still generate more outrage per error because the errors feel different. Algorithmic mistakes are framed as systemic failures, as hubris, as corporations gambling with lives. Human mistakes are framed as inevitable, as the cost of practicing medicine, as "we did our best."

Policymakers and journalists are not equipped to think in population-level statistics. They think in anecdotes. And anecdotes about AI failure are inherently more newsworthy than anecdotes about AI success, because "software works as intended" is not a headline. Our healthcare industry, which is already incredibly risk-averse, sees the reputational downside of AI deployment and rationally concludes that the safest career move is to wait. Let someone else go first. Let someone else take the headline risk.

Meanwhile, the patients who would have benefited from earlier diagnosis, faster triage, more accessible expertise never knows what he or she lost. Their harm is invisible. And invisible harm does not make the front page, nor does it sell sponsorships or subscriptions.

Denials, Prior Auth, and RCM: Downstream Effects of Managed Care Woes

Payors Continue to Bypass Incumbents for Their Own Bottom Lines

National payors continue to develop vertical integration strategies and are building delivery networks that bypass hospitals and employed physicians. CVS announced a $20B technology investment over 10 years and is launching an "AI-native consumer engagement platform" targeting 185 million consumer connections annually. The platform is explicitly designed to act as an 'AI-enabled' sinister consumer-facing utilization management product aimed at directing members away from expensive sites of care. This is the new phase of UM.

Hospital operators must invest aggressively in ambulatory strategy, capturing outpatient volume through employed physicians, ASCs, infusion, and other at-risk ambulatory services before losing it to payor-owned alternatives. Create specialty centers of excellence that demonstrate superior outcomes and total cost of care, making your organization harder, or even impossible, to bypass.

The combined financial pressure from VBC retrenchment, vertical integration, specialty drug margin compression, AI-enabled utilization management, and inadequate government program rates represents the most challenging contracting environment in decades. The gap between 8-11% medical cost trends and 3-8% payor revenue growth must close somewhere. Payors have made clear through investor day presentations and earnings guidance where they intend to find that margin: provider rates, network optimization, and benefit reductions.

While payors retreat from risk-sharing with independent providers, they are simultaneously doubling down on owned delivery assets. Despite recent economic woes and headwinds, and constant sub capitation value resets, there is still undoubtedly long-term enterprise value unlock from owning care delivery assets and verticalizing. Take CenterWell, for instance. Scaled involvement in advanced primary care, PBM, home health, and other ambulatory functions. Humana has noted CenterWell assets produce 2-4x greater enterprise margin potential compared to external care sources, and CVS made a similar (overpriced) bet with Oak Street Health. This enterprise-wide margin differential creates overwhelming financial incentive for continued vertical integration, particularly as the centers mature and the contribution margin yield curve plays out as intended. And as valuations in VBC land have plummeted, scaled players are eyeing significant M&A opportunities to consolidate smaller provider organizations to verticalize further at attractive multiples. The arms race for ambulatory assets – among both payors and health systems – is on in 2026.

The managed care industry is bifurcating between payor-delivery integrated platforms (Humana/CenterWell, UnitedHealth/Optum, CVS/Oak Street) and pure-play insurance models partnering with independent providers. Both models create margin pressure for health systems, but integrated platforms pose existential competitive threats. Whatever dynamic you're dealing with, it benefits your health system to think about your strategy more holistically as an enterprise rather than siloed, disparate service lines to know where your strategic levers lie. Your better capitalized, vertically integrated payor counterparts are already well down this road.

Denials, Prior Auth, and RCM: Downstream Effects of Managed Care Woes

The managed care industry is not experiencing a cyclical correction. It is undergoing a fundamental restructuring that will permanently alter the economics of hospital contracting, the viability of risk-based arrangements, and the competitive landscape for patient access. The combined signals from CVS and Humana investor days, layered onto UnitedHealth's operational challenges and Elevance's Medicaid crisis, reveal an industry facing an unprecedented gap between medical cost trends (8-11%) and revenue growth (3-8%). That compression has to go somewhere. It's going to providers.

The Value-Based Care Retreat: Capitation Economics Needs a Reset

The most consequential development in managed care is the quiet industry admission that value-based care, as currently constructed, needs a major face lift. It's like a balloon fizzling out, slowly losing its air. Very few health systems are discussing value-based care as an attractive place to play entering 2026 unless your local markets force you to play ball. The reality is that value-based care as a whole needs a reset, and recent utilization woes have broken the model. It doesn't work with its current financing mechanisms and structural setup.

Not for payors.

Not for their owned provider assets.

And certainly not for independent health systems not structurally set up to hold or manage capitated risk.

Take CVS for instance. Massive company. Too big to fail, really. CVS recorded a $5.7B goodwill impairment on Oak Street Health, announced clinic closures for 2026, and shifted strategic focus from growth to margin improvement. Management explicitly acknowledged "the world has changed in value-based care." UnitedHealth expects VBC margins under 1% in 2025 and 2026, down from over 5% historically, with Optum Health projecting 10% membership decline in 2026 before returning to growth. The company is retreating to "narrower, more integrated" VBC models with "appropriate managed benefit product and patient base."

The fundamental issue, stated plainly by UnitedHealth leadership, is the rising utilization effect combined with insufficient reimbursement (ability to risk adjust) leading to rampant margin compression. If vertically integrated, financially engineered payor-owned providers with complete data visibility and aligned incentives cannot make capitation economics work under V28 risk adjustment and elevated utilization, where do you think that leaves health systems? Those holding full-risk contracts are operating with a structural disadvantage.

Humana has taken Part D risk back from many provider partners where "the IRA shift cost in a very significant way," essentially unwinding pharmaceutical risk transfer that providers cannot manage under new economics. The pure MA player absorbed 160 basis points of margin pressure from V28 alone in 2025. Clearly value-based care is going through a valuation reckoning and a full-on reset, and for now, it's best to resist full-risk capitation arrangements. Not to say it can't work in pockets. Players like Privia are reintroducing the possibility of capitation in certain populations and markets where density is sufficient. But the broader managed care industry's VBC failures demonstrate that even vertically integrated payors with information asymmetry advantages cannot generate acceptable returns.

Denials, Prior Auth, and RCM: Downstream Effects of Managed Care Woes

Technology Investment and AI Deployment: Benefits Flexibility and CDI

Relative to the rest of the healthcare industry, payors have been a laggard in AI adoption. This is a historical phenomenon that continues to persist. There are many reasons for this dynamic, including cultural conservatism, tech debt, integration complexity and political risk. Nonetheless, it's becoming clear that payors who don't evolve their AI strategy will be at a competitive disadvantage. With obvious pressures ahead, payors will be more open to partnering with emerging AI companies in 2026, particularly those who can help them capture margin in two key areas.

- **Pricing and claims processing**. Providers have rapidly scaled AI-driven documentation and coding tools, coinciding with sharp increases in denials, audits, and average claim values. Coding-related denials alone have grown more than 100% over the last two years, with denied Medicare Advantage claims now averaging roughly $1,000. In response, plans are increasingly focused on modernizing their payment integrity programs, shifting from retrospective "pay-and-chase" models to pre-pay clinical validation, anomaly detection, and automated adjudication designed to counter provider-side AI optimization in real time.
- **Dynamic benefit design**. Competitive pressure – most notably from UnitedHealthcare's Surest product, which has reported double-digit total cost savings and materially lower member out-of-pocket spend – is pushing plans to modernize network and benefit designs rather than rely solely on utilization management to reduce cost. Importantly, the transparency and shop-ability enabled by products like Surest are hallmarks of the ongoing regulatory push for price transparency, and is furthered by recent regulatory actions.

In 2026, expect health plans to feverishly invest in modernizing tech stacks, rethinking how AI can help them sophisticate claims and utilization management, pricing, and benefit / network design. And as the empire strikes back, understand what your levers are and how to adapt to a rapidly changing payor environment – both from a policy and technological standpoint.

CVS committed $20B over 10 years to technology, explicitly building an "AI-native" platform architecture. The consumer engagement platform launching in 2026 is designed to integrate experiences across CVS entities and "participating industry partners," positioning CVS as the care coordinator for 185 million consumer connections. Management noted their mid-teens EPS CAGR outlook "does not reflect earnings contribution from open platform work," suggesting this represents pure upside optionality beyond guided targets. Whether I actually believe CVS can be a consumer company or not remains to be seen.

UnitedHealth expects nearly $1B in AI-driven cost reductions in 2026, deploying automation for "automated, seamless, frictionless claims processing." Read that carefully. Automated claims processing means algorithmic denial rates without human physician reviewer discretion. Prior authorization, concurrent review, and retrospective audit functions will increasingly operate through AI systems optimized for cost reduction. We all probably saw the recent Wall Street Journal article stating UnitedHealth has identified 'over 1,000' use cases in AI.

Humana is generating over $100M in operational savings from "outsourcing consolidation and agentic AI implementation." All major payors are investing in predictive analytics that identify high-risk members earlier, enabling intervention before costly hospitalizations. This is the clinical rationale for upstream investment, but the financial reality is starker: the goal is to reduce hospital admissions and emergency department utilization.

Denials, Prior Auth, and RCM: Downstream Effects of Managed Care Woes

Another dominant theme of 2025 was the unraveling of Medicare Advantage margin assumptions that had driven a decade of vertical integration. UnitedHealth Group suspended financial guidance in May after CEO Andrew Witty's abrupt departure after strategic missteps, an over-indexing on sub-capitated Medicare Advantage arrangements and a faltering in the high-flying vertical integration strategy. The company's stock shed roughly 50% of its value (~$300B market cap decline), sending shockwaves through managed care. This dynamic obviously wasn't an isolated event and has been playing out for several years, amid rising senior Medicare utilization, prevalence of specialty drugs and GLP-1s, star ratings declines, and risk adjustment changes.

Policy Outlook: Structural Headwinds Without Relief

The mood isn't changing on Capitol Hill anytime soon either as ACA subsidies are set to expire and the Big Beautiful Bill slashes healthcare spending elsewhere.

The regulatory environment offers no near-term relief for payors and associated downstream provider economics, and so the push-pull between the two sides will continue. V28 risk adjustment implementation continues compressing MA revenues, with Humana absorbing 160 basis points of margin pressure in 2025 and UnitedHealth facing a $6B headwind. CMS's approach to MA rate-setting has become structurally more conservative. Medicaid faces an acute margin crisis and member disenrollment as automated enrollment shuts off and work requirements are on the horizon. Elevance projects at least 125 basis points of margin decline in 2026 as "rates continue to lag acuity and utilization trends remain elevated." Centene recorded a $6.7B goodwill impairment on its Medicaid segment. The entirety of managed care is going through an existential reset after a decade-plus of thriving in the sun.

When the two largest Medicaid managed care organizations signal unsustainable economics, the downstream impact flows directly to provider rates. Payors facing inadequate state rates will reduce provider reimbursement to preserve their own margins, forcing providers into impossible choices between network participation and financial viability.

Then specialty drug utilization and costs enter the mix. CMS' proposed GLP-1 demonstration for 2026 coverage remains undefined in scope, timing, and funding mechanism. This represents a material wildcard for pharmacy benefit economics and medical cost trends across all lines of business. With subsidies expiring, the ACA faces potential marketplace risk pool disruption, threatening the exit of material Marketplace 'healthy' population membership and creating uncertainty for health systems with significant exchange population exposure. Centene experienced 29% Marketplace membership growth but rebased 2026 rates to reflect "higher projected morbidity" covering 95% of membership. Consequently, the individual market, and therefore a less lucrative but still important part of your commercial payor mix, remains structurally unstable. Health systems with exposure to ACA plans will experience significant payor mix deterioration and an influx of cash-pay or uninsured individuals.

Carefully evaluate which Medicaid plans and product lines cover your costs and exit those that don't. In Commercial contracting, resist multi-year flat rates given 8-11% trend environments. Build trend protection and reopeners into agreements. Assume the policy environment remains hostile to provider economics through 2026 and plan accordingly.

How do you respond to payor woes and the downstream effects of these various factors? Business model flexibility and responding with your own technological capabilities in revenue cycle areas like prior authorization will be key.

Denials, Prior Auth, and RCM: Downstream Effects of Managed Care Woes

As payors push AI deeper into pricing, claims, and utilization management, pressure is shifting to providers and revenue cycle teams. The old human-first, retrospective model is breaking, so systems are rethinking how work gets done.

Revenue cycle complexity has moved upstream: Teams are now focused on completeness and accuracy upfront to prevent rework. Doing it right the first time helps reduce denials, shorten cycle time, and lower cost.

AI Agents for workflow optimization: Organizations are using AI to handle routine cases automatically, only escalating unresolved issues to humans. Staff time is reserved for clinical judgment and complex cases.

Dual focus on cost and revenue: While lowering administrative expenses remains critical, teams are unlocking revenue upside with faster intake, comprehensive documentation, and payor-ready clean claim submissions.

Prior authorization and coding hold the clearest front-end unlock: Prior authorization and coding have become major friction points. Costs compound quickly, especially with errors. Providers are shifting toward completeness, clinical appropriateness, and submissions that succeed at machine speed.

Practical Implementation Strategies

- **Start narrow, then scale**: The most successful organizations are starting with specific, well-defined problems. Picking two to three high-volume workflows, such as prior auth or coding, delivers faster results and creates a foundation to scale.
- **Balance best-of-breed with end-to-end RCM platforms**: Most organizations began with best-of-breed tools. However, the greatest success is seen from investing in unified AI RCM platforms that connect the front, middle, and back end.
- **Treat change management as part of the product**: Leading teams invest in onboarding, communication, and open feedback loops to build trust and ensure staff understand that AI is augmenting their work.

Innovaccer's Approach

Innovaccer has been focused on building solutions to make their customers successful amidst this shift. Their AI RCM platform, Flow, is built as a connected suite across intake, authorizations, coding, and collections.

Flow builds on Innovaccer's foundation and years of experience integrating fragmented systems and working with providers. That experience is reflected in workflows, user experience, and how the system fits into day-to-day operations to drive efficiency and reduce errors.

Denials, Prior Auth, and RCM: Downstream Effects of Managed Care Woes

It's Time to Think About Going Direct as the Parallel Healthcare System Develops

Here's another way to think about mitigating payor woes. Go direct.

Healthcare in 2026 will increasingly operate on parallel rails, and the divergence is intentional as our current healthcare system is losing trust and structurally set up to fail consumers. Given the expected massive influx of uninsured populations (voluntary or not), cash pay is here and presents a compelling market opportunity to do things differently…and correctly. Here's why the time is now for going direct.

The traditional fee-for-service track is getting harder to run. Denial rates have spiked, administrative costs chasing down collections are wasteful and burdensome, and the resources required to negotiate for better reimbursement or jump through payor hoops keeps climbing even as margins compress. And also as discussed, health systems are not really interested whatsoever in current risk-based or value-based care models. Nothing is really working nor is any of it sustainable, which is why a growing cohort of health systems are quietly building direct relationships that bypass the payor intermediary entirely. For instance:

- **Baylor Scott & White** launched Levanto Health, a direct-to-employer primary care and benefits administration platform designed to capture employer relationships without ceding economics to a third-party payor.
- **Henry Ford** partnered with Nomi Health to offer self-insured employers a direct contracting model that cuts administrative overhead and improves price predictability.
- And perhaps most notably, **Northwell Health** inked a deal with the 32BJ Health Fund covering 100,000 union workers in New York City, with projected 20% cost savings in year one driven largely by eliminating the administrative layer between employer and provider.

Health systems with sufficient scale are sick of jumping through hoops and are uniquely positioned to package a complete care product and sell it directly to large employers frustrated by annual premium hikes and opaque carrier economics. And startups like Judi Health are emerging to facilitate this exact model, rethinking employer benefits administration, making it operationally feasible for mid-market employers to bypass traditional carriers. As these enablement layers mature, the direct contracting playbook will extend beyond scaled, self-insured employers with dedicated benefits teams.

Consumerism only serves to accelerate things. Patients with means are increasingly willing to pay cash for access, speed, and experience. Concierge medicine, direct primary care memberships, and self-pay surgical bundles are all growing categories. Health systems that once viewed these as niche offerings are starting to recognize them as margin-accretive business lines that don't require payor contracting headaches.

In 2026, the most operationally sophisticated health systems will formalize dual-track strategies: maintaining payor relationships for broad population coverage while aggressively building direct-to-employer and direct-to-consumer channels that capture better economics and reduce administrative friction, allowing for cash-pay dynamics to flourish, and signaling the beginning of the end for the traditional managed care business model. This bifurcation could lead to complete phase-out of managed care altogether, but that is a pretty existential thought and unlikely to happen any time soon.

Cash pay, and direct contracting will rise in prevalence over the coming years. Rise in chronic disease dictates LTV:CAC that involves longitudinal, long-term disease management relationships that only consumer-focused care can solve for.

Denials, Prior Auth, and RCM: Downstream Effects of Managed Care Woes

As longitudinal patient care becomes the norm, something uncomfortable is happening to the patient-physician relationship. It now has an intermediary. That intermediary is (mostly) free, infinitely patient, available at 2 AM, and does not make anyone feel stupid for asking questions. Trust is migrating to your AI chatbot. And the same patients comparing your portal to ChatGPT are the ones willing to pay $200/month for a doctor who actually picks up.

Health systems are watching this happen from the sidelines. Given the consumer opportunity emerging here, that passivity borders on malpractice. But health systems are also uniquely positioned to win in consumer-forward care. They have the connectivity. The local market brand equity. The downstream specialists, imaging, labs, surgical capacity, and the ability to offer continuity that no DPC startup or longevity clinic can match. This is why disruption efforts need to come from within. Those trying to invoke real change without this infrastructure cannot structurally compete with what a hospital provides.

A system-affiliated concierge practice is not just a doctor who answers the phone. It is a front door to an integrated delivery network with preferential access to the best surgeons, fastest imaging reads, and most coordinated cancer care in the region. No independent concierge doc can replicate that value proposition. But capturing it requires components health systems are historically bad at.

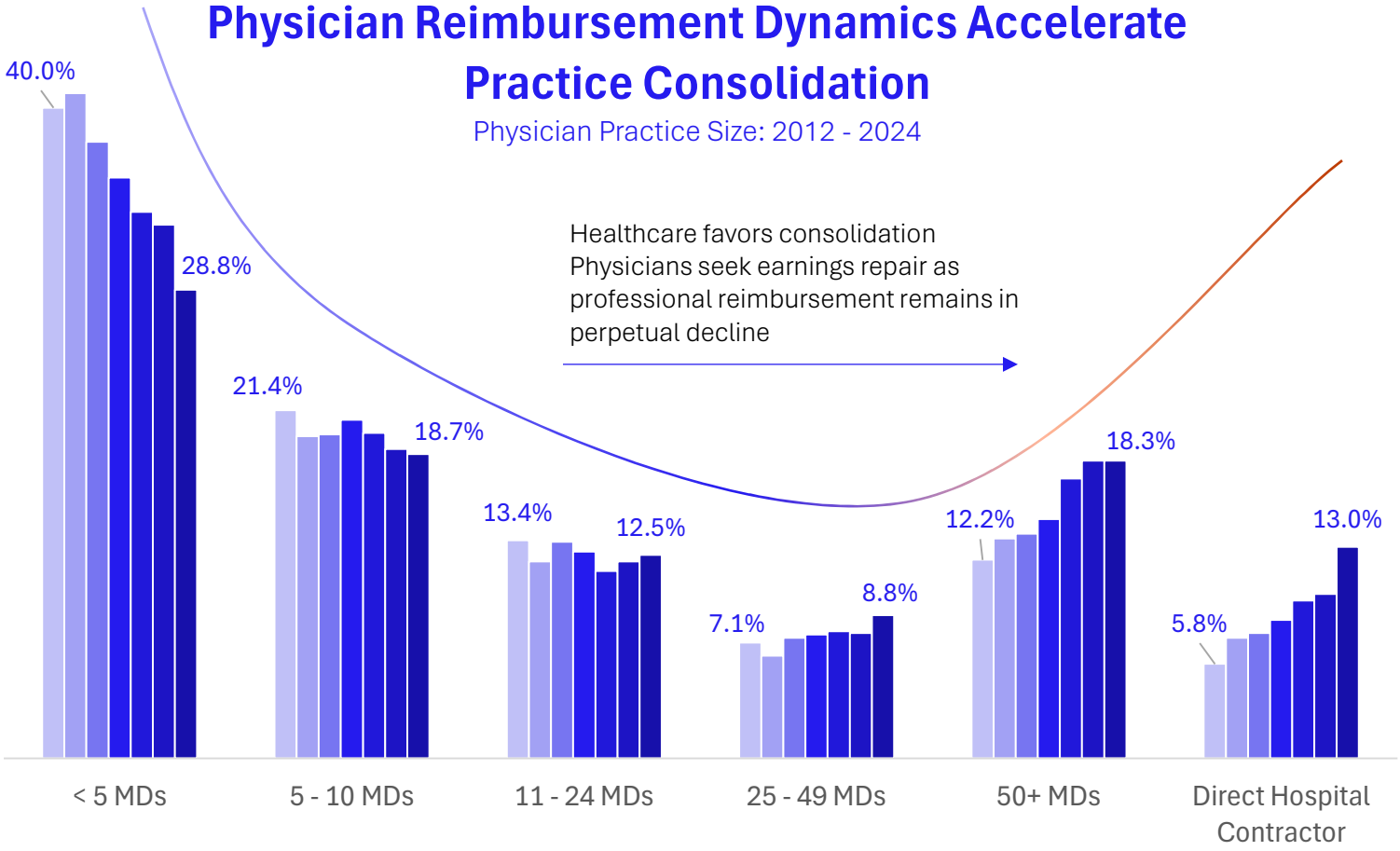
It requires building consumer-grade experiences for patients who now compare you to Amazon, not to the clinic down the street. It requires pricing transparency that makes CFOs uncomfortable. It requires service levels that employed PCPs will view as inequitable. It requires cash-pay functionality that most revenue cycle teams have never touched. And most critically, it requires buy-in from your captive physician workforce. Many employed PCPs will see tiered access models as a betrayal of professional ethics. They became doctors to care for everyone, not to run a two-track system where paying patients get white-glove service and everyone else gets the waiting room. That tension is real. Leaders who pretend it does not exist will find their concierge initiatives sabotaged from within by passive resistance and quiet attrition. But as cash-pay models prove out, competition will increase and prices will fall, leading to greater access over time. The uncomfortable path forward is also the path toward broader availability.

The alternative is worse for hospitals economically. If health systems do not build premium primary care offerings, someone else will, and the longevity startups already are. Private equity is rolling up DPC practices. A dozen imitators are pitching wealthy consumers on a future where traditional primary care is an artifact of a broken system they no longer need to participate in. This is not about abandoning mission. It is about financial sustainability. Margin from cash-pay primary care can subsidize employed physician costs and cross-subsidize access elsewhere in the network. The concierge patient paying $3,000/year helps fund the Medicaid panel that loses money on every visit. That is not a betrayal of mission. That is how mission survives margin pressure.

The unbundling is here. Health systems have structural advantages in consumer care that no DPC startup or longevity clinic can replicate: integrated networks, specialist access, downstream capacity, and local brand equity. The question is not whether premium primary care models will scale, but whether health systems will capture that margin or cede it to competitors who lack the infrastructure but not the ambition.

MD Economics: The Unsustainable Trajectory of Physician Subsidies

Hospitals and health systems employ physicians, and the subsidy model has emerged as the predominant model for physician employment in the hospital setting. Hospitals are the main employers of physicians as seen on the following page. But what hospitals have been woefully ignorant to – until now – is the Physician Fee Schedule.



It is harder than ever to sustain an independent physician practice, and many (especially in primary care) are practically begging to be bought – or saved, rather – by the health systems able to stomach their expanding losses. Reimbursement isn't getting better anytime soon. You need to be rethinking your employment subsidy model.

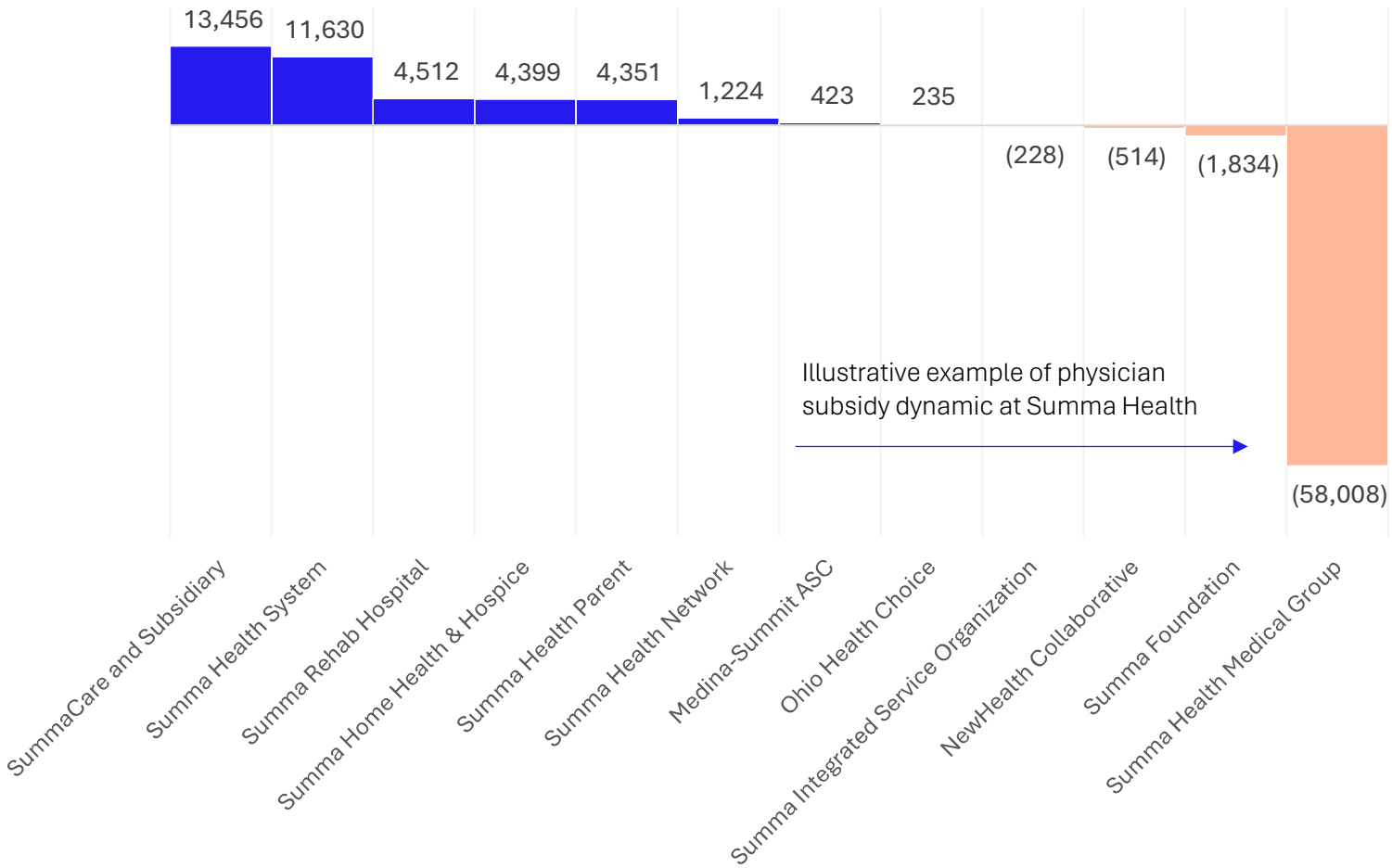
MD Economics: The Unsustainable Trajectory of Physician Subsidies

For years, health system CFOs treated physician employment losses as a tolerable cost of doing business. The downstream economics made it work: employ the surgeon, capture the OR cases, book the inpatient revenue, generate the margin. The subsidy was an investment, not an expense.

That logic is fracturing. And the current model(s) for physician compensation is holding healthcare back given that over half of compensation models incorporate wRVU-based productivity incentives.

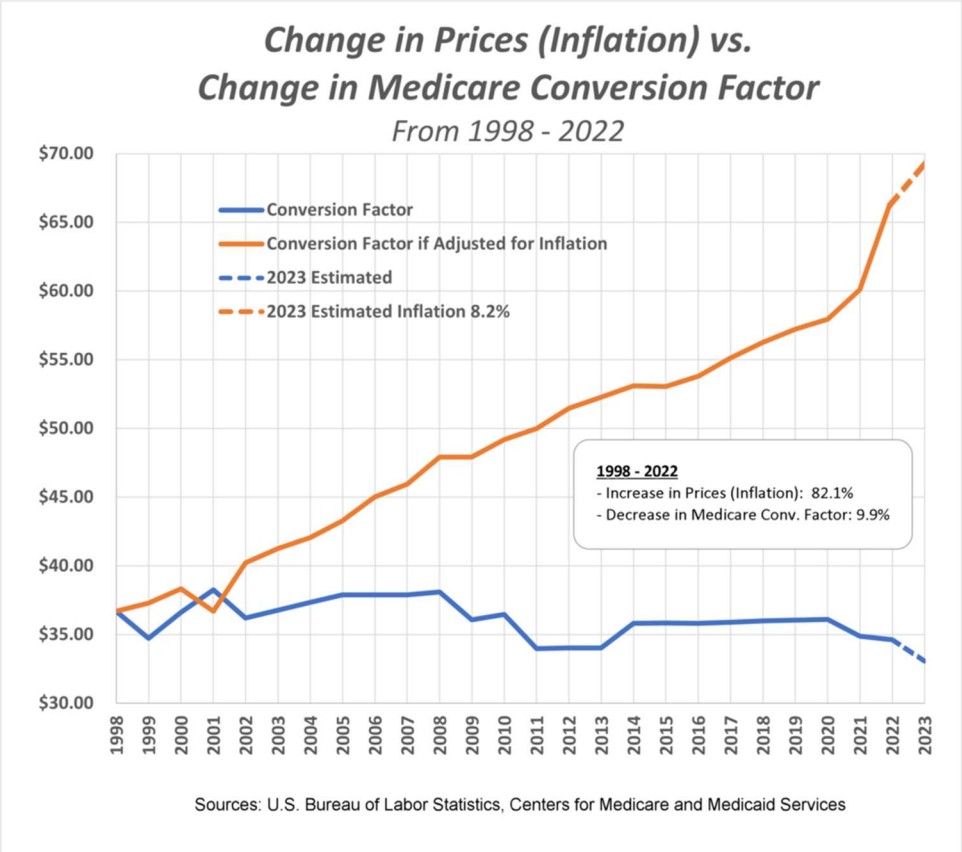
Professional fees for hospitalist coverage, radiologists, anesthesiologists, is one of the largest pressure points on the labor front for health systems entering 2026.

Summa Health Net Income by Subsidiary, YTD ended Q3 2024



MD Economics: The Unsustainable Trajectory of Physician Subsidies

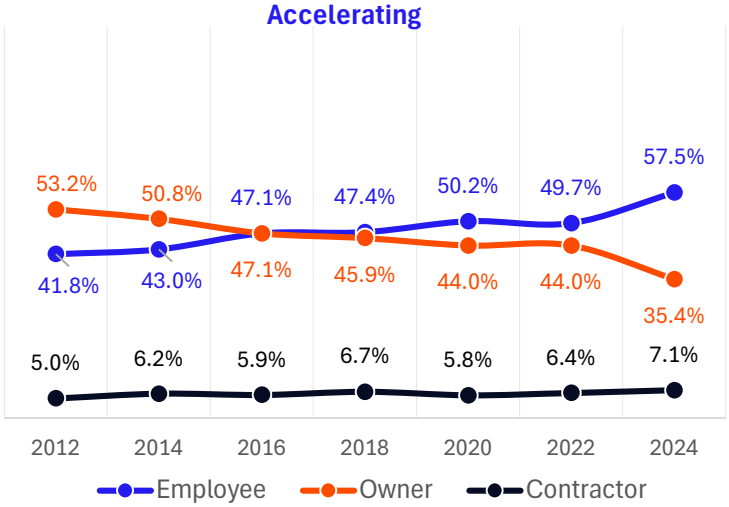
Policymakers are aware of the gap between professional reimbursement and cost inflation



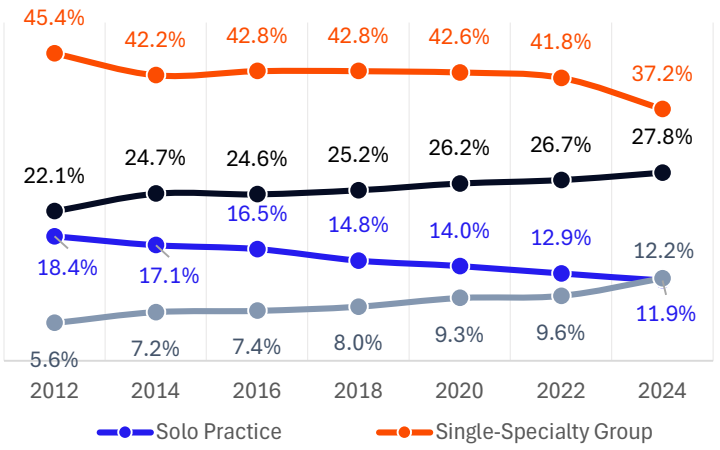
You'll see a chart like this out of the AMA or a consulting group pretty much every year since the dawn of time. Given budgetary statutes, Medicare is required to cut Physician Fee Schedule reimbursement. This 'real earnings loss' effect has been ignored by hospital lobbying efforts in years past. Now, it is likely to receive more attention in the coming years as professional subsidies grow increasingly untenable.

In 2026, Congress enacted a one-time 2.5% increase to professional reimbursement as part of the MPFS – a small band-aid and win for professional practices. Much talk (even presented in the House in 2025) has been made of tying professional reimbursement to the Medicare Economic Index.

Physician Employment is Increasing, and Accelerating



Mom-and-Pop's are Consolidating



MD Economics: The Unsustainable Trajectory of Physician Subsidies

The subsidy per employed physician FTE continues to march upward, but the structural drivers of this trend are not some mysterious black box. Medicare physician payments have declined 29% from 2001 to 2024 when adjusted for practice cost inflation, with another 2.8% cut baked into 2025. Provider compensation per FTE, meanwhile, rose 3% year over year. Revenue is increasing, but physicians are working more while generating less. The gap between what payors reimburse and what the market demands for physician labor is widening, and health systems are absorbing 100% of the delta. Meanwhile, every provider group under the sun – particularly in worse off markets – seems to be begging health systems to acquire them. So in the grand scheme of things, this dynamic is not simply a margin pressure story. This is a business model crisis – a crisis which involves physicians, which you KNOW means it's more than just numbers on a page.

Practice Size	**Private**	**Hospital**	**PE**
< 5 MDs	49.2%	16.1%	12.9%
5 - 10 MDs	19.7%	23.0%	21.9%
11 - 24 MDs	11.6%	16.4%	20.9%
25 - 49 MDs	7.8%	13.3%	11.7%
50+ MDs	11.8%	31.3%	32.6%

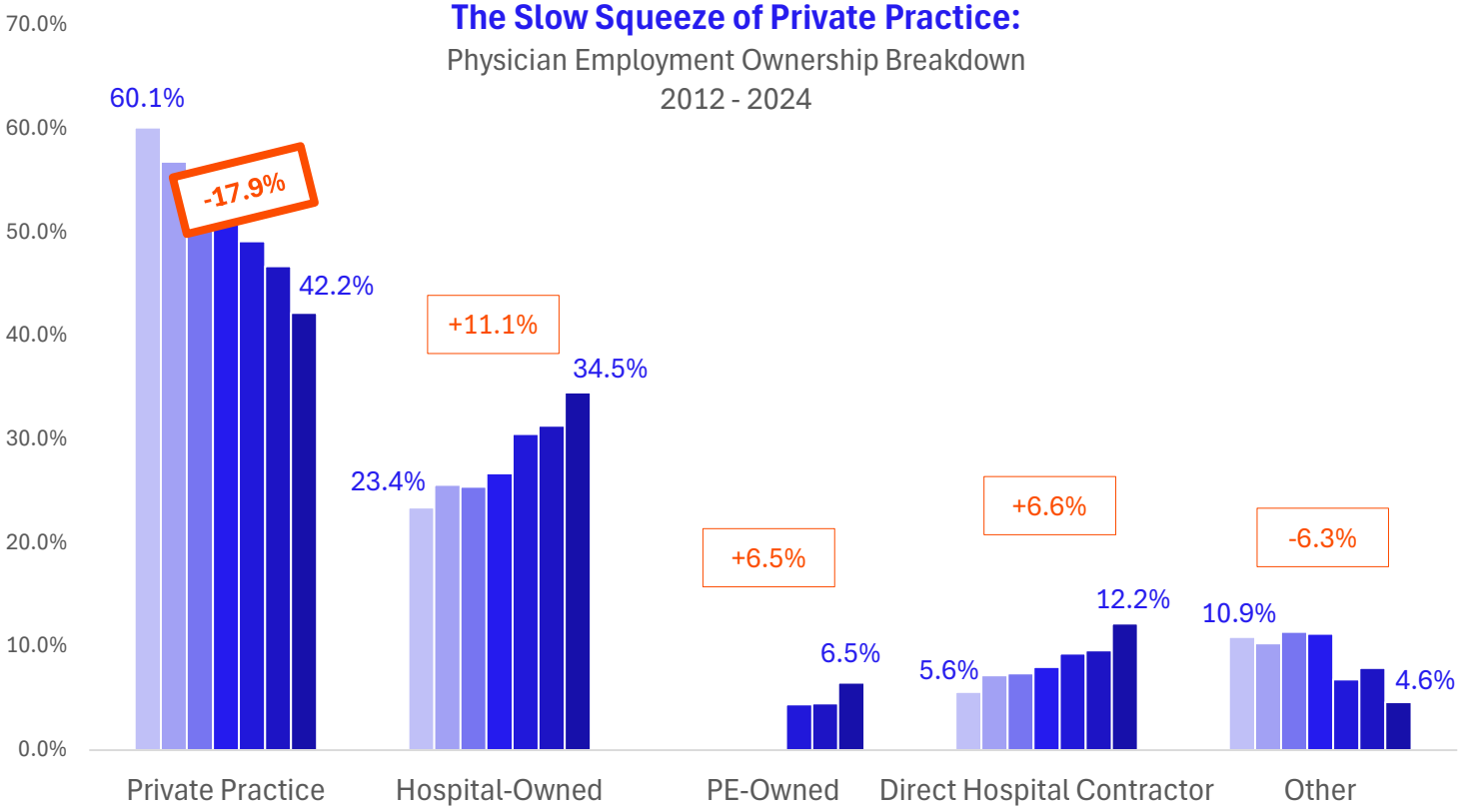
Let's be precise about what "unsustainable" means in this context. It does not mean health systems will stop employing physicians. Mission-driven organizations will continue to subsidize access, particularly in rural and underserved markets. Academic medical centers will continue to employ faculty for research and teaching. Trauma centers will continue to pay trauma surgeons to take call. What is unsustainable is the rate of subsidy growth absent structural intervention.

With expenses rising at roughly 6% annually and revenue increasing at only 3%, the compounding effect is brutal. A $300K per physician subsidy today becomes $350K in five years if nothing changes, and your comp to collections ratio continues to shrink. Multiply that effect across a 500-physician employed network, and the effect exacerbates, with no improvement in downstream capture.

The regulatory overlay adds another layer of risk. Compensation that results in a practice operating loss can still meet fair market value and commercial reasonableness standards under Stark and Anti-Kickback. But higher deficits invite more scrutiny. The civil penalties for violations run into the millions, and qui tam whistleblowers are paying attention.

Health systems are trapped between market forces demanding higher physician compensation, reimbursement trends moving in the opposite direction, and compliance regimes that constrain creative restructuring.

MD Economics: The Unsustainable Trajectory of Physician Subsidies



The Emerging Playbook for Physician Employment

There isn't some magical silver bullet here nor has a 'best' path emerged. But The CFOs and CMOs who are getting ahead of this are deploying a mix of operational and structural interventions, and all of them require sustained execution:

- **APP workforce expansion**: As the most near-term and 'easiest' lever – NPs are the fastest growing job in the nation and comprise over 40% of the physician/clinician workforce, and organizations with higher APP proportions tend to find an easier time outperforming on professional workforce metrics. Still, there are roadblocks. Scope of practice regulations vary by state. Physician resistance to team-based care remains real. Onboarding and supervision require infrastructure. But the health systems that figure out how to deploy APPs at scale, autonomously where regulations allow, will see structural economic improvement.
- **Productivity-Based comp redesign**: Systems are moving toward pay for performance models with quality overlays rather than pure productivity. Some have coined the term 'proxy' wRVUs to assign organizationally 'productive' values to tasks not defined by CMS (unlisted procedures, admin work) – just be careful with Fair Market Value.
- **Alternative alignment models**: medical directorships, quality incentive payments, carve-out arrangements for specific locations or subspecialties. Clinic consolidation, staff ratio optimization, CIN formation

MD Economics: The Unsustainable Trajectory of Physician Subsidies

- **Asking the government for more money**: The AHA seems to have overlooked the Physician Fee Schedule as an area in sore need of being addressed. Never hurts to ask Congress to tie professional payments to the medical economic index inflation basket.

The Physician Employment Sacred Cow has been Sacrificed

Physician Employment Status	2012	2014	2016	2018	2020	2022	2024	CHANGE
Employee	41.8%	43.0%	47.1%	47.4%	50.2%	49.7%	57.5%	15.7%
Owner	53.2%	50.8%	47.1%	45.9%	44.0%	44.0%	35.4%	(17.8%)
Contractor	5.0%	6.2%	5.9%	6.7%	5.8%	6.4%	7.1%	2.1%

Physician Employment Status	2012	2014	2016	2018	2020	2022	2024	CHANGE
Solo Practice	18.4%	17.1%	16.5%	14.8%	14.0%	12.9%	11.9%	(6.5%)
Single-Specialty Group	45.4%	42.2%	42.8%	42.8%	42.6%	41.8%	37.2%	(8.2%)
Multi-Specialty Group	22.1%	24.7%	24.6%	25.2%	26.2%	26.7%	27.8%	5.7%
Hospital Employee/Contractor	5.6%	7.2%	7.4%	8.0%	9.3%	9.6%	12.2%	6.6%
Faculty Practice Plan	2.7%	2.8%	3.1%	3.0%	2.9%	3.5%	3.7%	1.0%
Other	5.8%	5.9%	5.7%	6.2%	5.0%	5.5%	7.2%	1.4%

Here is the scenario that health system boards need to internalize.

Physician subsidies continue to grow at 3-5% annually. Reimbursement remains flat to slightly positive. The result is a Darwinian sorting, and a bifurcation effect for hospitals and health systems you've probably read so much about. Large, well-capitalized systems with diversified payor mix and strong downstream economics continue to subsidize employed networks because they can afford to. Smaller systems, particularly those in rural or Medicaid-heavy markets, face existential choices: divest employed groups, partner with PE or payor-owned entities, close service lines, or accept chronic operating losses that erode balance sheets and bond ratings.

The physician employment model is not dead. But the version of it that assumed unlimited subsidy capacity, guaranteed salaries, and downstream margin that covered all sins? That model is dying.

The systems that adapt, aggressive on APP deployment, disciplined on productivity expectations, creative on alignment structures, financially rigorous on specialty-level economics, will navigate this transition.

The systems that treat physician employment as a sacred cow, immune to the same cost discipline applied to every other part of the enterprise, will not.

Everyone Piles into the Specialty Drug Rocket Ship

Where the margin goes, the money follows. Entering 2026, that margin is entrenched firmly in specialty drugs, and this growth vector will drive capital and investment decision in the coming years.

The specialty drug pipeline is not slowing down. It is accelerating. Oncology, immunology, rare disease, gene therapy, cell therapy, GLP-1s and adjacent metabolic agents. The FDA approved 55 novel drugs in 2024, the majority of them specialty products with six-figure annual price tags. The next five years will bring CAR-T therapies moving earlier in treatment lines, bispecific antibodies replacing chemotherapy, ADCs proliferating across tumor types, and GLP-1s expanding indications into cardiovascular disease, NASH, and kidney protection.

Specialty drugs now account for over 50% of total U.S. drug spend despite representing less than 3% of prescriptions. That ratio is going to get more extreme, not less.

Exhibit 1: Specialty Distributor Sales, by Therapeutic Area, 2020
Inflammatory/gastroenterology represents 12% of distributors' specialty sales

Therapeutic Area	Percent of specialty distributors' sales
Oncology (includes blood, breast, prostate, and lung cancers)	52%
Inflammatory/gastroenterology (including rheumatoid arthritis, Crohn's disease)	12%
Supportive care (e.g., anemia, blood modifiers)	7%
Ophthalmology	6%
Hemophilia, bleeding disorders (includes renal disease)	7%
CNS (includes multiple sclerosis, Alzheimer's)	4%
Cardiovascular (includes pulmonary arterial hypertension)	3%
All other areas	10%
Total	**100%**

Oncology represents 50%+ of specialty distributor sales which makes for a red-hot oncology physician M&A market and strategic buyers willing to pay exorbitant multiples to lock in market share and favorable specialty drug economics. Source: Bank of America

The question is not whether specialty drugs will reshape healthcare economics. The question is who captures the margin and, of course, **who absorbs the cost**.

McKesson, but more recently Cencora and Cardinal Health have spent the past decade building specialty distribution, GPO services, and are piling billions into physician practice management platforms. Recent moves are accelerating and we've seen some huge, splash acquisitions in the specialty drug space, many focused on oncology and oncology-adjacent areas like urology.

- Cencora's $7.4B acquisition of OneOncology AND $4.6B purchase of Retina Consultants of America;
- Cardinal Health's $3.9B acquisition of GI Alliance

These are not defensive plays. These are 20-year customer lock-in strategies and billions upon billions of strategic acquisition capital.

This rollup strategy is the playbook that built Optum's physician empire, except the distributors are running it through the drug channel rather than the payor channel. Different entry point, same endgame: capture the physician, capture the patient, capture the downstream economics – in this case, drugs and associated ancillaries (ASCs, OBLs, data, analytics, back-office support, and clinical research capabilities). And implications for health systems are significant. Community specialty practices that might have been acquisition targets five years ago are now aligning with distributor-backed networks that offer better economics than hospital employment. Competitive market dynamics shift where these players are looking to build density in attractive metropolitans. The competition for specialty physician alignment is no longer just health system versus PE. It is health system versus trillion-dollar distribution conglomerates with long time horizons and patient capital as an alternative to current employment models and retainment of relative independence.

Everyone Piles into the Specialty Drug Rocket Ship

Payors aren't Sitting Still, Either: a Structural Reshaping

Payor vertical integration, PBM activity, and specialty drug cost and utilization dynamics will define healthcare costs for years to come. PBMs, specialty infusion, biosimilars, 340B, will all make or break bottom lines. To that end, payors are making their own investments in the space, playing the utilization management and scale game on the insurance side while capturing value on the downstream care delivery effects of specialty drug spend. For instance, Cigna doubled down on its services strategy with the $3.5B Shields Health Solutions investment, extending Evernorth's specialty pharmacy reach to 80+ health systems and 1,000+ hospitals. The emerging model involves own the high-margin services infrastructure (PBM, specialty pharmacy, care management) while maintaining arm's-length relationships with risk-bearing provider assets.

The obvious defensive play on the risk side is utilization management. GLP-1s are the immediate overnight crisis. Semaglutide and tirzepatide are miracle drugs with miracle demand and miracle price tags. At $12,000-$15,000 per patient per year, even modest utilization rates blow holes in pharmacy budgets. Payors are deploying prior authorization, step therapy, and indication restrictions to manage the tidal wave. Some are carving out GLP-1s into separate benefit structures. Others are negotiating manufacturer rebates that effectively create parallel pricing tiers.

The offensive play is vertical integration into specialty pharmacy and infusion services.

CVS Health's Cordavis biosimilar subsidiary. Cigna's Evernorth and Accredo specialty pharmacy. UnitedHealth's Optum Rx and growing infusion footprint. The payors understand that specialty drug margin lives in the dispensing and administration, not just the benefit management. Owning the infusion center, owning the specialty pharmacy, owning the distribution relationship creates margin capture opportunities that PBM spread pricing alone cannot deliver.

Biosimilars are an area of payor interest and a reason why we're seeing the drug distributor vertical integration play out. Payors are betting that biosimilar adoption will accelerate as more reference products lose exclusivity, and owning biosimilar-focused distribution and dispensing infrastructure will generate returns. Humira biosimilars are the proof of concept. The next wave, Keytruda, Opdivo, Eylea, and eventually the GLP-1s themselves, represents far larger dollar pools.

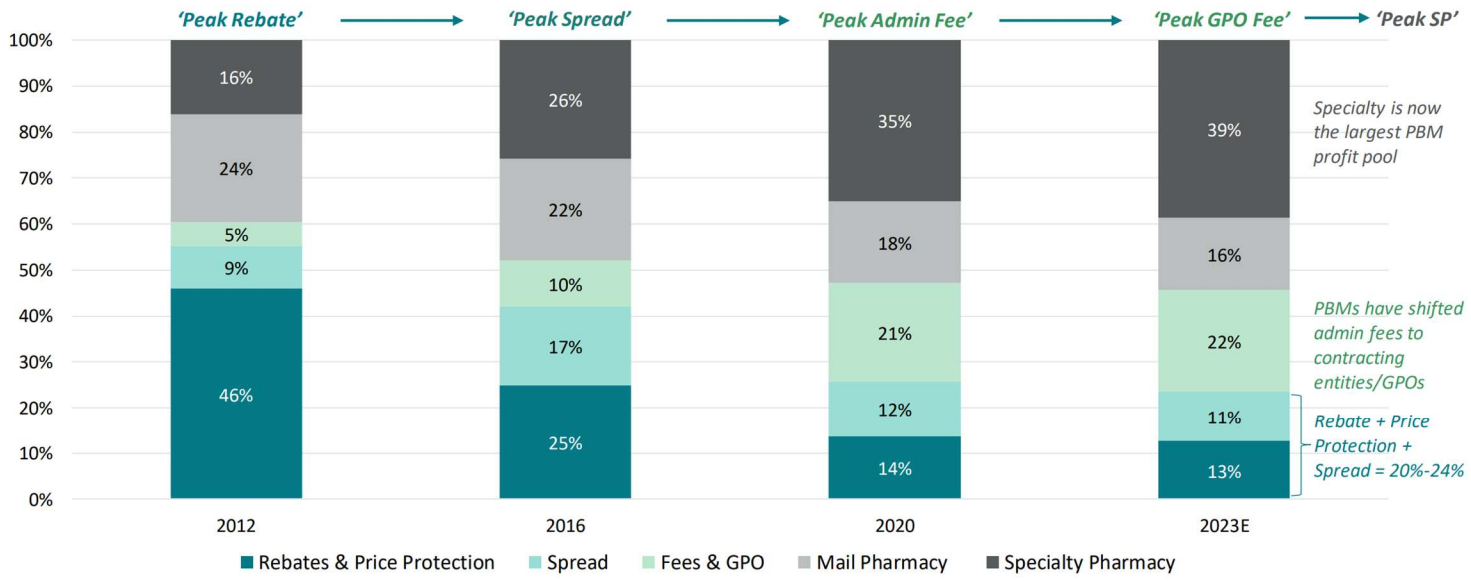
Thematically, payors want to own as much of the premium dollar themselves and they do so by bypassing other players – whether that's in the drug value chain or care delivery. As managed care gets scrutinized in the public eye and perception continues to plummet, the underlying business model doesn't get any easier, either. Health systems with infusion centers and specialty pharmacies should expect continued erosion of referral volume as payors steer toward mail-order and payor-owned specialty channels. Cigna's investment in Shields and Carelon's acquisition of infusion player Paragon signal continued encroachment.

Everyone Piles into the Specialty Drug Rocket Ship

PBMs are Under Fire

More generally, the PBM business model is undergoing its most significant transformation in decades, which holds downstream implications for health system specialty pharmacy operations, 340B economics, and oncology service lines. Facing immense pressure from society at large, PBMS are shifting profits away from rebates into other areas (GPOs) and claiming more transparency with their customers and policymakers. CVS Caremark launched its TrueCost pricing model, claiming first-mover status on drug-level pricing aligned to acquisition costs, pass-through of 99%+ rebates, and "hyper transparent" contracting. Management explicitly stated the model is "built for transparency, durability and stable margins." Cigna announced a complete transition to rebate-free pricing by 2028.

Fig. 1: Source of PBM Gross Profits Over Time: A Shift from Rebates and Spread to Fees and Specialty Pharmacy



Source: Nephron Research PBM Gross Profit Model, August 2023

Employers Wake Up to the Cancer Math

The employer market is where the specialty drug cost crisis becomes most visible. Self-insured employers have always absorbed catastrophic claims. A premature infant in the NICU. A transplant patient. A severe trauma case. These were one-time events, statistically manageable across a large employee population. But interestingly, cancer has changed the math a bit. Oncology drugs have transformed many cancers from acute death sentences ***into chronic diseases***. This is an *amazing* clinical triumph...but an economic cost nightmare. Every month of survival is another month of $15,000-$30,000 drug costs.

Employers are discovering that their highest-cost claimants are no longer unpredictable acute events. They are ***predictable chronic specialty drug utilizers***. A single employee on Keytruda represents $150,000+ per year in pharmacy spend, potentially for five or ten years. Multiply that across a population, and the actuarial assumptions that underpinned self-insured benefit design start to crack.

Everyone Piles into the Specialty Drug Rocket Ship

340B: The Silent Subsidy Engine

No discussion of specialty drug economics is complete without 340B.The 340B Drug Pricing Program was designed to help safety-net providers stretch scarce resources. It has become a multi-billion dollar margin engine that subsidizes hospital operations, funds community health center expansion, and creates economic incentives that distort site-of-care decisions across the specialty drug landscape.

For health systems with significant 340B-eligible patient populations, the program can generate tens or hundreds of millions in annual contribution. Specialty drugs are where 340B economics get interesting. A $10,000 per month oncology drug purchased at 340B pricing for $5,000 and reimbursed at $10,500 generates $5,500 in margin per patient per month. Multiply across an oncology service line, and 340B revenue can exceed the operating margin of the entire service line on a non-340B basis – even help the ***entire health system*** stay in the black. A program wildly out of scope with its intention is now high stakes margin capture particularly during the era of specialty drug growth.

The incentive to maintain 340B eligibility, to direct specialty drug volume to 340B-eligible sites, and to resist site-of-care shifts to non-hospital settings becomes overwhelming. And the regulatory and political pressure on 340B is intensifying. Manufacturers are restricting 340B pricing on drugs dispensed through contract pharmacies. CMS is revisiting hospital outpatient drug reimbursement. Congressional scrutiny is increasing, and lawsuits galore. The program's future is uncertain. But the strategic implication is clear: health systems that have built operating models dependent on 340B margin are exposed to regulatory risk that could materially impact financial performance. And payors and employers who have watched 340B economics inflate site-of-care costs are increasingly aggressive about steering specialty drug volume away from hospital outpatient settings.

Adding another layer to the 340B rabbit hole is looming Medicaid cuts and redeterminations. No longer will individuals get automatically re-enrolled into Medicaid. In general, expect to see a surge in uninsured and cash pay populations as consumers roll off ACA and Medicaid plans. The secondary, unintended effect of Medicaid disenrollment is that certain hospitals may no longer maintain the necessary Medicaid days to qualify for supplemental payments or 340B, which would be massive financial catastrophes for many hospitals reliant on this funding for profitability and cash flow.

What's Next: The Supercharged Specialty Pharmacy Platform

Specialty drug spend will continue to grow at 8-12% annually, outpacing overall healthcare cost growth by 2-3x, creating a dynamic where every stakeholder wants a hand in the honeypot. Drug distributors will deepen vertical integration into physician practice services. Payors will accelerate biosimilar investment and specialty pharmacy ownership, using data and benefit design to steer volume toward owned assets. Utilization management on high-cost drugs will intensify, creating friction with patients, physicians, health systems, payors, and employers.

340B will remain contested. Legislative and regulatory pressure will continue, and the program's long-term trajectory is uncertain. Health systems with material 340B exposure should be planning for multiple scenarios. Oncology and adjacent specialties will remain hot in M&A. The winners will be the organizations that understand specialty drugs as an enterprise-wide ecosystem play, not a pharmacy silo. To that end, look for health systems to enable and strengthen specialty pharmacy capabilities, following in the footsteps of LongitudeRx's partnership with Innovaccer. LongitudeRx will leverage Innovaccer's AI-enabled Gravity platform to accelerate pharmacy operations helping to capture more prescriptions, unify data, automate reimbursement workflows and prior auth, and strengthen 340B compliance.

The question for every healthcare executive is simple: where does your organization sit in the specialty drug value chain, how can you supercharge your pharmacy operation, and what are you leaving on the table?

Health System Trend and Benchmarking Analysis

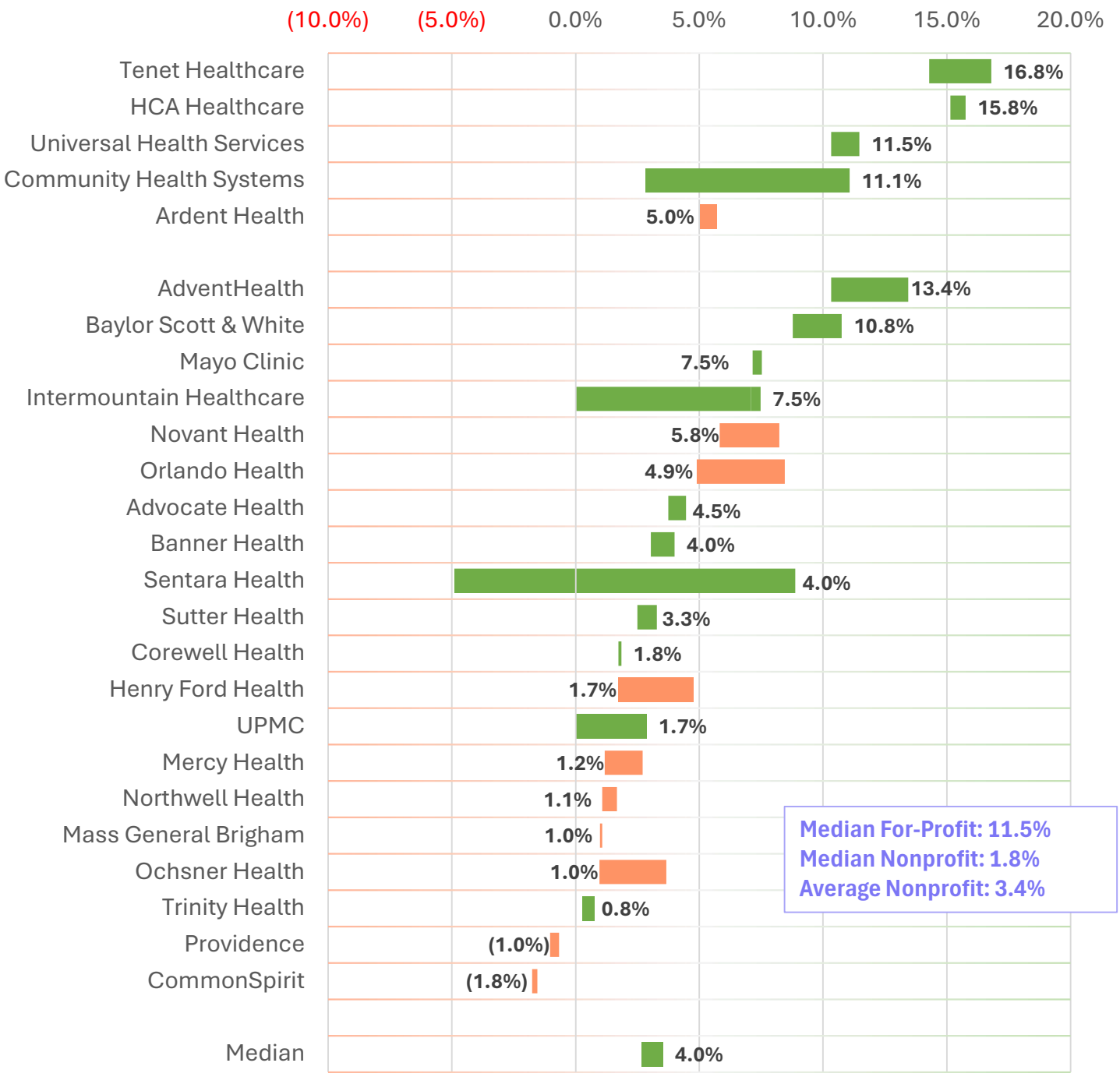
3

Section Contents

Health Systems Saw Broad Margin Recovery in 2025

Change in Total Health System Operating Margin – YTD 2025 vs. 2024

Green = margin improvement YoY | Orange = margin decline YoY | Labels denote YTD operating margin | Sorted by tax status, then operating margin

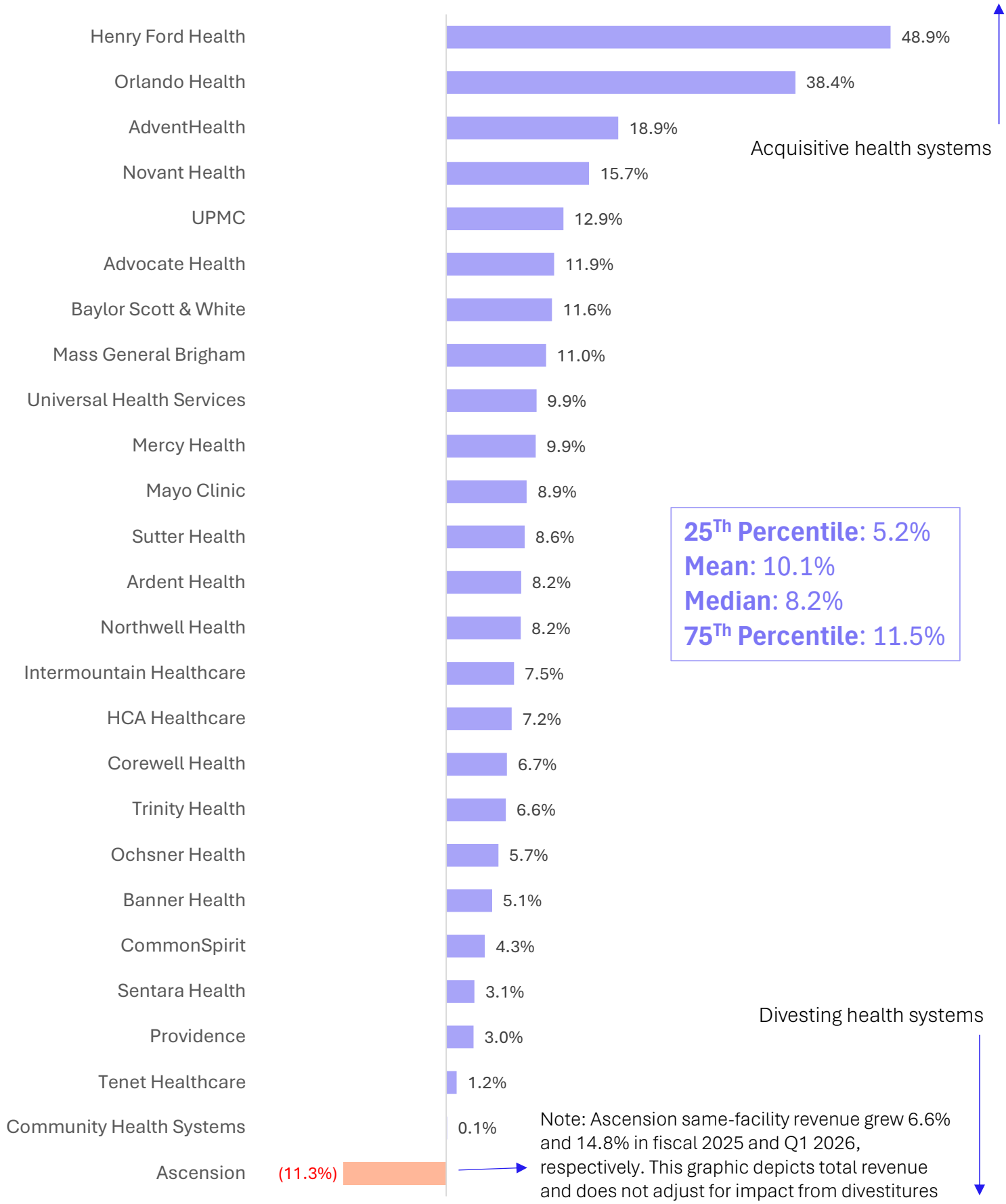


Of the 26 for-profit and nonprofit health systems analyzed, 16 experienced margin expansion while 10 saw margin contraction. Most notable margin expansions included Sentara, Ascension (not pictured due to lack of comparability given divestitures), AdventHealth, and Community Health Systems. Median operating margin was calculated at 4.0% and the median change was 0.6%. Median for-profit operating margin hit 11.5% (up from 10.3% in YTD 2024). Median nonprofit operating margin amounted to 1.8% in 2025, down from 2.7% during the same period in 2024. Interestingly, nonprofit average operating margin was 3.4%, up from 2.9% a year ago, meaning the data is positively skewed. This dynamic implies the presence of a handful of exceptional outperformers on the nonprofit health system side (Baylor, AdventHealth, Intermountain, to name a few)

Health System Revenue Growth Analysis

Change in Total Revenue, YTD 2025 vs. YTD 2024

Sorted by total revenue growth



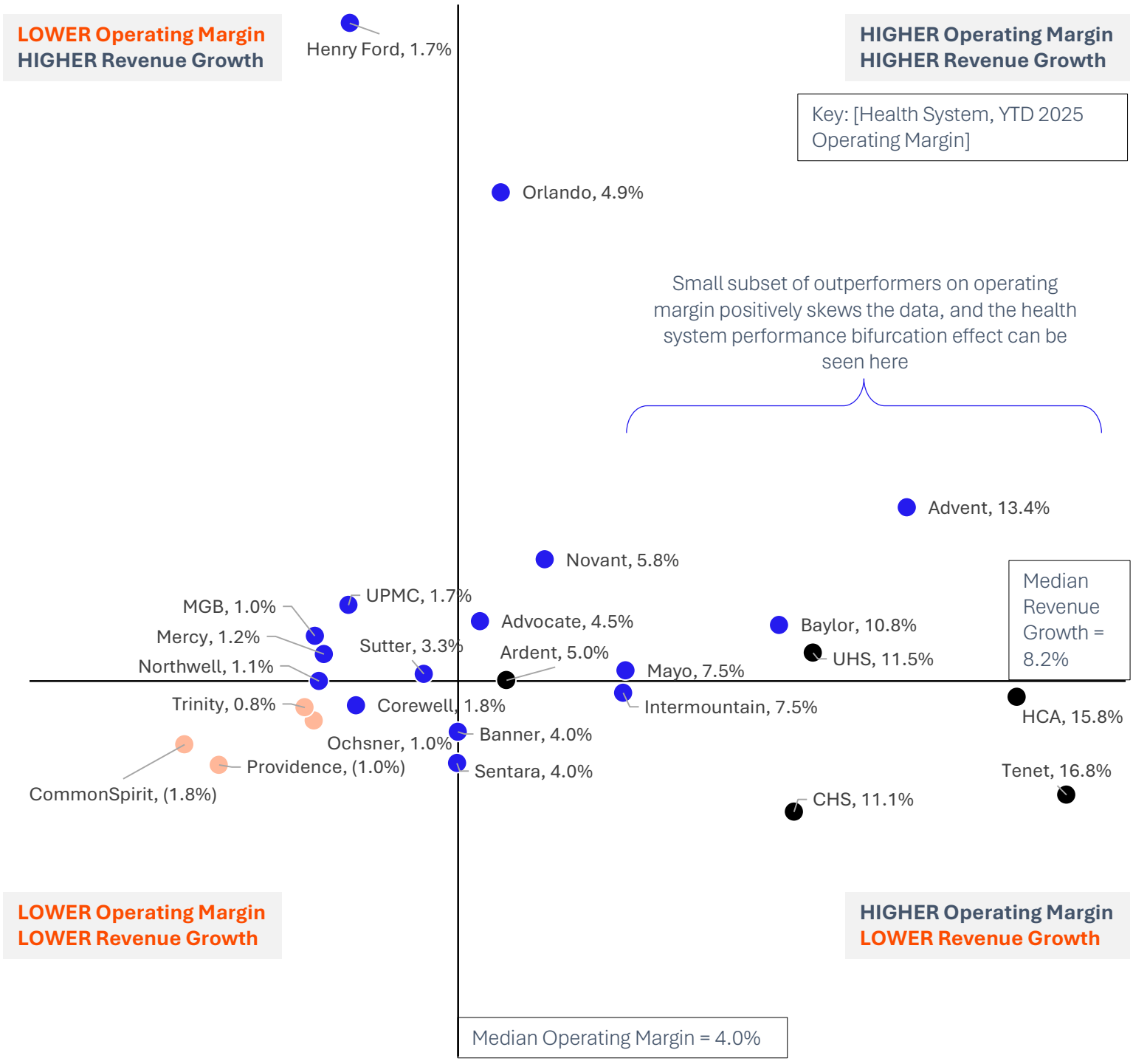
25Th Percentile: 5.2%
Mean: 10.1%
Median: 8.2%
75Th Percentile: 11.5%

Note: Ascension same-facility revenue grew 6.6% and 14.8% in fiscal 2025 and Q1 2026, respectively. This graphic depicts total revenue and does not adjust for impact from divestitures or acquisitions.

AdventHealth, Baylor Lead while Providence, CommonSpirit Lag Amid Year of Portfolio Realignment

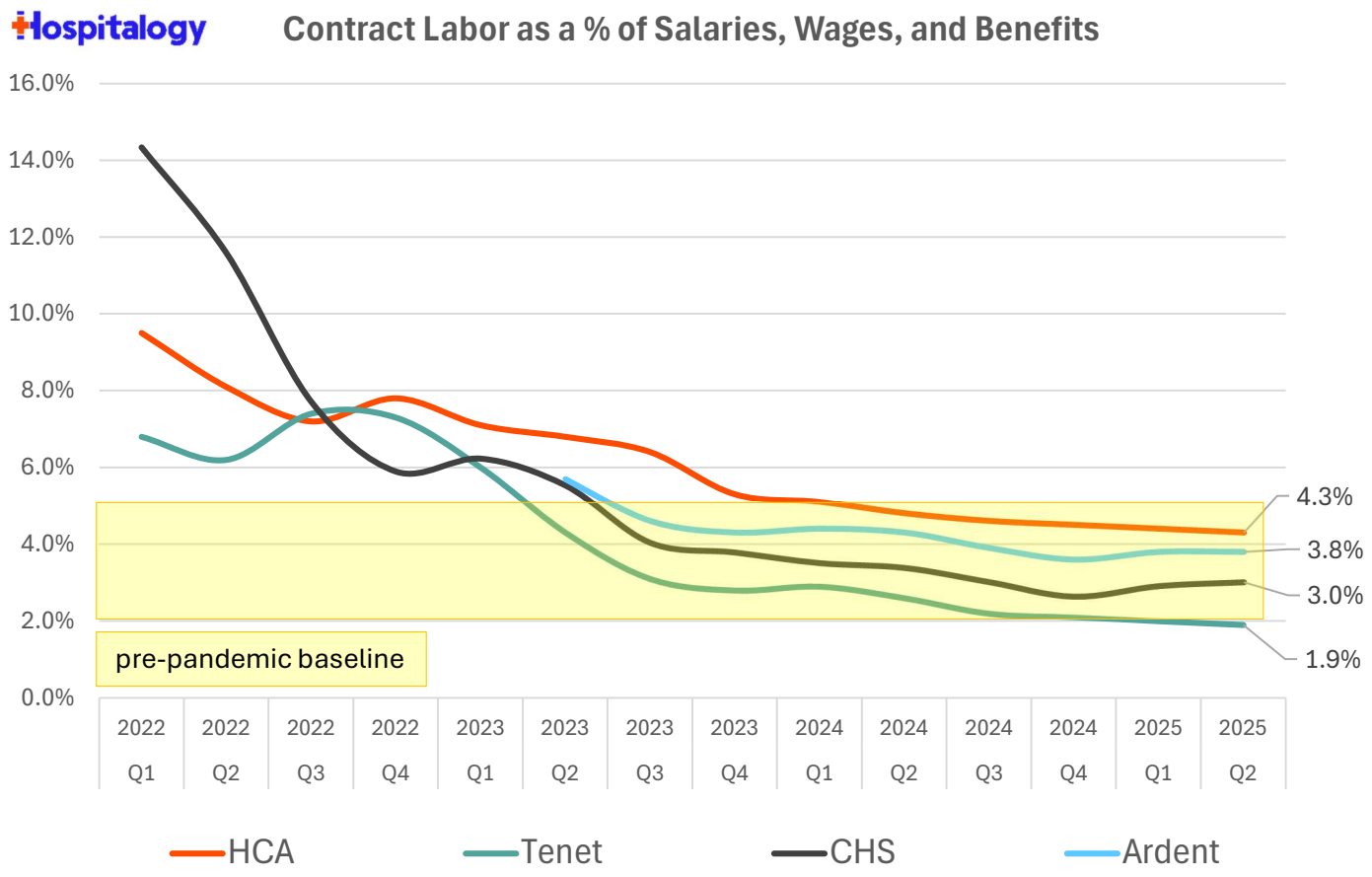
Health system comparative analysis – based on 2025 YTD total revenue growth & operating margin

The below chart plots operating margin against total revenue growth for the cohort of 26 health systems analyzed. While some names (Henry Ford and Orlando Health) see some skew due to acquisitions or divestitures (Ascension, Tenet, CHS), There are a few clear standouts: AdventHealth, Baylor, UHS, HCA, and Tenet all are excelling with strong revenue growth and impressive 10%+ operating margins. Among the more interesting names is Henry Ford, which saw 49% topline growth after an acquisitive year sitting at just 1.7% operating margins.



Benchmarks, Trends and Cross Analysis of Major Nonprofit Health Systems

Apart from Physician Workforce, Labor Concerns among Health Systems have Dropped Significantly



As seen in the graphic above, general labor and workforce concerns have taken a back seat for much of 2025 and entering 2026. The labor market is stable, and certain players (Tenet, HCA) have experienced unprecedented levels of operating leverage in their salaries, wages, and benefits line items through site of service shifts, staffing ratio optimization, and virtual nursing efforts. Many health systems either have readily available labor pools or have focused retention, pipeline, and upskilling efforts in place to maintain their workforces. Cost issues have now shifted to (1) professional fees inflation and (2) supplies and procurement.

HCA Healthcare — Company Tearsheet — 2026 Outlook

HCA: Scale Advantage, Execution Story

Volume + Utilization: HCA entered 2025 expecting 3-4% volume growth, delivered mid-2%, and economics improved anyway. Miss came from Medicaid and self-pay (lowest-margin segments) while payor mix rotation produced favorable net revenue growth despite the volume shortfall. HCA focus on acuity proves shrewd. 19 consecutive quarters of YoY volume growth demonstrates sustained market share capture. Length of stay hit below pre-pandemic levels with management calling themselves "middle innings" of optimization. Asset utilization improvements accelerating across bed turnover, ER throughput, and OR utilization as the resiliency program gains traction.

Revenue + Payor Mix: Payor mix doing the heavy lifting as volumes moderate. Exchange represented 8% of HCA volume. Baby boomers aging into Medicare maintains elevated levels through 2026-2028. When exchange patients lose EPTC subsidies, HCA expects some migrate to ESI (particularly in HCA's non-expansion state footprint), while others drop to lower metal tiers, and those becoming uninsured reduce utilization by less than 50% rather than disappearing entirely. Management sees 2-3 year transition if EPTCs expire, not a cliff.

Expenses + Margin: Strong margin performance through first ten months driven by operating leverage and resiliency program execution. Four-pillar framework (revenue integrity, asset utilization, variable cost management, fixed cost optimization) generating efficiency gains independent of payor mix tailwinds. Clinical labor stabilized with multi-year workforce development investments (Galen School expansion, residency programs). Professional fee challenges shifted from ER and hospital medicine to anesthesia and radiology where supply-demand imbalances persist. HCA building internal employment capabilities as contract groups implode.

Capital Allocation + M&A: $5B annual capital spend split 40% maintenance, 60% growth. Inpatient adding ~600 beds annually. Outpatient expansion accelerating toward 20 sites per hospital by decade end, up from current 14, through urgent care, freestanding EDs, surgery centers, and physician clinics. $6.7B funded pipeline. Balance sheet in excellent condition. Share repurchases $10B for 2025.

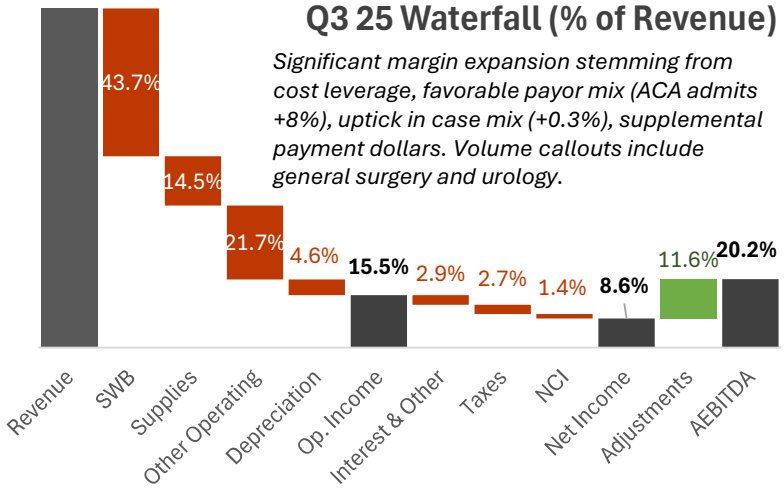
Outlook + Guidance: 2026 volume guidance 2-3% with EPTC as 1% swing factor. 4-6 week window for policy resolution. Supplemental payment reforms (DSH/UPL) start fiscal 2028 with 5-7 year phase-in, bifurcating impact between expansion and non-expansion states. Resiliency program provides three-way optionality for margin: accelerate tech investments, absorb external challenges, or expand margins. AI deployment scaling across administrative domain (fastest ROI with centralized data across Parallon, supply chain, IT, HR). Nurse handoff tool live in 8 hospitals with broad 2026 rollout. Fetal heart monitoring algorithm under FDA review. AI-driven scheduling live in just under 100 hospitals. EMR replacement in flight.

Takeaway: HCA is transitioning from externally-driven margin expansion (payor mix tailwinds) to internally-driven margin expansion (operational efficiency, AI leverage, asset utilization). Harder to execute but more sustainable and defensible. The capital deployment machine ($5B annual growth spend while returning $10B to shareholders) creates network density moats that smaller systems cannot replicate. Administrative domain AI advantage (centralized, standardized data) enables faster deployment than competitors with fragmented systems. As tools mature across clinical, operational, and administrative domains, HCA's 44M annual patient interactions and 315k colleagues translate to per-unit cost advantages at scale. Near term momentum solid with 19-quarter growth streak. Outer year risk is EPTC expiration timing (though 2-3 year transition buffers shock) and execution on resiliency program as tailwinds stabilize.

Key Performance Results	Q3 24	Q3 25	$ Change	% Change
Net Revenue	17,487	19,161	1,674	9.6%
Adjusted EBITDA	3,267	3,870	603	18.5%
Net Income	1,270	1,643	373	29.4%
Operating Margin	13.8%	15.5%	1.7%	12.3%
Adjusted EBITDA Margin	18.7%	20.2%	1.5%	8.1%
Net Income Margin	7.3%	8.6%	1.3%	18.1%
Same-Store Adjusted Admissions	985,269	1,008,805	23,536	2.4%
Same-Store Net Revenue per Adjusted Admission	17,245	18,390	1,145	6.6%
Revenue per Adjusted Patient Day	3,630	3,957	327	9.0%
SWB as a % of Revenue	45.0%	43.7%	(1.3%)	(2.9%)
Supplies as a % of Revenue	15.2%	14.5%	(0.7%)	(4.4%)
Other Operating Expense as a % of Revenue	21.3%	21.7%	0.5%	2.2%
Weighted Occupancy	71.9%	71.7%	(0.2%)	(0.3%)
Average Length of Stay	4.79	4.66	(12.7%)	(2.7%)

Q3 25 Waterfall (% of Revenue)

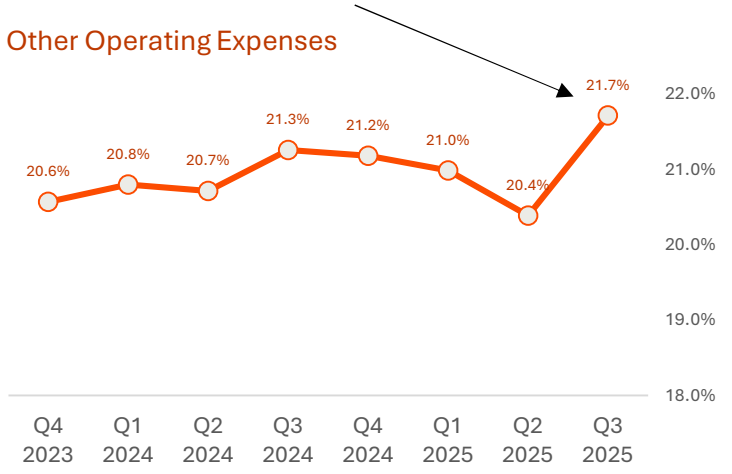
Significant margin expansion stemming from cost leverage, favorable payor mix (ACA admits +8%), uptick in case mix (+0.3%), supplemental payment dollars. Volume callouts include general surgery and urology.



Per Adjusted Patient Day	Q3 24	Q3 25	$ Change	% Change
Adjusted Patient Days	*4,816,761*	***4,842,027***	*25,266*	*0.5%*
Revenue	3,630	3,957	327	*9.0%*
Salaries & Wages	1,632	1,727	95	*5.8%*
Supplies	552	575	23	*4.2%*
Other Operating Expenses	772	859	88	*11.4%*

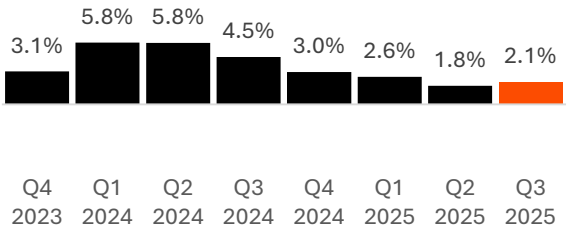
Notable Expense Trends:

Headwinds persist in professional fees. HCA brought Valesco in house to combat at least part of this. Expect to see health systems continue to rethink professional fees and third-party compensation

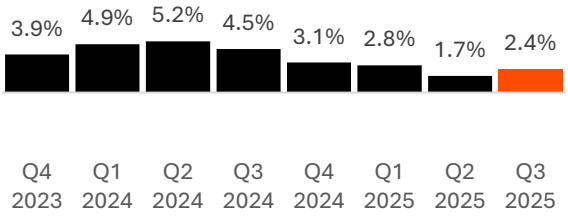


Same-Facility Growth: Q4 23 – Q3 25

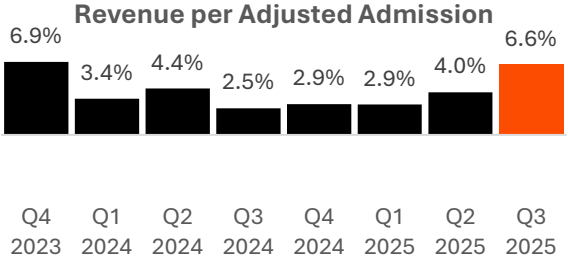
Admissions



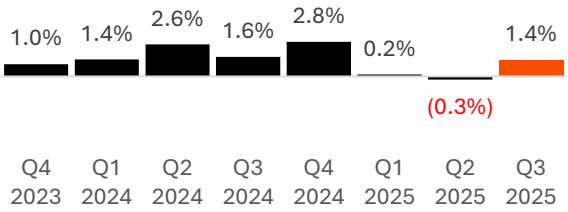
Adjusted Admissions



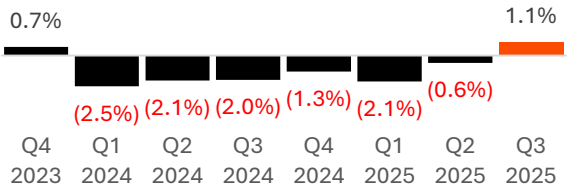
Revenue per Adjusted Admission



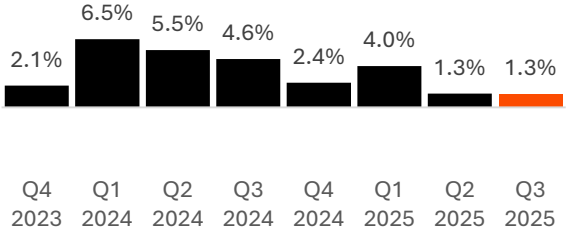
Inpatient Surgery Cases



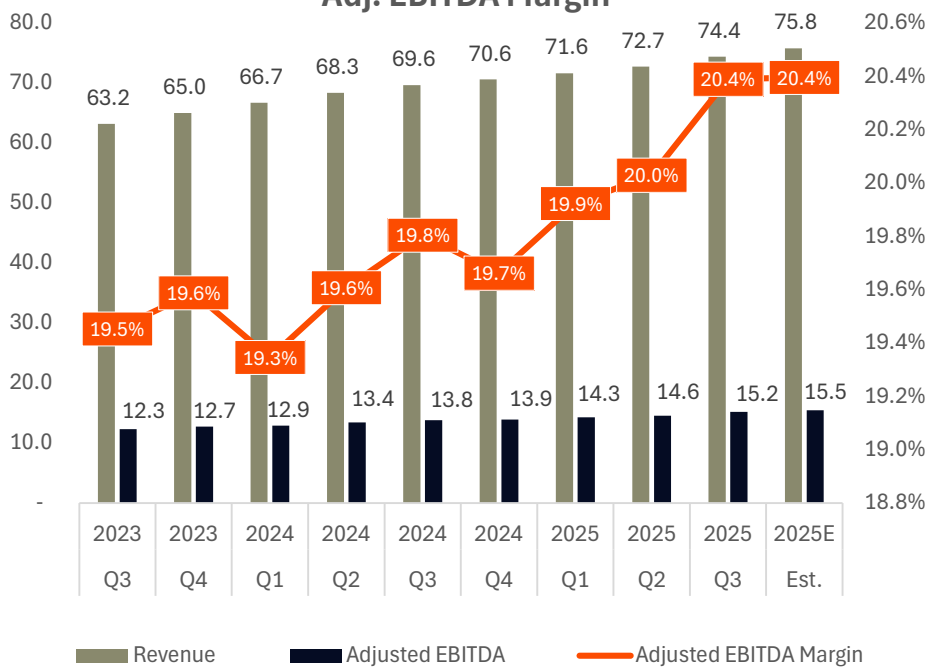
Outpatient Surgery Cases



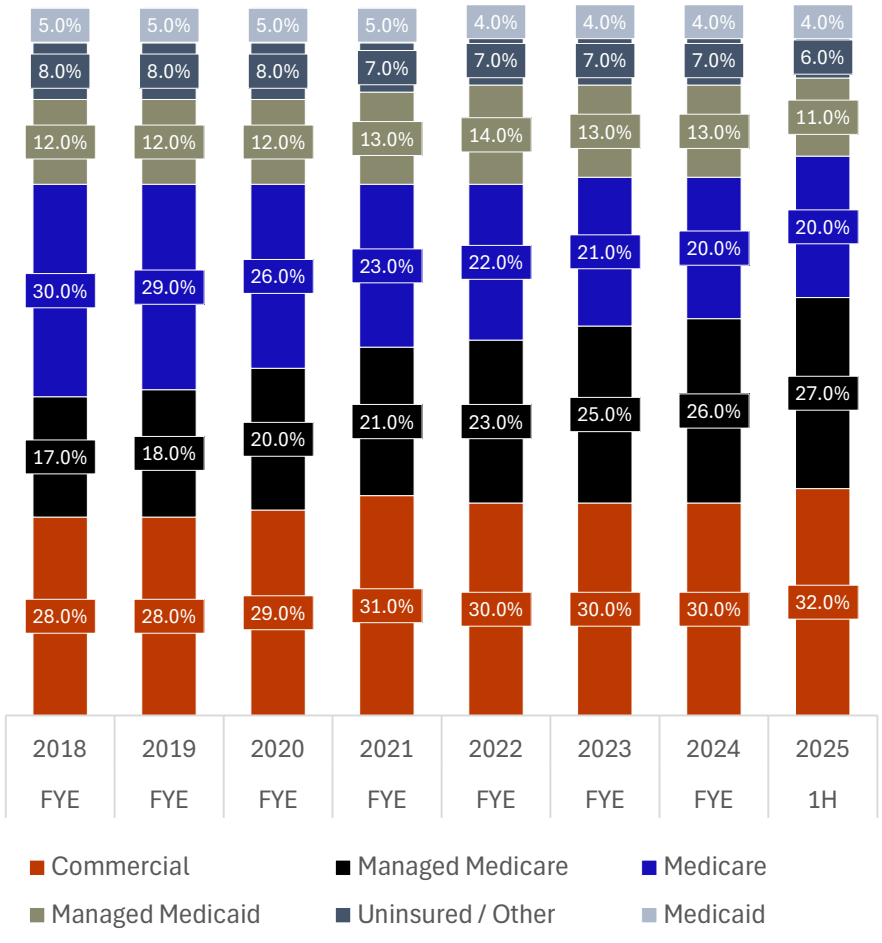
ER Visits



Rolling 12-Month Revenue, Adj. EBITDA, and Adj. EBITDA Margin



HCA Payor Mix, % of Admissions, 2018 - 1H 2025



THC: Solid Ops, Uncertain Policy

Volume + Utilization: Volumes stayed healthy with mix doing the work. Same store hospital adjusted admissions rose 1.4% and revenue per adjusted admission climbed 5.9% on higher acuity and payor mix. USPI posted same facility revenue +8.3% on net revenue per case +6.1% and cases +2.1%; total joints +11%. Ortho, spine, and robotics remained strong; GI recovered late in the quarter. Outpatient respiratory and infectious disease trends were lighter than expected, likely a later season start. Capacity planning is in place for the typical fourth quarter run.

Revenue + Payor Mix: Price and mix continue to carry the publicly traded hospitals and THC was no exception. Hospital RPAA rose 5.9%; USPI net revenue per case rose 6.1% on higher acuity. ACA exchange represented 8.4% of admissions and 7% of consolidated revenue in Q3, broadly stable. USPI carries lower exposure to Medicaid and exchange and bills freestanding rates.

Expenses + Margin: AEBITDA margin 20.8% (+170 bps YoY). Hospitals delivered 15.1% (+160 bps) and USPI 38.6%. SWB 41.7% of revenue (improved 160 bps YoY) with contract labor 1.9% of SWB (likely an all-time low). Medicaid supplemental programs contributed $346M in Q3 including $38M from prior years; YTD $1.02B with $148M out of period, the largest normalization to watch into 2026.

Capital Allocation + M&A: THC ticked up share repurchasing –$1.2B YTD. Cash $2.98B, leverage 2.3x EBITDA (2.93x EBITDA less NCI), no significant maturities until 2027. USPI added 11 acquisitions and 2 de-novos in Q3 with YTD M&A spend near $300M. FY25 capex raised to $875M–$975M, focused on cath labs, ICUs, advanced imaging, and surgical platforms; new hospital opened in Port St. Lucie.

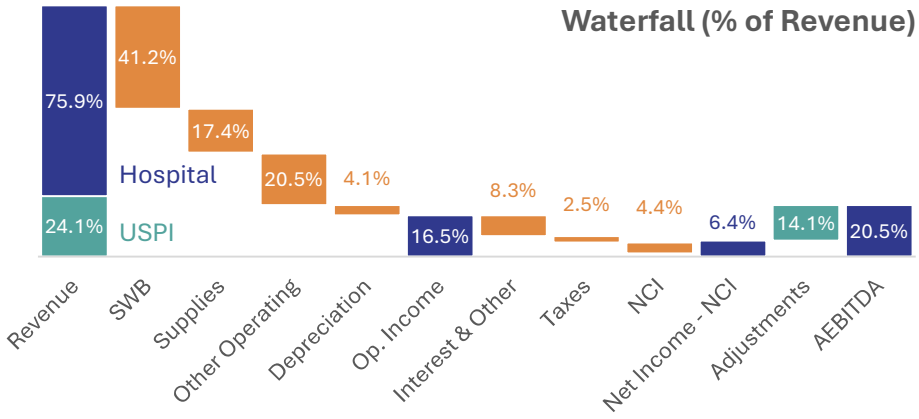
Outlook + Guidance: 2025 guidance raised yet again as THC continues to crush this year. Drivers include sustained high acuity strategy, stable labor and cost discipline, and USPI growth from M&A and de-novos. 2026 watch items remain ACA exchange subsidy timing and pending approvals for state directed Medicaid payments; USPI less exposed. CMS prior auth begins in limited states, including Texas, with minimal expected disruption given documentation readiness.

Takeaway: While perhaps underperforming vs. the street, THC's grand strategy is all engines go. Acute mix and ASC acuity keep margins expanding, cash conversion is robust, and the company is redeploying into high return growth. Near term momentum is solid; outer year risk is policy not demand.

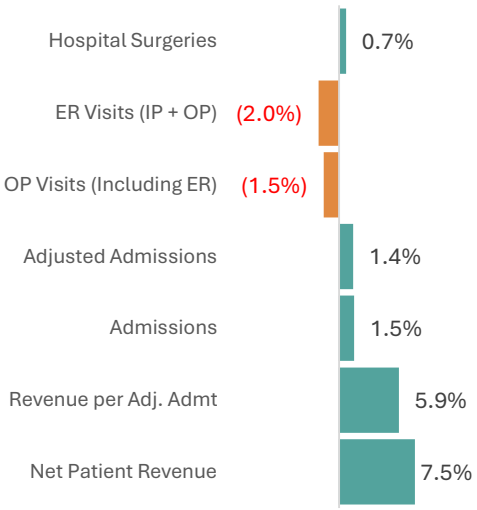
Key Operating Results ($M)

	Quarterly Results			YTD Results		
	5122	5066	Change	2024	2025	Change
Net Operating Revenue	5,126	5,289	***3.2%***	15,602	15,783	***1.2%***
Net Income available to Tenet	472	342	***(27.5%)***	2,882	1,036	***nmf***
Net Income to Tenet per Diluted Share	4.89	3.86	***(21.1%)***	29.27	11.28	***nmf***
Adjusted EBITDA	978	1,099	***12.4%***	2,947	3,383	***14.8%***
Adjusted Diluted Earnings per Share	2.93	3.70	***26.3%***	8.47	12.10	***42.9%***
Adjusted EBITDA Margin	*19.1%*	*20.8%*	***1.7%***	*18.9%*	*21.4%*	***13.5%***
Net Income Margin	*9.2%*	*6.5%*	***(2.7%)***	*18.5%*	*6.6%*	***nmf***

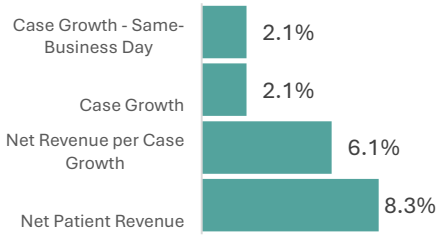
Waterfall (% of Revenue)

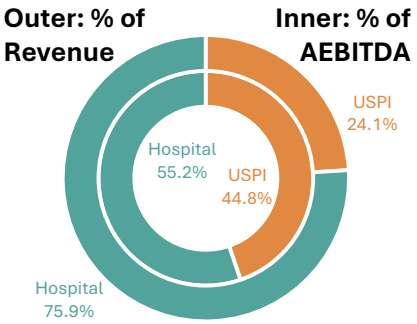


Hospital Same-Store YoY Change: Q3 25



USPI Same-Store YoY Change: Q3 25

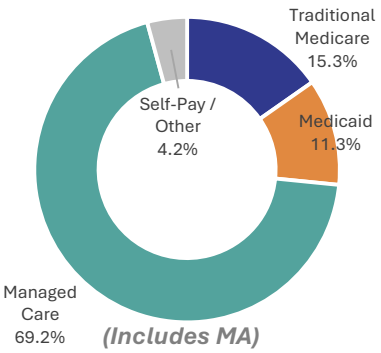




2025 Outlook

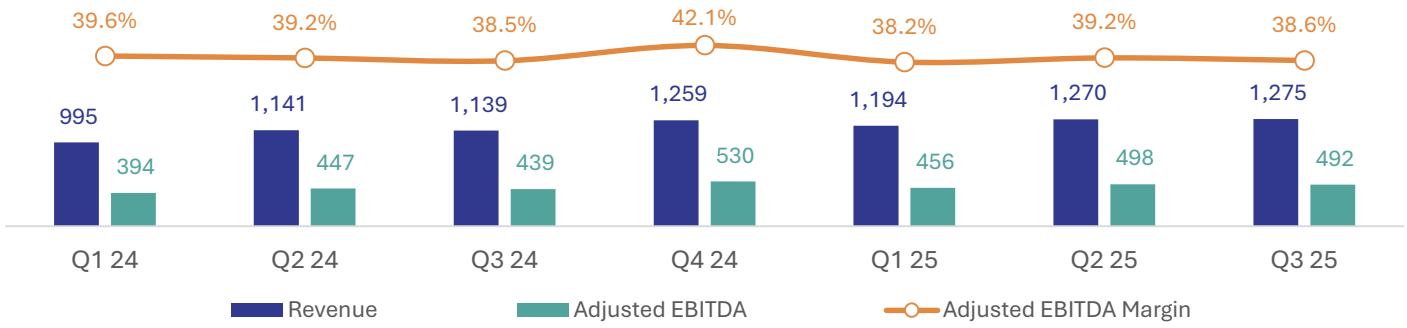
	2025E Guidance - Q3		
	Low	High	Mid
Consolidated Revenue	21,150	21,350	21,250
Consolidated AEBITDA	4,470	4,570	4,520
Consolidated AEBITDA Margin	*21.1%*	*21.4%*	*21.3%*
Hospital Revenue	16,050	16,200	16,125
Hospital AEBITDA	2,470	2,530	2,500
Hospital AEBITDA Margin	*15.4%*	*15.6%*	*15.5%*
Inpatient Admissions Growth	*2.0%*	*3.0%*	*2.5%*
Adjusted Admissions Growth	*1.5%*	*2.5%*	*2.0%*
USPI Revenue	5,100	5,150	5,125
USPI AEBITDA	2,000	2,040	2,020
USPI AEBITDA Margin	*39.2%*	*39.6%*	*39.4%*
Same-Facility Rev Growth	*5.5%*	*7.5%*	*6.5%*

YTD 2025 Payor Mix (% Revenue)

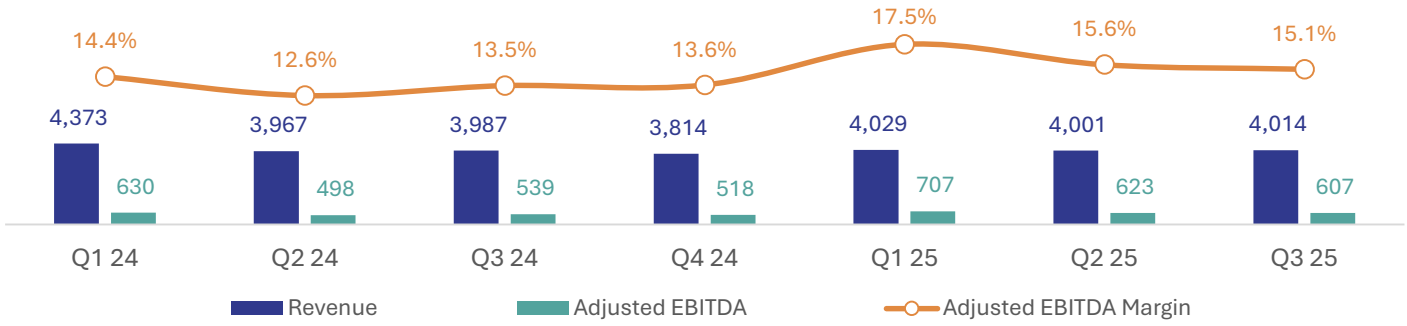


Quarterly Revenue and Profitability by Segment

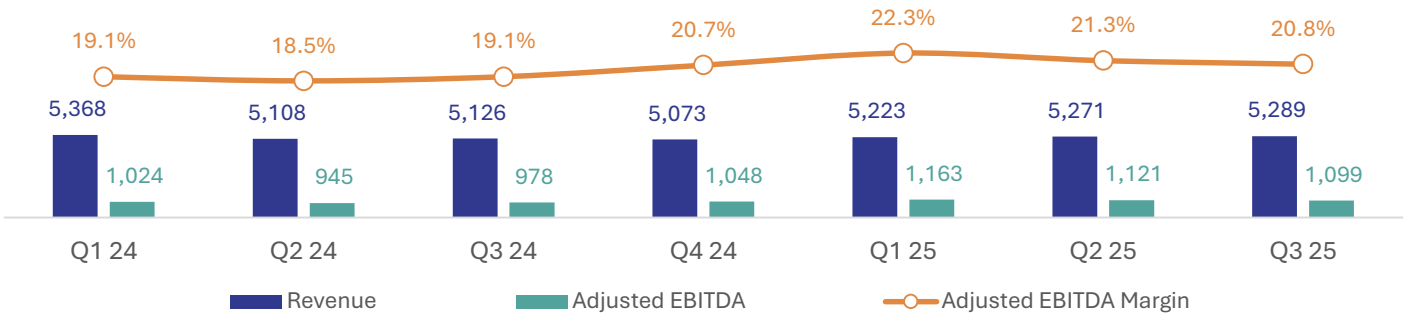
USPI



Hospital



Consolidated



Company Tearsheet

2026 Outlook

UHS: Execution Amid Eroding Tailwinds

Volume + Utilization: Acute care same-store adjusted admissions +2.0% YoY (includes 50-60 bps drag from West Henderson cannibalization, implying ~2.5-3.0% organic growth). Surgical volumes inflected positive in Q3 after 1H declines. Cardiology/cardiac "particularly strong." Behavioral health constrained: same-store adjusted patient days +1.3% vs. 2-3% target. Labor tightness affects 25-33% of behavioral facilities. Outpatient acceleration: 34 freestanding EDs (added 4 YTD), ~100 behavioral outpatient access points, 10 new "step-in" programs under Thousand Branches Wellness brand (de-stigmatized, non-hospital branding).

Revenue + Payor Mix: Acute revenue per adjusted admission +7.3% ex-insurance/DC benefit (~5% core). Behavioral +7.1% ex-DC benefit. Sustainable pricing: 3%+ acute, 3.5-4.5% behavioral. Exchange volumes now 6-6.5% of acute admissions, trending up (TX/FL concentrated). Patients behave like Medicaid (ER-centric). No "pull-forward" evidence. UHS using competitive pricing intelligence in negotiations: "We still see pricing lagging competitors in certain markets."

Expenses + Margin: Acute EBITDA margin 15.8%, +190 bps YoY (ex-DC benefit). Operating expenses +4.0% per adjusted admission. Behavioral margins stable despite volume shortfall. SWB growth elevated but strategic: "Preparing to absorb more patient volume." Revenue cycle excellence driving margin expansion. Zero tariff impact. Additional malpractice reserves ($35M) and legal settlement ($18M) offset some DC supplemental upside.

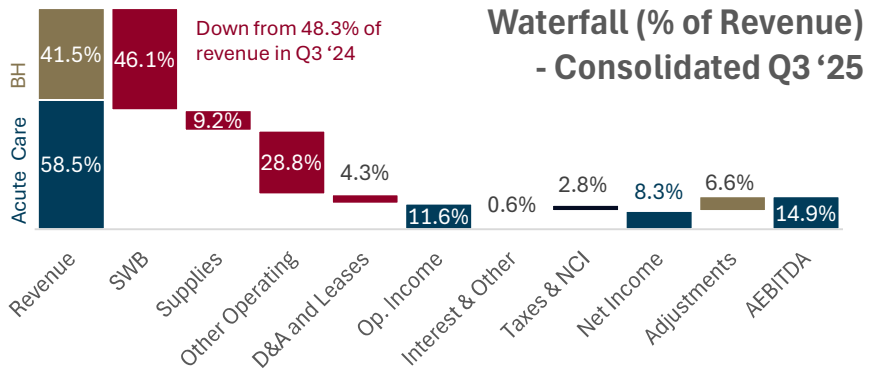
Capital + M&A: $734M CAPEX YTD. Alan D. Miller Medical Center (Palm Beach Gardens) opening spring 2026. Behavioral outpatient $1-2M per clinic. Dominant theme: share repurchases. Bought $566M YTD; repurchased 36% of shares since 2019. Board authorized new $1.5B buyback (total $1.759B authorization). Maintaining low leverage despite policy uncertainty but willing to "lever up even more" for buybacks.

Outlook + Guidance: Raised 2025 adjusted EPS to $21.80 (+6%). Critical headwind: $1.3B supplemental Medicaid benefit in 2025, but OB3 legislation will reduce by $420-470M annually by 2032, starting fiscal 2028. ACA subsidy expiration risk: $50-100M negative impact (trending high end). Pending: FL $47M + NV $30M approvals.

Analyst Q&A + Takeaways: West Henderson immediately profitable (rare); Cedar Hill lost $50M in 2025. Behavioral demand exists but delivery fragmented across ERs/urgent care/"mom-and-pop operations." UHS reorganized from "inpatient-centric" to dedicated outpatient focus. Notable: zero technology/AI/digital health discussion—executing traditional hospital operating model via operational excellence.

Key Quarterly Results

	Acute Care	Behavioral	Intercompany	Combined	YoY Change
Revenue	2,630	1,860	5	4,495	13.4%
Income from Operations	300	347	(126)	522	35.8%
Adjusted EBITDA *(allocated by % of revenue)*	397	403	(129)	671	27.4%
Net Income (allocated by % of revenue)	225	259	(111)	373	44.2%
Income from Operations - Margin	11.4%	18.7%	(2.8%)	11.6%	1.9%
Adjusted EBITDA - Margin	15.1%	21.6%	(2.9%)	14.9%	1.6%
Net Income - Margin	8.6%	13.9%	(2.5%)	8.3%	1.8%



Same-Facility YoY Growth

	Acute Care		Behavioral	
	Quarter	YTD	Quarter	YTD
Revenues	12.8%	9.1%	9.3%	7.9%
Adjusted Admissions	2.0%	2.1%	0.5%	(0.2%)
Adjusted Patient Days	0.4%	0.6%	1.3%	0.7%
Revenue / Adj. Admission	9.8%	5.4%	8.8%	8.2%
Revenue / Adj. Patient Day	11.5%	7.0%	7.9%	7.2%

Segment Analysis

Acute Care Same-Facility

	Q3 24	Q3 25	Change	% Change
Hospitals owned and leased	27	27	-	0.0%
Average Licensed Beds	6,797	6,869	72	1.1%
Average Available Beds	6,625	6,697	72	1.1%
Patient Days	401,479	401,148	(331)	(0.1%)
Average Daily Census	4,364	4,360	(4)	(0.1%)
Occupancy - Licensed Beds	64.2%	63.5%	(0.7%)	(1.1%)
Occupancy - Available Beds	65.9%	65.1%	(0.8%)	(1.2%)
Admissions	83,149	84,368	1,219	1.5%
Length of Stay	4.8	4.8	(0.1)	(1.5%)
Net Patient Revenue	2,156	2,433	277	12.8%

Segment Analysis

Behavioral Same-Facility

	Q3 24	Q3 25	Change	% Change
Hospitals owned and leased	334	334	-	0.0%
Average Licensed Beds	23,965	24,069	104	0.4%
Average Available Beds	23,865	23,969	104	0.4%
Patient Days	1,603,808	1,623,202	19,394	1.2%
Average Daily Census	17,433	17,644	211	1.2%
Occupancy - Licensed Beds	72.7%	73.3%	0.6%	0.8%
Occupancy - Available Beds	73.0%	73.6%	0.6%	0.8%
Admissions	118,638	119,608	970	0.8%
Length of Stay	13.5	13.6	0.1	0.4%
Net Patient Revenue	1,659	1,814	154	9.3%

CHS: The Same Tune, or a New Song?

Volume + Utilization: Steady IP trends but continued OP softness. Same-store adjusted admits +0.3%, surgeries down 2.2%, ED visits down 1.3%. Mix skewed medical over surgical as consumer softness / confidence weighed on electives, especially ortho and cardiac. Management cited TX and AZ markets still impacted by immigration and economic pressure. Sequentially improved volumes vs. Q2 but weak acuity limited lift. CHS added 160 new employed providers and rolled out new vascular, OB, urology, spine, and robotic programs.

Revenue + Payor Mix: Reimbursement carried the quarter for CHS. Same-store net revenue +6% YoY with net rev / adjusted admit +5.6%. About 1/3 of growth tied to Tennessee and NM state directed payments. Acuity pressure from delayed OP procedures limited growth. Exchange and commercial coverage both trended higher sequentially. No material Medicaid redetermination impact in Indiana, a key CHS state. Overall, rate growth offset modest volume softness.

Expenses + Margin: Adjusted EBITDA margin expanded +100 bps YoY to 12.2% (or +20 bps to 11.4% excluding $28M legal settlement). Supplies expense 15% of revenue (-20 bps YoY). Professional fees $165M (+4%), or 5.4% of revenue. Contract labor was slightly down; average hourly wages +~4%. Inflation stable but tariffs flagged as potential headwind. Expense management remains CHS' primary lever for incremental margin protection.

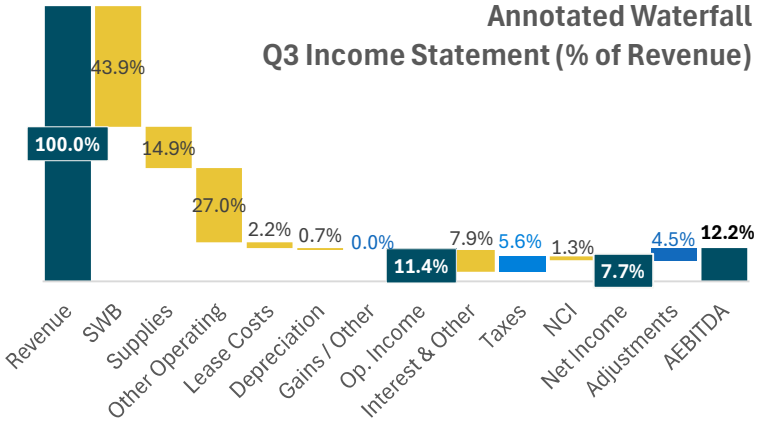
Capital + M&A: Leverage improved to 6.7x (from 7.4x) following debt refinancing. Next major maturity 2029. CHS sold Lake Norman, ShorePoint, and Cedar Park hospitals; outreach labs deal ($195M) to LabCorp is closing in Q4; received $91M Tenova Cleveland earn-out. Mgmt. focused on de-levering and ambulatory expansion—three ASCs opening Q4 25, 6 – 8 ASCs and 3-4 FSEDs slated 2026.

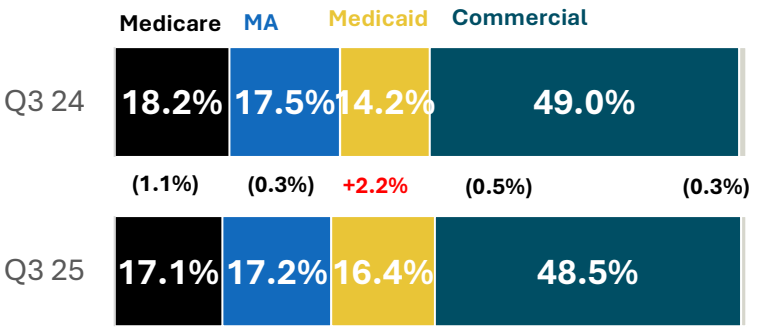
Innovation + Tech: ERP system fully live and driving workflow maturity. RCM investing in AI-enabled denial prevention and expanded physician advisor program after CHS saw a 2024 spike in payor friction. Robotics, neurosurgery, and spine buildouts launched in NM and TX to restore surgical acuity and support recruitment.

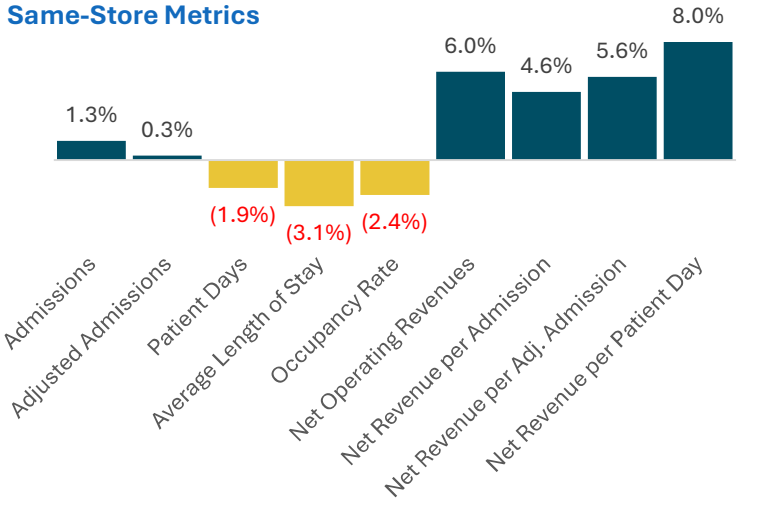
Outlook + Guidance: Expect more normal seasonality in Q4 as payor mix strengthens and commercial utilization stabilizes. FY25 AEBITDA range tightened to $1.5B–$1.55B (~12% margin). Free cash flow positive outlook reaffirmed post cash-tax adjustments. FY26 guidance constructive: Medicare IPPS rate increase a tailwind; OPPS proposal neutral-positive. Potential new state directed programs in GA, FL, and IN plus Rural Health Fund could lift revenue modestly. Management expects gradual elective rebound through 2026, aided by payor mix normalization and expanded access points.

Analyst Q&A + Takeaways: Analysts pressed management on persistent outpatient weakness. Leadership cited macroeconomic softness and consumer sentiment but expects a gradual recovery into 2026 as commercial confidence rebounds. CHS still trails larger peers on acuity and volume recovery given rural exposure and payor mix headwinds. System remains in stabilization mode—leaner, more disciplined, yet dependent on policy and macro tailwinds to truly re-rate alongside its fellow public hospital operators.

Key Performance Metrics	Q3 24	Q3 25	$ Change	% Change
Net Operating Revenue	3,090	3,087	(3.0)	*(0.1%)*
Net Income / Loss	(238)	279	517.0	***nmf***
Net Loss to CHS	(274)	238	512.0	***nmf***
Adjusted EBITDA	347	376	29.0	*8.4%*
Adjusted EBITDA Margin	*11.2%*	*12.2%*	0.0	*8.5%*
Net Cash from Operating Activities	67	70	3.0	*4.5%*







Outlook	Low	High	Mid
Revenues ($M)	12,400	12,600	12,500
Adjusted EBITDA ($M)	1,500	1,550	1,525
Implied Adjusted EBITDA Margin	*12.1%*	*12.3%*	*12.2%*
Diluted EPS	0.80	0.90	0.85

Ardent: Solid Execution, but Crushed by '26 Uncertainty and Systemic Headwinds

Volume + Utilization: Admissions had massive 5.8% growth, with IP surgeries up 9.7%; OP down 1.8%. Total surgeries turned positive at 1.4% after negative YTD trend. Exchange and managed Medicaid volumes both grew double digits. Non-exchange commercial up 8%. Adj. admissions hit 2.9% (top of guide). ARDT's transfer center strategy is working with robust IP growth. Service line rationalization continues with the OR excellence program ensuring "right surgeries in right setting." Mgmt. stayed quiet on specific specialties beyond noting surgical recovery.

Revenue + Payor Mix: Revenue grew 8.8% to $1.58B (11.7% excluding the $43M Kodiak accounting adjustment). Net revenue per adj. admission up 5.8%. 2026 contracting 75% complete. Rates "hedged down from historical levels" as payors play hard ball. One exchange contract got renegotiated after Ardent threatened termination, leading to better rates & favorable denial terms. **Final denials jumped 8% in Q3** vs 1H 25, prompting 60 demand letters in 90 days seeking $15M. **Appeals up 60% YoY with 25% faster turnaround**. Transition to Kodiak's RCA platform triggered $43M revenue hit.

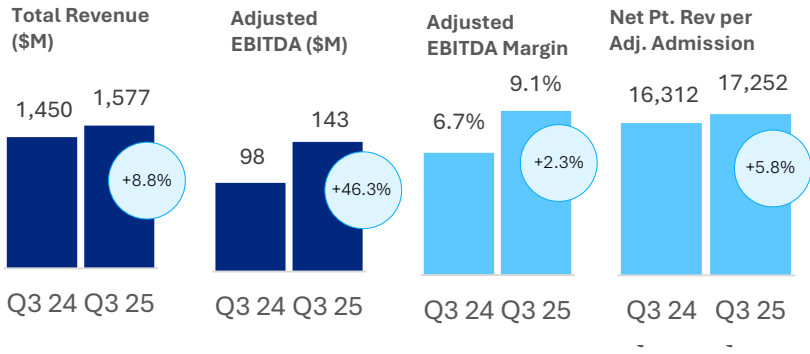
Expenses + Margin: AEBITDA grew 46% to $143M with 9.1% margins (+240 bps) but missed expectations badly. 70% of AEBITDA adjustments stemmed from malpractice liability, RCM denials issues, and Epic implementation. Prof fees accelerated from 6% growth Q1 to 11% Q3 (radiology the surprise culprit), accounting for 50% of guidance reduction. Huge problem. Contract labor improved to 3.5% of SWB. ARDT's IMPACT program launched $40M+ in annual savings: exchange plan renegotiation, targeted workforce reduction, agency labor contract revisions. New Mexico took a $54M malpractice hit from a single provider (2019-2022).

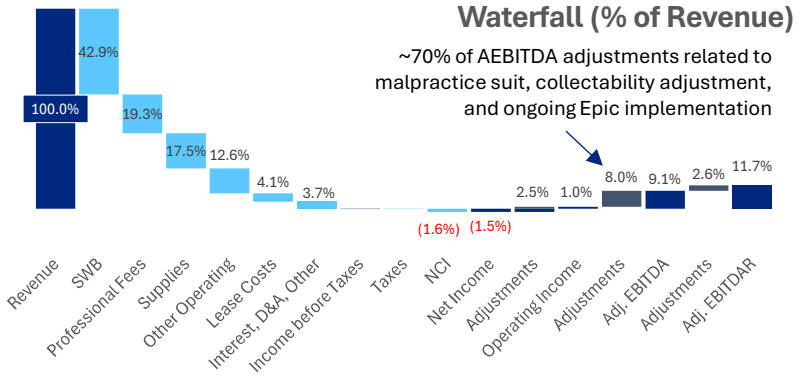
Capital + M&A: Lease-adjusted leverage improved to 2.5x from 2.7x. 2H '25 priorities: opening urgent cares and imaging centers. 2026 pipeline: 2 ASCs, 4 urgent cares, 1 freestanding ED. ARDT CDO is building partnership interest for core and new market expansion.

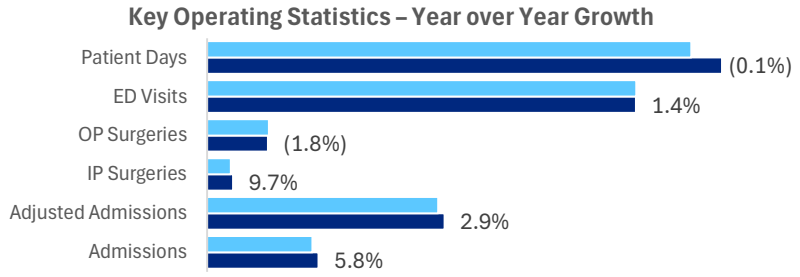
Outlook + Guidance: Slashed adjusted EBITDA guidance to $530M-$555M (9% growth, 20 bps margin expansion) while maintaining revenue at $6.2B-$6.45B. The cut assumes Q3 headwinds persist through Q4. $15M-$20M of Q4 earnings got pulled into Q3 (mostly DPP timing). New Mexico independently funding exchange subsidies to 400% FPL provides partial cushion. Mgmt. reaffirmed long-term mid-teens margin target but timeline now extended given the reset baseline.

Analyst Q&A + Takeaways: Analysts hammered on 2026 base-setting given timing noise and persistent headwinds. Mgmt. stayed cagey citing "policy uncertainty and exchange uncertainty" while emphasizing the $40M IMPACT savings as just the beginning. The paradox is striking: markets growing 2-3x national average, volumes crushing it, yet earnings can't keep up with professional fee inflation and payor games. Ardent's betting operational excellence can overcome structural headwinds. But they have quite a few of those.

Key Performance Metrics	Q3 24	Q3 25	$ Change	% Change
Total Revenue ($M)	1,450	1,577	127	*8.8%*
Adjusted EBITDA	98	143	45	*46.3%*
Adjusted EBITDA Margin	*6.7%*	*9.1%*	*2.3%*	*34.5%*
Adjusted Admissions	86,833	89,328	2,495	*2.9%*
Admissions	39,568	41,862	2,294	*5.8%*
IP Surgeries	8,871	9,732	861	*9.7%*
OP Surgeries	23,220	22,813	(407)	*(1.8%)*
Total Surgeries	32,091	32,545	454	*1.4%*
ED Visits	161,343	161,198	(145)	*(0.1%)*
Net Pt. Revenue per Adj. Admission	16,312	17,252	940	*5.8%*







	Admissions	Adjusted Admissions	IP Surgeries	OP Surgeries	ED Visits	Patient Days
Q3 24	39,568	86,833	8,871	23,220	161,343	182,023
Q3 25	41,862	89,328	9,732	22,813	161,198	193,558

Guidance	Mid	Previous	Change
Total Revenue	6,325	6,325	*0.0%*
Net Income - Ardent	134	265	***(49.6%)***
Adjusted EBITDA	543	595	***(8.8%)***
Rent Expense Payable to REITs	164	82	*100.0%*
Diluted EPS	0.94	1.87	***(49.7%)***
Adjusted Admissions Growth	2.5%	2.5%	*0.0%*
Net Pt. Revenue per Adj. Admission Growth	3.3%	3.3%	*0.0%*
CAPEX	225	225	*0.0%*
CAPEX % of Revenue	*3.6%*	*3.6%*	*(1.2%)*
Adjusted EBITDA Margin	*8.6%*	*9.4%*	***(8.8%)***

50% of guidance drop related to spike in prof fees

KAISER PERMANENTE®

2025 Tearsheet

Executive Summary

Kaiser as an integrated giant is executing a national platform play through Risant Health, committing $5B+ to acquire 5-6 regional health systems and extend its value-based care model beyond its traditional geographies. It's at 2 health systems today. Geisinger closed March 2024 and Cone Health closed December 2024. Kaiser has significant capital commitment to 'acquired' Risant systems. Risant sits at $11.6B in revenue to date.

An interesting Renown Health JV was announced September 2025 in which Kaiser acquires a majority interest in Hometown Health, assists in building an ambulatory footprint, and Renown hospitals remain independent. Kaiser's emerging organizational strategy involves infusing its operational DNA to systems committed to VBC without requiring full integration into Kaiser's health plan.

October 2025 brought a 46K-worker strike that is ongoing (union rejected the first offer of 21.5% wage increases over 4 years). Leadership has specifically flagged inflation, rising acuity, high specialty drug / pharma cost, and labor as margin pressures.

CommonSpirit Colorado partnership expanded Sept 2024; HCA HealthOne relationship deepened Oct 2024

Notable Callouts and Takeaways

Efficiency is King at Kaiser: As an integrated delivery network giant, Kaiser management is consistent: keep investing in capital + tech while squeezing overhead and standardizing operations. Consumer experience and productivity gains are strategic, not optional.

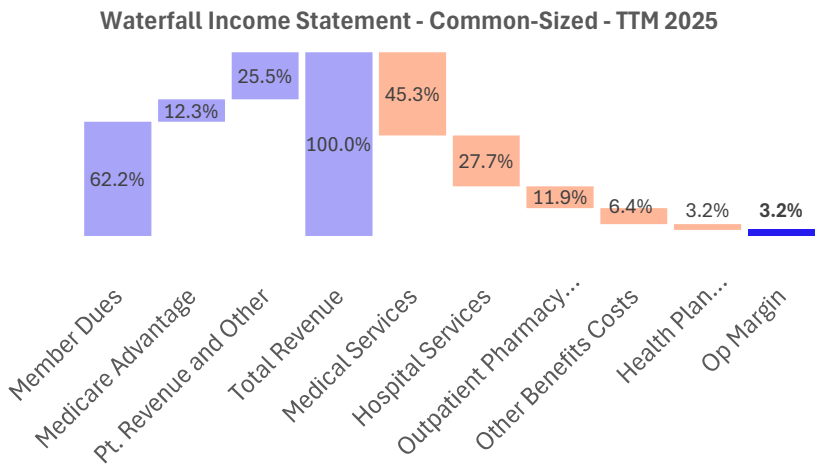
Kaiser's vertical integration model evolves from 'closed' to 'open': Risant is Kaiser's attempt to monetize a differentiated operating model without requiring geographic Kaiser expansion or full insurance membership conversion. Nevada JV is a second pattern: growth via insurer control + ambulatory build, while leaving incumbent hospital assets independent (Kaiser flexing into partnership economics).

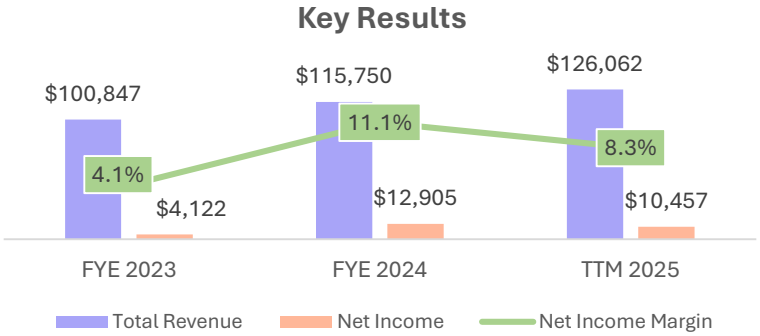
AI at scale: Kaiser is using ambient documentation as workforce capacity strategy.

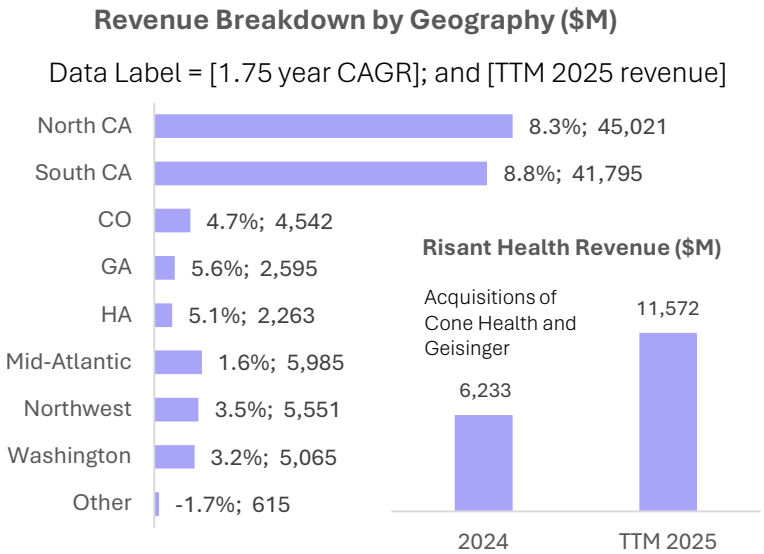
Kaiser accounted for gains of $4.8B and $2.3B stemming from Risant acquisitions of Cone and Geisinger respectively.

Key Results and Ratios (TTM 2025 ended 9/30/2025)

$126.1B	Total Revenue	220	Days Cash on Hand
13.1M	Membership	19.2	Days' Sales Outstanding
3.2%	Operating Margin	3.2%	Capex % of Pt. Revenue
8.3%	Net Income Margin	15.5%	Debt to Cap







CommonSpirit

2025 Tearsheet

Executive Summary

The nation's second-largest nonprofit is executing a synchronized portfolio restructuring and partnership strategy, market by market, after years of margin pressure. SF hospitals went to UCSF (August 2024), Trinity Health System OH is headed to UPMC via LOI (October 2025, 3 hospitals), and Kaiser expanded its Colorado partnership in early 2025 across 4 hospitals. The LifePoint behavioral health JV now covers 4 sites with a target of 8+ by 2028.

CommonSpirit's AI story is underappreciated: 230 applications live, $100M+ annual savings claimed. Stroke intervention time dropped from 2 hours to 25 minutes. Breast cancer detection improved 29%. Heart failure mortality declined 42%.

High leverage continues to be a challenge.

CommonSpirit is ranked #1 or #2 in market share across 26 of its 35 markets nationally and is focused on expanding ambulatory access points. In 2025 CommonSpirit added 34 ambulatory sites in 9 states and formed the JV with LPNT for behavioral and rehab services.

Digital front door efforts have led to material new patient acquisition growth for CommonSpirit.

Notable Callouts and Takeaways

Portfolio rationalization at this scale ($40B system divesting major markets) signals sector-wide asset reallocation is accelerating.

Recent investments include areas like robotics and disorder recovery.

System-ness: Key pillars of CommonSpirit's strategy include consolidating to a single EHR and ERP, restructuring divisions (into 5 regions rather than 8 divisions), development of an internal GPO for supply chain, and a focus on retention.

Notably, CommonSpirit's case mix index and reimbursement is declining.

New consumer app / experience led to 120% increase in online scheduling. Each new patient booked through online scheduling led to 2.5 visits with CommonSpirit.

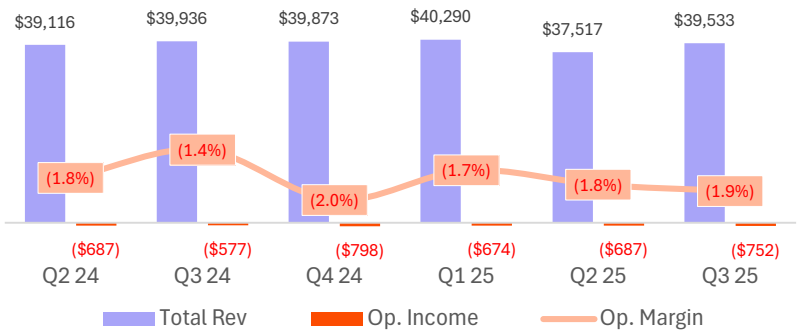
Portfolio transformation has included planned development and acquisition of ~70 ambulatory sites

Other priorities include denials management, automated arbitration, managed care negotiation, and service line diversification (recent behavioral health partnership, CommonSpirit Health at Home).

Key Results and Ratios (TTM 2026 ended 9/30/2025)

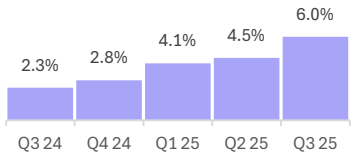
$39.5B	Total Revenue	159	Days Cash on Hand
$34.8B	Patient Revenue	55.2	Days' Sales Outstanding
(1.9%)	Operating Margin	6.3%	Capex % of Pt. Revenue
2.7%	Net Income Margin	48.2%	Debt to Cap

Rolling 12-Month Revenue and Operating Margin

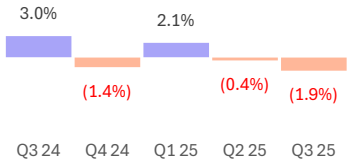


Year-over-Year Growth Metrics (TTM 2026 ended 9/30/2025)

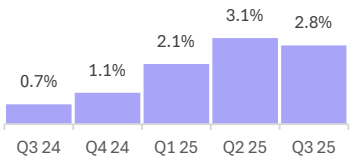
Adj Admissions



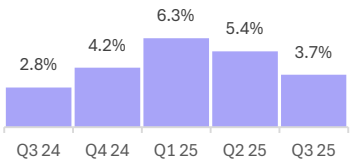
ED Visits



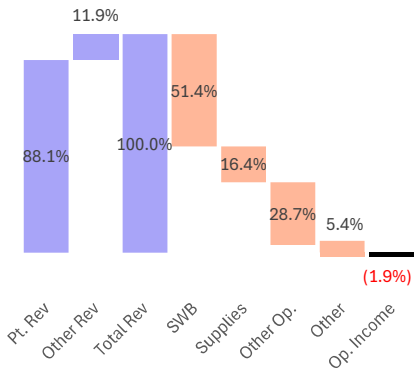
Adj Patient Days



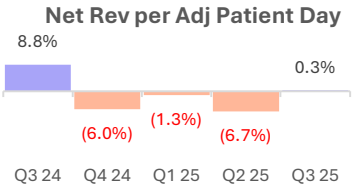
OP Visits



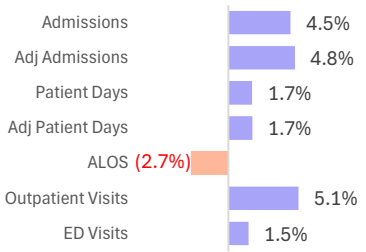
Waterfall Income Statement - Common-Sized - TTM 2026



Net Rev per Adj Patient Day



Volume Trend: 2.25 Yr CAGR



ADVOCATE 2025 Tearsheet

Executive Summary

The Advocate Aurora/Atrium merger is producing the financial and operational results that most mega-mergers promise but fail to deliver. TTM 2025 operating margin hit 4.1% (vs. 3.5% in 2024), and all liquidity measures are strong.

Advocate's announcement of a $1B South Side Chicago investment (52-bed hospital + 10 Neighborhood Care locations) is a strategic bet on ambulatory-first care redesign in an underserved market.

Advocate enterprise is afforded the ability to invest in these initiatives given its sprawling footprint and cross-subsidy model with the booming Charlotte greater metropolitan, highly profitable area. The Pearl recently opened in Charlotte ($1.5B, 700K sq ft facility housing Wake Forest medical school), and occupancy is strong.

CEO Eugene Woods: "If you build it they will come. Well, we built it, and they're coming."

Advocate enjoyed strong pharmacy growth and supplemental payments in 2025. As depicted in the % of operating income chart, the cross-subsidization model appears to be working well thus far into the mega-merger.

Notable Callouts and Takeaways

2030 REWIRE strategy involves standing up of national service lines, curating systems of intelligence enterprise-wide, establishing an ecosystem for innovation and venture investment / piloting, and compete on a national scale.

Advocate recently announced a move into South Carolina. The Charlotte and surrounding areas enjoys significant demographic population growth, which affords Advocate much capital dispersion across its sprawling multi-state, disconnected enterprise. North Carolina successes cover up the mess that is the greater Chicago market.

AI deployment is enterprise-scale and measurable. Advocate runs one of the largest ambient documentation deployments in healthcare, with burnout dropping from 51.9% to 38.8%, among the most compelling evidence in the sector. Imaging AI processes 8M studies annually, benefiting 63,000 patients per year. Virtual nursing across 22 hospitals saved 42,000+ nursing hours in 2024.

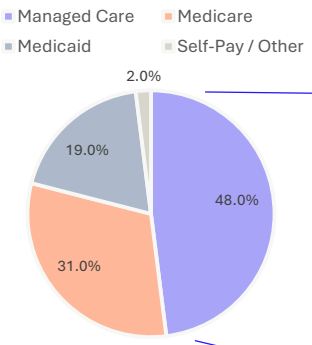
Atrium also runs one of the largest hospital at home programs in the country, affording it better throughput with acute bed capacity and better patient satisfaction via at-home care.

Key Results and Ratios (TTM 2025 ended 9/30/2025)

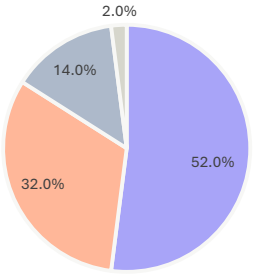
$37.9B	Total Revenue	**281.0**	Days Cash on Hand
$31.8B	Patient Revenue	**41.0**	Days' Sales Outstanding
4.1%	Operating Margin	**7.0%**	Capex % of Pt. Revenue
9.4%	Net Income Margin	**19.8%**	Debt to Cap

Combined Payor Mix

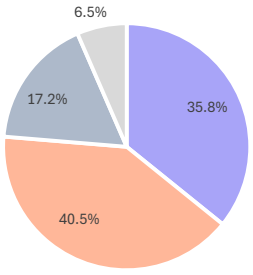
% of Patient Revenue, YTD 2025



Advocate Aurora

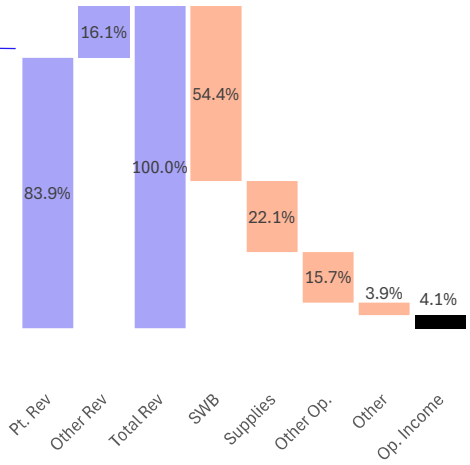


Combined CMHA

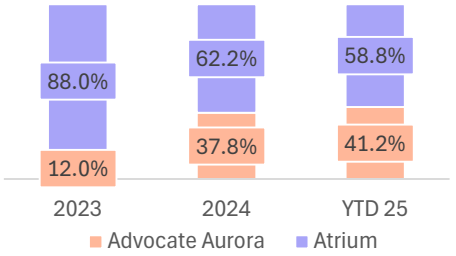


Note: CMHA reported mix as % of charges (gross revenues)

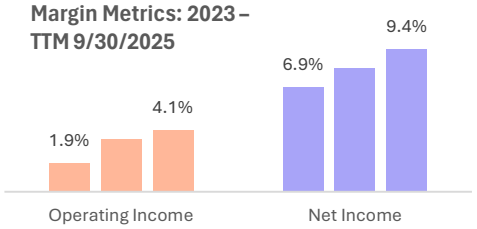
Waterfall Income Statement - Common-Sized - TTM 2025



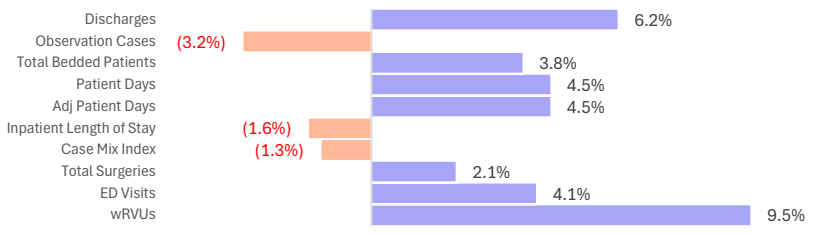
Health System % Contribution of Operating Income



Margin Metrics: 2023 – TTM 9/30/2025



Volume CAGR: FYE 2023 – TTM 2025 ended 9/30/2025



Providence 2025 Tearsheet

Executive Summary

Providence's strategic moves reflect a system under a battle for margin creation through strengthening core competencies and systematic review of non-core functions (lab, health plan). The system is currently undergoing a pivotal transition from its 2025 roadmap into a new Strategic Direction 2030, taking a more disciplined, streamlined approach to operating the sprawling health system.

To date, Providence's margin expansion efforts have been a mixed bag as it eked out positive operating margin in Q3 2025 driven by high volumes and acuity mix – down from $310M in the prior year to date period.

Providence restructured its regions from 7 down to 3 divisions to simplify decision-making and direct more resources toward more attractive service line offerings.

The Compassus home health JV (October 2024) spun off 24 home health sites and 17 hospice agencies across 5 states to PE-backed Compassus.

Labor costs are the other structural challenge. Providence dealt with a 46-day strike early in 2025 involving 5,000 caregivers. Providence has invested in nursing pipeline programs and its nurse residency program resulted in significant retention improvement and $175M in savings.

Similar to other health systems, Providence is also dealing with elevated denials and reimbursement delays.

Length of stay management has been top of mind and Providence has been successful with throughput.

Providence announced the sale of 10 skilled nursing and assisted living ministries to The Ensign Group in early 2025, with closures occurring through early 2026.

Providence downscaled its health plan membership by nearly 15% in 2025 as it shifts away from broad insurance.

Notable Callouts and Takeaways

Providence spun off its venture arm to create an independent venture capital firm called Allumia Ventures, with $150M in Fund III over the coming 10 years. It also participates in Longitude Health.

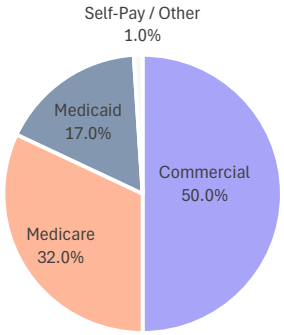
Transformation priorities include clinical support tooling, ambient documentation, care navigation and in-basket management, along with inbox management. Providence has redirected 160K messages away from provider inboxes and deployed ambient charting with 1,700 clinicians and physicians.

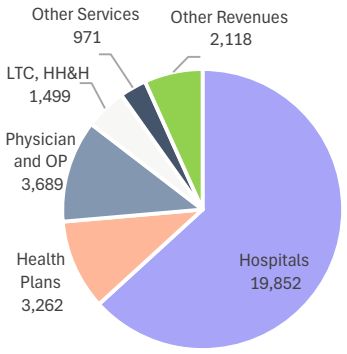
Providence reduced contract labor by ~30% in 2025.

Key Results and Ratios (TTM 2025 ended 9/30/2025)

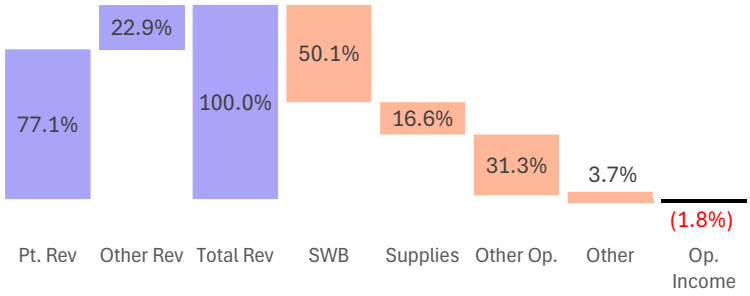
$31.4B	Total Revenue	83.6	Days Cash on Hand
$24.2B	Patient Revenue	42.4	Days' Sales Outstanding
(1.8)%	Operating Margin	3.7%	Capex % of Pt. Revenue
0.3%	Net Income Margin	45.9%	Debt to Cap

Payor Mix (% of Pt. Revenue) and Revenue Segments

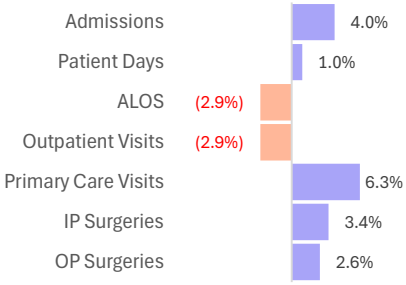




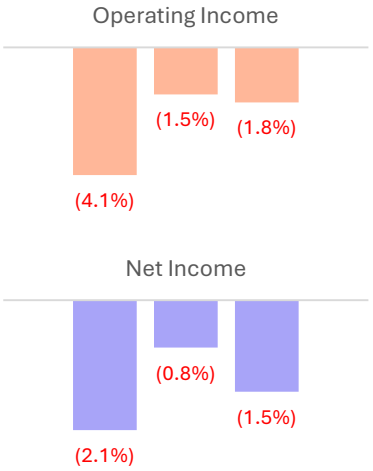
Waterfall Income Statement - Common-Sized - TTM 2025



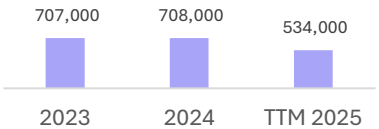
Volume CAGR: FYE 2023 – TTM 2025



Margin Metrics: 2023 – TTM 9/30/2025



Health Plan Membership



Ascension 2025 Tearsheet

Executive Summary

All eyes were on Ascension in 2025, and for good reason. That's what happens when you buy a massive ambulatory surgery center management company (AmSurg) and everyone else wants to know what you're gonna do next with all of those ASCs.

Apart from Tenet, Ascension is **executing the most aggressive, ambitious portfolio transformation in the sector**, and the moves reveal a fundamental strategic pivot from acute care dominance to ambulatory positioning. Ascension's transformation includes major portfolio realignment, with the below recent M&A noted:

- 4 hospitals and associated assets sold to Beacon Health Systemin July 2025
- 4 senior care facilities sold to Recover Care in July and August 2025
- Acquired Cedar Park Medical Center in June 2025
- Bought AmSurg announced in June 2025
- Sold dozens more in 2024 to Prime Healthcare, UAB Health, MyMichigan, and others.

On top of the above, the AmSurg acquisition (~$3.9B for 250+ ASCs) creates one of the largest ambulatory transactions in healthcare history and repositions Ascension as a major outpatient player.

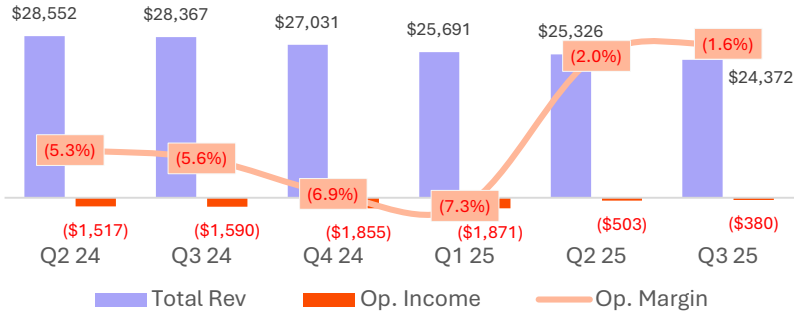
Ascension's 'ascension,' so to speak, is playing out in real time and other leaders are taking note of the nonprofit giant's playbook. Its portfolio realignment and divestiture strategy is bolstering the coffers to generate liquidity and shore up future initiatives, and the AmSurg acquisition provides a compelling narrative for investors to get behind while focusing on patient-friendly outpatient care.

More recently, post-divestiture, Ascension has been experiencing some notable revenue, volume, and expense trends. Driven by acuity and improved payor mix, its same-facility net revenue per adjusted discharge ***rose 10.8%***. In Q1 2026 (calendar year ended September 30, 2025), Ascension experienced some short-term volume softness in outpatient surgeries and outpatient physician visit volumes. Meanwhile, supplies and purchased services and other expenses are rising dangerously above or close to patient revenue growth at 9.5% and 12.1% respectively. Post divestiture, expense management and procurement will be something to watch.

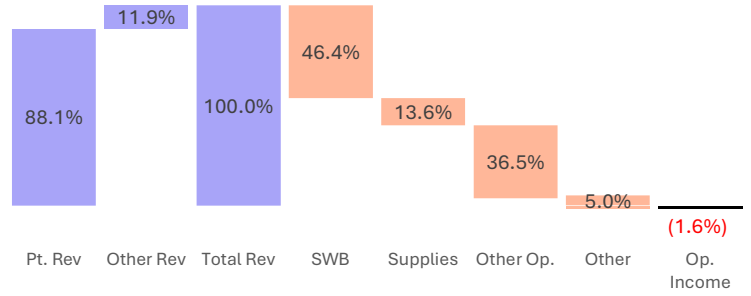
Key Results and Ratios (TTM 2026 ended 9/30/2025)

$24.4B	Total Revenue	**235**	Days Cash on Hand
$21.5B	Patient Revenue	**48.7**	Days' Sales Outstanding
(1.6)%	Operating Margin	**6.1%**	Capex % of Pt. Revenue
0.3%	Net Income Margin	**20.7%**	Debt to Cap

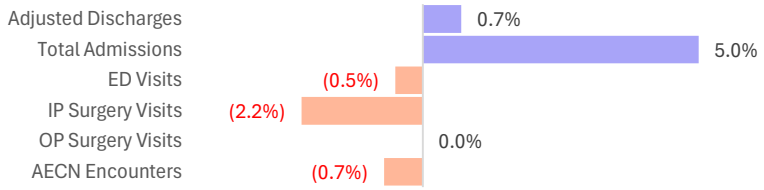
Rolling 12-Month Revenue and Operating Margin



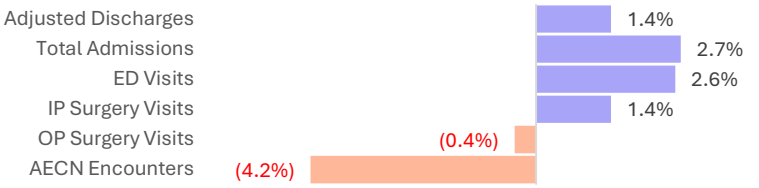
Waterfall Income Statement - Common-Sized - TTM 2026



Same-Facility YoY Growth: FYE 2025

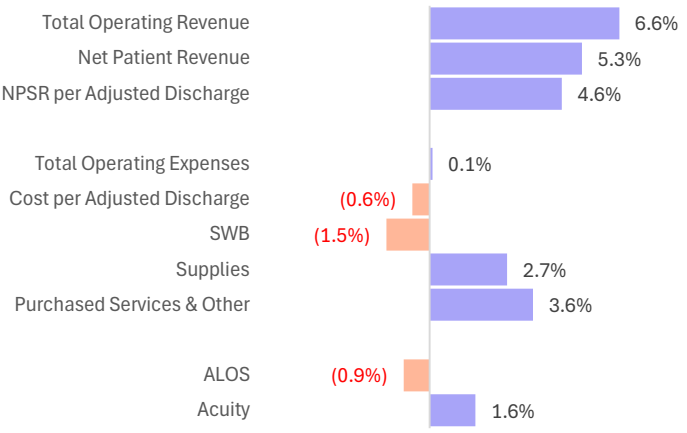


Same-Facility YoY Growth: Q1 2026

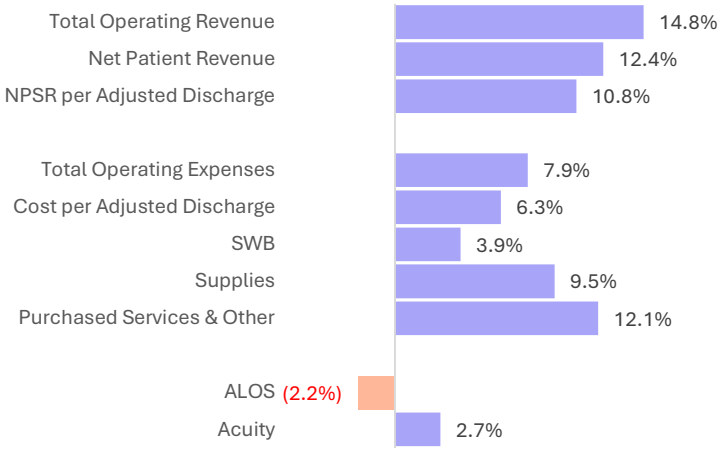


2025 Tearsheet

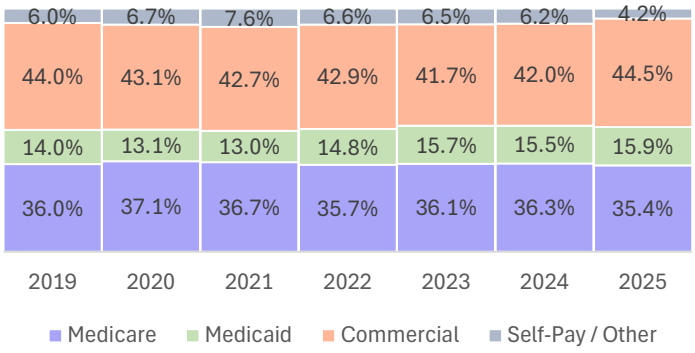
Same-Facility YoY Growth: FYE 2025



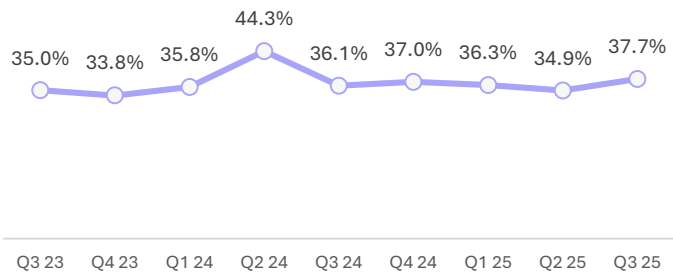
Same-Facility YoY Growth: Q1 2026



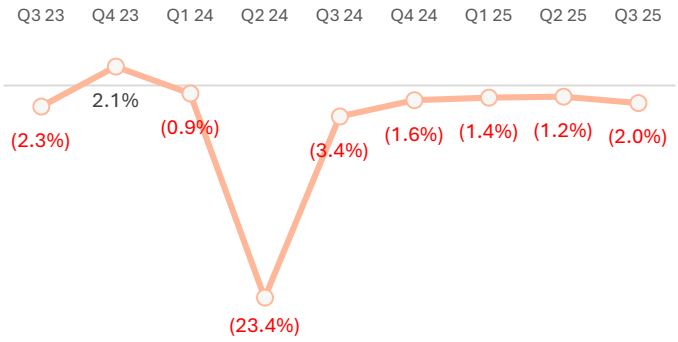
Payor Mix, % of Net Revenue



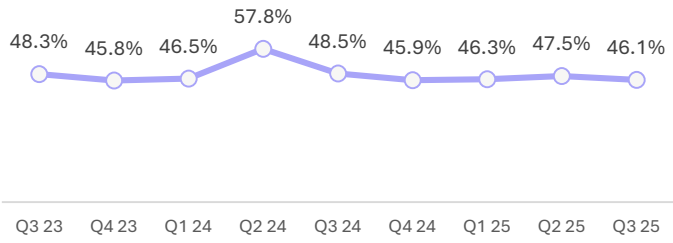
Other Operating Exp, % of Revenue



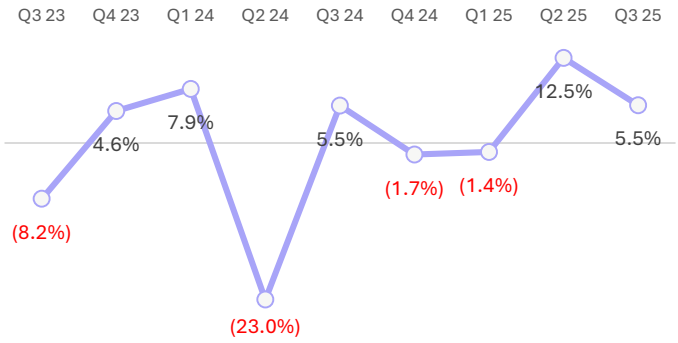
Operating Margin



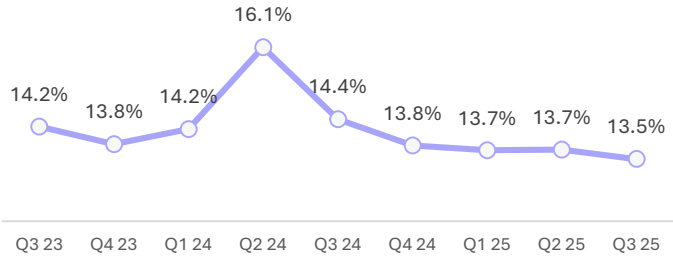
Salaries and Benefits, % of Revenue



Net Margin



Supplies, % of Revenue



2025 Tearsheet

Executive Summary

Texas's largest nonprofit is pursuing a differentiated growth strategy centered on consumer-forward ambulatory expansion, betting that areas including psychiatric services represent the next major supply-demand imbalance in healthcare.

The Geode Health JV (2025) is the campaign centerpiece of how Baylor thinks about partnerships. This partnership covers 13 existing Texas psychiatric sites with 10 new locations planned in the next 12 months and a 5-year target of 100+ sites statewide. The model is distinctive: team-based psychiatry (psychiatrists, therapists, care coordinators), TMS and other advanced treatments, and hybrid in-person/virtual care.

Baylor's bet is straightforward: Texas has one of the worst psychiatrist-to-population ratios in the country, employer demand for behavioral health benefits is surging, and reimbursement for psychiatric services is improving. Geode provides the operational model; Baylor Scott & White provides the patient base and brand. The JV structure allows rapid scaling without the capital intensity of owned facilities.

Ambulatory expansion continues on other fronts. The Surgery Partners JV (December 2025) brings Physicians Centre Hospital in Bryan, TX into a partnership structure. The NextCare JV covers 46 urgent care locations across the Texas footprint – a demographically rich arena to work within.

Financial performance is out of this world. Baylor continues to thrive as one of the best run health systems in the country, nonprofit or not.

Notable Callouts and Takeaways

The Geode Health JV (100+ behavioral health sites target) is the most aggressive psychiatric capacity play by any health system. If behavioral health is a strategic priority, study this emerging model.

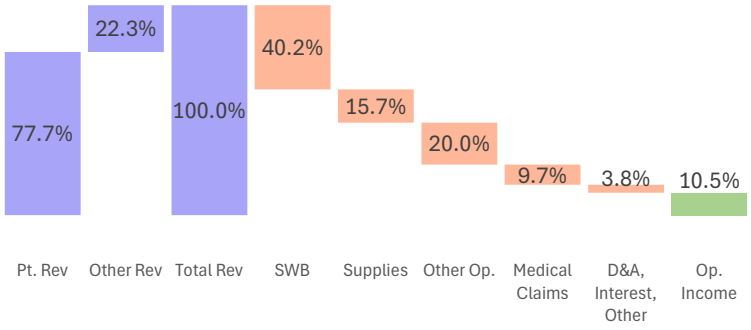
JV structures for ambulatory (Surgery Partners, NextCare, Geode, Lumexa) allow capital-light expansion.

Texas demographics (population growth, commercial payor mix, employer concentration) create favorable tailwinds that other states cannot replicate. Don't benchmark Texas margins against Midwest or Northeast peers. As they say, everything is bigger in Texas.

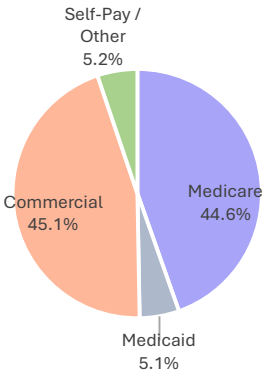
Key Results and Ratios (TTM 2026 ended 9/30/2025)

$17.9B	Total Revenue	**311.8**	Days Cash on Hand
$13.9B	Patient Revenue	**31.4**	Days' Sales Outstanding
10.5%	Operating Margin	**8.0%**	Capex % of Pt. Revenue
14.2%	Net Income Margin	**22.4%**	Debt to Cap

Waterfall Income Statement - Common-Sized - TTM 2026

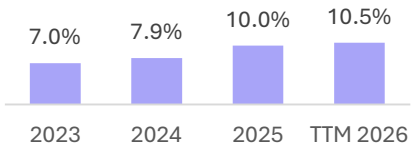


Payor Mix (% of Gross Revenue)

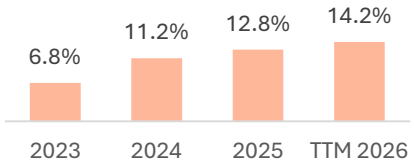


Margin Metrics: 2023 – TTM 9/30/2025

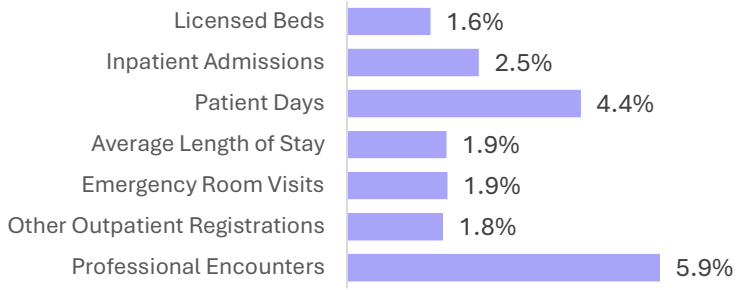
Operating Margin



Net Margin



Volume Trend: 2023 – TTM 2026 (2.25 Yr CAGR)



Conclusion

4

Section Contents

What's Next and the 2026 Outlook

Here is what the next five years will reveal. Some health systems will look back at this moment and recognize it as the inflection point where they chose transformation. They will have made uncomfortable decisions. They will have weathered internal resistance, board skepticism, and the gravitational pull of "nobody ever got fired for waiting." They will have treated AI not as an IT procurement category but as a strategic capability worthy of executive obsession. They will have cannibalized their own workflows before competitors did it for them. These organizations will be unrecognizable from their 2025 selves. Leaner. Faster. More clinically effective. More financially sustainable. They will have moved beyond administrative automation into clinical and operational transformation. They will have hired differently, organized efficiently, and deployed capital with a sense of urgency that felt foreign to an industry conditioned for incrementalism. Most importantly, they will have won.

Other health systems will look back at this moment and wonder what happened. They will have done the "responsible" thing. Formed committees. Waited for the EHR or to see what everyone else is doing first. Protected every stakeholder equally until there was nothing left to protect. They will have treated transformation as a line item instead of an identity. Of course, these organizations will not disappear overnight. Healthcare doesn't work that way. But they will lag out over a decade of margin compression and talent flight.

The difference between these two futures is not anything physical or tangible today. The difference is leadership. How do you think Nick Saban always won? The organizations that die during paradigm shifts rarely lack the raw materials for survival. They lack the conviction to deploy them. You have assets that matter. Trusted brands built over decades. Employed physicians who are the backbones of transformed care models. A sprawling healthcare enterprise to be your sandbox during the most exciting technological time in history. Data at a scale that, if properly orchestrated, becomes a genuine competitive differentiator. But every quarter you wait, the value of incumbency declines and the capability gap with aggressive competitors widens. The healthcare AI paradox is real, but it is not destiny. Yes, local politics make workforce transformation difficult. Yes, mission statements create constraints that Amazon does not face. Despite the limitations and regulations and red tape in healthcare, the organizations that navigate the paradox will do so by leading through it. They will communicate a vision that reframes technology substitution as workforce sustainability. They will reinvest savings visibly into patient-facing capacity. They will make the case that the alternative to transformation is not stability but…collapse.

I'm an eternal optimist, and I mean it when I say we are living through the most exciting era in the history of healthcare. The tools becoming available in the coming years will reshape what is possible in ways that would have seemed like science fiction a decade ago. The autonomous era is the new paradigm – and now the single greatest opportunity for cost transformation, quality improvement, and workforce sustainability that this industry has ever seen. The tragedy would be standing at the threshold of genuine transformation and choosing to wait. The tragedy would be explaining to your board in 2029 why you are now a turnaround situation when the path forward was visible in 2025.

Do not let fear of disruption blind you to the possibility of reinvention. The survivors in every industry that faced technological discontinuity did not merely defend against the new. They became something new. They found ways to leverage what made them distinctive while shedding what no longer served. They accepted short-term pain for long-term positioning. They led when leadership was uncomfortable. You have that opportunity. It is sitting in front of you, waiting to be seized or squandered. The orchestration era is beginning. The policy environment is shifting toward consumer-directed spending. The AI capabilities are compounding faster than any technology cycle in history.

None of this is slowing down to wait for your committee to finish its assessment. This is the beginning. Seize your moment.

Why Healthcare Needs Administrative Autonomy

Health systems are operating under growing pressure. Costs are rising faster than revenue, with staffing now close to 65% of total spend. Teams are being asked to do more with the same or fewer people, while too much time still goes to low-value administrative work. The outcome is familiar: burnout, errors, denials, compliance risk, revenue leakage, and patient experiences that miss the mark.

Hiring more people will not solve this. What's needed is a more efficient operating model that deliberately drives cost out of core processes, routine work is handled by technology, and care teams focus on clinical judgment, complex cases, and bonding with patients.

We call it an Autonomous Health System.

Leading systems are moving past disconnected point solutions toward automated execution across clinical, operational, and financial workflows. Organizations that do not invest in AI-enabled operations will find it increasingly difficult to compete over the next decade, as expectations around speed, quality, and experience continue to rise.

At Innovaccer, we built our platform and solutions to make this transition real. Our unified data and AI foundation connects workflows in real time and enables automation at scale.

We would like to invite you to join us for an executive briefing to share our vision for an autonomous health system, and how your organization can move from manual, fragmented administrative work to AI-driven administrative automation at system scale.

In this briefing, we will walk through how health systems are using Innovaccer to:

- Augment staff to reduce low-value administrative work
- Reduce errors, denials, and delays
- Drive better patient outcomes and experience
- Unlock new revenue opportunities

If this resonates, we would welcome the opportunity to host you for a focused executive discussion on what healthcare autonomy looks like in practice, and the financial and operational leverage it can unlock for your organization.

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Hospitalogy

About Blake

Blake Madden is the Founder and Creator of Hospitalogy, a newsletter affiliated with Workweek Media that provides the latest insights on health system transformation. Blake brings relevant thought leadership and in-depth analysis to more than 50,000 healthcare decision makers since launching Hospitalogy in April 2022. Prior to joining Workweek, Blake worked at healthcare consulting firm VMG Health, where he provided valuation and advisory services for clients across all healthcare services verticals including nonprofit health systems, ambulatory surgery centers, urgent care, imaging centers, physician practices, and more.

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