The Strategist

HEALTH MANAGEMENT TheAcademy

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Key Market Dive

How top-performing systems are continuing to grow their Hospital-at-Home capabilities

The market for Hospital-at-Home services was a hot topic in 2020 during the initial rollout of Medicare's Acute Hospital Care at Home waiver program. However, health system interest has receded somewhat since then. The market has divided into haves and have-nots: while some health systems have closed their programs because of meager uptake (like **ProMedica and Adventist Health**), a select few have reached mature scale.

For this week's Key Market Dive, we spoke with program leaders from **Mass General Brigham**, **Mayo Clinic**, **Advocate Health**, and **Mount Sinai Health System** to understand the factors that have helped their programs endure and scale. Each of these systems have continued to grow their programs' average daily census to sustainable levels, with a clear strategic vision for how advanced home care capabilities can meet clinical and financial needs. We'll share snapshots of several of these models below.

In many ways, these successful systems are outliers. The vast majority of programs have not reached critical scale, with average daily censuses hovering around just 10-20 patients. While the experiences of the top programs are atypical, we think their success offers lessons for other programs that are still struggling to achieve scale.

Before we get into these lessons, let's first address the elephant in the room: uncertainty about the long-term fate of the Medicare H@H waiver.

Uncertainty over the federal waiver

Policy uncertainty over the fate of Medicare's AHCAH waiver program has made other systems more reluctant to invest in these capabilities.

H@H has a long track record of success internationally. However, adoption in the U.S. was anemic prior to the pandemic, with roughly 20 HaH programs across the U.S., mostly in Medicare Advantage and Veterans Affairs settings. Since the Medicare AHCAH program's launch in late 2020, nearly 380 hospitals in 39 states have received a waiver.

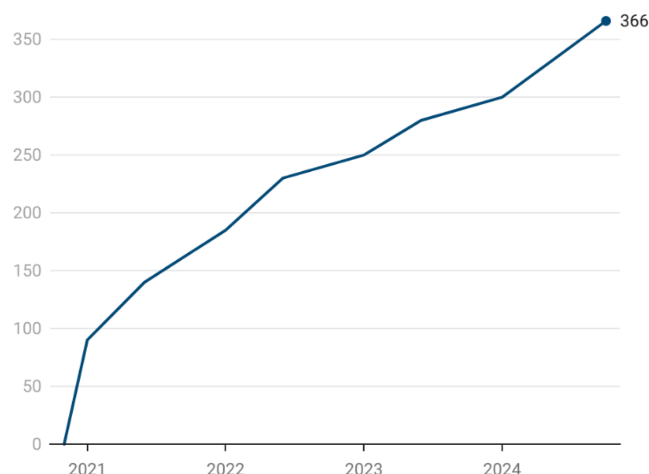
The waiver lets systems care for patients in the home without 24/7 onsite nursing. The Medicare-led proof of concept has also sparked private payer interest in similar models (with most following the federal government's example).

The AHCAH program has been extended twice by Congress: for two years in 2022 and for a further 90 days in December 2024. While bipartisan legislation to permanently extend the program was widely expected to pass last year, opposition to a lame duck healthcare reform bill sunk the effort to pass a permanent legislative fix.

Congress now faces a March 31 deadline to extend the program. While most stakeholders expect lawmakers to meet that deadline, some expect Congress to authorize a two to five year extension instead of making the program permanent.

"Our teams have been very active in Washington, we've done Hospital-at-Home demos on the Hill so that those leaders can feel and touch what it is. We are optimistic still that even if the waiver is pushed a little bit, it will continue to be there." - Denise Keefe, SVP of the Continuing Health Division at Advocate Health

While many health systems have sought to expand their programs beyond the waiver (thus diversifying revenue away from just Medicare), the program's expiration would likely shutter some programs. Sensing a shift in the tide, some programs have plans to shift their focus from inpatient replacement to early discharge programs (i.e. an outpatient-at-home model) if the waiver expires.



With this uncertainty in mind, we've researched how the top programs are diversifying their revenue sources and finding strategic value in H@H, despite financial and operational hurdles.

Six lessons from our research into top-performing programs

Before we dive into snapshots of the top programs, here are six lessons that repeatedly cropped up from our interviews and other research into the market:

1. **Many programs are expanding beyond care outlined in the waiver:** Some of the most successful programs in this space are continuing to grow their average daily census by reaching new patient populations, often at higher levels of acuity or need (e.g., post-surgical care at home, SNF at home, palliative care at home, oncology-at-home). While these services often fall outside of the umbrella of the federal hospital-at-home program, they draw on many of the same resources and serve as a complement to home hospital capabilities.
    - Broad trends are pushing the industry in this direction: while the number of seniors with chronic diseases is projected to double this decade, inpatient hospital and SNF closures have reduced capacity to care for these patients in traditional settings.
    - Some programs are also weighing expansion to pediatric populations, which have their own unique challenges and opportunities.
    - **Systems are also targeting higher acuity patients within their H@H programs.** While most programs initially focus on patients with simpler conditions (e.g. UTIs or cellulitis) with shorter average LOS, private payers that reimburse for H@H are concerned that a focus on low-acuity patients undercuts the value proposition and potential for savings. Therefore, several systems are targeting these higher-acuity patients to engage private payers and grow contracts.

"As we've matured, we certainly see higher acuity patients coming into the home. The expectation that we'll be taking care of complex patients in the home has really gone up." - Denise Keefe, SVP of the Continuing Health Division at Advocate Health

2. **Many systems see strategic value despite a financial subsidy:** Systems typically reach a financial breakeven point at an average daily census of around 30 patients, but most programs are still well below this figure. A variety of indirect benefits justify these programs' costs to some system leaders:
    - **Capacity and arbitrage:** Many systems with strong HaH programs face problems with a lack of sufficient capacity in their inpatient facilities. In addition, some systems also face strict limits on their ability to build additional inpatient beds (factors include capital constraints, rising construction costs, and CON laws). By moving eligible patients into the home, these systems are freeing up inpatient beds for higher-acuity patients.
    - **Quality and cost:** Payers are interested in home hospital care's potential for higher quality care (e.g., lower readmissions) and cost savings. With that said, several of the program leaders we interviewed say they've negotiated for reimbursement parity with inpatient care and would prefer to reinvest any savings back into the program.
        - Some providers such as **DispatchHealth** do offer payers discounts for home hospital care, creating competitive pressures.
    - **Patient satisfaction:** Systems want to give patients options, and many patients express a preference for home care when offered. A 2024 survey conducted by the **University of Southern California** found that 47% of U.S. adults expressed a preference for home hospital care, compared to 17% who disagreed (with the remaining 36% neutral).

"We want to go from acceptable to preferable… When we can get to the point where it's smooth and sleek like Amazon, and the patient can get what they need instantaneously with an app on their phone, then we've won the game, that's really what we're aiming for." - Dr. Michael Maniaci, medical director for Mayo Clinic's Care Anyplace division

3. **There's greater urgency to work with private payers:** Uncertainty about the fate of the federal waiver program has driven urgency among many systems to establish or expand home hospital contracts with commercial and MA payers. In addition to the higher-acuity service lines mentioned above, some systems are also catering to lower-acuity patients that need less monitoring than required by Medicare in the waiver.
    - For example, **Ochsner Health**, **Los Angeles General Medical Center**, and **Tru PACE** in Colorado are all offering simpler versions of the home hospital program with greater potential for cost savings than the full Medicare program.

4. **More systems are looking at partnerships for scale:** Health systems have leaned on partnerships with other providers and vendors to drive faster growth, especially with respect to technology and software platforms that often fall outside of their core competencies.
    - Some home hospital programs have sought to jumpstart their connections with payers by leveraging their partners' existing relationships. This has been a key selling point for **Contessa** and **Medically Home**, although these partnerships have sometimes fallen short of these expectations.

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- Some health systems without their own substantial HaH programs are also considering partnerships with other health systems that have scaled-up programs in their market or adjacent markets. This could allow them to leverage these capabilities (and get capacity relief) without investing in their own infrastructure.
  - Program leaders at Advocate Health told us they've formed an "affinity group" with other systems with strong H@H programs (who do not have competitive overlap), where best practices and market intelligence are freely shared.

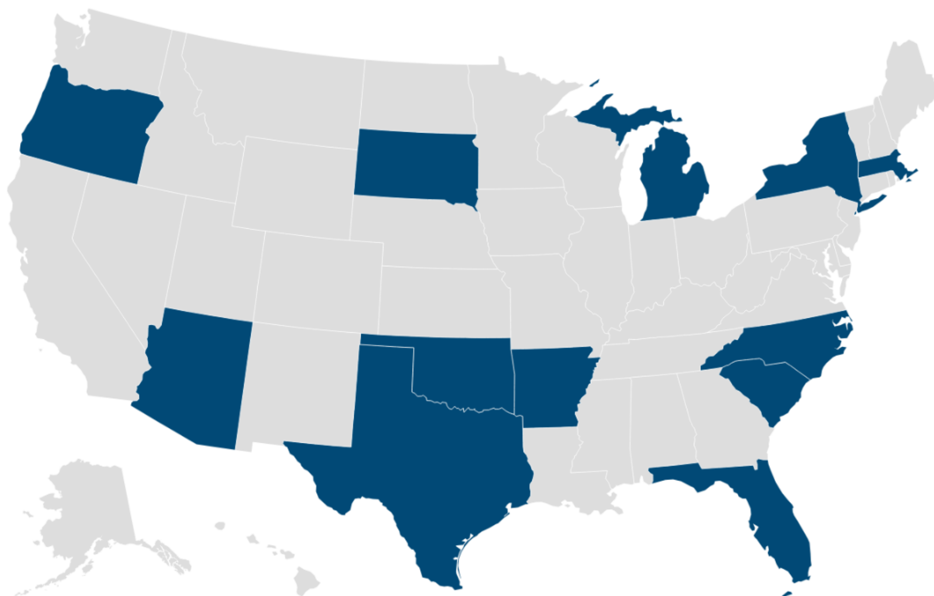
5. **Staffing remains a key limit on growth, even for scaled programs:** Industry-wide shortages of clinical staff (including nurses) and high turnover make it more difficult to build out home hospital programs as they start to achieve greater scale. This challenge is compounded by the fact that home hospital staff need additional training to operate effectively in this relatively novel care setting.
   - There's growing interest in the industry to enable paramedics to provide in-home support in lieu of an APP or nurse—a model that 18 states currently allow.

"Our top three challenges are staffing, staffing, and staffing…it takes time, you need to hire the right people, and you need to make sure they're trained properly in this relatively new and growing model of care." - Dr. Ania Wajnberg, president of Mount Sinai at Home.

6. **Local market conditions can limit or expand a program's growth potential:** Even if your system's program is doing everything right, local factors can put a hard limit on scale and cost-effectiveness. And conversely, some markets are a natural fit for Hospital-at-Home expansion.
   - **Density:** Home hospital programs in dense urban markets benefit from reduced travel times for staff (who are traveling from the participating hospital and between multiple patient homes).
   - **Facility construction:** Real estate is also typically more expensive in these markets, adding to the challenges of building out inpatient capacity. CON laws are also a limiting factor in some states. This makes H@H more compelling financially.
   - **Hospital type:** A study published in *JAMA* last year found that uptake of the Medicare AHCAH waiver was concentrated among large urban teaching hospitals.
     - In addition to their dense geography, these systems often have greater resources that they can invest in the program during early stages.
   - **Policy environment:** Some states have more complex regulations for home health and home hospital care that add to the compliance burden for systems.
     - Only 12 state Medicaid programs offer reimbursement for home hospital care.

Twelve state Medicaid programs support H@H

State Medicaid programs that provide coverage for Hospital-at-Home



Source: State Campaign for Hospital at Home • Created with Datawrapper

Our snapshots of top-performing programs

To help our readers see many of these lessons in action, we've compiled three brief snapshots based on our interviews with program leaders from MGB, Mayo Clinic, and Mount Sinai:

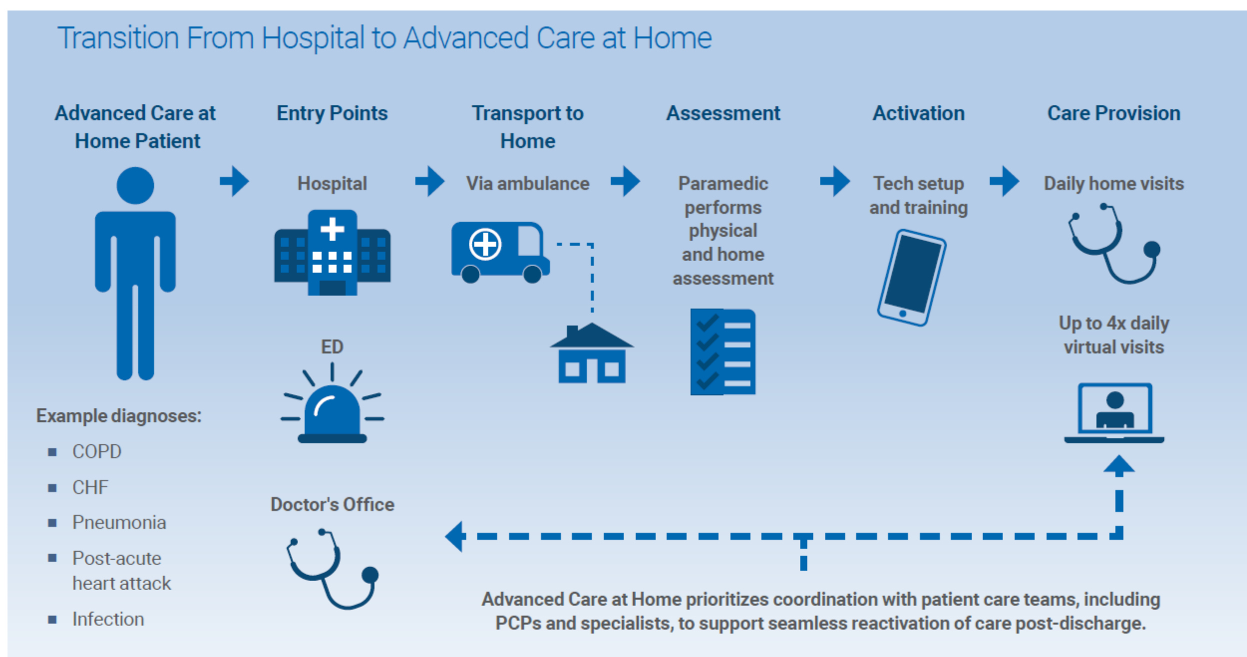
Snapshot: Mayo Clinic's hub-and-spoke model gets a tech upgrade

We spoke with Mayo Clinic's Dr. Michael Maniaci, who serves as the medical director for Mayo's Care Anyplace division. He discussed how the system's centrally managed program is expanding its reach with the help of **innovative AI algorithms and more advanced RPM capabilities.**

What they offer:

Mayo Clinic's Advanced Care at Home program was launched in 2020 in collaboration with **Medically Home**. The program employs a virtual-hybrid model, with a command center headquartered in Jacksonville, Fla. and satellite care sites in Wisconsin and Arizona.

Providers in Jacksonville care for patients across state lines in combination with daily in-person visits from nurses, paramedics, or APPs. Clinical staff working at the command center receive specialized training and rotate between the virtual hospital and the physical hospital.



Initially, the program adopted a technology-lite approach without significant reliance on remote patient monitoring. More recently, Mayo has expanded its capabilities to include point-of-care blood testing and is piloting wearable devices for remote diagnostics (e.g. a patch that measures blood pressure and heart rate). Some of these advancements are being made in partnership with Medically Home, while others are developed in-house.

According to Maniaci, more advanced monitoring helps provide longitudinal flexibility after the patient's discharge from home hospital. As the system brings in more technology, he says their focus will be on simplicity and ease of use.

For patients that have travelled for surgeries or procedures, Mayo also offers patients the option to stay in a specialized "care hotel" with RPM capabilities while they recover.

What's new:

- **Broader eligibility:** Mayo has focused on expanding its home care capabilities to take on a broader range of patients. Instead of focusing on discrete conditions (like cellulitis or pneumonia), Mayo is targeting a given level of acuity and greenlighting any patients at or below that level for home care. Broadly speaking, if a patient is located close enough to the hospital and doesn't need advanced radiology, surgery, or ICU-level care, they're eligible for treatment at home.
  - Mayo has accomplished this in part by adding new capabilities (e.g. suction devices for advanced wound care).
- **Additional types of care:** In addition to home hospital care, the system is now using its home care infrastructure for:
  - Chemotherapy patients with support from oncologists.
  - A pilot program that offers family medicine patients virtual same-day assessments, with triage to in-home care when appropriate.
  - Post-procedure post-operative care.
- **New technology:** AI and advanced data analytics for identifying eligible patients from chart data and connecting them with resources by showing their providers an estimated likelihood

of success in at-home care. The system is working towards building a unified application to track patient needs and supply chain demands.

- The system is also looking to try a pilot for drone-based medication, laboratory, and medical equipment delivery.

Growth and finances:

The program sees over 200 monthly admissions, and the average daily census across the three sites consistently reaches between 30-40 home hospital patients, up from 10-20 patients in 2023. In addition, the command center also handles up to 20 post-surgical patients at a time, as well as a handful of chemotherapy patients.

Maniaci attributes the program's overall financial sustainability to three factors:

1. Driving volumes to keep a full virtual hospital ward.
2. Generating care efficiencies with better care coordination (ultimately reducing the number of staff needed for daily visits) and proper medical care (to reduce waste).
3. Partnering with Medically Home on supply chain efficiencies to optimize paramedic and nursing visits throughout the market.

Payer relationships:

While Maniaci says the majority of Mayo's home hospital patients have Medicare coverage, **more patients with commercial insurance are now able to receive inpatient level care in their homes.** The system's payer mix is now 64% traditional Medicare, 27% commercial (including system employees), and 9% Medicare Advantage.

While commercial payer adoption was slow in the early stages of the program, more commercial payers are recognizing the value of the Hospital at Home care and providing coverage. That value includes a better patient experience, fewer readmissions to the ED or hospital, and a lower cost of care to patients over time. For now, the emphasis is on continuing to streamline high-quality care in the home.

Snapshot: How Mass General Brigham keeps growing one of the nation's largest home hospital program

We spoke with MGB's VP of Strategic Business Operations Danny Metzger-Traber about how the system has been able to achieve scale. **As of last August, the system stated that it runs one of the largest hospital-at-home program in the country,** and they plan to grow by expanding to new patient populations and new settings.

What they offer:

MGB provides a wide range of home-based services under the umbrella of their MGB Healthcare at Home division. The Home Care service line offers traditional home health services (skilled nursing, physical/occupational/speech therapy, nutrition, home health aides, case management), while the Home Hospital program offers an alternative to traditional inpatient stays for acute patients.

The MGB Home Hospital services include frequent visits from program staff, technology to monitor and communicate with patients, personalized care plans, and wraparound services. While many of these features are typical, the program's utilization of 24/7 continuous RPM is fairly unique.

Home Hospital Service Components

Dedicated Program Staff	Technology	Monitoring
▪ Daily visit from a licensed MGB provider (MD or APP); twice daily visits from a registered nurse or paramedic; 24-hour provider coverage ▪ Mobile integrated health (MIH) paramedics	▪ Two-way text and video communications promote access ▪ Clinically validated questionnaires are promoted on MGB's app ▪ EMR-based patient screening tools ▪ Video interpreter services	▪ 24/7 continuous RPM ▪ Wearable biosensors collect outputs; analytics are applied to incoming data ▪ Centralized RPM RNs respond to clinical escalations
Care Personalization	**Health Equity**	**Metrics**
▪ Home Hospital conditions include heart failure, COPD, pneumonia, UTIs, skin infections, and more ▪ Other conditions can also be managed easily; each care plan is tailored to unique patient needs. Patients must reside within specific zip codes to be eligible for care.	▪ Care teams perform early needs assessments of sensory or cognitive impairment and provide augmentation devices and integrated interpreter services ▪ Wraparound services	▪ **Clinical:** escalations (unplanned returns to the hospital during care episode), readmission rates ▪ **Operational:** referral origin, response time, time on scene, on-time performance ▪ **Financial:** direct cost, utilization 30-day cost, payer type ▪ **Experience:** patient satisfaction

MGB partnered with **Best Buy Health** to leverage their technology and support services, including the **Current Health** care-at-home platform, logistics support (patient kit processing, in-home setup and training on technology), and a personal emergency response device through **Lively Mobile**. Metzger-Traber says the system chose to work with Best Buy because they needed a thoughtful industry partner with software experience to co-develop platforms that help grow the program.

What's new:

- **New capabilities:** In addition to general medicine, the program has recently expanded its post-operative footprint (e.g., for patients recovering from colorectal/spinal/lumbar procedures). The program also now offers hypertension care for postpartum patients as part of an OB service line.
- **New settings:** MGB is also collaborating with the **New England Center and Home for Veterans** to offer care for homeless veterans in their Safe Haven residences. This has been a difficult population to reach because patients that have secured public housing are often reluctant to do an inpatient hospital stay because they fear their housing will be reassigned to someone else during the stay.

Growth and finances:

The Home Hospital program has the capacity to care for 70 patients at a time (up from 40 patients in 2023) and covers five hospitals in the Greater Boston area. On a monthly basis, the program sees approximately 350 discharges. The hospitals' physical proximity and the region's high population density help MGB achieve economies of scale.

"There is so much involved in the culture change for your clinicians and your community to be doing this care at home. If you think you're just dipping your toe in, or that you'll just have one doctor doing this on the side, you're never going to invest enough in it, it's never going to take off." - Danny Metzger-Traber, MGB VP of Strategic Business Operations

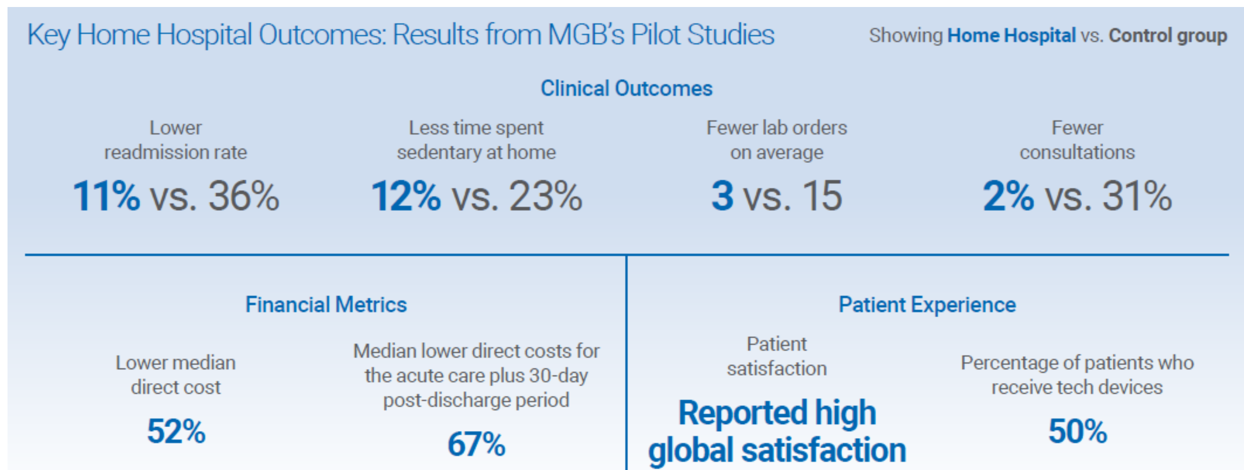
The cost for a Home Hospital patient is similar to brick-and-mortar. While providing the direct care is slightly more expensive in Home Hospital because individual services can be less efficient, overhead is less expensive than in brick-and-mortar. As MGB continues to scale the program, they

expect efficiency to increase as these fixed costs continue to get spread over a larger volume of patients.

Metzger-Traber says that the system also benefits from “**acuity arbitrage**”: by caring for lower acuity patients in the home, MGB frees up inpatient beds for higher acuity patients. MGB often faces high facility occupancy rates exceeding 115%.

Payer relationships:

Two internal studies conducted by MGB (in 2016 and 2019) have helped the system attract substantial business from commercial payers. Metzger-Traber estimates that **30% of the program’s volume comes from commercial plans**, with roughly half that amount attributed to Medicare Advantage plans.



MGB is negotiating for payment parity between hospital-provided services and home-based services, which has been a difficult sell given initial expectations throughout the industry that HaH care would be a lower-cost alternative. The health system is also working with payers to transition certain post-acute patients to the home setting more quickly (e.g., for a C-section patient that wishes to go home earlier).

While nearly a third of MGB’s home hospital volume comes from commercial payers, Metzger-Traber acknowledged that uncertainty over the extension of the federal Acute Hospital Care at Home program remains a potential risk for the current model. Commercial payers often follow the federal government’s lead, although he notes that the system was already working with at least one local payer on home hospital capabilities before the pandemic.

At the state level, Metzger-Traber says Massachusetts’ state Medicaid agency has been supportive and willing to reimburse at parity with inpatient stays. As of June 2024, it’s one of only 12 states to provide Medicaid coverage for home hospital care.

Snapshot: Mount Sinai’s home hospital program achieves steady growth with expanding capabilities

We spoke with Dr. Ania Wajnberg, president of Mount Sinai at Home. She discussed how growth has been driven by the program’s **expanding list of covered diagnoses, the importance of early partnerships, technology integration, and a supportive payer landscape.**

What they offer:

Mount Sinai's hospital at home program was initially established in 2014, making it one of the earliest offerings in this space. In addition to home hospital care, the system also offers sub-acute rehabilitation care in the home, palliative care at home, and more traditional home health services.

In accordance with New York State regulations, the home hospital program includes twice-daily in-person visits provided by nurses rather than paramedics.

In terms of technology, the system has worked with **Biofourmis** to provide patients with a two-way communication tablet that also offers patients the ability to check their vital signs. Mount Sinai has also developed advanced telemedicine capabilities, such as an audio-enhanced stethoscope that lets providers hear heart and lung sounds remotely.

To accelerate the program's launch and growth in 2017, Mount Sinai partnered with **Contessa** (now owned by **Amedisys**, which itself is in the process of being acquired by **UnitedHealth Group**). Wajnberg says the partnership was critical in part because of the complexity of the New York market and its regulatory requirements.

Growth and finances:

Mount Sinai's home hospital program has more than quadrupled in size over the past two years, growing to an average daily census of approximately 30 to 35 patients.

Wajnberg says the program has achieved steady growth by expanding the array of diagnoses and treatments that the program covers, including dialysis, post-surgical care, and monitoring for complex cardiac conditions. The program has also partnered with the system's oncology specialists to help cancer patients reduce their length of stay and receive some treatment in the home (e.g., treatment for related infections).

In terms of finances and logistics, Wajnberg says the relatively small, dense geography of the NYC market makes it easier and more efficient to deliver care in the home.

Payer relationships:

The program's payer mix is split roughly 50-50 between Medicare and private plans (although the latter group includes MA plans). Unlike many other systems' programs, Mount Sinai already had contracts with payers that predate the Medicare waiver.

Patients can be admitted to the home hospital program through the ER if they have an insurance plan with **Healthfirst, Aetna**, **Empire**, or FFS Medicare. If patients have been in the hospital for more than 48 hours, the program accepts all insurance plans.

Wajnberg says the program appeals to payers as both a lower-cost and higher-quality setting for certain patients. However, while the system's relationships with payers predates the Medicare waiver, she says many payers are now waiting to see what happens with the waiver to see if federal support for this kind of care becomes permanent.

Market Scans

1. Breaking News: Walgreens revives PE deal to go private

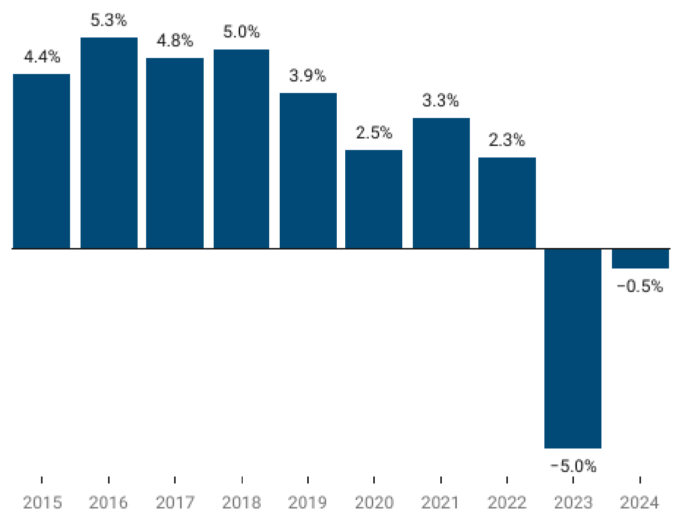
According to a new report in *The Wall Street Journal*, **Walgreens** is getting nearer to a deal with PE firm **Sycamore Partners** to take the struggling retail chain private in a $10B deal. The deal could be completed as soon as this week, and Walgreens' stock rose 10% on the news.

If the deal goes through, Sycamore is expected to keep the core U.S. retail business and sell off (or take public) other parts of the company. The PE firm followed a similar playbook when it acquired the office-supply retailer **Staples** for $6.9B in 2017.

The news comes several months after Walgreens announced plans to close up to 1,200 underperforming locations (15% of their overall footprint) and sell off its remaining stake in **VillageMD**. Walgreens also sold off shares in the drug distributor **Cencora** for $1.1B last August and a further $300M last month. Together, these moves have been widely interpreted as a retreat from the company's ambitions to become a retail primary care disruptor.

So What?

As we wrote when the potential deal was first reported on last December, the acquisition could provide Walgreens with a much-needed infusion of cash and give the retailer a longer runway to figure out its faltering healthcare ambitions, but a leveraged buyout could also create financial pressures that lead to bankruptcy.



Like other retail pharmacy chains (including CVS), Walgreens' margins have steadily eroded since 2018. While turning around this trend is a tall order, Sycamore's likely decision to spin off other parts of the business into their own business units could give the pharmacy unit a renewed focus. Closing hundreds of underperforming stores and reducing the complexity of their offerings could help them more easily identify profit centers to expand and cost drivers to cut. However, each business line would be unable to rely on the other components, which might doom smaller businesses (such as its Shields specialty pharmacy) if it has to re-build it's infrastructure for patient engagement.

So What for LHS?

Perhaps the biggest upside for health systems with this news is that the sale of VillageMD will likely proceed (it's not even mentioned in the Sycamore news coverage), offering the Village Medical assets fairly cheaply in many markets. Some systems like **Banner Health,** are reportedly already in talks to acquire primary care sites.

From the perspective of health systems, Walgreens' struggles and retreat from healthcare have eliminated its competitive threat as a disruptor. Compared to a few years ago, the overall threat to volumes posed by retail disruptors has faded as many have face challenges or pulled back from their offerings, although some (e.g., **One Medical** and **Amazon**) still could be a threat. This also doesn't exclude payviders which are still growing volumes in some markets and some forecasters like **Bain** expect will continue to gain market share.

While Walgreens has struggled to grow its U.S. healthcare segment, it's possible that spinning off this part of the business could create a more disciplined retail healthcare business that once again eyes growth. However, given the unit's $14B operating loss in 2024, we think it's perhaps more likely that it will get sold off for parts. In that case, it could be an opportunity for health systems (or payviders) to also scoop up Walgreens store assets on the cheap.

2. Teladoc faces allegations of AI misuse in therapy sessions

Virtual primary care and behavioral health disruptor **Teladoc** saw its stock fall nearly 20% amid allegations that the company's therapists are cutting corners by using AI-generated responses.

The report, released by short seller **Blue Orca Capital**, also argues that Teladoc is "far less profitable and generates far less cash than investors are led to believe." Teladoc's recently released Q4 earnings report recorded a net loss of $1B in FY2024, including a $790M non-cash goodwill impairment charge linked to its **BetterHelp** acquisition.

The Blue Orca report includes alleged examples of generative AI use by BetterHelp therapists, including an alleged admission by a therapist:

11:51am

May I ask, was AI used to write all or part of that response? It struck me as odd, so I ran it through a couple AI checkers. I am concerned if my privileged communications were shared with an AI model.

12:05pm

Hi thank you for asking. I do refer to AI at times **without** revealing any client information,. Sometimes it helps me form my thoughts in ways I would like to express to my clients. If this is a concern please let me know so I can handle it accordingly and not refer to Ai any more. Thank you!

1:00pm

January 8, 2025

Video live session cancelled
Thu, Jan 9, 2025 at 12:00pm EST

1:37am

Source: Excerpts from Therapy Session of Whistleblower Patient #1

In a response through its legal counsel, Teladoc says Blue Orca's allegations are "vague and unsubstantiated" and that therapists are prohibited from disclosing members' personal or health information to third-party AI services. The company also says it promotes live video calls over text-based messaging, and that an internal Trust and Safety team monitors for non-compliant use of AI. BetterHelp's privacy policy includes a disclosure of AI use for repetitive tasks and session documentation.

Across the industry, the use of AI chatbots for therapy has attracted increasingly negative attention. According to a recent article in *The New York Times*, the chief executive of the **American Psychological Association** gave a presentation to the FTC that cited two ongoing court cases featuring AI chatbots posing as therapists.

So What?

The controversy with Teladoc highlights several of the themes we discussed in *The Strategist* last June in our deep dive on AI chatbots and scaling virtual behavioral health.

Disruptors like Teladoc and **One Medical** are setting consumer expectations with technology and access, but their models also often push the envelope on staff productivity. While AI can be a workforce enabler if used responsibly, it can also be a dangerous way for overworked staff to cut corners or put patient privacy at risk—which may have been the case at Teladoc, if Blue Orca's allegations pan out. However, it's worth remembering that Blue Orca is a short seller with a vested interest in portraying Teladoc in the worst possible light.

Here are three broader lessons that we think health systems can take from this episode:

1. Clinical staff can "go rogue" and use generative AI in prohibited ways.

Teladoc claims to have internal guidelines against the use of external AI tools, but the Blue Orca report appears to show admissions from several therapists that nonetheless did so—raising the question of whether these therapists did so of their own initiative without Teladoc's knowledge.

If large organizations (like health systems) want to avoid the risk of similar incidents, it will likely require a combination of better training and advanced monitoring to prevent the use of unauthorized AI services on company devices. This kind of unauthorized "shadow" AI use is increasingly common, and health systems need to prioritize trainings that discourage dangerous practices like inputting sensitive patient information.

It's possible that Teladoc's rapid growth led to compromises in training, or that it's virtual-only model makes it harder to monitor staff working from home.

2. Some patients are on the lookout for generative AI and feel discomfort with its use.

In several instances in Blue Orca's report, patients reported their own suspicions that therapists were using AI, and one patient ran the responses through an online GenAI detection tool because they struck him as "odd." When their suspicions were confirmed, patients said they found the experiences "dehumanizing" and "uncomfortable."

As public awareness of GenAI tools (and their limitations) grows, patients are getting better at recognizing their use and are forming their own opinions about appropriateness. Health systems should consider which uses of AI have greater public acceptance (e.g., automated phone trees at call centers) versus those that could generate greater controversy (e.g., messaging with a live therapist). Health system leaders should consider formalizing this work by convening patient councils and other feedback mechanisms.

It's worth pointing out that Teladoc's defense only claims that it bans the use of *external* AI tools.

3. Health systems' trusted brands could give them a competitive advantage over disruptors.

The negative attention generated by the Blue Orca report adds to the list of controversies that Teladoc and BetterHelp have faced in recent years related to staffing and patient data misuse. Consumer concerns about AI and data privacy could give health systems an opportunity to lean on their strengths as trusted pillars of their community with long track records. With that said, most health systems aren't offering therapy and therefore aren't in direct competition with BetterHelp's services.

As AI use continues to proliferate, large organizations (including health systems but also disruptors like **Optum** and **One Medical**) will need to publicly account for how they apply these technologies.

Other News to Know

1. Trump administration keeps Biden-era merger guidelines

- In late February, FTC Chair Andrew Ferguson notified his agency's staff that the stricter merger guidelines finalized under Biden in December 2023 will remain in place under the new administration.
    - In the memo, Ferguson emphasized the importance of stability in the merger review process across different administrations. If guidelines changed with every

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administration, he wrote that they would be "worthless to businesses and the courts" and "destabilizing."
        - Ferguson did leave the door open to further revisions after a transparent and careful review process.
    - The decision is disappointing for some business leaders who were anticipating an uptick in corporate consolidation under a newly loosened framework for evaluating mergers.
- As a reminder, the Biden administration made several changes to the FTC review process:
    - **The updated 2023 merger guidelines** give regulators more aggressive tools to challenge horizontal and vertical mergers, with a greater emphasis on reducing market concentration and harms to competitors and labor.
        - While these guidelines are not legally binding, they provide transparency into the agency's decision-making process.
        - At the time, the **AHA** criticized the guidelines for ignoring modern economic scholarship and ignoring the benefits of both horizontal and vertical integration in healthcare.
    - **Changes to the HSR premerger notification requirements**, finalized in October 2024, require greater disclosures and documentation from merging parties.
        - The HSR revisions recently went into effect, and Ferguson's memo notes that the agency received a burst of merger applications just before the new reporting requirements went into effect.

So What?

- While it's not unusual for enforcement agencies to seek a measure of stability across administrations, the decision to keep the guidelines as-is is somewhat surprising given the Trump administration's tendency to swiftly reverse Biden-era policies. While it's possible that the new administration will enforce the guidelines differently in practice, it's worth remembering that former FTC Chair Lina Khan's stricter approach to antitrust did have some fans on the right (including Vice President JD Vance).
- As we've written in the past, the Biden-era guidelines (and HSR rules) will force health system leaders to take a more careful approach to M&A, with "best effort" covenants to reduce the risk of drawn-out mergers and heftier break-up fees for failed deals. Health systems may also seek to cultivate better relationships with payers and regional systems whose hostile testimony could help scuttle deals.
    - The guidelines' focus on vertical consolidation could limit the growth of payviders like UHG, whose scale and aggressive tactics have been a growing source of frustration. On the other hand, these same guidelines could limit health systems' ability to grow via M&A (with other systems or smaller assets like ASCs).
        - The Biden-era guidelines also call for greater scrutiny of cross-market mergers that had become more common in recent years as a way to avoid traditional antitrust scrutiny. Even mergers that feature no competitive overlap can now be challenged.

News Flashes

According to a report in *The Wall Street Journal*, the Justice Department is investigating **UHG**'s risk-adjustment practices in Medicare Advantage.

- Reportedly, this civil investigation is separate from the DOJ antitrust probe that was originally reported on in February 2024.

Memorial Sloan Kettering is partnering with **Amazon Web Services** to accelerate oncology research using AI. The goal is to analyze troves of patient data to predict the patients' disease trajectories and recommend individualized treatments that take into account factors like genetics and patient preferences.

MultiPlan is rebranding as **Claritev**. The announcement comes several months after the healthcare cost management company faced lawsuits and accusations of collusion with health insurers.

In a legal filing on Feb. 19, the Trump administration indicated it would defend the legality of the Medicare drug price negotiation program created during the Biden administration in legal challenges brought by drugmakers.

In Case You Missed It

JAMA Open — *Health Care Staffing Shortages and Potential National Hospital Bed Shortage*

- Researchers with UCLA forecast a rise in hospital occupancy rates over the next decade due to the aging population, rising from a national average of 75% in 2024 to a new average of 85% by 2032. Some experts say this level of occupancy would constitute a dangerous shortage, raising questions about how the healthcare system as a whole will cope.

The Wall Street Journal — *Why We Don't Trust Doctors Like We Used To*

- A trend piece discussing the factors driving declining trust in physicians, including disjointed care, poor doctor-patient communication, and the rise of online self-help.

Milbank Memorial Fund — *The Health of US Primary Care: 2025 Scorecard Report — The Cost of Neglect*

- This report offers state-level and national indicators on the state of primary care access. It identifies key barriers limiting patient engagement in the U.S., including declining investment, a diminished workforce, arguably misdirected graduate medical education funding, low investment in EHRs, and a lack of research.

In the Numbers

$44B is the combined amount that 41 states would need to spend next year to maintain expanded Medicaid coverage if Republican lawmakers in Congress move forward with proposed federal cuts, according to a report by **Urban Institute** and the **Robert Wood Johnson Foundation**.

$144B of U.S healthcare spending went towards the treatment of type 2 diabetes between 2010 and 2019, the most of any single condition, according to a recent study in *JAMA*. The researchers also

found that 42% of overall spending went toward ambulatory care, compared to 24% on hospital inpatient care.

50% is the approximate decrease in median household wealth experienced by patients in the years leading up to a dementia diagnosis, according to a 2023 *JAMA* study recently cited by **AARP**.

70% of healthcare workers work in provider settings, including 7.4M who work in hospitals. However, more than half of the U.S. healthcare workforce are in non-clinical roles.

Idea of the Week

"You don't trust those people with the big fancy desks. They're not being honest. They're transferring our jobs to the Philippines."

– An anonymous employee for UnitedHealth speaking with *STAT* about the company's recent layoffs.