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In cooperation with: Kurt Salmon

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Utilization of Healthcare Services *Special Report*

Most healthcare leaders would agree that the industry is in the midst of one of the most transformational changes in its history. There is recognition from payors, providers, and government officials that the current system is based on a perverse incentive model that rewards the provision of "sick care" as opposed to "well care." Tolerance for the current model is rapidly declining. Today, numerous healthcare organizations have started their transformational journeys, and promising models have emerged that are having early successes. While best practices will continue to evolve, the care delivery models and incentive structures that need to be developed for future success are becoming more defined. Networks of providers will be accountable for managing the health of defined populations, and provider reimbursement will be at risk for providing high value care. It is our belief that to have success in this new paradigm, organizations must remove significant amounts of excess utilization and lower the medical cost of their attributed lives. What is not clear is how much utilization will need to be removed and how quickly it must happen. While these two factors will certainly be market dependent, this report explores the expectations of healthcare executives on how healthcare utilization will change in the future and compares their expectations to where we believe healthcare organizations will need to drive utilization levels to be successful in the future.

Factors Impacting Utilization Change

There are numerous factors that will continue to transform healthcare delivery and provider payment models over the next five to ten years. Types of changes include new care delivery models, technology advancements, and new value-based reimbursement methodology. While the healthcare market has experienced movement in the direction of providing "well care" over the last several years, it is our opinion that the movement will accelerate over the next five years as the providers that are first to market with high-value networks will have distinct competitive advantages.

Some of the key factors that will account for organizations removing excess utilization and the associated cost are:

- Programs that educate physicians on ways to provide care more efficiently
- Disease management programs that actively manage patients with chronic conditions and that are at risk
- Utilizing care teams with physician extenders to allow physicians to focus on caring for sicker, high-risk, and chronic patients
- Demand management programs that teach members when to seek medical assistance
- Changes in health plan design that incentivize patients to seek care in more appropriate settings and incentivizes healthy behaviors and preventative care
- Active use of case managers to facilitate treatment of acute and chronically ill patients, and coordinate their care
- Increased care management and changes to reimbursement models that require providers to first use less costly medical options prior to interventions
- Financial incentives that reward providers for efficient utilization and quality outcomes
- Integrated networks that coordinate the use of appropriate levels of care (e.g., post-acute, ambulatory care) and limit duplication
- Information systems that support the monitoring of utilization and compliance with evidence-based practices
- Clinical data warehouses and analytical tools that locate chronic populations and use predictive modeling to determine high-risk populations to be targeted for early intervention
- Digital channels that utilize algorithm for treatment of minor health issues and the use of telemedicine

Methodology

An electronic survey was distributed in March 2014 to executives and board members at hospitals and health systems around the country. The survey asked respondents to predict changes in utilization of various services. In each case, they were asked if, over the next five years, they expected to see an increase or decrease and the magnitude of the change.

123 surveys were completed. Over 80% of respondents were C-level officers, with the remainder consisting of Presidents, Senior VPs, and board members. Responses came from 38 states. There was broad representation from both small and large hospitals as well as respondents representing independent hospitals and hospitals part of health systems.

The survey responses were compared to the differences between Well Managed and Loosely Managed utilization benchmarks for healthcare delivery systems as defined by actuarial consulting firm Milliman, in its Health Cost Guidelines (HCGs). The HCGs are a set of benchmarks for healthcare utilization and cost, based on data from commercial insurance carriers and Medicare. The two sets of benchmarks make up a spectrum that ranges from organizations with limited medical management activities (Loosely Managed) to organizations that perform extensive medical management activities (Well Managed). The Well Managed benchmarks in aggregate represent a theoretically achievable model of care, but are not necessarily being achieved by any organization across all metrics in today's environment.

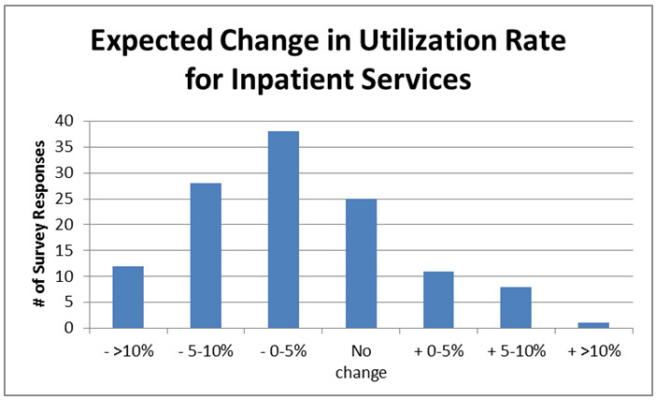
Currently, the utilization for most health care delivery systems falls closer on the spectrum to the Loosely Managed benchmarks than the Well Managed benchmarks. The assumption used for our analysis is that health care delivery systems will be moving toward the Well Managed benchmarks over the course of the next five years (although it is our expectations that the majority of healthcare organizations will take longer than five

years to achieve Well Managed utilization levels). Therefore, by measuring the gap between the Loosely Managed and Well Managed benchmarks of the HCGs, we can begin to estimate the potential change in utilization as organizations transition over time and compare this to the expectation of the healthcare executives from the survey.

Detailed Findings

Inpatient Comparison

When asked how the utilization of all inpatient services, measured by admissions per 1,000 population, would change over the next 5 years, 63% of our survey respondents expected a decrease, 16% expected an increase, and the remaining 21% expected no change. On average, the expected change was a 3% decrease. Among the executives predicting the largest decreases, 5 out of 12 executives specifically cited increased population health management as a primary contributor to the decline.



Based on the estimates built using the HCG data, a well-managed population should see a reduction of inpatient admissions per 1,000 population of 30% relative to loosely managed levels (which are already 10% lower than they were 5 years ago). This figure is based on real data observed from plans and providers that have more mature population health management in place. While it is unlikely that care will fully transition to Well Managed levels over the next five years the discrepancy between the survey estimate and these models (along with recent historical trends) suggests that executives are not preparing for demand changes of this scale.

To gain additional insight, we asked similar questions about the utilization of specific inpatient services. Surprisingly, when asked about Cardiovascular, Orthopedic, General Surgery, General Medicine, Oncology, and Neurosciences inpatient services, the average executive expected an increase in utilization for all of these other than General Medicine. Even among those executives who expected overall inpatient services to decrease by at least 5% (40 of the 123), almost two-thirds expected an increase for any particular non-General Medicine service line in the next 5 years. Based on our data-driven models, all of these should expect decreases of 25-35% from a transition to Well Managed population health.

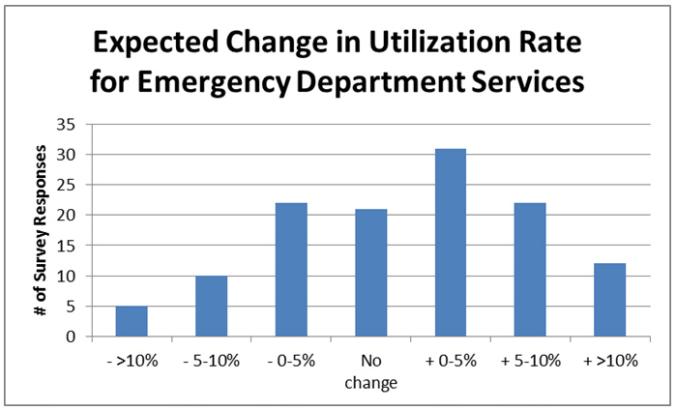
A total of 8 executives referenced the aging population at least once in their responses, with the references spread around the various service areas. We recognize that while changing reimbursement models and population health management should result in decreasing utilization of many services, the steady aging of the US population is expected to counteract the impact somewhat. The percentage of US residents, older than 65, is projected to increase from 14.5% to 16.3% by 2019, which should result in a 4-5% increase in utilization of inpatient days based on current utilization patterns.

Another frequently-cited reason to expect fewer inpatient visits was a shift towards observation care. CMS's changing definition of observation care makes it difficult to project using data, but 77% of survey respondents expect increased utilization, with 30% expecting an increase of at least 10%. This latter figure is by far the most extreme response of any question surveyed.

Emergency Services

Of the areas surveyed, there was the least consensus about the future utilization of Emergency Services. Over 40% of executives expect changes of at least 5%, but they are split on whether that will be an increase or decrease. On the whole, the respondents tended slightly towards increase, with

53% expecting some amount of growth. Of those predicting utilization increases that provided a rationale, the most common was lack of access to primary care. The executives predicting decreased utilization cited competition from urgent care centers, and better utilization of primary and specialty care.



The HCG data suggests a reduction of visits per person of around 35% between a loosely-managed population and a well-managed population. As with inpatient services, the discrepancy between the survey response and this calculated figure suggests executives are not expecting this level of dramatic change in the near future. However, unlike Inpatient Services where the overall trends were in the same direction, there was more disagreement among executives on the direction the use rate will shift in the future.

Diagnostic and Treatment Services

Roughly, 75% of survey respondents expected changes of less than 5% in utilization of both major imaging (CT, MRI, PET) services, and interventional labs (Cath, Electrophysiology, Interventional Radiology). A slight majority did expect some increase in Interventional Labs, resulting in an average projection of 2% growth. For major imaging the average was a small fractional percentage decrease. Here again we see a large discrepancy between the survey responses and the HCGs. In this case, the data suggests that most markets have significant over utilization of Major Imaging and decreases of over 50% utilization will be seen if markets fully transition from Loosely Managed to Well Managed care. Additionally, decreases in many markets could end up being around 30% for interventional procedures.

The executives expected more changes to surgical services. By asking about both inpatient and ambulatory surgery, it is clear they collectively anticipate a shift in utilization from the former to the latter. Nearly half the respondents expect inpatient surgery to decline, with most of the rest expecting no change. Almost 80% expect an increase in ambulatory surgery, giving an average projection of 4% growth. However, despite this near-unanimity, it is again in conflict with the HCG data, which anticipate declines of 24% in inpatient surgery admissions, and over 40% of facility-based ambulatory surgery visits. These ambulatory surgery figures represent the widest discrepancy between survey response and the data model.

We agree with the respondents, there will be a shift of inpatient to outpatient surgery over time. The HCG data is a current snap shot of benchmarks from Well Managed and Loosely Managed markets that does not take into account the potential for additional services to be performed in outpatient settings over time. That being said, after conducting comparative market utilization analysis for numerous markets we have seen significant difference in the utilization of ambulatory surgical services, where arthroscopic knee surgery may have a 60% higher use rate in one market than the national median or laparoscopic cholecystectomy occurring 120% more often in another market than the national median. To that end, it is our belief that even with the shifting of surgical settings as markets transition to Well Managed ambulatory surgery use rates will decline in the future.

Ambulatory Clinics

The closest we came to agreement between the executives and the data model was in terms of Ambulatory Clinic services. The model predicts very modest declines of 3% for primary care and 11% for specialty clinics, both of which would also be offset by approximately a 2% increase in utilization due to aging. In our survey data, less than 10% of executives projected declines in each of

primary care and specialty care clinic utilization. While in both cases large majorities projected small changes, those changes were almost all positive. On average they project a 5% increase in primary care along with 3% in specialty care. It is important to note that the HCG data does not take into account the utilization of digital channels for providing ambulatory care in the future. While predicting the impact of technology on ambulatory clinic use rates is difficult; some healthcare technology experts are projecting 30-40% of visits could be conducted via telephone or through digital channels in the future.

Conclusions

The local aspect of healthcare mean the level of healthcare utilization decreases will happen at differing paces throughout the country; however, the results of the survey show that many healthcare organizations likely do not understand the potential magnitude for utilization reductions and/or believe that most healthcare organizations will not have the structures in place to make significant changes over the next five years. It is our opinion that most healthcare organizations will not achieve Well Managed benchmarks over the next five years (although some will surpass them on selected metrics), but organizations should be conducting long-term planning that takes into account these types of reductions. Provider organizations will also need to consider how their asset portfolios will evolve in the future and begin to think in terms of consolidation and delivering care in alternative lower cost settings instead of planning for growth as they have been historically accustomed.

Additionally, the scale of the opportunity to remove duplication and waste and to create value will have a significant impact on most healthcare market places. The first movers to value-based delivery will have a distinct market advantage over those that continue to live in the fee-for-service world if they are able to capture the value that they are creating. Most markets have significant opportunity to lower excess utilization and medical loss. The health systems that are able to do this well will be able to go to market at a substantially lower price point and shift considerable numbers of lives and market share to their delivery network. The impact of which will accelerate the pace of consolidation in the healthcare market. ■

About the authors

This report was produced in collaboration with the Health Care Group of **Kurt Salmon**, a global management and strategy consulting firm that enables health care organizations to realize critical strategic advancements, create value from clinical integration, transition to population health management and achieve performance improvement. For further information, visit: www.kurtsalmon.com/healthcare.

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