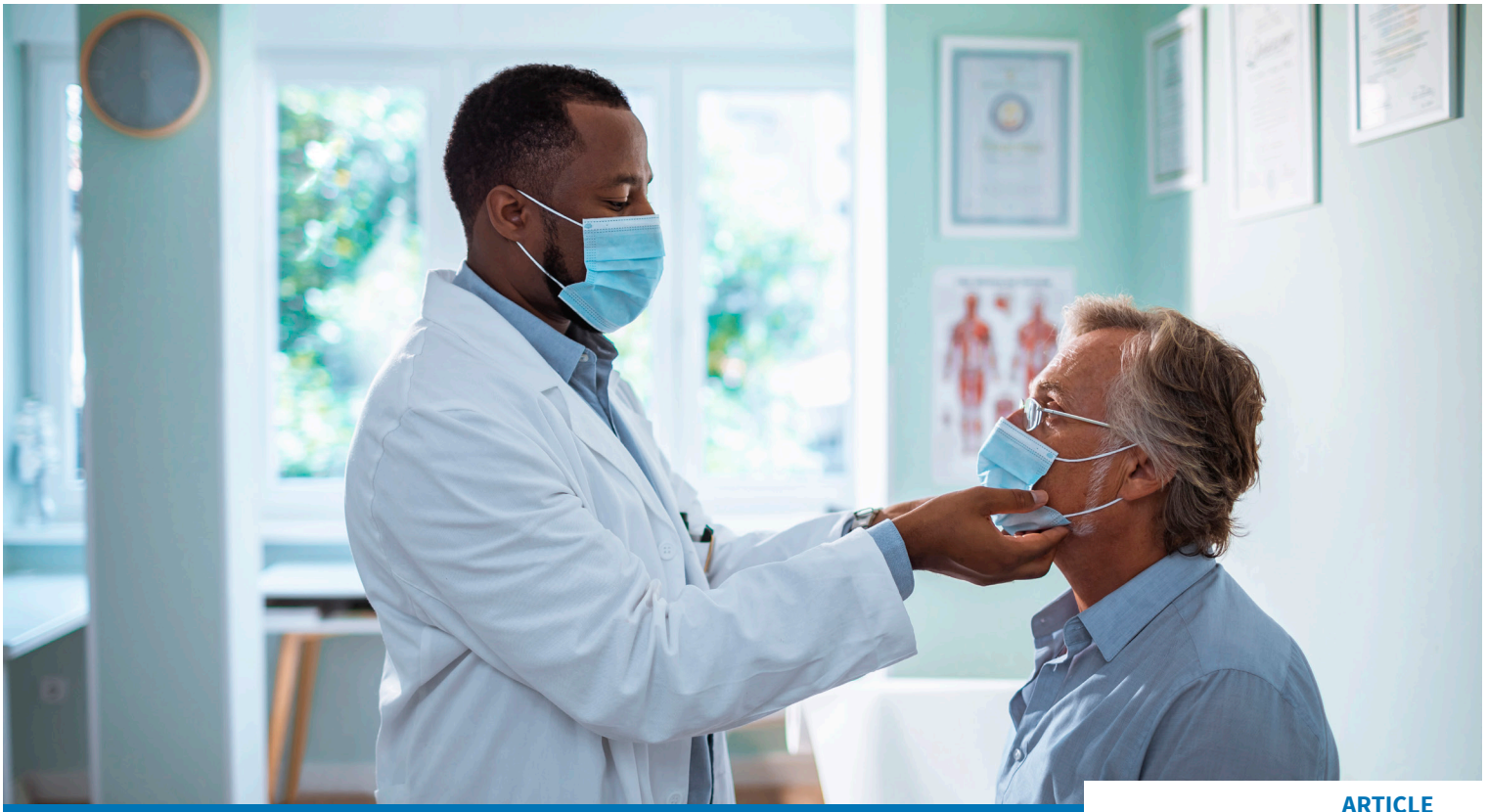

ARTICLE

The Transformation of Ambulatory Care

Ambulatory care is undergoing a fundamental transformation. Increasingly, physicians are employed by hospitals, health systems, payers and most recently, private equity firms. Strategic partnerships such as with ambulatory surgical centers (ASCs) and accountable care organizations (ACOs) have superseded M&A as a local market growth strategy. Consumer segmentation, based on values, beliefs, priorities, attitudes and lifestyle, is becoming essential to attract, engage and retain patients. Value-based care is driving business models that focus on fewer emergency department visits, hospitalizations and re-admissions.

Hospitals and health systems need to adjust their ambulatory strategy. Though they still account for one-third of healthcare spending, the centrality of "brick and mortar" hospitals and health systems is no longer sustainable in an increasingly consumer-centric, value-based and technology-oriented ecosystem.[1]

In this article, we highlight the trends leading to our conclusion and formulate recommendations.

[1] Centers for Medicare and Medicaid Services. National health expenditures projected https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected

Healthcare trends: Aging, consolidation, consumerism and clinician shortages

The U.S. population age 65 and older is forecast to increase from 54.8 million in 2020 to 72.1 million in 2030, reflecting a compound annual growth rate of 2.8%. The elderly population accounting for higher costs — those over 75 years of age — is growing at 4.0% per annum.[2] A rapidly aging population, along with emerging technology and payer and provider consolidation, contribute to rising costs; national healthcare expenditures are projected to reach $6.2 trillion or 19.7% of GDP in 2028.[3] Seventy-four percent (284) of MSA-level markets had highly concentrated payers (Herfindahl-Hirschman Index >2,500) in 2019, with an average HHI of 3,473.[4] During the past year, there were 79 hospital and health system transactions.[5] Consumerism is driven by changes in retail purchasing experience and digital transformations, the latter including use of telehealth during the pandemic. Clinician shortages of nurses and physicians are already evident.

The implications of these trends are fundamentally altering care delivery.

Healthcare Trends

Trend	Implications
Rapidly aging population	Increased demand for services; focus on chronic disease management (prevention); need for care delivery innovation
Rising costs	Increased focus on value-based care; i.e., payment innovation; fewer hospitalizations, readmissions and ED visits Rising importance of primary care physicians (and advanced practice practitioners) Shift of procedures from higher-cost hospitals to lower-cost ASCs; from HOPD to outpatient clinic
Payer consolidation	Increased patient steerage to lower cost physicians and settings
Hospital consolidation	Higher prices and local market share
Rising consumerism	Growing importance of value, convenience, affordability, transparency, experience, privacy Growth of on-demand provider access; ie., telehealth, urgent care, retail clinics
Digital transformation	Increased automation, use of machine learning and predictive (risk) analytics
Clinician shortages	Higher wages for nurses and primary care physicians

[2] The Next Four Decades: The Older Population in the United States, 2010 to 2050 https://www.census.gov/prod/2010pubs/p25-1138.pdf

[3] Centers for Medicare and Medicaid Services. National health expenditures projected https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected

[4] American Medical Association, Competition in Health Insurance: A Comprehensive Study of U.S. Markets; 2020 update https://www.ama-assn.org/delivering-care/patient-support-advocacy/competition-health-insurance-research

[5] National Institute for Healthcare Management. Hospital Consolidation: Trends, Impact and Outlook, Slide 4 https://nihcm.org/publications/hospital-consolidation-trends-impacts-outlook; Kaufman Hall: Hospital industry made 79 deals in 2020, down from 92 in 2019; January 12, 2021 https://www.fiercehealthcare.com/hospitals/kaufman-hall-hospital-industry-made-79-deals-2020-down-from-92-2019

Shift to outpatient volume

Despite a growing and aging population, the number of hospital admissions has declined 10.7% since 1980.[6] During this period, length of stay has declined by 26.5%, from 7.4 to 5.4 days.[7,8] The declines in admissions and length of stay reflect the adoption of DRGs in 1983, the implementation of the two-midnight rule in 2014, the shift to outpatient procedures, the growth of high deductible plans and the emergence of value based care.

A recent study published by Health Affairs found Medicare Advantage (relative to Medicare fee-for-service) was associated with "higher use of preventive care visits, fewer hospital admissions, fewer emergency department visits, shorter hospital and skilled nursing facility lengths-of-stay, and lower health care spending."[9] The Medicare Advantage penetration rate is 36%, with 25 million enrollees; the annual growth rate is 9%.[10] The Congressional Budget Office (CBO) projects that Medicare Advantage enrollees will make up 51% of all Medicare beneficiaries by 2030.[11]

Accountable care organizations (ACOs) are highly focused on emergency department visits, hospitalizations and re-admissions.[12] In 2021, approximately 11.9 million Medicare beneficiaries were enrolled in 518 ACOs; 10.7 million (90 percent) in the Medicare Shared Savings Program (MSSP) and 1.2 million (10 percent) in Next Generation ACOs.[13]

The Acute Hospital Care at Home program is an expansion of the Hospital Without Walls initiative launched by the Centers for Medicare & Medicaid Services (CMS) in March 2020 and allows for the home treatment of patients seen in the emergency department and inpatients occupying hospital beds. Data from Johns Hopkins and Mt. Sinai substantiates an improvement in outcomes; i.e., fewer ED visits, a lower readmission rate and reduced costs.[14] As of April 9, 2021, 53 health systems, 116 hospitals are participating in the program.[15]

In 2019, private health insurance accounted for 40.3% of hospital expenditures, whereas government funded programs such as Medicare, 25.3%, and Medicaid, 16.4%, accounted for much of the remainder.

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[6] Statista https://www.statista.com/statistics/459718/total-hospital-admission-number-in-the-us/

[7] Statista https://www.statista.com/statistics/183916/average-length-of-stay-in-us-community-hospitals-since-1993/

[8] Length of Average Hospital Stay Drops 22%. New York Times; May 25, 1988 https://www.nytimes.com/1988/05/25/us/length-of-average-hospital-stay-drops-22.html

[9] Rajender Agarwal, John Connolly, Shweta Gupta, and Amol S. Navathe, Comparing Medicare Advantage and Traditional Medicare: A Systematic Review. Health Affairs; June 2021 https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.02149?utm_medium=email&utm_source=hat&utm_campaign=june2021issue&utm_content=agarwal&utm_source=Newsletter&utm_medium=email&utm_content=Comparing+Medicare+Advantage+And+Traditional+Medicare&utm_campaign=HAT%3A+6-22-21&vgo_ee=02LyKJ6GDHXv1XDcEhOn3WD11sNKPU9s6kBG1B0E%2FXI%3D

[10] Medicare Advantage National Penetration Rates. Medicare Guide; June 2, 2021 https://medicareguide.com/medicare-advantage-national-penetration-rates-84150

[11] Ibid.

[12] Hospices take note: ACOs focused on reducing hospitalizations. Hospice News; January 13, 2020 https://hospicenews.com/2020/01/13/hospices-take-note-acos-focused-on-reducing-hospitalizations%EF%BB%BF/

[13] Centers for Medicare & Medicaid Services — Shared Savings Program Fast Facts, as of January 1, 2021 https://www.cms.gov/files/document/2021-shared-savings-program-fast-facts.pdf

[14] Mount Sinai's hospital-at-home model improves patient outcomes. Modern Healthcare; June 25, 2018 https://www.modernhealthcare.com/article/20180625/TRANSFORMATION03/180629954/mount-sinai-s-hospital-at-home-model-improves-patient-outcomes

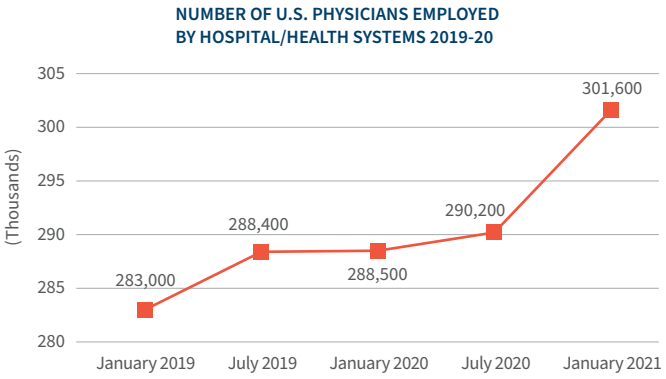
[15] Acute Hospital Care at Home Program. Centers for Medicare and Medicaid Services; April 9, 2021 https://www.cms.gov/files/document/covid-acute-hospital-care-home-program-approved-list-hospitals.pdf

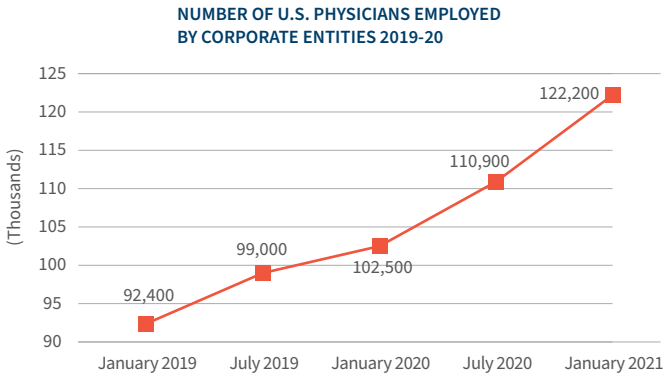
[16] National healthcare expenditures Fact Sheet. Centers for Medicare and Medicaid Services; December 16, 2020 https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet

Demise of independent physicians (impending)

Independent physician practices are disappearing as hospitals and health systems, payers and private equity firms purchase physician practices. Scarcity value is increasing as physician shortages of 60,000-100,000 are projected for 2025; 44.9% of physicians are currently over the age of 55.[17] As of January 2021, 37.1% of active physicians were employed by hospitals.[18,19] Optum alone employs more than 50,000 employed or affiliated physicians, with a broad range of ambulatory capabilities, including ambulatory surgical centers.[20] Private equity has been purchasing specialty practices such as ophthalmology, dermatology and GI, and to a lesser extent, primary care.[21] Physician employees of corporate entities, including private equity, approximate 122,000 or 15.0% of the total.[22]

52.1% of physicians are employed by hospitals/health systems and corporate entities, inclusive of private equity





Covid-19' Impact On Acquisitions of Physician Practices and Physician Employment 2019-2020
http://www.physiciansadvocayinstitute.org/Portals/0/assets/docs/Revised-6-8-21_PAI-Physician-Employment-Study-2021-FINAL.pdf?ver=K6dyoekRSC_c598QDIV-A%3d%3do

Hospital price transparency and site-neutral reimbursement to affect price disparities

Hospitals charge premium prices, a factor compounded by recent consolidation activity. Higher local market share strengthens their negotiating position relative to payers. In general, Medicare Advantage rates are lowest, followed by Managed Medicaid and private insurance, the last with a broad range of pricing based on negotiated prices by insurance carriers and health plans.[22]

As part of the federal government's efforts to promote price transparency, facilitate informed decision-making and increase market competition in healthcare, CMS introduced the Price Transparency of Hospital Standard Charges regulation, effective January 1, 2021.[23] Effectively, through this rule, CMS has mandated that hospitals and health systems publish not only standard charges (prices), but also various other pricing information, including gross charges, payer-specific negotiated charges (including minimum

[17] The Complexities of Physician Supply and Demand: Projections From 2018 to 2033. Association of American Medical Colleges; June 2020 https://www.aamc.org/media/45976/download

[18] Nearly 70% of U.S. physicians now employed by hospitals or corporations, report finds. Modern Healthcare; June 29, 2021 https://www.modernhealthcare.com/providers/nearly-70-us-physicians-now-employed-hospitals-or-corporations-report-finds?utm_campaign=KHN%3A%20Daily%20Health%20Policy%20Report&utm_medium=email&_hsmi=137034923&_hsenc=p2ANqtz-8VNNDuvvY91hgloqoaTDTyVLa1SkYQGev41FPlc7v893svRwJa8i49IOuw1l0iQT7OyFo0NaQ2bSLHtqqpE24pfNfcpsIMfHPhFkrYKpO7Vp9dykI&utm_content=137034923&utm_source=hs_email

[19] AAMC Physician Specialty Data Report, 2020 https://www.aamc.org/data-reports/workforce/interactive-data/active-physicians-largest-specialties-2019

[20] Optum has 50,000 employed, affiliated physicians and a vision for the future. Becker's ASC Review; September 17, 2019 https://www.beckersasc.com/asc-transactions-and-valuation-issues/optum-has-50-000-employed-affiliated-physicians-and-a-vision-for-the-future.html

[21] Appelbaum, Eileen and Batt, Rosemary, Private Equity Buyouts in Healthcare: Who Wins, Who Loses? (March 15, 2020). Institute for New Economic Thinking Working Paper Series No. 118 https://doi.org/10.36687/inetwp118 , Available at SSRN: https://ssrn.com/abstract=3593887

[22] Early results from federal price transparency rule show difficulty in estimating the cost of care. Peterson-KFF Health System Tracker; April 9, 2021 https://www.healthsystemtracker.org/brief/early-results-from-federal-price-transparency-rule-show-difficultly-in-estimating-the-cost-of-care/?mkt_tok=ODUwLVRBQS01MTEAAAF8ai-DVWxbfgM4A_xGGEWDDaTd1LGomnG4MNh0I9Y4cSxsg1kL9BMI5KFodIneygYIoMsyLNTqAT7KOM47XRTZnC9tjjrNXN9DDBRYJHux1ElS

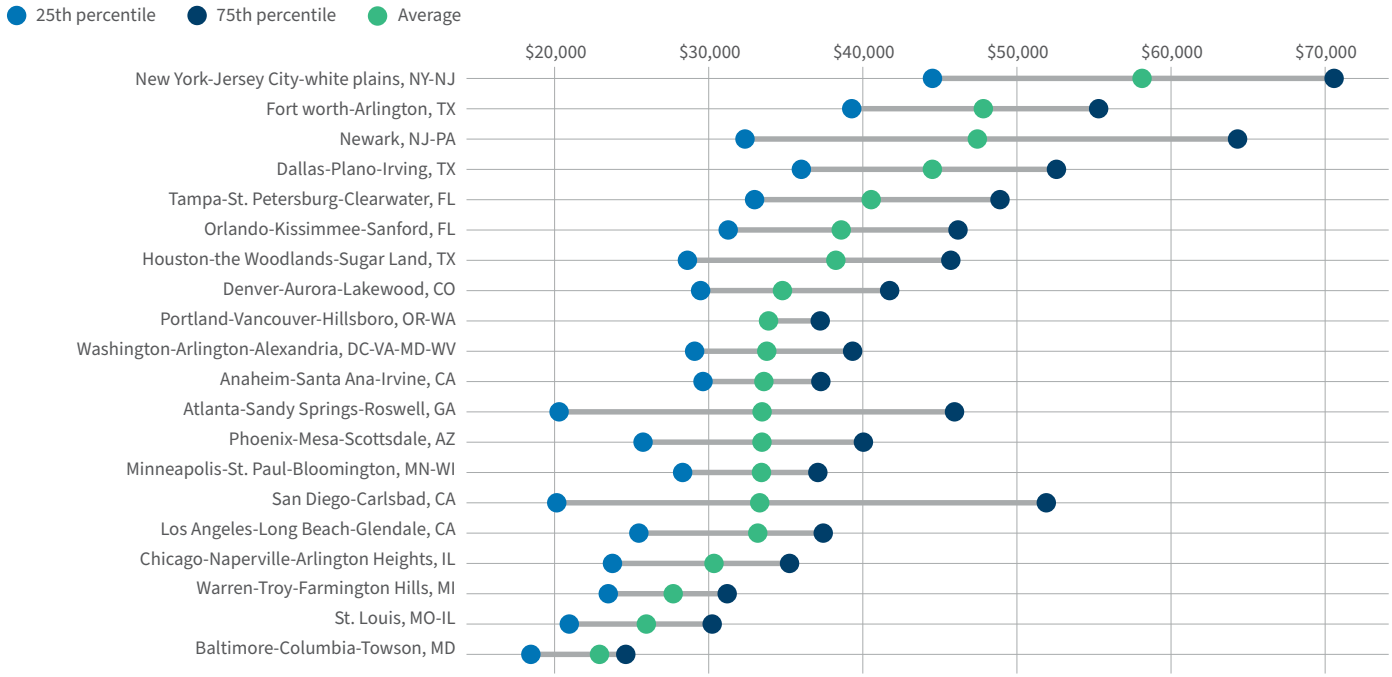
and maximum rates) and the discounted cash price. CMS mandates 70 of the 300 services that require pricing data; 230 services can vary from hospital to hospital. Many hospitals are not complying with the price transparency rule.[24]

In terms of price variation across MSAs, the New York MSA has the highest average prices for joint replacement surgery at $58,193, more than double the charges in St. Louis and Baltimore. The range of prices [for joint replacements] in the New York MSA is exceedingly broad — from $44,597 to $70,610 — which highlights the importance of price transparency and the potential for "shopping around," assuming no difference in the quality of outcomes.

In late June, the Supreme Court ruled it will not hear an appeal from the American Hospital Association about the ability of the U.S. Department of Health & Human Services (HHS) to impose site-neutral payments, i.e., apply the same Medicare payments to an (exempted) hospital off-campus provider-based department (PBD) as apply to independent physicians. The appeal follows a contested decision by HHS to impose site-neutral payments to all off-campus PBDs in 2019. In the intervening period, a judge made an affirmative decision that was overturned in July 2020 and appealed thereafter by the AHA.

Price variations irrespective of settings (i.e., on- and off-campus) are estimated to cost $153 billion in incremental Medicare spending over 10 years. If private insurers follow Medicare's lead, the cost savings approximate $346 billion to $672 billion.[25]

Average allowed charges for in-network joint replacements in Large Employer Plans by MSA



Note: Results shown for 20 largest MSAs, by population, with available data.
Source: https://www.healthsystemtracker.org/brief/price-transparency-and-variation-in-u-s-health-services/

[22] Early results from federal price transparency rule show difficulty in estimating the cost of care. Peterson-KFF Health System Tracker; April 9, 2021 https://www.healthsystemtracker.org/brief/early-results-from-federal-price-transparency-rule-show-difficultly-in-estimating-the-cost-of-care/?mkt_tok=ODUwLVRBQS01MTEAAAF8ai-DVWxbfgM4A_xGGEWDDaTd1LGomnG4MNh0l9Y4cSxsg1kL9BMI5KFodIneygYIoMsyLNTqAT7KOM47XRTZnC9tjjrNXN9DDBRYJHux1ElS

[23] Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals To Make Standard Charges Public. A rule by the HHS; 11/27/2019 https://www.federalregister.gov/documents/2019/11/27/2019-24931/medicare-and-medicaid-programs-cy-2020-hospital-outpatient-pps-policy-changes-and-payment-rates-and

[24] Ibid.

Perceived growth drivers

In a recent survey of healthcare executives, physician engagement and alignment was identified by 66% of respondents as the number-one variable that will influence growth during the next three years.[26] Other factors frequently mentioned include cultivating strategic partnerships (60%), engaging customer segments in a targeted way (44%) and advancing value-based care contracts (33%).[27] Only 18% of respondents mentioned mergers or acquisition. *Physician engagement and alignment, strategic partnerships, consumerism and value-based contracts are all critical components of an emerging ambulatory strategy.*

As care shifts to alternative settings, the need for strong physician leadership and clinician engagement is essential to the viability of any ambulatory strategy. Organizations must work collaboratively with their most valuable resource, aligning incentives with quality outcomes. Organizations must also understand and continuously adapt to the ever-changing needs and desires of the patient populations they serve. Strategic partnerships (involving preventive services and home health, walk-in/urgent care, employer-based services, ambulatory surgery or post-acute care) can help ensure that organizations are effectively meeting the needs of even the most at-risk patients and ensure seamless care delivery across the continuum. Beyond a simple conceptual understanding, the rise of consumerism will continue to require organizations to alter their approach. While an effective digital strategy and evening or weekend hours may target younger professionals, the need for health coaching, behavioral health and prescription reconciliation targets alternative patient segments. Expanded access and ancillary service offerings are intended to establish a certain level of patient "stickiness" and alignment.

Realignment of ambulatory care

In preparation for fluctuations in health policy and new payer guidelines, organizations have made concentrated efforts to move away from unsustainable operating models. Hospitals and integrated delivery systems are looking beyond their traditional four walls and beginning to take stock of their existing ambulatory footprint and outpatient service offerings. Through capital investment, acquisitions and nontraditional partnerships, organizations are committing to long-term ambulatory strategies that serve to preserve brand recognition, maintain quality, reduce cost and expand access.

For example, Jefferson Healthcare is committed to having a provider site of access within five miles of consumers residing in its multistate service area.[28] Baylor Scott & White maintains more than 956 ambulatory assets, including 30 ambulatory surgical centers.[29]

Ambulatory care delivery goes beyond traditional primary and specialty-care physician offices. A well-defined ambulatory care strategy serves as a vehicle to support growth and geographic expansion, development of new programs and services, and advancement of alternative care models (including home health, post-acute care and telehealth services). By reallocating services under one ambulatory platform and organizational structure, operational leaders can begin to better measure and better manage variation across outpatient sites of service.

Bottom line

An ambulatory services platform could serve as a blueprint for organizations to optimize existing sites of service, enhance operational efficiency and reduce total cost of care. A consumer-focused, integrated approach, combined with a prioritization of services, is necessary.

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[25] Healthcare Financial Management Association, Site-neutral payments could reduce healthcare spending by at least $350 billion over 10 years, report finds; March 22, 2021 https://www.hfma.org/topics/news/2021/03/site-neutral-payments-could-reduce-healthcare-spending-by-at-lea.html

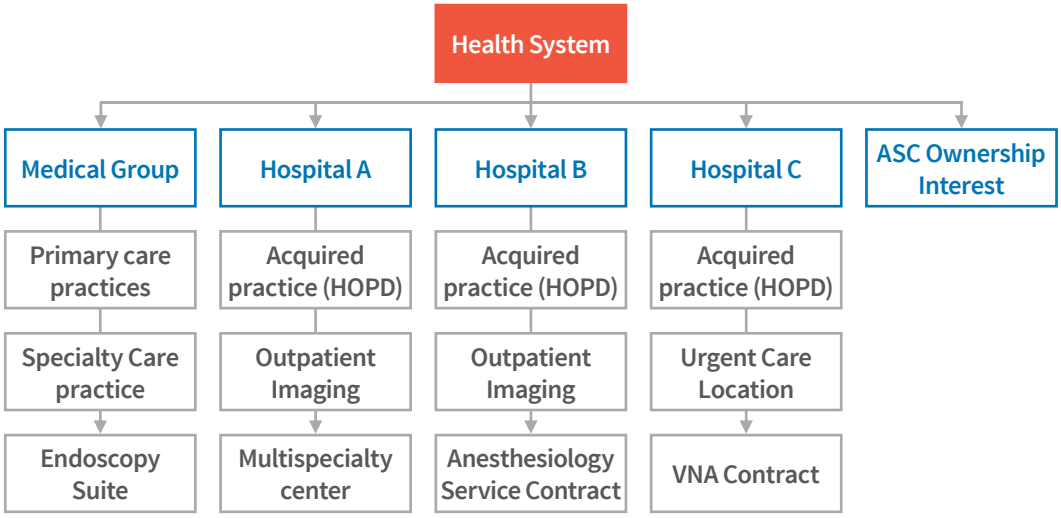
[26] New Survey Reveals Data's Powerful Influence on Hospital Growth. Health Leaders and Optum Health; May 2021 http://promos.hcpro.com/pdf/Hospital-Growth-Data.pdf?spMailingID=18900114&spUserID=NjU1MjgwNzYzMjk4S0&spJobID=2144634902&spReportId=MjE0NDYzNDkwMgS2

[27] Ibid.

[28] 8 hospital executives share outpatient strategy – ASCs, retail clinics, key partnerships and more. Becker's Healthcare; February 17, 2017 https://www.beckershospitalreview.com/hospital-management-administration/8-hospital-executives-share-outpatient-strategy-ascs-retail-clinics-key-partnerships-more.html

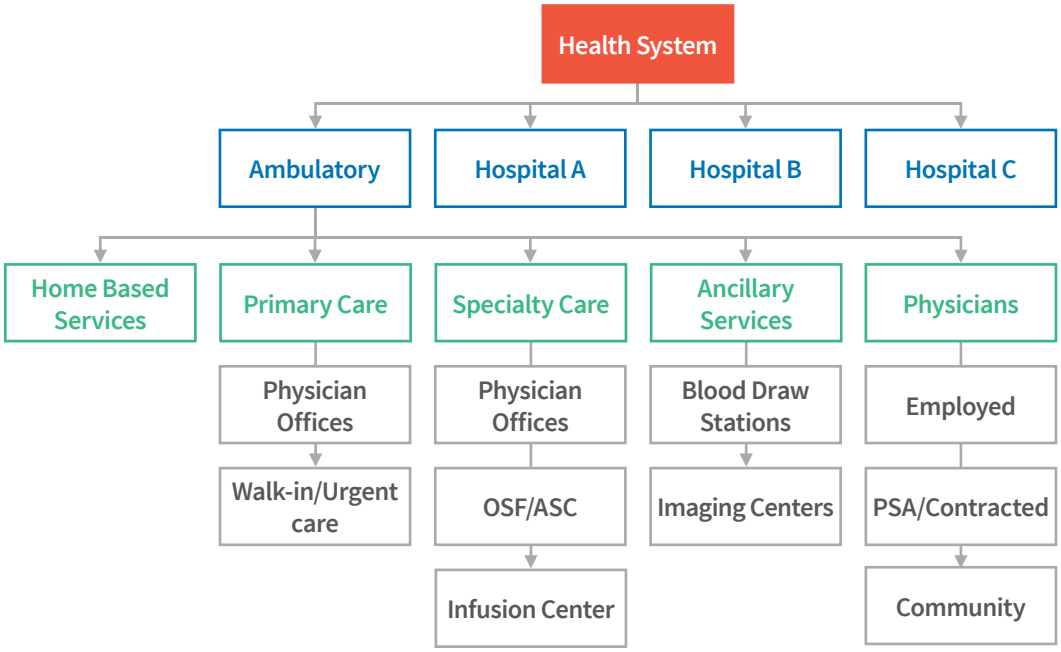
[29] Ibid.

Current state



*Non-academic health system with three community hospitals, an employed medical group and minority ownership interest in a physician-owned ASC. Over time, each hospital has acquired physician practices under their own unique hospital licenses. They offer outpatient imaging at each facility with limited community presence. Various PSA arrangements exist with non-employed physician groups.

Future state



*Development of new ambulatory corporate structure with responsibility and oversight for outpatient programs and services. Former Hospital Outpatient Department structure eliminated, with new sites licensed as outpatient clinics. Consolidated physician enterprise with direct/indirect oversight of employed, contracted and hospital-based community physicians.

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