Walking out of the hospital: The continued rise of ambulatory care and how to take advantage of it

Ambulatory care is one of the fastest-growing and highest-margin segments of the healthcare industry. Analyzing variations in Commercial claims data and doctor surveys shows that significant growth potential remains. While many health systems have benefited from investing ahead of this trend, significant opportunity remains to be captured.

Pooja Kumar and Ramya Parthasarathy
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With the continued rise of COVID-19, hospital capacity across many US states has been taxed considerably, with inpatient beds at or near full occupancy in a number of hard-hit areas.¹ This pressure on acute settings has heightened the important role that ambulatory care can and does play in the healthcare landscape by providing an alternative site for necessary procedures.

While COVID-19 has accelerated the interest in ambulatory care, this shift began long before the pandemic for a number of reasons. Take ambulatory surgical centers (ASCs) as an example: Often more conveniently located than hospitals, ASCs allow patients to be discharged within 23 hours of care, reducing their risk of infection and allowing recovery to take place in the comfort of their own homes. The ASC is often more intimate than the hospital, giving patients a greater sense of personalized care and contact with their care team. Perhaps most persuasively, costs to both patients and payers can be significantly less at ASCs, as their entire operating chassis is often configured at a lower cost base across staffing, space, and some types of supplies, while margins for healthcare providers can often be the same or higher. Indeed market research suggests that the ASC market alone is projected to grow at a compound annual growth rate of 6 percent between 2018 and 2023—reaching around $36 billion by 2023.²

Though ambulatory surgery is not appropriate for all patients (including those with complex comorbidities), its increasing presence is reflective of a broader healthcare trend. Namely, the rise of ambulatory sites reflects how medical care has been shifting out of hospitals and into outpatient sites.

Within the broader healthcare arena, while hospital care is still the largest segment of the healthcare market overall, a disproportionate share of growth in the coming years will be in ambulatory settings. This includes both free-standing sites as well as hospital outpatient departments. Non-hospital-provider segments—everything from diagnostics to pre-, non-, and post-acute services and physician offices—could account for almost 65 percent of projected profit pools by 2022, with an average growth rate of around 2 percent that started in 2019.³ These projected growth rates are consistent with employment forecasts. The healthcare and social assistance sector will generate around 3.4 million new jobs through 2028; more than half of these new jobs will be in ambulatory care services, while only 350,000 will be in hospitals, according to the US Bureau of Labor Statistics.⁴ Employment in outpatient care centers alone is projected to grow around 35 percent over the next decade, making it the second-fastest-growing industry overall⁵ (including those outside healthcare) behind only home healthcare services. While the effects of COVID-19 on these healthcare workforce trends are still unknown, ambulatory care sites are likely to remain a core part of the healthcare employment landscape.

Health systems have recognized the importance of ambulatory care. Many institutions have focused on the proliferation of solutions and technologies supporting ambulatory care, along with health systems’ increasing focus on extending care along the continuum. Importantly, these trends will not dissipate soon, as they are driven by more fundamental, interrelated market changes:

1. **Innovation and technology:** Advances in clinical approaches and technology, including new developments in anesthesia and pain control, as well as minimally invasive surgical procedures, have enabled numerous procedures (for example, knee replacements, tonsillectomies) to migrate into the ambulatory setting.

2. **Consumer demand:** Consumers, who increasingly care about lower costs, improved access, and better experience, are choosing out-of-hospital medical care.
   
   With the rise in narrowed networks and high-deductible health plans, consumers are increasingly cost-conscious in their medical choices. Though the out-of-pocket savings opportunity varies by plan and procedure, studies have shown consistently lower costs at ambulatory sites—providing strong incentives for patients to shift their site of care. For example, BCBS’s Health Report of America estimates that when members elect to have a knee or hip replacement performed in an outpatient facility, costs can be 30 to 40 percent lower. On average, the price of an inpatient knee or hip replacement was $30,000, compared with $19,000 and $22,000 respectively in the outpatient setting. These underlying consumer preferences have only been reinforced by COVID-19, as consumers have reported that they are significantly less comfortable returning to hospitals or emergency rooms in light of the pandemic.

3. **Payer pressure:** The growth of at-risk contracts and value-based care are creating new incentives for providers and payers to find the lowest-cost sites of care. As we discussed in “Implications for value-based payment programs: Weathering COVID-19,” these shifting incentives are further augmented by regulatory changes, including Medicare reimbursement for knee replacements and certain hip procedures in the ambulatory setting, as well as telemedicine. This incentive structure may change in the wake of COVID-19, as its impact on value-based payment programs remains to be seen.

4. **Provider opportunity:** Shared ownership models financially align physicians to accelerate this shift to outpatient care. As potential equity owners in these ambulatory sites, doctors have both the incentive and the opportunity to channel their patients to procedures outside the hospital. In addition, as COVID-19 continues to put pressure on acute sites of care, nearly 40 percent of physicians are reporting that they are more likely to refer their patients to non-hospital locations for procedures and surgeries.

Despite growth in this space, our research indicated that wide variation in the use of ambulatory or outpatient care exists. This variation represents value to patients in cost and time. It also represents value to our healthcare systems in cost and capital invested in bed stock and acute facilities that could be redeployed; value to payers who typically pay significantly less at an ambulatory site than they would for the same procedure at an inpatient facility; and value to patients, who benefit when they have a better experience and lower out-of-pocket costs.

We sought to quantify this opportunity and prioritize where it could be captured—an exercise which revealed key insights for health system leaders to consider: First, opportunities to accelerate site of care shifts exist only in targeted pockets (not across encounter types)—requiring strategic focus on where to prioritize new investments. Second, to make the shift to outpatient sites effective, health systems need to engage physicians deeply, via shared equity models or other ways of ensuring they have “skin in the game.” Finally, given the influence of consumer preference, health sys-

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and other care, the claims were grouped together into 615 million encounters for ambulatory and inpatient care that represented $490 billion in cost. Each encounter was then given a priority procedure to enable comparisons to be made. Of the 615 million encounters, roughly 10 percent were coded as primarily surgical, 13 percent as primarily medical, and the remaining roughly 77 percent spanned office appointments, preventive care, and emergency department visits.

The tool supports comparisons of variations across many dimensions, including by specialty, geography, patient age, and patient risk.

Despite this valuable view into a significant proportion of the spend in the United States, we should note that the Commercial segment represents a subset of the population with lower comorbidities and complications; therefore, it implies a higher potential to move to an ambulatory setting.

Quantifying variation today
We first analyzed the current scale of variation between sites of care. By our estimates, $60 billion of encounters take place almost exclusively in an inpatient setting, while $300 billion of encounters take place almost exclusively in an ambulatory care setting (Exhibit 1), where

Understanding variation
Despite the growth in ambulatory care sites since 2000, as well as health systems’ recent heightened focus on expanding into the community, the opportunity to expand services in such settings remains vast. Our research into three questions shows the scope of the opportunity for health systems and the overall healthcare ecosystem through accelerated migration of appropriate cases to ambulatory sites. Specifically, our analysis asks:

— What does the current variation across sites of care tell us about the value at stake?
— What are the potential sources of this variation?
— What could be the opportunity from reducing this variation?

We created a tool that analyzed a database of Commercial claims from across the United States in 2016. This database represented 1.4 billion national medical claims and more than $620 billion in cost. After excluding post-acute

Exhibit 1

While most care is exclusively ambulatory or inpatient, nearly 30% of spend ($132 billion) has meaningful variation in site of care choice.

<table>
<thead>
<tr>
<th></th>
<th>Almost all inpatient</th>
<th>Mixed</th>
<th>Almost all ambulatory/ outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary encounter codes</td>
<td>676</td>
<td>2,483</td>
<td>2,898</td>
</tr>
<tr>
<td>Total volume</td>
<td>5.6 million</td>
<td>10.1 million</td>
<td>600 million</td>
</tr>
<tr>
<td>Value</td>
<td>$55 billion</td>
<td>$132 billion</td>
<td>$302 billion</td>
</tr>
</tbody>
</table>

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Exhibit 1 of 8

While most care is exclusively ambulatory or inpatient, nearly 30% of spend ($132 billion) has meaningful variation in site of care choice.
“exclusively” is defined as encounter codes where more than 95 percent of care takes place in one setting. This means 27 percent of spend represents encounters that have meaningful variations in site of care choices. These “mixed” encounter codes represent bundles where a notable volume of activity takes place in an ambulatory setting and suggests that the approach, technology, and clinical protocols exist to support care in these settings. Across the analysis, an average cost saving of $21,000 for the same encounter code bundle took place in an ambulatory setting instead of an inpatient setting. Given this variation, disseminating practices that support more patients in ambulatory care could be of value to cost-conscious patients, providers, and payers.

We had a strong ongoing hypothesis that lots of variation would exist across the spectrum, but the data show that the vast majority of encounter codes are concentrated at either end of the spectrum (Exhibit 2), suggesting that providers must therefore be tightly targeted as they proactively seek to shift sites of care. Specifically, providers should look to focus on (1) “low-hanging fruit,” where 65 to 95 percent of encounters are already in outpatient settings, and (2) “leading procedures,” where 5 to 35 percent of encounters are already in outpatient settings, suggesting a slow, sub-scale migration out of acute sites.

Drivers of variation
There are expected reasons why similar encounters may be provided in different sites of care, ranging from the preferences of the referring physician to the clinical risk for a given patient. For example, a higher-risk patient with multiple chronic conditions or with complex anesthesia needs will need the increased clinical backup available in an acute setting. However, other reasons are linked with variations in practice. Below, we present descriptive statistics on three potential drivers of variation in sites of care: (1) specialty, (2) patient risk, and (3) geography.

Exhibit 2
Where meaningful ambulatory/outpatient volume exists, providers can be persuaded to shift sites of care.

Encounters by share of ambulatory/outpatient care

<table>
<thead>
<tr>
<th>IP only</th>
<th>Mixed</th>
<th>OP only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of unique encounter codes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>676</td>
<td>807</td>
<td>451</td>
</tr>
<tr>
<td>Total value of encounters, $ billion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>55.4 (12%)</td>
<td>2.5 (1%)</td>
<td>22.0 (5%)</td>
</tr>
<tr>
<td>Total volume of encounters, million</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.6</td>
<td>2.6</td>
<td>0.9</td>
</tr>
</tbody>
</table>

Leading procedures

<table>
<thead>
<tr>
<th>5–34%</th>
<th>35–64%</th>
<th>65–94%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.6</td>
<td>0.2</td>
<td>0.1</td>
</tr>
<tr>
<td>0.4</td>
<td>0.1</td>
<td>0.2</td>
</tr>
<tr>
<td>0.1</td>
<td>0.1</td>
<td>0.4</td>
</tr>
<tr>
<td>0.1</td>
<td>0.4</td>
<td>0.2</td>
</tr>
<tr>
<td>0.5</td>
<td>0.6</td>
<td>0.4</td>
</tr>
<tr>
<td>1.0</td>
<td>1.8</td>
<td></td>
</tr>
</tbody>
</table>

Low-hanging fruit

<table>
<thead>
<tr>
<th>5–34%</th>
<th>35–64%</th>
<th>65–94%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.2</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>0.4</td>
<td>0.1</td>
<td>0.2</td>
</tr>
<tr>
<td>0.1</td>
<td>0.1</td>
<td>0.4</td>
</tr>
<tr>
<td>0.1</td>
<td>0.4</td>
<td>0.2</td>
</tr>
<tr>
<td>0.5</td>
<td>0.6</td>
<td>0.4</td>
</tr>
<tr>
<td>1.0</td>
<td>1.8</td>
<td></td>
</tr>
</tbody>
</table>

12 Encounters were categorized by service location using type of bill and place of service codes (in some cases CPT and revenue codes were also used).
13 Cost difference represents the difference between inpatient and outpatient costs for the same bundle, averaged across all bundles.
tients based on three levels of clinical risk: healthy (low risk), moderate chronic (moderate risk), or severe chronic (high risk).

Across all encounters, high-acuity patients were in exclusively ambulatory settings for only 43 percent of cases, whereas low-acuity patients were in this care setting for 75 percent of cases. More interestingly, the data showed that for select procedures, such as gallbladder removals or spinal fusions, some high-risk patients received care in an ambulatory setting. Lower-risk patients almost always received care in an ambulatory setting (Exhibit 4).

**Geography:** In addition to variation across and within specialties, we examined geographic variation in the volume of ambulatory care provision by dividing the United States into four regions—Northeast, North Central, South, and West—and focusing on surgical procedures that currently take place in both ambulatory and inpatient settings. Overall, the Northeast offers less ambulatory care than the rest of the country, with around 58 percent of such volume in ambulatory settings compared with 64 to 67 percent across the rest of the country.

**Specialty:** It is not surprising that some specialties show different mixes of exclusively inpatient and exclusively ambulatory care, based in part on the technological advances that have allowed for minimally invasive procedures, as well as new techniques in anesthesia and pain control. For example, while cardiovascular surgeries still have nearly a quarter of encounter codes in the exclusively inpatient setting, less than 5 percent of musculoskeletal and gastrointestinal (GI) procedures take place in hospitals (Exhibit 3). Additionally, all five specialties below show a significant share (50 to 65 percent) of encounters in the mixed category—meaning they occur in both ambulatory and inpatient settings. Mixed encounter codes within these specialties alone account for around $91 billion in value—nearly 70 percent of the total value at stake.

**Patient risk:** Unsurprisingly, patients with higher risk profiles are more likely to have care in an inpatient setting, due to the (potential) need for complex anesthesia or increased clinical backup. In the data below, we distinguish between patients based on three levels of clinical risk: healthy (low risk), moderate chronic (moderate risk), or severe chronic (high risk). Across all encounters, high-acuity patients were in exclusively ambulatory settings for only 43 percent of cases, whereas low-acuity patients were in this care setting for 75 percent of cases. More interestingly, the data showed that for select procedures, such as gallbladder removals or spinal fusions, some high-risk patients received care in an ambulatory setting. Lower-risk patients almost always received care in an ambulatory setting (Exhibit 4).

**Exhibit 3**

Across the major surgical specialties, 50–65% of encounters (~$91 billion in value) show variation in site of care choice.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Exclusively inpatient</th>
<th>Mixed</th>
<th>Exclusively ambulatory/outpatient</th>
<th>Total value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical procedures on the respiratory system</td>
<td>4</td>
<td>66</td>
<td>31</td>
<td>15.6</td>
</tr>
<tr>
<td>Surgical procedures on the cardiovascular system</td>
<td>25</td>
<td>65</td>
<td>10</td>
<td>26.3</td>
</tr>
<tr>
<td>Surgical procedures on the musculoskeletal system</td>
<td>4</td>
<td>56</td>
<td>40</td>
<td>52.7</td>
</tr>
<tr>
<td>Surgical procedures on the digestive system</td>
<td>2</td>
<td>53</td>
<td>45</td>
<td>48.0</td>
</tr>
<tr>
<td>Surgical procedures on the nervous system</td>
<td>12</td>
<td>49</td>
<td>40</td>
<td>19.8</td>
</tr>
</tbody>
</table>

¹ Figures may not sum to 100%, because of rounding.

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14. If we revise the approach to define “exclusively ambulatory” as greater than 90 percent and “exclusively inpatient” as less than 10 percent, these specialties still show a meaningful share (40 to 80 percent) of encounters in the mixed category, which account for around $65 billion in value.

15. We ran the 3M Clinical Risk Grouper (CRG) on Truven data and classified them into Low, Medium, and High risk based on the health status group. Low includes groups 0–3 (Healthy/Non-User—Concurrent; Healthy/Non-User—Prospective; Significant Acute—Current and Prospective; Single Minor Chronic). Medium includes groups 4–6 (Multiple Minor Chronic; Single Dominant or Moderate Chronic; Dominant or Moderate Chronic Pair). High includes groups 7–9 (Dominant Moderate/Chronic Triplets; Malignancy Under Active Treatment; Catastrophic).

16. We excluded any procedure that is exclusively (or greater than 95 percent) ambulatory or inpatient.
Each physician was told what share of a common procedural technology (CPT) code’s activity was in an inpatient setting today. They were then asked to estimate the percentage of activity they believed would exist in ten years’ time. Each code was surveyed at least 75 times to give strong statistical confidence.

The CPT codes surveyed represented 15 million encounters across inpatient and ambulatory settings. Today, 10 percent of this activity takes place in an ambulatory setting (compared with a 64 percent average for all encounters in these specialties). With-in ten years, care delivered in an ambulatory setting is expected to grow to 32 percent of the total activity. This increase represents an average growth of 12 percent per annum, with meaningful differences across specialties. More specifically, orthopedics is expected to see higher growth from a lower base, from 5 percent ambulatory activity today to 26 percent in a decade, while cardiology is expected to grow from 16 percent today to 40 percent in a decade (Exhibit 7).

Understanding future opportunities

Analysis of existing clinical practice patterns shows clear, targeted opportunities for ambulatory growth. Further innovations in clinical practice will create new opportunities to provide additional care in ambulatory settings.

Prior to the onset of COVID-19, we surveyed 150 cardiology and 150 orthopedic physicians on their expectations of where they think opportunities exist to make targeted moves over the next decade.

We prioritized procedures where at least 60 percent of care was conducted in inpatient settings today, because we wanted to identify where ambulatory innovation could have the greatest disruption on hospitals. Each physician was told what share of a common procedural technology (CPT) code’s activity was in an inpatient setting today. They were then asked to estimate the percentage of activity they believed would exist in ten years’ time. Each code was surveyed at least 75 times to give strong statistical confidence.

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These growth rate projections are driven by significant expected change in certain high-volume procedures. For example, in orthopedics, total knee replacements consisted of 1.6 million encounters but saw an estimated change in ambulatory volume to 30 percent, from 2 percent, over the next ten years. In cardiology, catheter placement, which had 1.2 million encounters, saw an estimated change in ambulatory volume to 59 percent, from 38 percent, over the same period. Though not captured in this survey, there are likely to be other procedures beyond cardiology and orthopedics where significant innovation and changes in the site of care could be captured, as well as greater interest from physicians in the wake of COVID-19 to shift procedure volume away from the hospital setting.

Exhibit 5

Scale of ambulatory care varies across the country, with the slowest uptake in the Northeast.

Ambulatory care, % of surgical procedures¹

1 Includes only procedures that currently take place in both inpatient and ambulatory/outpatient settings; excludes any procedure that is exclusively (or >95%) ambulatory or inpatient.

Exhibit 6

Regional variation in the prevalence of ambulatory care exists even within specific specialties.
Understanding the value of ambulatory care expansion

Significant value can be realized from expanding access to ambulatory care, particularly for patients and payers who are focused on costs. Patients prefer faster access, shorter stays, and lower costs. Payers typically pay significantly less for the same procedure than they would at an inpatient facility. Payers can incentivize ambulatory care options through levers such as patient education, co-payments, network design, deductibles and plan design, reimbursement rates, and an approvals process that illuminates the benefits of ambulatory options.

Based on our research, physicians often report preferring ambulatory care operations, because they can see patients in more service-oriented settings. Moreover, ambulatory sites can provide physicians with access to shared-equity ownership models. While shifts to ambulatory care are more complicated for hospitals and health systems, embracing these trends may help:

— Realize savings from moving procedures to lower-cost sites: Whether in value-based or fee-for-service contracts, health systems can benefit financially from building out their ambulatory presence in targeted service lines (for example, orthopedics, cardiology, GI). Under value-based contracts such as capitation or global budgeting, with reimbursement linked to outcome cost and quality rather than volume, health systems will benefit from shifting to lower-cost sites of care, promoting retention of savings.

— Defend against competition: If competitive ambulatory care centers are opening and taking market share, establishing an owned option provides some defense for health systems. This strategy may be particularly important in retaining physician loyalty, where the health system may be able to offer a shared-equity model, in order to retain higher-value, complex inpatient cases.

— Build or strengthen presence in strategic markets: Ambulatory care can offer improved access for patients and physicians without the need to invest significant capital in—and, depending on state licensing and regulations, approvals for—a new acute hospital. However, most payer contracts still pay hospitals and health systems based on the fee-for-

Exhibit 7

Practicing physicians anticipate that ambulatory activity will grow 12% per annum over the next decade.

<table>
<thead>
<tr>
<th>Cardiology, CPT codes</th>
<th>Surveyed CPT codes</th>
<th>More than 60% inpatient volume today</th>
</tr>
</thead>
<tbody>
<tr>
<td>All cardiology activity</td>
<td>100% = 107 million</td>
<td>69 million (69%) 31 million (31%)</td>
</tr>
<tr>
<td>Today</td>
<td>16 million</td>
<td>84 million (52%) 16 million (10%)</td>
</tr>
<tr>
<td>In 10 years</td>
<td>6 million</td>
<td>60 million (74%) 40 million (67%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Musculoskeletal (MSK) medicine, CPT codes</th>
<th>Surveyed CPT codes</th>
<th>More than 60% inpatient volume today</th>
</tr>
</thead>
<tbody>
<tr>
<td>All MSK activity</td>
<td>100% = 71 million</td>
<td>56 million (78%) 15 million (22%)</td>
</tr>
<tr>
<td>Today</td>
<td>8 million</td>
<td>95 million (118%) 8 million (11%)</td>
</tr>
<tr>
<td>In 10 years</td>
<td>8 million</td>
<td>74 million (97%) 7 million (10%)</td>
</tr>
</tbody>
</table>

CPT, current procedural terminology.
service model. Significant revenue for hospitals and health systems would be lost—for example, ASCs are typically reimbursed at about 60 percent of what a hospital would be paid for the same procedure.\(^{17}\) Surgical cases are usually very profitable, and typically help to subsidize the hospital’s other less-profitable departments. Despite the potential revenue loss from shifting procedures to outpatient sites, ASCs with operational discipline and strategic positioning typically enjoy nearly two times the margins of acute sites, which can bolster the bottom line for health systems.\(^{18}\)

--- Enhance physician alignment: If health systems are strategic about the locations where they partner or build new ambulatory sites, they can quickly become the preferred locations for physicians who have to split their days between ambulatory and acute settings for patients with different needs, especially if the health system is able to partner with independent physician investors to open new sites. Competitive pressure, potentially heightened by the growth of value-based contracting, could increasingly tip the balance for health systems toward expanding their ambulatory care offers. Investments by large provider groups are clear evidence of this. An analysis of local circumstances, pressures, and opportunities also will determine a tipping point.

Opportunities for health systems
Health systems’ actual preparations are not equal to the opportunity available. Our survey of 300 physicians found only 40 percent of providers making meaningful preparations (that is, three or more levers across the eight available in the survey). The most common levers were building new facilities, updating clinical guidelines, offering patient education, and changing physician incentives (Exhibit 8).

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17 Using Truven Commercial/Medicare limited data sets data and based on reimbursement difference between ASC and hospital outpatient department for top 20 common procedure codes.
18 Using Truven Commercial/Medicare 2019 data sets.
19 Includes “other.”
agreement, or shared equity in the site with the management company.

In addition, health systems should take advantage of the staffing models possible at such sites. For example, unlike traditional hospital operating rooms, which often rely on floating nurses to support surgical procedures, ASCs can reap the operational gains\(^{20}\) from having surgeons work with a single set of dedicated nurses and physicians’ assistants for their blocks.

3. **Understand what value the hospital/health system brings to an ambulatory partnership**
   A hospital/health system should aggregate the volume through existing relationships with physicians and surgeons. This volume, in addition to the existing funding and infrastructure around billing, collecting, and regulatory requirements, may be an asset when negotiating with payers and suppliers. In addition, physicians may prefer to avoid administrative, operational, or vendor complexities. A hospital/health system could consider highlighting its ability to take on these tasks, freeing doctors to focus on patient care. Finally, a hospital may be able to have capital at a scale needed to build and furnish the site with specialized equipment. This level of funding is usually too risky for a small group of surgeons to comfortably pursue.

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4. **Transform operations to support expansion of ambulatory care services**

Processes, systems, policies, and staff culture will transform to support expansion of ambulatory care services. This support can include raising awareness for patients; redesigning clinical pathways to support clinicians as they decide when to offer safe, evidence-based alternatives to inpatient stays; ensuring risk-mitigation protocols, such as inpatient transfers plans; providing training for staff on high-quality care outside the hospital setting; adjusting workforce plans and rosters for changing operations; reviewing metrics and reporting to address unwarranted variation; and building a culture that promotes collaboration across different sites of care.

5. **Ensure contracting strategy matches the planned shifts in site of care**

As systems are proactive about planning shifts in sites of care that maximize patient experience and expectations, they should ensure that their contracting strategy is shifting at a granular level. In some markets, the opportunity for this shift may represent “win-wins” between payers and health systems in lowering the overall cost of care while maintaining or growing margins for healthcare providers, but operational discipline will be the foundation of this strategy coming to fruition.

The US healthcare system could create significant value by reducing variation in sites of care. This value will grow significantly over the next ten years as procedures that take place only in an inpatient setting today are moved safely and effectively to ambulatory care settings. Patients, physicians, and payers all support these trends, and an increasing number of hospitals/health systems have announced they plan to benefit as well.

Hospitals and health systems should position themselves on the same side as patients, payers, and physicians. Those who reach this goal will be able to shape the future, not be shaped by it.

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