have to understand what the play might do and then move in a direction that you've learned is the best place to get—and keep—a good look," he says. "Otherwise, if you're unable to anticipate what might happen, you get a 'closed look.' In that situation, when referees try to make a call, chances are, the call they make is a guess—and studies show that when referees guess, they get it wrong a huge percentage of the time. The same can be true in health care."

After a game, refs will re-review the calls made and reexamine the rules, often with other referees who have more understanding, to try to gain more perspective. "The more philosophies and experience you bring to the table in understanding the right call for a given situation," he says, "the higher the chances that the right decision will be made if the situation presents itself again." Referring to both refereeing and business, Heilsberg says, "You have the best chance to make an even better call when you take the time to become better informed and keep open yourself to other people's perspectives."

What's New on Our Blog

Anticipating Utilization Trends Key to Adapting in an Evolving Market

Dawn Samaris

The following excerpt recently appeared on the hfm *Healthcare Finance Blog, hfma.org/hfmblog. The blog includes posts from a wide range of experts in healthcare finance, with new posts appearing at least weekly.*

Hospitals and health systems must prepare for utilization declines as they navigate healthcare reform coupled with changing demographics. Having a thorough understanding of the organization's current positioning and the likely impact of healthcare reform and market forces is essential if a provider is to project utilization to support an accurate multiyear financial plan. From there, the provider can project trends in the communities it serves and develop and implement strategies to achieve its objectives.

There is some debate about how the forthcoming changes will affect patient volumes, but we believe that current trends and increasing market pressures will drive overall utilization down over time. Inpatient volumes already are on the decline. In a recent study, encompassing nearly half of the U.S. population, we found that inpatient use rates per 1,000 people fell more than 5 percent between 2006 and 2011 in 71 percent of participating states.

By contrast, outpatient utilization increased. That trend is expected to continue in the short term, driven largely by increased physician visits through expansion of health coverage to about 32 million uninsured Americans under the Affordable Care Act. But opposing forces ultimately will counteract that growth. With "more skin in the game," patients are likely to seek fewer services as they assume greater responsibility for the cost of care with higher deductibles and copayments.

Meanwhile, providers will be motivated to decrease utilization by increasing care efficiency as they assume more risk and face new quality incentives from both government and commercial payers. Under a value-based model, providers will have incentives to improve care management. Through initiatives to improve patient outcomes, such as providing at-home, follow-up care to patients after they are discharged from the hospital, organizations can lower utilization by reducing unnecessary readmissions.

Reducing utilization can help organizations decrease costs and increase their eligibility for narrow or tiered networks. To participate in these highly selective networks, hospitals and health systems need to demonstrate to payers that they can reduce costs significantly by driving utilization out of the system. In exchange, payers agree to direct more patients their way and potentially share a portion of the savings.

Several urban markets already have seen compelling utilization declines as large regional providers position themselves for success in this market. A major health system in Pennsylvania, for example, reported an 18 percent drop in hospital admissions and a 7 percent

decline in patient costs three years after launching its patient-centered medical home model in 2007 (Gilfillan, R., et al., "Value and the Medical Home: Effects of Transformed Patient Care," *The American Journal of Managed Care*, August 2010).

Providers that do not proactively participate in new value-based care and payment programs leave themselves vulnerable to utilization declines, without the benefit of shared savings or value-based payments.

In addition to anticipating declines in utilization, hospitals and health systems should expect changes in their payer mix that are likely to decrease revenues. For example, more people will become eligible for Medicaid and new federal and state insurance exchanges, which are expected to reimburse close to Medicare levels or below. Estimates of the number of commercially insured who will move into insurance exchanges range from 4 to 40 percent.

Scenario modeling is vital. Organizations should clearly define their credit goals and understand how various volume and payment scenarios could impact their ability to reach those goals. The key is anticipating how forces—such as utilization declines or changes in payer mix—might affect revenues and cash flow. By proactively outlining the levels of performance improvement required to maintain a healthy credit profile under different circumstances, organizations can ensure they are prepared to weather the changes ahead.

Dawn Samaris is a senior vice president in the strategic financial planning practice at Kaufman, Hall & Associates, Inc. (dsamaris@kaufmanhall.com).