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Hospital CFO Report

Watch Westchester

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Around the country, healthcare markets are changing, and experts are debating where it will end.

Here in New York, suburban Westchester County's market transformed dramatically and rapidly. In just 18 months, Westchester County's hospital market went from locally-run entities to domination by three large systems from outside the County. Of 11 community hospitals, only two remain independent. Understanding the dynamics of these changes and highlighting key issues to follow make Westchester a valuable case study for foretelling the healthcare system's evolution—with its significant consolidation, regionalization, and new focus on "value" (defined as outcomes relative to costs).

The impact of population health management and risk-sharing has become critical since Medicare's 2015 announcement of its plan to move moving 50% (from 14% today) of enrollees into Accountable Care Organizations ("ACOs"). Where Medicare leads, commercial insurers generally follow. Westchester provides a laboratory for new, potentially cost-effective approaches and relationships between community hospitals and tertiary hospital systems.

As an affluent suburban market, Westchester (median household income $81,000 vs. $53,000 in US, 2013) may foretell the future for similar markets nationwide. Here, hospitals led the change, which carries implications for insurers, physicians, and communities. Community hospitals lose autonomy as consolidation results in regionalization of strategy. Network decision-making will have an uncertain impact on local care. **Caveat Emptor (let the buyer beware)**, and buyers include individuals, healthcare market players, and governments.

The drivers for the dramatic shift in the hospital market includes weakening hospital financials, regional systems' network expansion goals and need for scale in hospitals, doctors, and investments in risk-sharing (an economic approach to paying providers more—or less, based on the overall cost of care). The speed of change is remarkable - since drafting this article began, yet another clinical affiliation occurred, a system partnership developed, Anthem announced its intention of acquiring Cigna, and Aetna is purchasing Humana. These patterns are not restricted to Westchester.

As insurers, governments, and large employers push risk-sharing, utilization falls, driving down hospital revenues. Physician networks expand to retain or grow market share. For insurers, hospital rates may increase given the negotiating power of hospital parents, further driving movement into risk-sharing models and consolidation. Even large medical groups face difficulty bending hospitals to their will, as their local dominance is not felt in distant executive suites. Their likely reaction is to continue growing and developing costly infrastructure for risk-sharing. Small groups will likely merge, join hospitals, or join networks as insurers' push down traditional fee for service rates. Community access will therefore change.

Westchester Experience in Detail

Hospitals: Westchester's hospital market swiftly went from locally-run independent hospitals to domination by large

systems outside the County. New York-Presbyterian now owns two hospitals, plus medical groups. Montefiore owns two hospitals, has a Board-level relationship with another, and a clinical affiliation with a fourth. North Shore-LIJ controls two hospitals and their employed physician groups. Thus, only two acute care players remain independent. St. Joseph's has no partner, likely due to its unfavorable payor mix. Westchester Medical Center, the region's sole academic center, creatively adapted by partnering with the three Bon Secours hospitals (adjacent County) and expanding their referral network. Finally, Manhattan's Memorial Sloan-Kettering Cancer Center opened its second major outpatient facility in Westchester.

Hospital financial challenges helped drive the consolidation—making Westchester far from unique. Hospitals face utilization declines and reimbursement cuts (e.g., "observation status", Sequestration, Disproportionate Share and other ObamaCare cuts). High deductible health plans reduced utilization while driving up unpaid balances. Hospital bankruptcies and imminent financial distress drove several to seek partners. Furthermore, cost pressures are significant, as workforce shortages increased recruitment costs and salaries, and new demands, like ICD-10 and re-admission management, also take a toll. Finally, the need to upgrade facilities and establish community-based presence puts further demand on limited resources.

Going forward, hospitals will behave differently, as they join larger regional networks with greater financial resources. Strategy and network decisions will be made outside the County. Regional systems will create the infrastructure for ACOs and risk-bearing. Network development will continue with greater resources and a larger regional view. Initial plans are not focused on driving most cases to university hubs. Only time will tell, however, whether the new idea of strong, lower-cost community hospitals will flourish or if the old strategy of hub-and-spoke focus on the academic centers returns.

Insurers and ACOs: Historically, four plans dominate the commercial market, with more consolidation anticipated. Medicaid moved aggressively into managed care, with 75% of eligible residents enrolled. Medicare Advantage plans have growth potential, with only 24% of Westchester's eligible recipients enrolled, versus 37% statewide (and 32% nationally). New York's ACO market is strong, with 25 operating—more than any states except California and Texas, and 10 new plans approved. Although enrollment is modest, it will grow as in other states.

Going forward, risk- and value-based contracting look poised for growth. Therefore, hospitals, physicians, and integrated networks need to demonstrate cost and quality performance. Hospital revenues fall as cost reduction efforts focus on ER and inpatient use. Physicians seek larger partners to provide risk management infrastructure and reduce overhead. Collaboration between hospitals and physicians will become increasingly important in care management. Again, the recent changes in Westchester will drive strategy and infrastructure development decisions toward the regional networks and likely accelerate risk-sharing with payors/ACOs.

Physicians/Medical Groups: Westchester reflects a market in transition, from solo and small practices to large groups. Hospital and payor consolidations will accelerate this process. Only 19% of physician practices report being open to new patients. The County's primary care physician (PCP) base will further erode as doctors retire, the high cost of living impedes recruitment, and fewer resident physicians enter primary care.

Even before recent events, Westchester physicians increasingly joined larger groups. Statewide, physician employment by hospitals grew 75% since 2000. Local hospitals established captive physician groups. Even before acquiring hospitals, New York-Presbyterian bought practices in Westchester, and Montefiore established a satellite office network. Westchester's two largest multi-specialty groups are moving aggressively. Mt. Kisco Medical Group, now with 450 physicians, and WestMed, with 280 physicians, are investing in community access like urgent care and infrastructure. Medium-sized players are expanding or considering joining another entity. Westchester Health

Associates expanded into neighboring Connecticut. Finally, given Westchester's affluence, some physicians may shift to concierge medicine, worsening the PCP shortage and making networks/groups even more critical.

Conclusions and Implications

The events in Westchester should be of great interest to other suburban markets—especially those near tertiary healthcare hubs. The Westchester case demonstrates that even apparently stable markets can change dramatically and swiftly. Community hospitals will not likely drive healthcare delivery, but rather form components of larger networks. Physicians will seek leverage in the market through consolidation and development of risk-sharing infrastructure. Insurers will continue to consolidate and control costs, while seeking better clinical outcomes.

Many key points remain to be evaluated, so following Westchester will prove valuable. The tension between regional systems seeking volume for their tertiary hubs versus the imperative of local (often lower cost) services will prove important. Hospitals and physicians need to consider when and how to affiliate. Those who delay will lose choices.

To demonstrate "value," physicians will become either network leaders or network employees. Increasingly, regional networks will drive changes to which payors will respond, with consolidation and greater focus on "value." In parallel, experts will be watching trend lines about how well "risk-sharing" works to improve access and reduce costs. And consumers will choose to look for value, including customer responsiveness, in an ever-consolidating marketplace.

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