Community Report | GREENVILLE · S.C.
Spring 1999

Competition Intensifies After Proposed Merger Fails

INTENSE COMPETITION AMONG HOSPITAL-BASED SYSTEMS CONTINUES TO CHARACTERIZE THE GREENVILLE HEALTH CARE MARKET AFTER A PROPOSED MERGER BETWEEN THREE MAJOR HOSPITALS FAILED BECAUSE OF PUBLIC OPPOSITION IN 1997. TODAY, HOSPITALS CONTINUE TO COMPETE IN THREE HISTORICALLY DISTINCT SUBMARKETS. HOWEVER, SOME ARE NOW ALSO TARGETING AN AREA OF RAPID ECONOMIC GROWTH OUTSIDE OF THEIR TRADITIONAL SPECIFIC AREAS. MEANWHILE, HOSPITAL SYSTEMS ARE CONTINUING TO DEVELOP THE INFRASTRUCTURE BOTH TO ACCEPT RISK AND MANAGE THE PHYSICIAN PRACTICES THEY AGGRESSIVELY ACQUIRED. BUT GIVEN THE TIGHT LABOR MARKET, EMPLOYERS REMAIN LESS CONCERNED WITH CONSTRAINING COSTS, AND MORE WITH OFFERING BROAD PROVIDER NETWORKS. AS A RESULT, ENROLLMENT GROWTH IN HEALTH MAINTENANCE ORGANIZATIONS (HMOS) HAS BEEN SLOWER THAN EXPECTED.

AMONG THE MAJOR TRENDS SHAPING THE GREENVILLE HEALTH CARE MARKET TODAY:

- HEALTH PLANS' INTEREST IN RISK-BASED CONTRACTS WITH PROVIDERS HAS DIMINISHED.
- HOSPITAL SYSTEMS HAVE IMPLEMENTED PRODUCTIVITY-BASED PAYMENT FOR PHYSICIANS AND EXPANDED CLINICAL CARE MANAGEMENT EFFORTS.
- DESPITE IMPROVEMENTS TO THE SAFETY NET, GAPS REMAIN.

In January 1999, a team of researchers visited Greenville, S.C., to study that community's health system, how it is changing and the impact of those changes on consumers. More than 30 leaders in the health care market were interviewed as part of the Community Tracking Study by the Center for Studying Health System Change (HSC) and The Lewin Group. Greenville is one of 12 communities tracked by HSC every two years through site visits and surveys. Individual community reports are published for each round of site visits. The first site visit to Greenville, in January 1997, provided baseline information against which changes are being tracked. The Greenville market is defined as a five-county area, including Greenville, Spartanburg, Anderson, Cherokee and Pickens counties.

Greenville Demographics

	Greenville, S.C.	Metropolitan areas above 200,000 population
Population, 1997 [1]	904,729	
Population Change, 1990-1997 [1]	8.5%	6.7%
Median Income [2]	$23,605	$26,646
Persons Living in Poverty [2]	15%	15%
Persons Age 65 or Older [2]	13%	12%
Persons with No Health Insurance [2]	12%	14%

Sources:
1. U.S. Census, 1997
2. Household Survey, Community Tracking Study, 1996-1997

Hospital activities reflect the emergence of direct competition among hospitals that had long confined their service areas to more narrowly defined submarkets.

Hospital Competition Escalates in Light of Failed Merger

The Greenville market, which encompasses a five-county area in the upstate region of South Carolina, continues to be noted for significant economic growth. Multinational companies such as BMW and Michelin are contributing to this expanding economic base, creating a tight labor market. Population in the area increased at a rate of 8.5 percent between 1990 and 1997, and unemployment is only 1.8 percent.

Three concentrated and distinct submarkets for health care center around Greenville, Spartanburg and Anderson counties, with some overlap in the area between Greenville and Spartanburg, where economic growth has been most rapid.

- Greenville County is home to the largest health care institution in the market, Greenville Hospital System (GHS). GHS controls 75 percent of inpatient services in the county and is the area's only teaching hospital. Also in Greenville County, St. Francis Health System is GHS's major local competitor. The two systems have a long-standing rivalry, with GHS offering discounts to health plans that exclude St. Francis from their networks. At the time of HSC's first site visit, St. Francis had opened a women's hospital in the area between Greenville and Spartanburg, and GHS quickly bought up the property surrounding it.
- In Spartanburg County, the largest hospital system is Spartanburg Regional Healthcare System. Its chief competitor, Mary Black Memorial Hospital, is owned by Quorum Health Group, a national hospital chain. Spartanburg Regional is the major tertiary care provider in the county and accounts for 70 percent of inpatient care in Spartanburg County.
- Anderson Area Medical Center is the sole hospital system serving Anderson County.

Despite the distinctiveness of each of these submarkets, large companies, which account for more than half of the local work force, draw their employees from the entire region. As a result, employers are demanding that health plans offer provider networks that can serve residents in all three areas.

In 1995, GHS, Spartanburg Regional and Anderson Area Medical Center proposed merging into a single system, known as AGS, that would span the Greenville market's three major counties. The new provider entity sought economies of scale in operations and information systems and a strong negotiating position with insurers. It also would have appealed to plans seeking a single, geographically dispersed provider network to serve large regional employers.

Within the Greenville community, opposition to the merger emerged amid fears that local control over health care would be lost to a monopoly controlled by GHS. Community distrust of GHS, fueled in part by a marketing campaign spearheaded by St. Francis, culminated in a 1996 referendum in which 75 percent of voters rejected the merger proposal. Although the referendum was nonbinding, the message sent by voters was so strong that GHS decided to pull out of the deal and repair its relations with the community.

After the AGS merger fell apart, local hospitals sought to solidify and improve their position relative to competitors, both in their immediate submarkets and in the market as a whole. In Greenville County, St. Francis stepped up its strategy to capture market share from GHS by broadening its subspecialty service mix and marketing itself as a patient-friendly hospital offering a range of services comparable to those of GHS. St. Francis recently received certificate-of-need (CON) approval from the state to offer open-heart surgery, which several plans, including Blue Cross and Blue Shield of South Carolina and CIGNA/ Healthsource, had said was necessary if they were to include St. Francis in their

networks. But despite several large purchasers' special appeals to one of these plans, both continue to exclude the hospital from their networks because of the steep discount offered by GHS.

GHS and its former AGS partners continue to participate in certain activities begun in expectation of the merger, including the joint ownership of a health plan, HealthFirst, created largely in anticipation of mandatory Medicaid managed care. At the same time, however, Spartanburg Regional and Anderson Area Medical have moved to strengthen their positions as tertiary care providers. Anderson has applied for a CON to perform open-heart surgery, and Spartanburg is currently building a cancer center.

Meanwhile, competition for the expanding health care market between Greenville and Spartanburg has intensified, reflecting the emergence of direct competition among hospitals that had long confined their service areas to more narrowly defined submarkets. GHS is now completing a large ambulatory surgery and physician office complex in this strategic area, on the property surrounding St. Francis's women's hospital. Spartanburg Regional has established pediatric and orthopedic physician practices and family care centers. At the same time, Mary Black Memorial has placed obstetrics-gynecology practices in this demographically desirable area. Hospitals also have built urgent care centers and are marketing their occupational health services to employers based there.

Two recent market developments point to potential further changes in Greenville hospitals' competitive environment. First, it was recently announced that St. Francis Health System is up for sale, as its owner, the Franciscan Sisters of the Poor Health System, decided to leave the health care business on the heels of losses in other markets. A change in ownership of this hospital could affect the market position or strategies of St. Francis, altering competition in Greenville County and in the market at large.

Second, Spartanburg Regional recently agreed to consider joint venture opportunities with Charlotte, N.C.-based Carolina Medical System. Respondent reactions to this announcement were mixed. Since no joint ventures have been identified yet, some respondents indicated that it was too soon to assess the implications of this arrangement. Others noted, however, that if Spartanburg moves forward with these activities, it will give an organization from an adjacent market an important foothold in the area and may lead to more regionally based competition.

Plans Back Away from Provider Risk Contracting

At the time of the first site visit in 1997, HMO enrollment was limited, but it was expected to increase. National plans such as CIGNA/HealthSource and Aetna had established a strong presence in the market. With half of the insured work force enrolled in preferred provider organizations (PPOs), an ongoing transition into HMOs and more restrictive provider networks was anticipated. Plans had begun to establish risk-based contracts with providers, which also were expected to grow.

Two years later, however, HMO enrollment has increased more modestly than expected, as employers remain reluctant to usher employees into more restrictive products. Greenville continues to have the lowest HMO penetration of the 12 communities HSC tracks.

At the same time, health plans' interest in risk-contracting arrangements with providers has diminished. Maxicare, a national plan, had established capitated contracts with hospitals, but has since left this market after failing to recover from its national bankruptcy in the 1980s. Blue Cross and Blue Shield, the leading health plan with respect to market share, has several capitated contracts, yet it has found that improved utilization review techniques have enabled it to rein in costs

Health System Characteristics

Greenville compared with the highest and lowest HSC study sites and metropolitan areas with over 200,000 population

STAFFED HOSPITAL BEDS† PER 1,000 POPULATION, 1996

Greenville, S.C	*2.8*
Little Rock, Ark.	*5.3*
Seattle, Wash.	*1.9*
Metropolitan Areas	*3.2*

Source: American Hospital Association
†At nonfederal institutions designated as community hospitals

PHYSICIANS†† PER 1,000 POPULATION, 1997

Greenville, S.C.	*1.5**
Boston, Mass.	*2.6*
Metropolitan Areas	*1.9*

Source: American Medical Association and American Osteopathic Association
††Nonfederal, patient care physicians, excluding certain specialties—e.g., radiology, anesthesiology, pathology
** Lowest study site*

HMO PENETRATION, 1997

Greenville, S.C.	*8.4%**
Miami, Fla.	*64%*
Metropolitan Areas	*32%*

Source: InterStudy Competitive Edge 8.1
** Lowest study site*

HMO enrollment has increased more modestly than expected, and health plans' interest in risk-contracting arrangements with providers has diminished.

more effectively through discounted fee-for-service. As a result, its fee-for-service arrangements are now less costly than its capitated contracts, and it is reportedly less inclined toward capitation for future contracts.

Meanwhile, HealthFirst, the health plan formed by the AGS partners, has established itself as an independent competitor among health plans in the market, expanding well beyond its role as a vehicle for AGS partners to accept risk. Over the past two years, HealthFirst's enrollment has increased substantially, its product offerings have broadened and it is expected to yield a profit for the first time in 1999. In the wake of the failed merger, the hospital owners now appear to view the plan primarily as an investment rather than as a vehicle for shared risk contracting.

Other provider-initiated efforts at risk contracting have also been unsuccessful. The multispecialty group, Carolina Multispecialty Associates (CMA), noted two years ago for its aggressive move to organize physicians in anticipation of managed care, has dissolved. At the time of the first site visit, CMA was rapidly building its management infrastructure, and was actively seeking capitated contracts. Both GHS and St. Francis expressed interest then in purchasing this emergent competitor. But when risk contracting failed to materialize, CMA physicians were less inclined to support costly information and contracting systems with dim prospects for returns on these investments. Starting with cardiologists, specialists began leaving CMA, its ranks shrinking from 75 physicians to 45 before it dissolved.

CMA's demise presents a striking example of failed expectations of change in the Greenville market. In 1997, market observers noted CMA as the organization most likely to manage full-risk capitation contracts, and, as such, it represented a potential physician-led challenge to a market historically dominated by hospital-based systems. CMA's failure reflects the lack of change in the underlying market conditions in Greenville, as fee-for-service payment and the unrivaled leadership of hospital-based systems continue to prevail.

Hospitals Continue to Pursue Integration

Despite the movement away from risk-based contracting, hospitals have continued their efforts to develop the infrastructure necessary for these arrangements. In 1997, hospitals were continuing an aggressive campaign to acquire primary care practices. Ultimately, almost 75 percent of the area's primary care physicians came under the ownership of local hospitals—more than in any other HSC study site. Integration was limited, however, because hospitals did not have the information systems to monitor cost and quality.

Two years later, hospitals have taken steps toward integration by strengthening their information systems and establishing profiling systems to monitor physician practice patterns. A significant reduction in length of stay across most diagnosis-related groups (DRGs) at a number of local hospitals was attributed to hospital-initiated physician profiling efforts.

In addition, the hospitals are beginning to move physicians from salary arrangements to productivity-based payment. Although this change is still too new to assess its impact, it marks the implementation of an important step to align physicians' financial interests with those of the hospital. However, some respondents expect this change to result in a significant decline in physicians' income in the short term. Physicians' response to these changes and their implications for hospital integration efforts remain to be seen.

Hospitals have also initiated a variety of care management programs, in contrast to two years ago, when little such activity was evident. In addition, these programs are notable for their

efforts to improve care within the hospital and beyond the hospital walls.

For example, GHS has implemented a knee and hip replacement program that aims to reduce length of stay and improve overall recovery and functioning. Spartanburg Regional has implemented a program for patients with congestive heart failure, where nurses initiate contact with discharged patients to monitor and follow up on their chronic conditions. Readmissions have been lowered as a result.

But because they have not been accompanied by new financial arrangements, hospitals' continued efforts to improve care delivery have been hampered. In fact, with per diem reimbursement by health plans, hospitals that implement programs to reduce readmission rates and length of stay achieve significant cost savings for health plans—but they also substantially reduce the hospitals' own inpatient revenue.

Spartanburg Regional, for example, has tried to use these cost savings from quality improvement programs to negotiate better payment rates from plans, but has had limited success. Given the potential revenue loss, it is not known whether local hospitals will continue to pursue quality initiatives under current market conditions, or whether they will succeed in securing contracts that allow them to benefit financially from these activities.

Local Safety Net Improves, but Barriers Remain

While providers and social service groups noted serious gaps in the safety net in 1997, there appeared to be little public concern in the Greenville market about care for the poor. With no public hospital in the area, local hospital systems and community clinics acted as the major providers of indigent care, and their capacity was severely limited. Lack of public transportation—eliminated in early 1997 due to Greenville County's budget shortfalls—has exacerbated access problems. Meanwhile, Medicaid patients reportedly had difficulty getting appointments with private physicians, particularly pediatricians and primary care providers.

During the past two years, attention to the local safety net has heightened, and resources for meeting the needs of the poor have increased substantially. A community health assessment sponsored by the United Way brought to light the severity of Greenville's safety net problem and, according to market respondents, was an important catalyst for change. In addition, GHS has made significant new investments in care for the poor as it sought to improve its public image after the failed AGS merger. Finally, concerns about inappropriate emergency room utilization motivated both GHS and St. Francis to pledge funds to community clinics to bolster the local safety net.

As a result of these and other investments, two major safety net providers—the Greenville Community Health Center and the Greenville County Free Clinic—have been strengthened considerably. Both clinics have relocated to renovated facilities with expanded capacity and hours of operation. The Free Clinic also has added specialty services, such as ophthalmology and obstetrics-gynecology, and has opened a dental clinic. With more volunteer clinical staff, it aims to increase patient visits by 20 percent in 1999. The Greenville Community Health Center reports that it has already seen increases in its patient load.

Hospital systems in Spartanburg and Anderson counties have also taken steps to improve access for the uninsured. Spartanburg Regional recently opened a primary care clinic in a lower-income area of the county and relocated a number of its obstetrics-gynecology and primary care clinics to more accessible locations. Anderson Area Medical Center has expanded its community health service network and implemented a telephone triage program.

Access to care for Medicaid-eligible children also appears to have improved. Under an enhanced primary care case management (PCCM) program imple-

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mented by the state in lieu of mandating enrollment in HMOs, the state streamlined enrollment and coordination of care, and increased payments for primary care physicians leading to higher participation rates.

In addition, under a new state program, Partners for Healthy Children, children's eligibility for Medicaid has been extended to 150 percent of the federal poverty level for children up to age 18. By November 1998, the state had increased enrollment under the expanded program by 56,000 (its target is 75,000), thanks to successful outreach activities by local public health departments and higher payments for participating physicians.

Persistent obstacles to Medicaid recipients' enrollment in HMOs, however, make it unlikely that the state's plans for mandatory HMO enrollment will move forward. Although the state won federal approval in 1994 to require Medicaid recipients to enroll in HMOs, it never implemented the program because of concerns about plan capacity and limited cost savings potential. Medicaid recipients can enroll in HMOs on a voluntary basis, but few Greenville-area beneficiaries opt for this choice because the enrollment process is reportedly cumbersome, and many physicians prefer the payment arrangements under PCCM.

Despite many improvements in the local safety net, barriers to access remain. It appears that demand for care among the poor continues to outstrip available capacity, as evidenced by long waits to see safety net providers. Lack of public transportation remains a major access barrier for low-income residents. Greenville Community Health Center, for example, discontinued its expanded Saturday evening programs reportedly due in part to residents' difficulty getting to the clinic.

Issues to Track

Other than some improvements to the safety net, there has been less change in the Greenville market over the past two years than was anticipated. Hospital competition continues to thrive in light of the failed AGS merger, with an increasing focus on an area of rapid economic growth between Greenville and Spartanburg. HMO enrollment remains minimal, and fee-for-service payment continues to prevail. Nonetheless, hospitals have established productivity-based payment for physicians and continue their efforts to improve clinical care delivery.

Key issues to track in Greenville include the following:

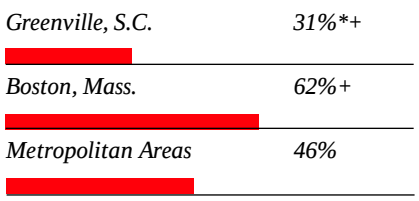
- How will hospital competition across the market and within submarkets evolve? What impact will anticipated ownership change and new opportunities for joint ventures have on local market dynamics?
- Will hospital systems succeed in negotiating contracts that allow them to benefit financially from their efforts to integrate physician practices and improve clinical care management?
- What effect will productivity-based compensation have on physicians and their relationships with hospitals?
- What impact will recent capital improvements to the safety net and improvements to Medicaid have on access to care for the poor?

Greenville Compared to Other Communities HSC Tracks

Greenville, the highest and lowest HSC study sites and metropolitan areas with over 200,000 population

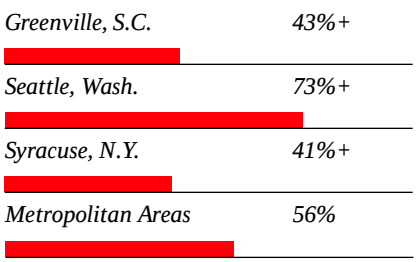
Gatekeeping and Compensation Arrangements

Insured Persons Covered under Gatekeeping Arrangements



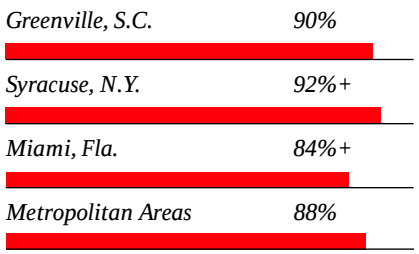
*Lowest study site

Physicians Receiving Capitation for at Least Some of Their Patients

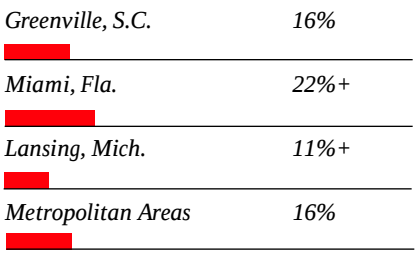


Consumer Perceptions of Access to Care

Families Satisfied with the Health Care Received in the Last 12 Months

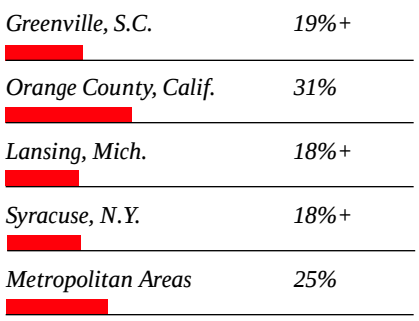


Patients Agreeing That Their Doctor Might Not Refer Them to a Specialist When Needed

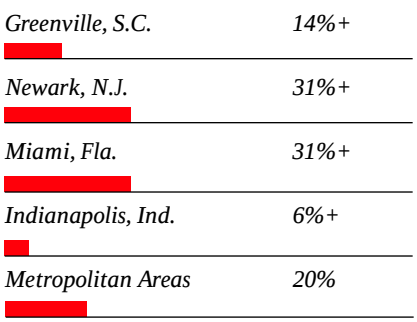


Physician Perceptions of Access to Care

Physicians Not Agreeing That It Is Possible to Provide High-Quality Care to All of Their Patients

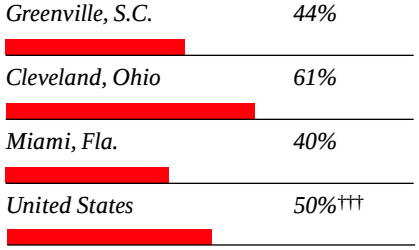


Primary Care Physicians Reporting That They Cannot Always or Almost Always Obtain Referrals to High-Quality Specialists When Medically Necessary



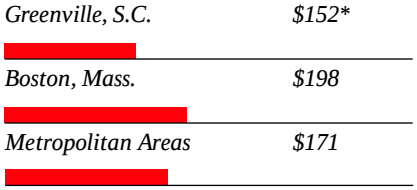
Employers and Health Insurance‡

Employers Offering Health Insurance



†††Metropolitan area data not available

Average Monthly Premium for Employer-Sponsored Insurance



‡Based on preliminary data
There are no significance tests for results reported.
*Lowest study site

The Community Tracking Study, the major effort of HSC, tracks changes in the health system in 60 sites that are representative of the nation. Every two years, HSC conducts surveys in all 60 communities and site visits in the following 12 communities:

- *Boston, Mass.*
- *Cleveland, Ohio*
- *Greenville, S.C.*
- *Indianapolis, Ind.*
- *Lansing, Mich.*
- *Little Rock, Ark.*
- *Miami, Fla.*
- *Newark, N.J.*
- *Orange County, Calif.*
- *Phoenix, Ariz.*
- *Seattle, Wash.*
- *Syracuse, N.Y.*

+Site value is significantly different from the mean for metropolitan areas over 200,000 population.

The information in these graphs comes from the Household, Physician and Employer Surveys conducted in 1996 and 1997 as part of HSC's Community Tracking Study. The margins of error depend on the community and survey question and include +/- 2 percent to +/- 5 percent for the Household Survey, +/-3 percent to +/-9 percent for the Physician Survey and +/-4 percent to +/-8 percent for the Employer Survey.

Health System Change (HSC), a nonpartisan research organization, seeks to provide objective, incisive analyses about health system change that lead to sound policy and management decisions, with the ultimate goal of improving the health of the American public.

Findings from the first round of the Community Tracking Study site visits are documented in *Health System Change in 12 Communities*. The Community Report series documents the findings from the second round. HSC conducts site visits in 12 communities in collaboration with The Lewin Group.

Authors of the Greenville Report
Sally Trude, HSC
Terry West, The Lewin Group
Sharrie A. McIntosh, The Lewin Group

HSC 12-Site Leadership Team
Paul B. Ginsburg, HSC
Cara S. Lesser, HSC
Raymond J. Baxter, The Lewin Group
Caroline Rossi Steinberg, The Lewin Group

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President: Paul B. Ginsburg
Director of Public Affairs: Ann C. Greiner
Editor: The Stein Group

For additional copies or to be added to the mailing list, contact HSC at:
600 Maryland Avenue SW, Suite 550
Washington, DC 20024-2512
Tel: (202) 554-7549
Fax: (202) 484-9258
www.hschange.com

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