Health System Change in Greenville, S.C.

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The health care system that serves the growing community of Greenville, South Carolina, is described by some local respondents as a "last bastion of no change." A number of forces have acted to keep change at bay in the Greenville market. Large employers are relatively satisfied with the costs of health care benefits, and managed care plans have not gained substantial market share or influence. State and local health care policy makers have not implemented any aggressive health care purchasing strategies or major reforms. In addition, consolidation among the major hospital systems has also created a barrier to managed care. Nevertheless, important signs of change are emerging as the region's economic growth begins to attract national and regional health care organizations, and local providers start positioning themselves in anticipation of increased managed care activity. Although these changes may appear small, they mirror trends observed in more active markets across the country.

The Greenville metropolitan statistical area (MSA) includes three communities: Greenville, Spartanburg and Anderson, which account for the bulk of the region's population but represent distinct health care markets. The area's population has grown steadily during the past decade, driven in part by new economic and industrial development in the Interstate 85 corridor between Greenville and Spartanburg. Nevertheless, the area's per capita income and educational attainment levels remain well below the national average. These factors, combined with South Carolina's stringent Medicaid eligibility requirements, reportedly have resulted in a large number of residents without adequate health insurance coverage. Greenville is a conservative community, and the concept of managed care conflicts with the high value many residents place on freedom of choice. The majority of the region's managed care contracts are for PPO products. Greenville's HMO penetration is low; several HMOs have made modest inroads but none is dominant.

The local health care system is dominated by several highly consolidated hospital systems. Competition between the two systems in Greenville County is acrimonious, while provider relationships in Spartanburg and Anderson have been much more collegial. In contrast to the consolidated market for hospital services, most community physicians practice independently and are not affiliated with a single hospital system. However, Greenville has one large multispecialty group practice that operates across the region and whose

influence is growing. Organizational change in the provider market has been described as defensive—"designed to keep outside health care organizations from entering the community."

Nevertheless, signs of organizational change have been escalating in response to local market competition and the perceived threat of competition from outside the community. For example:

- Hospital systems are moving to develop regional provider organizations. The most significant move was made by the three largest hospital systems in Greenville, Spartanburg and Anderson counties, which attempted to merge. However, the proposal was blocked in 1996 by a public referendum.

- Hospital systems are purchasing physician practices and investing in PHOs and other mechanisms to align hospital and physician services.

- Greenville's only large multispecialty group practice is preparing to enter into capitated contracts.

- The region's three largest hospital systems recently established a licensed HMO.

- National mergers in the insurance industry have shifted control of covered lives in Greenville to companies that are likely to be more aggressive in promoting managed care products.

It is unclear whether these developments signal an increase in the pace of health system change. Some respondents believe that unless health care costs increase significantly, other market conditions will act to preserve the status quo and keep outside managed care organizations from making major inroads.

The Greenville Community

The Greenville-Spartanburg-Anderson MSA is the largest metropolitan area in South Carolina, with about 884,000 residents.[1] It encompasses a five-county area in the "upstate" region of South Carolina and is approximately 100 miles southwest of Charlotte, North Carolina; 100 miles north of Columbia, South Carolina (the state capital); and 140 miles northeast of Atlanta, Georgia.

During the past 15 years, the MSA's population has grown by about 1.2 percent annually, slightly faster than the U.S. average.[2] About 30 percent of the MSA's employment is in manufacturing, nearly double the national average.[3] Greenville County's economy has been particularly strong, with annual job growth of 2.1 percent during the past 10 years. Its 1996 unemployment rate was 3.0 percent.[4]

Stimulated by national and international firms that have established and expanded their operations in the area, the regional economy has shifted from its heavy reliance on the textile industry to a more diverse manufacturing and service base. Greenville is attractive to businesses, in part because of its low labor and living costs and the absence of organized labor. However, the majority of new employment in Greenville County has been in the service sector. During the past 10 years, 2,700 manufacturing jobs were lost while 48,000 jobs were created in other sectors.[5] In contrast, neighboring counties have a higher percentage of manufacturing jobs and higher unemployment rates, between 4.0 and 5.0 percent.[6]

The three major counties in the metropolitan area are Greenville, Spartanburg and Anderson, each with a city of the same name. Greenville County has approximately 38 percent of the MSA's population, followed by Spartanburg with 27 percent and Anderson with 18 percent. The other two counties,

Cherokee and Pickens, are predominantly rural. Greenville lies between Spartanburg and Anderson; the drive from downtown Greenville to either of these cities is approximately 45 minutes.

About 17 percent of residents in the Greenville metropolitan area are African American, compared with 12 percent nationally.[7] There are few other ethnic minorities. Slightly more than 32 percent of the population has less than a high school diploma, and the average per capita income is about 15 percent below the U.S. average.[8] Greenville is located near the "buckle" of the "stroke belt" in the Southeast, where the high incidence of stroke identified by researchers is only partly explained by demographic and other population differences.[9] Gross mortality and mortality from cardiovascular disease in Greenville are also slightly higher than national averages.[10] Infant mortality in Greenville is 17 percent above the U.S. average among white infants and 24 percent higher among nonwhite infants.[11] Poor nutrition, smoking and obesity were mentioned as behavioral risk factors that affect local health outcomes.

THE HEALTH CARE MARKET

There are three distinct sub-markets in the Greenville MSA, each dominated by one or two hospital systems. Some patients come to Greenville from outlying areas, particularly to Greenville County for tertiary care. Occasionally, highly complex hospital care is referred to Columbia, Charleston or out of state. Greenville's hospital bed capacity is about equal to the national average, but it has 17 percent fewer physicians per capita.[12] Physician supply varies substantially, with the highest concentrations in Greenville and Spartanburg counties and the lowest in Cherokee and Pickens counties.

The region's employers include a diverse mix of international and national corporate operations, state and local governments, other large local employers, such as the hospital systems, and small businesses. Many of the large employers have workers dispersed throughout the region. The hospital systems and physicians are predominantly local, although several organizations, including the Greenville Hospital System and Carolina Multispecialty Associates, are increasing their involvement regionally.

Respondents described the Greenville community as highly religious, fiscally and socially conservative and distrustful of large bureaucracies such as government and big business.

Most insurers that do business in Greenville operate on a regional or national basis. Blue Cross and Blue Shield of South Carolina, Greenville's largest insurer, operates statewide. Most of the other managed care companies, like Aetna/U.S. Healthcare, Health source and Maxicare, are regional or national in focus. The new provider-sponsored networks are local in focus, although one, HealthFirst, is considering expanding to other areas of the state.

LEADERSHIP AND DECISION MAKING

Respondents described the Greenville community as highly religious, fiscally and socially conservative and distrustful of large bureaucracies such as government and big business. Greenville has not welcomed organized labor. The local Chamber of Commerce boasts that South Carolina is a "right-to-work state." Greenville is home to Bob Jones University, the largest nondenominational Christian university in the world. Respondents say the university has a strong influence on state and local politics. The area's economic growth has created an influx of residents, including a grow-

ing number of Europeans employed by international corporations such as Michelin and BMW. There is some "culture clash" between Greenville's newer residents and those who have lived there for generations, according to respondents.

Several prominent political issues have important repercussions for local health care delivery. The Greenville County Council recently voted to close down the city's public transportation system because of budget shortfalls, raising concerns about the closing's impact on access to medical services for low-income residents. Neighboring Pickens County recently passed a law that requires health care providers to report drug-addicted pregnant women to the police for prosecution on child abuse charges—raising a new barrier to prenatal care for some high-risk women.

Although 17 percent of Greenville residents are African American, this segment of the community reportedly has a limited voice in local decision making. Churches and community based-organizations have not been particularly active on health care issues, and there is little African American representation in the local physician community.

An informal network of local politicians and business leaders exerts substantial influence, according to a number of respondents. The community's formal business arm, the Chamber of Commerce, is active in local legislative issues, and business leaders are well represented on hospital boards. The most important political institutions are the Greenville County Council and the 17-member legislative delegation of elected state officials who represent Greenville County. The council deals with local issues, while the legislative delegation meets regularly to discuss local issues related to state policy. Both the council and the legislative delegation were active in the debate over the proposed merger of Greenville Hospital System, Spartanburg Regional Medical Center and the Anderson Area Medical Center. This deal, which was referred to locally as the "AGS merger," was placed by the council on a Greenville County referendum.

The AGS merger was defeated in a November 1996 voter referendum by a 4:1 margin. The overwhelming defeat reflected a public perception that, in pursuing this merger, Greenville Hospital System would become less accountable to the community. Voters were also concerned that the merger would produce a large health care bureaucracy. These perceptions were fueled by a media campaign supported by opponents of the merger.

Respondents agreed that the major hospital systems are important actors in local health care decision making, but they did not offer any consensus about the influence of other organizations. Some respondents mentioned the United Way of Greenville County, which supported a community health assessment and has convened meetings with a broad range of participants to discuss local health care issues. United Way also worked with the Appalachia Public Health District Two to set health improvement goals for Healthy Greenville, a local initiative based on the national Healthy People 2000 agenda. The Greenville Medical Society has sponsored public forums to discuss community health care issues, but its most visible public activity has been to promote a "patient's bill of rights" for managed care enrollees. In Anderson County, two groups were established to implement a community health improvement plan with the financial support of the Anderson Area Medical Center: Partners for a Healthy Community and the Anderson Alliance for a Healthy Future. The Greenville Taxpayers Association was also mentioned for its grassroots activism against the AGS merger.

External Forces Affecting the Health System

Health system change in Greenville has been driven primarily by competition among health care providers and plans rather than pressure from purchasers or public policy makers. External forces have affected Greenville's health system only marginally.

PUBLIC POLICY

South Carolina does not have a tradition of activism or innovation in health policy. However, in 1994, the state submitted a Section 1115 waiver application to the federal government to enroll all Medicaid recipients in managed care and to expand coverage to 250,000 uninsured residents below the poverty line. The state's waiver proposal for the Palmetto Health Initiative was approved by the federal Health Care Financing Administration but never implemented. According to the legislature and the new governor elected in November 1994, more time was needed to develop structural and provider support for managed care.

The state has enacted limits on rate variation for experience and health status among individuals and small groups, guaranteed issue for small-group insurance and a minimum loss ratio provision for the individual insurance market.

Since then, South Carolina has embarked on several more modest health care initiatives. For example, the "Partnerships for Healthy Children" proposal, slated to begin in the fall of 1997, would raise Medicaid eligibility to 133 percent of poverty for all children age 18 and under, adding about 50,000 to the Medicaid rolls. The state has enacted limits on rate variation for experience and health status among individuals and small groups, guaranteed issue for small-group insurance and a minimum loss ratio provision for the individual insurance market. In addition, South Carolina has enacted several laws to regulate managed care, including an "any willing pharmacist" law and a law that requires HMOs to base their beneficiary copayments and deductibles on the payment rates they negotiate with providers.

With two important exceptions, public policy has played a limited role in the Greenville health care market. The most prominent local public policy issue was the proposed AGS merger, which was debated by local politicians and regularly discussed by the news media. The other major public policy issue focuses on the state certificate-of-need (CON) process and its impact on provider competition.

In 1995, Greenville Hospital System, Spartanburg Regional Medical Center and the Anderson Area Medical Center proposed to merge into a single system spanning the three major counties in the Greenville MSA. The AGS merger would have created the largest hospital system in South Carolina, with annual revenues in excess of $1 billion and more than 75 percent of the area's inpatient volume. Supporters argued that the merger would create a system of sufficient scale to negotiate successfully with managed care plans, make needed investments in administrative and information systems and coordinate services effectively across the five-county region. Opponents argued that the merger would create a health care monopoly controlled by Greenville Hospital System. They also expressed concern that Greenville Hospital System, which serves the local community, would be controlled by a board with out-of-area representation.

The St. Francis Health System launched a marketing campaign against the merger and supported anti-merger groups such as the Coalition for Quality Health Care. The Greenville County Council ultimately decided to place the merger on a public referendum because Greenville Hospital System is considered a publicly chartered institution. On November 5, 1996, Greenville County voters rejected the proposed merger.

The state CON process also affects competition in the Greenville market. Respondents said that it is becoming increasingly important for hospitals to offer a full range of services in order to win managed care contracts. Greenville Hospital System is the only hospital in Greenville County that is licensed to provide open-heart surgery services. St. Francis officials claim that Greenville Hospital System has leveraged that monopoly to persuade Blue Cross and Healthsource to contract exclusively with it. The St. Francis PPO contracts with St. Joseph's Hospital in Atlanta for open-heart surgery and claims that Greenville Hospital System will not provide it with discounts comparable to what other payers receive.

St. Francis has considered opening a competing open-heart surgery program, but needs state CON approval to go forward. This poses an important policy question. Approval of St. Francis's CON request would establish St. Francis as a full-service alternative to Greenville Hospital System and diminish concerns about a Greenville Hospital System monopoly. However, many respondents believe the new program would create unnecessary service capacity. Some residents reportedly would support a compromise that would ensure St. Francis appropriate access to Greenville Hospital System's open-heart services, eliminating the competitive rationale for new service capacity. It is unclear whether public or private organizations in Greenville will be able to accomplish this arrangement.

PURCHASING

Greenville's employers were not described as a major force for health care system change. Many large employers have operations across the Greenville region, and these employers typically self-insure. Those that offer managed care options prefer HMOs or PPOs with broad provider networks. Major Greenville employers include BMW of North America, Michelin Tire Company, Kemet Electronics and the state of South Carolina. The health care industry is also a major employer: Greenville Hospital System is the second-largest employer in Greenville County, with more than 6,000 employees, and Spartanburg Regional and Anderson Medical are the largest employers in their respective counties. The benefits packages offered by these systems generally establish their own facilities as preferred providers. Greenville also has many small employers. In contrast to larger companies, these organizations are highly sensitive to premium costs and commonly use brokers to purchase their health benefits.

Employers have not promoted managed care options. Some employer representatives say their employees distrust managed care and dislike its limits on individual choice. Several employers also cited historical problems with HMOs, including Maxicare's bankruptcy and Companion Health Care's financial difficulties and subsequent rate hikes during the 1980s. Large employers generally view local health care costs as reasonable compared with those in other markets—another reason for their lack of interest in managed care. Respondents noted that many employers in Greenville have increased employee cost sharing to help control health benefits spending; this is consistent with national trends. However, many HMO benefit packages in Greenville reportedly include 10 or 20 percent coinsurance for hospitalization coverage, representing a substantially higher share of costs than the fixed copayments associated with HMO benefit

packages. Although employers say that quality is important to them, as a practical matter, those interviewed rarely looked beyond accreditation by the National Committee on Quality Assurance and board certification for physicians. There is little organized employer activity around health care issues in Greenville. One group meets informally to discuss health benefits and other related issues through the Chamber of Commerce, but its primary function is communication, rather than purchasing.

The state is one of the region's largest employers and provides coverage for nearly 61,000 Greenville-area workers and their dependents. Nevertheless, the state reportedly exerts limited influence as a purchaser of health services.[13] Approximately 90 percent of the state's covered lives in Greenville are in a self-insured PPO administered by Blue Cross, and most of the remaining 10 percent are in the Healthsource or Companion HMOs.

Similarly, the state Medicaid agency is not considered an assertive purchaser, even though it provides coverage for more than 65,000 Greenville residents.[14] Lack of action on the Palmetto Health Initiative has left a voluntary Medicaid managed care program that enrolls only about 1,000 Medicaid recipients in HMOs on a statewide basis. The HMO option is not offered to Greenville residents.

Organization of the Health Care System

The intense rivalry between Greenville Hospital System and St. Francis affects all aspects of health care delivery in Greenville. The actions of these two systems are propelling efforts to form regional hospital alliances and establish stronger ties between hospital and physician services. The region's only large physician group practice, Carolina Multispecialty Associates, is another major force, and its strength is thought to be growing. In contrast, Greenville's HMOs have low enrollment and limited market power. In addition, Greenville's new provider-sponsored networks, particularly the HealthFirst HMO/PPO owned by the AGS partner hospitals, may substantially affect the distribution of managed care market share.

PROVIDER ORGANIZATIONS

Greenville County's market is dominated by Greenville Hospital System, a state-chartered, not-for-profit organization with an 800-bed teaching and research hospital, a 60-bed children's hospital, two small community hospitals outside Greenville and several specialty hospitals and outpatient urgent care centers. Its principal competitor, St. Francis Health System, has a 257-bed main campus in Greenville and a new 50-bed women's hospital. The intense competition between Greenville Hospital System and St. Francis reportedly is driven by personal animosity between their leaders and has been played out repeatedly in the local news media.

For example, in 1992, Greenville Hospital System opposed St. Francis's plans to build a new women's hospital and lobbied against its CON application. When a CON was granted, Greenville Hospital System purchased land around the women's hospital site to block future expansion. More recently, Greenville Hospital System negotiated with several health plans to be their exclusive hospital provider in Greenville, reportedly using its open-heart surgery capacity as a bargaining chip. In response, St. Francis purchased billboard ads criticizing Blue Cross for its deal with Greenville Health System and urging people to call the Blue Cross CEO. Rancor between the two systems intensified when St. Francis assumed a leading role in opposing the AGS merger.

Relationships among hospital systems outside Greenville County are more collegial. In Spartanburg County, the Spartanburg Regional Healthcare System has a 588-bed medical center with a range of services (including open-heart surgery), and a small hospital outside Spartanburg. The 225-bed Mary Black Memorial Hospital is near Spartanburg Regional in Spartanburg. Formerly a not-for-profit hospital, Mary Black Memorial was recently purchased by the Quorum Health Group, a national, for-profit hospital management company. Some respondents believe this acquisition will increase competition in Spartanburg. The 587-bed Anderson Area Medical Center is the sole hospital serving Anderson County.

The proposed AGS merger launched a trend toward regional provider affiliations. Although the merger was blocked, the participants jointly own the HealthFirst HMO/PPO and are discussing other activities, such as joint purchasing of supplies. In response to the proposed merger, St. Francis and Mary Black Memorial formed Community Health Partnership, a network of nine upstate hospitals and affiliated PHOs, to contract with regional employers.

Most Greenville physicians practice in solo or small-group practices. Physicians generally are not aligned with a single hospital unless they are salaried employees. Most doctors admit to both Greenville Hospital System and St. Francis. Greenville's only large organized group practice, Carolina Multispecialty Associates, is a professional association of 30 upstate practices. Its 80 physician partners are split between primary care and specialty physicians. In addition, 130 specialists work closely with Carolina Multispecialty. Respondents said Carolina Multispecialty is ahead of other area providers in its capability for managing patient care and the financial risk associated with capitated contracts. Its competitive assets include strong leadership, tight organization, a large number of primary care physicians, extensive coverage of most specialty services and a good reputation, according to these respondents. Carolina Multispecialty has not announced any risk contracts, although it is in discussions with several HMOs.

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Hospital systems have taken the first steps to align themselves more closely with physicians in preparation for future managed care contracts. About half of Greenville County's primary care physicians reportedly are salaried employees of one of three entities: Partners in Health, a network of 70 primary care physicians employed by Greenville Hospital System; St. Francis, which employs about 40 primary care physicians; and Carolina Multispecialty Associates. In addition, Greenville Hospital System established the Upstate PHO as its primary managed care contracting vehicle. St. Francis established the Optimum Health Partners PHO and Optimum Physician Services, a for-profit management services organization. Because there are few HMO contracts in Greenville, PHOs have a relatively small volume of patients, and many of the salaried primary care physicians are free to refer patients to the hospital of their choice. However, the hospital systems consider these physician networks to be the core of their future capitated contracting networks.

INSURERS AND HEALTH PLANS

Managed care has been slow to arrive in Greenville. The area's HMO penetration is about 12 percent,[15] with virtually no enrollment reported in Medicare and Medicaid. Loosely structured PPO products are the preferred form of managed care among most employers. HMO penetration remains low because of the lack of aggressive employer purchasing, hospital consolidation that limits plans' ability to negotiate discounts and the community's general dislike of managed care constraints. But managed care organizations have shown increasing interest in Greenville, and 18 plans reportedly applied for South Carolina HMO licenses during the past year.

Blue Cross and Blue Shield (BCBS) of South Carolina, a mutual insurance company based in Columbia, historically has dominated South Carolina's health insurance market. BCBS reportedly controls approximately 25 percent of the commercial market in the upstate region. Most of its enrollment is in the Preferred Personal Care PPO network. BCBS also owns Companion Health Care, one of the state's oldest and largest IPA-model HMOs. It recently introduced a second HMO, Preferred Health, which offers a larger provider network and uses different information and reporting systems. The rationale behind this new product is two-fold: It will help BCBS shift its PPO accounts into an HMO product more easily and it will provide BCBS with another HMO to offer state employees. BCBS also has major national business lines in health care information processing, including contracts with the state Medicaid program, Medicare and CHAMPUS. Some observers questioned whether these national activities will distract BCBS from its efforts to "bring managed care to South Carolina."

Greenville's HMO and PPO networks for the most part are broadly inclusive with respect to hospitals and physicians, with several important exceptions. About half of the 7,000 physicians who participate in the BCBS traditional statewide indemnity product are also in the Companion HMO, which was described as one of the narrowest HMO physician networks in the region. According to Blue Cross, the Companion network initially had substantially fewer physicians, but has broadened in response to customer demand.

Healthsource, the New Hampshire-based HMO chain with regional headquarters in Columbia, reportedly has more than 40,000 enrollees in the upstate region, as well as the largest HMO market share in the Greenville MSA. Several years ago, Healthsource acquired Provident, a PPO that historically serviced the local textile industry. Healthsource has tried to introduce those former Provident accounts to HMO products; however, Healthsource recently announced that it planned to be acquired by CIGNA.

A number of other managed care plans enroll fewer than 10,000 people in the Greenville region, including Aetna, Maxicare and Physician's Health Plan, which is managed by United Healthcare of Minneapolis. Aetna, which recently merged with U.S. Healthcare, has been working to shift its predominantly PPO-based membership into HMO products. Maxicare is struggling to win back enrollment following its bankruptcy in the 1980s. Physician's Health Plan was described as an "up-and-coming" plan, with an open access product that allows enrollees to get specialty care without referrals from a primary care gatekeeper.

The recent establishment of provider-sponsored health plans has created some concern among commercial managed care plans. HealthFirst has several PPO contracts and recently received an HMO license. It began marketing the HMO to employers in April 1997. St. Francis does not have have an insurance license, but offers its Optimum Care

Network through a third-party administrator. Both systems plan to use these networks for direct contracts with employers and to compete with stand-alone managed care plans. Health plans are concerned that the owners of these provider-sponsored health plans, particularly Greenville Hospital System as the majority owner of HealthFirst, will use their hospital pricing policies to influence the HMO market to their advantage.

Interest among plans and providers in financial risk-sharing is increasing, but few such arrangements have actually been implemented. The Companion Health Care HMO capitates primary care services, but its market share is small and represents only a small portion of most physicians' total compensation. Similarly, HMOs and PHOs, including St. Francis and Mary Black, are experimenting with global capitation contracts involving several thousand covered lives. On balance, however, most provider organizations are only beginning to develop the capabilities needed to manage large risk contracts.

Clinical Practice and Delivery of Care

Greenville's providers are only in the early stages of implementing financial incentives and formal systems to monitor and improve clinical care. Financial incentives are limited to primary care physician capitation and small-scale global risk arrangements among PHOs. According to some respondents, financial incentives for hospital-based or group practice physicians are more likely to be linked to productivity measures, such as patient volume, than to other measures of performance.

Several HMOs mentioned "incentive programs," in which primary care physicians are eligible for bonuses based on access (e.g., hours of operation), quality (e.g., chart reviews, patient satisfaction) and utilization measures (e.g., specialty referral rates, inpatient days per 1,000 population, compared with their peers). However, because HMO penetration is low, these incentives only apply to a small proportion of patients, limiting their impact on physician behavior.

Most major hospital systems, physician groups and health plans in Greenville are reviewing or have implemented practice guidelines. Guidelines are used primarily as an educational tool without strict monitoring to ensure compliance. For example, Greenville Hospital System reported using nine inpatient-focused practice guidelines and Carolina Multispecialty Associates reported using radiology guidelines to encourage appropriate use of CT scans and MRIs. The Companion HMO has established physician committees to develop and promote practice guidelines.

Providers and health plans are also interested in disease management, but few such programs have been implemented. Companion HMO's asthma program uses telephone contacts and home health visits to monitor patient status and ensure appropriate medication. Greenville Hospital System is examining variations in pneumonia care, orthopedic treatment, cardiac catheterization and cardiac surgery by reviewing utilization data, average length of stay and readmission rates. Several organizations mentioned the use of Milliman & Robertson's appropriateness guidelines to review selected cases.

Clinical decision making in Greenville is controlled by physicians, according to respondents. Hospitals, PHOs and managed care plans have relatively little influence over physician practice, although external measurement and management of clinical care may expand under global capitation arrangements. For example, St. Francis is contracting with North American Medical Management, a PhyCor

subsidiary company, to implement financial and care management systems for capitated contracts in its PHO.

Carolina Multispecialty Associates is reported to have developed the most advanced clinical practice management capabilities. Its staff and contracted network include most major specialties, and the group reportedly is negotiating risk contracts with health plans. Carolina Multispecialty is also implementing practice guidelines in respiratory-related conditions, rehabilitation, outpatient surgery and other areas. In addition, it is developing clinical information systems to profile physicians and compare their performances against specific benchmarks.

Care of the Poor

Greenville does not have an organized "health care safety net," despite strong evidence of a need for indigent care services. Greenville's average per capita income is 15 percent below the U.S. average.[16] Some observers report that Greenville's economic growth has been a "beacon" for poor families in rural Appalachia looking for work, and many have found employment in service industries, but without health benefits. These factors, combined with the state's stringent Medicaid eligibility criteria, reportedly have resulted in a substantial number of Greenville residents without health insurance. There does not appear to be much public concern about indigent care, but the providers and social service groups that serve these populations contend that it is a serious problem.

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Several hospitals and clinics were consistently mentioned as the major providers of indigent care in the Greenville community. Greenville Hospital System is generally considered the largest provider of indigent care; it reported charity care charges of $27 million, or about 6 percent of its patient load, in 1995.[17] Spartanburg Regional reported $20 million in charity care charges in 1995. St. Francis reportedly provides charity care equal to about 4 percent of its total patient charges.

During the early 1990s, the county opened the Greenville Community Health Center (CHC), a federally qualified health center that sees about 25,000 patients annually. About 37 percent of its patients are Medicaid recipients; 38 percent are uninsured and pay according to a sliding fee scale. The Slater Marietta Family Health Center serves rural Pickens County, north of Greenville, as a satellite of the Greenville CHC. The CHC receives about $500,000 annually in federal grant funds. Greenville Hospital System historically has provided financial support, in-kind contributions and patient referrals to the CHC. Greenville Hospital System supplied the current CHC's physical plant and plans to donate land for a replacement clinic site.

The Greenville Free Medical Clinic is staffed with volunteer physicians and health professionals who serve uninsured walk-in patients. Its hours of operation, however, are limited, allowing only 30 people to be served daily. The overflow is referred either to the Greenville CHC or a hospital clinic. Both Greenville Hospital System and St. Francis provide free diagnostic services to the clinic. The clinic's future reportedly depends on continued financial support from Greenville Hospital System.

Medicaid patients reportedly have difficulty getting appointments with private physicians,

particularly pediatricians and primary care providers. Among the reasons cited for these access problems are: low payment rates, the state's "burdensome" claims processing system and a lack of capacity. Many of these patients ultimately are served by the same providers that deliver indigent care, especially the Greenville Hospital System outpatient clinics and the Greenville CHC. A substantial number of Medicaid patients are also served by the North Hills Medical Group and the Slater Marietta Family Health Center.

Public health in the Greenville MSA is the responsibility of Appalachia Public Health District Two. The agency's annual budget is approximately $15 million, of which 70 percent is devoted to personal health services. Approximately half of the budget is derived from home health and long-term care service revenue. Recent public health initiatives include a media and education campaign to reduce the percentage of births to women with inadequate prenatal care, which dropped from 11.4 percent to 5.7 percent between 1988 and 1993.[18] Pediatric immunization has also received increased attention under the state's new "no shots-no school" policy. Immunization rates among children ages 2 and younger on the rolls of the Greenville County Health Department rose from 53 percent in 1992 to 85 percent in 1995.[19]

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Greenville's health care systems for the poor have changed little during recent years. Establishment of the Greenville CHC and the Greenville Free Clinic added primary care capacity to the system, but with the failure of the Palmetto Health Initiative, state efforts to expand health insurance coverage and introduce managed care to providers serving low-income populations have been put on hold.

Issues to Track

Most of the sources driving change in other parts of the country have been absent from Greenville—until recently. Organizational change underway in Greenville's health care provider market appears to be taking place in anticipation of other potential changes, such as entry by managed care organizations, which may be attracted by Greenville's sizable population base, economic growth and low HMO penetration. It is not clear, however, whether managed care enrollment will be able to flourish in Greenville, given the market's structural and cultural characteristics. Among these are: the perception by employers that health care costs are reasonable, a consolidated hospital market that can hold its ground in negotiations with health plans and resistance by local residents to limits on health care choices.

Opinions were mixed concerning the impact of recent health system changes on Greenville residents. Several respondents noted that health insurance premiums were rising and that some of those increases have been passed on to workers through higher copayments and deductibles. Health care quality was viewed as generally good, although some people expressed concern that managed care interventions in physician decision making were adversely affecting quality. Finally, many people agreed that the community's access to primary care has improved (except for Medicaid recipients and the uninsured). However, concern was expressed about access to health insurance, particularly as businesses create more part-time positions that do not offer health benefits.

The direction and success of HealthFirst will have an impact on the Greenville health care market. Because it is owned by the area's

three largest hospitals, HealthFirst could become a platform for a provider-sponsored health plan capable of dominating the local managed care market.

HealthFirst's effectiveness as a managed care organization will depend on whether it can align its goals with those of its owner hospitals. HealthFirst could be operated as an "independent HMO" and use its negotiating power and care management tools to control health care costs. It could also be used as a vehicle for channeling patients into Greenville Hospital System, Spartanburg Regional and Anderson Area Medical. HealthFirst's top executives are professional HMO managers recruited from Group Health Cooperative of Puget Sound, a well-regarded staff-model HMO in Seattle. But the financial incentives for HealthFirst's owners to "fill hospital beds" may conflict with HealthFirst's operational strategies to reduce health service costs and premium rates. If organizational differences present an overwhelming barrier, HealthFirst presumably could be spun off as an independent company, allowing Greenville Hospital System to concentrate on health care delivery.

HealthFirst's success also depends on the public's willingness to accept what is perceived as a "Greenville Hospital System" HMO, because the community's faith in that system remains shaky in the aftermath of the AGS merger debate.

There is also the matter of whether Greenville Hospital System and St. Francis will continue their intense competition or develop more collegial relations. In addition, it remains to be seen whether the community and the legislature will approve St. Francis's CON application to start an open-heart surgery program, which would allow it to compete head-to-head with Greenville Hospital System as a full-service alternative. That could precipitate increased managed care penetration, if plans perceive an alternative to negotiating with Greenville Hospital System. However, some residents would prefer a compromise that provides St. Francis with access to Greenville Hospital System's open-heart services at "reasonable" prices. It is unclear whether community leaders can achieve such an arrangement.

The future of regional service networks should also be tracked in the aftermath of the failed AGS merger attempt. There are reports that the three systems plan to pursue collaborative activities in lieu of a full-asset merger. Some respondents, however, expressed skepticism that these activities will be significant. Similarly, it is unclear whether Community Health Partnership, established in response to the AGS venture, will continue to move forward with joint contracting initiatives.

The biggest wild card in Greenville is Carolina Multispecialty Associates, which was identified as the organization most prepared to manage full-risk capitation contracts. So far, Carolina Multispecialty has maintained referral relationships with Greenville Hospital System and St. Francis. However, if Carolina Multispecialty does indeed become a major vehicle for global risk-contracting, its choice of a preferred hospital could tip the balance of power between Greenville Hospital System and St. Francis. Its selection of preferred physician affiliates could also shift the distribution of patient volume and revenues.

Finally, a number of forces could affect the provision of indigent care in Greenville. Most important, will the state look again at the Palmetto Health Initiative? Or will it take other steps to control costs through Medicaid managed care and expand insurance coverage for low-income residents?

NOTES

1 U.S. Bureau of the Census, March 1996.

2 *Ibid.*

3 South Carolina Employment Security Commission, March 1997.

4 U.S. Bureau of Labor Statistics.

5 DuPlessis J., "Greenville County's Job Growth Continues," *Greenville News*, April 27, 1997.

6 South Carolina Employment Security Commission, March 1997.

7 Area Resource File as of February 1996, Office of Research and Planning, Bureau of Health Professions, U.S. Department of Health and Human Services.

8 *Ibid.*

9 Colburn D., "Stroke Belt's Buckle Baffles Experts: Known Risk Factors Account Only in Part for Southern State's Higher Rates," *Washington Post*, May 27, 1997.

10 Area Resource File as of February 1996, Office of Research and Planning, Bureau of Health Professions, U.S. Department of Health and Human Services.

11 *Ibid.*

12 American Hospital Association, database of the 1995 Annual Survey of Hospitals. Figure does not include long-term care units in hospitals. Physician estimates are based on the 1996 American Medical Association Master File and 1996 American Osteopathic Association Master File. Includes physicians in direct patient care, excluding some specialties (radiology, anesthesiology, pathology), residents and fellows.

13 The state program covers local school district employees and some county employees, although Anderson is the only county in the region that currently participates.

14 South Carolina Department of Health and Human Services, Medicaid Management Information System (MMIS) Medicaid Enrollment by County Report, July 1996.

15 InterStudy Competitive Edge Regional Market Analysis 6.2, February 1997.

16 Area Resource File as of February 1996, Office of Research and Planning, Bureau of Health Professions, U.S. Department of Health and Human Services.

17 Hawes, J., "The AGS question: Is bigger better?," *Greenville News*, October 30, 1996.

18 United Way of Greenville, "Community Indicators: A Report Card on Greenville County," January 1996.

19 *Ibid.* Figure does not include children seen only by private physicians.