Health System Change in Indianapolis, Ind.

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Compared with other major U.S. cities, the health care market in Indianapolis is relatively stable, although it has the potential for significant changes in the coming years. Change in Indianapolis will hinge substantially on the activities of its hospital-based health care systems, which dominate the local market. Other industry players—including employers and state and local policy makers—are doing little currently to initiate major changes in health care organization and delivery.

As of January 1997, four major health care systems accounted for 78 percent of all hospital admissions in Marion County,[1] which shares boundaries with Indianapolis. These systems, which cover different though somewhat overlapping geographic service areas, exert considerable influence. For example, managed care plans that want to offer community-wide provider networks must contract with most of the four systems because of how the systems are configured geographically. In addition, most primary care physicians are closely aligned with these systems, either through direct employment or contractual relationships. In a relatively new strategy, some health systems are seeking to leverage their dominance in geographic sub-markets and their primary care physician networks to secure full-risk, global capitation contracts with HMOs.

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These hospital-based systems have entered the insurance business by creating their own health plans, including HMOs and PPOs, either independently or in collaboration with other systems. To secure their referral bases, the systems have pursued statewide affiliations with other providers in response to employers' demands for plans with large provider networks and extensive geographic coverage.

HMOs have found it difficult to enter this market or increase their enrollment. Respondents report that 15 to 20 percent of the commercial market is enrolled in HMOs, mostly in plans owned by the local health systems. However, the bulk of the commercial market is enrolled in PPOs or indemnity plans. Again, the strongest PPOs

are those owned by the health systems, with the exception of Anthem, Inc., a regional Blue Cross and Blue Shield plan.

Purchasers in Indianapolis have not demonstrated strong support for tightly managed HMO products, although they are turning increasingly to PPO products because of their competitive premiums and the access they offer to a broad range of providers. Except for the state and local governments and the health care systems themselves, few employers in Indianapolis are large enough to force health care change through their purchasing activities. In addition, employer coalitions formed to date have not engaged in any joint purchasing activities.

For now, state and local policy initiatives appear secondary to the actions of the provider systems in shaping health care delivery in Indianapolis. Care for the indigent is not perceived as a major issue, and the consensus is that the Marion County public hospital and local clinics are financially stable and accessible.

In general, respondents said they believe that the quality of health care provided in Indianapolis is good, and that costs are relatively stable and acceptable, compared with those in other major metropolitan areas.

The Indianapolis Community

The Indianapolis metropolitan statistical area (MSA) covers 3,532 square miles in central Indiana, which includes Indianapolis (Marion County) and eight surrounding counties. Indianapolis shares its borders and a consolidated local government with Marion County, and is home to about 820,000 of the 1.46 million residents in the Indianapolis MSA. With the exception of Hamilton County to the north, which includes the city of Carmel, and Madison County in the northeast, which includes the city of Anderson and hosts a major General Motors plant, the remaining counties are predominantly rural.[2]

Demographic characteristics are similar to national averages, but with substantial variations across counties. For example, about 21 percent of Marion County residents are black, compared with less than 1 percent of residents in all other counties except Madison. In 1993, Indianapolis's average annual per capita income of $22,019 was about 6 percent higher than the U.S. average. However, the median family income in Hamilton County was more than 50 percent higher than that in Madison or Marion counties. Indianapolis has a robust economy, with unemployment below 4 percent in 1995.[3]

Indianapolis ranks very near the U.S. average with respect to many common health status indicators. However, infant mortality is about 14 percent above the U.S. average among white residents and 3 percent above average among non-whites.[4] Those rates declined substantially between 1988 and 1994, possibly as a result of community initiatives aimed at reducing infant mortality.[5]

THE HEALTH CARE MARKET

Indianapolis has about 13 percent more hospital beds per 1,000 population than the U.S. average, and its inpatient utilization rates are about 22 percent higher.[6] Most of that bed capacity is located in the urban core of Marion County. Indianapolis also has about 6 percent more primary care physicians and 17 percent more specialty physicians per 1,000 population than the national average.[7]

In addition to serving Marion County residents, the Indianapolis health care system

receives referrals from the southern and central regions of the state. As a referral center, it offers the full spectrum of specialty and subspecialty services through its large, hospital-based health care systems and the University of Indiana School of Medicine. The major health care systems in the core market have distinct geographic service areas for routine care, although certain systems are considered the providers of choice for specific clinical services. Despite above-average service utilization rates, most informants described Indianapolisís health care costs as moderate.

LEADERSHIP AND DECISION MAKING

During recent years, Indianapolis has engaged in a substantial number of economic development activities, most directed at revitalizing its downtown area. These activities have been carried out primarily by local government with the strong support of civic leaders. Thus, collaborative decision making around community issues has an important history in Indianapolis, with results that generally are viewed as positive. However, health care to date has not received similar attention from community leaders.

Instead, health care decision making has remained primarily the province of the major health care delivery systems. Many of the physician leaders within these systems are Indiana natives with long tenure. A significant percentage of local physicians and administrators were educated at Indiana University and the IU School of Medicine and have a common educational and cultural bond.

Religious and consumer organizations appear to play limited leadership roles with respect to health care decision making. The Citizens Action Coalition is establishing a task force on managed care, and the Indiana Primary Health Care Association has worked in support of community health centers and their clients. However, these are very targeted efforts with limited impact on the market as a whole.

External Forces Affecting the Health System

PUBLIC POLICY

Indianapolis is relatively conservative with respect to health care policy. Because it is the state capital, health care policy in Indianapolis is initiated at the state and county levels. At the state level, legislative attention during the past few years has focused on small-group insurance market reform, managed care and care for the uninsured. Legislative efforts to enact small-group health insurance reforms have been relatively modest. In 1994, insurer blacklisting of specific employed groups was banned. The legislature has been more active recently in the managed care arena. Indiana has a relatively weak “any willing provider” law that applies to PPOs but not to unlicensed provider networks or to HMOs. The state also enacted a law mandating 48-hour hospital stays for vaginal births and 96-hour stays for cesarean sections, prior to federal action on this same issue. A proposal mandating direct patient access to any physician within a managed care organization failed. This flurry of legislative activity directed at managed care led to the formation of a two-year, 12-member legislative committee to study managed care, which planned to gather information during the 1997 legislative session.

The Marion County Health and Hospital Corporation (HHC), which includes

Wishard Hospital and the Marion County Health Department, is viewed as an attractive and efficient safety net provider, and has been a focal point for local health care policy. State efforts to develop new financing approaches for indigent care carry important local implications, because Wishard Hospital is a major provider for the indigent population. In 1992, the legislature formed a committee to study the costs of universal insurance coverage, but there was little support for state-financed expansions in coverage. Wishard's revenue base was reduced in 1994, when Indiana's Medicaid program implemented substantial cuts in payments for physicians and hospitals, making it more difficult for Wishard to provide indigent care. In 1996, a state commission on health care for the working poor was formed to explore options to finance and provide health care for the indigent, indicating that this issue remains on the state's policy agenda.

The proposed merger announced in 1996 between University Medical Center and the Methodist Health Group became another high-profile local health care issue and sparked intense public debate. The governor established a nine-person task force, which included local business leaders, legislators and the state attorney general. The task force addressed a range of issues, including:

- the implications of converting a publicly funded institution to private status;
- the relationship between the merged entity and Wishard Hospital, including the likely impact of the merger on the volume of indigent care provided at Wishard;
- the merger's effect on indigent patient access to James Whitcomb Riley Memorial Hospital, a nationally renowned children's care facility that would become part of the new entity; and
- the overall market power of the merged entity.

The merger proceeded in early 1997 after proponents supplied the task force with the information it sought, thereby relieving its concerns.

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PURCHASING

The largest employers in the Indianapolis MSA are local governments, including nine counties that employ a total work force of 62,700 but purchase health insurance individually; the state, with 28,800 employees in the MSA; and various community health care systems. The bulk of private sector employment is in firms with fewer than 1,000 employees. Notable exceptions include Eli Lilly and Co., which is based in Indianapolis and employs about 7,500 workers, and various subsidiaries of or suppliers to General Motors, with a combined employment of more than 20,000 workers.[8]

Employers believe that health care costs in Indianapolis are reasonable compared with those of other cities of similar size. They have not aggressively sought to contain costs, as reflected in their limited demand for tightly managed, highly integrated health benefits options.

HMOs must offer broad provider networks to attract employer interest, especially when they have to compete with PPO and indemnity insurance products. Because of a generally tight local job market and only modest increases in health benefits costs in recent years, most employers are reluctant to try to steer employees into lower-cost, more restrictive health plans. Unions exert considerable influence in the design of health benefits plans for state and county employees and for General Motors suppliers and subsidiaries, and they tend to support relatively comprehensive benefit coverage and provider networks. Furthermore, a substantial number of Indianapolis employers are units of national or regional firms headquartered elsewhere, and decisions regarding health benefit offerings typically are not made locally.

All of these factors combine to dilute pressures on larger employers to adopt aggressive and coordinated purchasing policies. Even the state, one of the largest employers in Indianapolis, has not used its purchasing power to vigorously pursue cost containment strategies, particularly those that promote enrollment in managed care plans. In contrast, nearly all employees of Indianapolis city and county government agencies are enrolled in HMOs. In addition, the local school district union contract mandates that at least one HMO be offered to all employees.

A considerably different picture emerges for small employers, which are perceived as highly sensitive to small differences in premium levels when choosing health plans for their employees. In the small-group market, respondents said that employers readily switch plans in exchange for lower premiums. PPOs are attractive to small employers that want to offer only one benefit package to their employees because they include a broad range of physicians and their premiums are competitive. Small employers in Indianapolis commonly use brokers to help them select health plans and structure benefit choices.

Quality of care generally is not a major factor in purchasers' health benefit decisions, in part because of the general perception that Indianapolis providers deliver high-quality care and in part because health plans offer broad physician networks. In addition, little information about health plan quality throughout the market is available, although a few large employers collect their own data on various aspects of health plan performance, including employee satisfaction. Eli Lilly, for instance, distributes information to its employees during open enrollment that compares health plans on certain quality-related measures and enrollee satisfaction. Health plans and provider systems are beginning to produce and distribute their own report card information for marketing purposes, but employers expressed skepticism about the usefulness of these data.

There has been relatively little cooperative health care purchasing activity among employers, although interest in this area appears to be growing. The Indiana Employers Health Care Coalition, which consists of 14 firms with more than 1,000 employees each, has attempted to collect data on hospital costs from the major provider systems in Indianapolis. In the small-employer market, a subsidiary of the Indiana Manufacturers Association plans to form a health insurance purchasing cooperative that will offer a range of HMO products to small employers.

Organization of the Health Care System

Health care delivery in Indianapolis is dominated by several large, not-for-profit, locally based health care systems created by the hospitals. These systems serve distinct but somewhat overlapping geographic market areas or population subgroups within Indianapolis. They offer health plans, either by themselves or in partnership with other systems, and they own or have close collaborative relationships with physician practices. For-profit hospital systems play a minor role in the Indianapolis market, but they have been aggressively seeking to expand that role. There has been considerable jockeying for position among the health care systems, resulting in a successful merger between two large systems and another failed merger attempt.

PROVIDER ORGANIZATIONS

Indianapolis hospital-based health care delivery systems include:

- Methodist Health Group/Indiana University Medical Center (central city);
- St. Vincent's Hospital and Health Care Center (north);
- St. Francis Hospital and Health Center (south);
- Community Hospitals of Indianapolis (northeast and south);
- Suburban Hospitals, Inc. (suburban Marion County and counties surrounding the city); and
- Wishard Memorial Hospital (central city).

In addition, two for-profit hospitals are located in central Indianapolis: Columbia Women's Hospital, a 132-bed facility owned by Columbia/HCA Healthcare Corporation, and Winona Memorial Hospital, a 170-bed facility owned by OrNda Health Corporation.

The Methodist Health Group includes Methodist Hospital of Indiana, one of the largest hospitals in the country, with more than 900 beds. Although the hospital is centrally located, it has established 17 outpatient and ambulatory surgical centers in Indianapolis's suburbs to expand its service area and referral base. It has clinical affiliations with hospitals in surrounding communities and joint ventures with other hospitals in the metropolitan area. Methodist Health Group owns and manages a physician-hospital organization (PHO), a network of five community health centers called HealthNet and an IPA-model HMO, M-Plan. In early 1997, it completed a merger with Indiana University Medical Center (IUMC) to form the Clarian Health System. IUMC includes the 380-bed University Hospital and Outpatient Center, a specialized adult hospital, and the 230-bed James Whitcomb Riley Memorial Hospital, a highly regarded comprehensive pediatric inpatient facility that serves the entire state.

St. Vincent's Hospital and Health Care Center is owned by the Catholic Daughters of Charity National Health System in St. Louis, Missouri. It consists of three hospitals in the Indianapolis area, St. Vincent's, Mercy and Mt. Carmel; a network of primary care physician practices; and a PHO. It owns 25 percent of Sagamore Health Network, which offers PPO and HMO products, and 50 percent of Cooperative Managed Care Services, which provides administrative and clinical management services. St. Vincent's has two large cardiology groups on its campus and joint ventures in catheterization laboratories with each group. These groups

reportedly are responsible—directly or indirectly—for approximately 50 percent of St. Vincent's revenues.

St. Francis Hospital is owned by the Catholic Sisters of St. Francis Health Services, based in Mishawaka, Indiana. St. Francis has 428 beds at its main Indianapolis campus and 78 beds at its south side campus, where it provides primarily outpatient services. It is also a part owner of Sagamore Health Network and a 50 percent owner of Cooperative Managed Care Services. It owns and manages primary care physician practices and owns the St. Francis Health Network PHO, with 75 primary care physicians and 350 specialists.

Community Hospitals of Indianapolis is a four-hospital, locally owned system with approximately 1,200 beds. In addition to inpatient facilities and specialty treatment centers, Community owns physician practices and Indiana ProHealth, which functions as a PHO. Indiana ProHealth contracts with payers and offers a PPO product that now has approximately 150,000 covered lives.

Suburban Hospitals, Inc., is a more loosely organized provider system consisting of 10 hospitals. This 10-year-old alliance was created to bolster its members' negotiating power with insurers. Suburban Health Organization, an offshoot of Suburban Hospitals, was created in the early 1990s to serve as a PHO for the alliance's participating hospitals.

Wishard Hospital, with 311 beds, is Indianapolis's public hospital. It is operated by the Marion County Health and Hospital Corporation, an independent municipal corporation that is funded in part by its own tax district. Clinical services at Wishard are provided under contract with the University of Indiana School of Medicine. Wishard manages six community clinics and is the principal provider of indigent care in the city.

Most physicians in Indianapolis are in small, single-specialty groups that are closely aligned with these large health care systems. PHOs are important mechanisms for accomplishing these alignments. These PHOs include primary care practices owned by the systems, as well as other primary care and specialist physicians on the medical staffs of sponsoring health systems. Respondents reported that area residents have strong loyalties to specific health care systems and their associated physicians, and generally believe that these systems deliver high-quality care.

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ORGANIZATIONAL CHANGE: PROVIDERS

The large hospital-driven systems are engaged in horizontal and vertical integration activities within Indianapolis and statewide. The most dramatic example of horizontal integration was the recently completed merger of Methodist Health Group and IUMC to form the Clarian Health System. Once combined, the new entity's inpatient facilities reportedly will make it the second-largest hospital in the country, with the capacity to provide virtually every type of medical service. Participants said the merger was spurred by the opportunity for organizational efficien-

cies and the ability to offer geographically broad but administratively integrated managed care products. Some respondents predicted that the inclusion of James Whitcomb Riley Memorial Hospital as a provider of pediatric inpatient services will enhance Clarian's attractiveness to purchasers and managed care plans. Other respondents described the Methodist/IUMC deal as a competitive response to the proposed merger between St. Vincent's and Community Hospitals, a union that ultimately did not take place.

The widespread perception is that merger and realignment activities among the health care systems in Indianapolis are not finished. For example, some respondents viewed St. Vincent's and St. Francis as potential merger partners, because they are already collaborating on a variety of joint ventures and serve different geographic areas. Several respondents believe Community Hospitals is open to merger or affiliation discussions, although it recently declined an offer to affiliate with Columbia/HCA.

Virtually all the large health systems in Indianapolis are pursuing horizontal collaborations with hospitals outside the metropolitan area, primarily through contractual relationships. St. Vincent's is creating networks with smaller regional hospitals and their affiliated physicians to solidify its referral base; Clarian has an affiliation with Health Indiana, a group of five hospitals located throughout the state; and Community Hospitals has joined with nine hospital systems, including Suburban Hospitals, in a statewide HMO called Healthpoint. St. Francis has affiliations with other hospitals in the state through its parent organization, and the four Catholic orders operating hospitals in the state are discussing the possibility of collaborating in a hospital network. These four orders already jointly sponsor Sagamore Health Network.

The hospital systems also have been pursuing vertical integration opportunities with physicians, mainly by purchasing primary care practices and by developing PHOs, in anticipation of intensified managed care activity. Competition for primary care practices intensified in 1992, when St. Vincent's became very active in this arena, launching what several respondents described as a "bidding war." By 1996, most primary care practices in the area were owned by health care systems, cardiology practices or American Health Network, a physician network sponsored by Anthem.

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PHOs allow health care systems to integrate both primary care and specialty physicians for the purpose of contracting with managed care plans or directly with employers. PHOs seek full-risk contracts with HMOs and assume responsibility for managing care delivery and information systems. In addition, some health systems have formed HMOs, using their own hospital medical staffs and primary care practices they acquired to serve as the core of their provider networks.

Although the bulk of provider integration activity in Indianapolis has been driven by

large health systems, physicians and insurers have initiated a few attempts at horizontal integration. For example, in addition to American Health Network, Anthem has created a multispecialty physician network called SpecialMed, which accepts capitated payments from health plans and capitates specialty practices in its network. On the other hand, the two largest cardiology groups in Indianapolis are pursuing a different physician integration model, without direct sponsorship from a health system or insurer. One of the groups, Nasser, Smith and Pinkerton Cardiology, is attempting to build a multispecialty group and has purchased primary care physician practices throughout Indiana to solidify its referral base.

HEALTH PLANS

No single plan, or small group of plans, dominates the health plan market in Indianapolis. This market has accepted PPO-based managed care, but respondents estimated that HMO penetration rates were only 15 to 20 percent of the employed group market. The Indianapolis market has accepted PPOs, but respondents estimated that relatively low penetration levels reflect in part the lack of strong employer interest in HMOs. In addition, several negative local experiences with HMOs during the 1980s may have reduced employers' interest in them. For example, Anthem's Key Health Plan had 160,000 enrollees in 1988, but has only 18,000 in Indianapolis today. It reportedly underpriced its product, incurring substantial operating losses. Subsequent large rate increases caused employers to drop the plan. The bankruptcy of Maxicare during the mid-1980s also raised concerns among local employers about the quality of HMO management.

Anthem, Inc., formerly the Associated Group, is the largest insurance carrier in the Indianapolis market. It began as Blue Cross and Blue Shield of Indiana, and then acquired the Blues of Kentucky and Community Mutual Insurance of Ohio. Anthem is now apparently attempting to make the transition from a regional to a national health insurer and has explored mergers with Blues plans in Connecticut, New Jersey and Delaware, although only the Connecticut merger remains a possibility at present. Anthem has developed two local physician networks: American Health Network, consisting of 274 primary care physicians who are joint network owners, and SpecialMed, a multispecialty IPA with more than 500 physician members. Most Anthem enrollees in Indianapolis are in indemnity or PPO products. Anthem's two HMO products, Key Health Plan and Anthem Health of Indiana, are relatively small, with a combined statewide enrollment of approximately 60,000.[9]

The local Maxicare HMO survived Maxicare's bankruptcy proceedings of the 1980s, and now has approximately 70,000 commercial enrollees in Indianapolis, along with about 3,000 Medicare members.[10] Maxicare, a for-profit, IPA-model plan, recently was approved as a Medicaid managed care contractor in central Indiana. For inpatient care, it contracts primarily with Community Hospitals, St. Vincent's and St. Francis. Methodist Hospital is not included in its network.

The remaining significant health plans in Indianapolis are owned or sponsored by health systems. M-Plan, owned by Methodist Health Group, is an IPA-model HMO with a statewide service area. It has approximately 120,000 members state-

wide and recently added a Medicare product that attracted about 4,000 enrollees.[11] Most Indianapolis hospitals, with the exception of Community Hospitals, are offered as part of M-Plan's provider network.

Sagamore Health Network is a for-profit organization jointly owned by four Catholic hospital systems that operate in Indiana. It offers HMO and PPO products, and reportedly has more than 600,000 enrollees, with approximately 150,000 enrollees in Indianapolis, almost all in its PPO product. Sagamore contracts with more than 100 hospitals statewide for its PPO product, but does not include Community Hospitals in its inpatient provider network.

The newest plan in the market is Healthpoint, which began enrollment in March 1997. It is a provider-sponsored network-model HMO owned by hospitals throughout the state. In Indianapolis, Community Hospitals and Suburban Hospitals are owners, with participation in the network by their respective PHOs.

Many of the major HMOs have global capitation contracts with the PHOs owned by the health systems, although the number of individuals served under these contracts represent only a small proportion of Indianapolis's total population. Global capitation rates, which cover all inpatient and outpatient care, are reportedly about 90 percent of the HMO's premium. Under these contracts, HMOs are responsible for marketing and administration, while PHOs are responsible for care management and utilization review. The HMOs offer different management services to PHOs, based on each PHO's capabilities.

Capitated payments to providers, as well as PPO and HMO premiums, have all been relatively stable during the past few years. However, Anthem recently announced a plan to reduce its fee-for-service payments dramatically. It is unclear whether it will be able to carry out this plan in the face of provider opposition.

ORGANIZATIONAL CHANGE: HEALTH PLANS

Two trends have characterized the Indianapolis health plan market during the 1990s: expansion of provider networks in response to the perceived desires of purchasers, and an increase in the number and types of products offered by health plans. The networking and consolidation activities involving health care systems and physicians have not been evident to the same degree in the health plan market. There is a widespread perception, however, that the configuration of the Indianapolis health plan market could change considerably during the next five years if:

- a national, for-profit HMO firm enters the local market;
- Anthem seeks to increase enrollment in its HMO products in Indianapolis;
- PPO premiums increase, triggering heightened employer interest in HMOs;
- Medicaid managed care becomes mandatory, attracting new HMO competitors into the market; or
- additional health system mergers produce new unions among the health plans owned by those systems.

Clinical Practice and Delivery of Care

Efforts by health systems and health plans to influence the delivery of care or change care processes are in their early stages. With respect to outpatient care, these efforts are occurring primarily under the aegis of the health system-owned PHOs. PHOs that accept global risk face the responsibility of managing care within a fixed budget. The increasing number of primary care physicians who are salaried health system employees facilitates implementation of new care initiatives by PHOs. These initiatives include restrictions on physician referrals, as well as physician profiling, practice guidelines, disease management programs and targeted quality improvement initiatives.

Referrals within Indianapolis are increasingly influenced by physician affiliations with PHOs and health systems and by financial incentives in PHO contracts. Primary care physicians employed by health systems such as St. Vincent's and Methodist Health Group, for example, are expected to refer to other physicians affiliated with these systems, and global capitation contracts between PHOs and health plans typically are structured so that physicians refer to a "preferred" group of specialists. For example, American Health Network, which accepts global capitation, negotiates sub-capitated arrangements with selected specialists in the community, limiting referrals to these groups. To date, there are no data documenting the actual impact of these policies with respect to patient referrals.

The practices of individual physicians are monitored and evaluated using physician profiling techniques. For example, Community Hospitals monitors physician practices using a new profiling and quality assurance data system. St. Vincent's distributes physician practice profiles to its physicians through its computer system, a practice that reportedly has upset a few physicians, although most have responded with questions and suggestions for change. American Health Network and SpecialMed also have implemented physician profiling activities. SpecialMed uses its physician profiling capabilities for benchmarking and quality improvement initiatives.

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Disease management programs also are increasing in popularity with health care organizations in Indianapolis. Amid reports that its asthma center has had a positive impact on costs and clinical outcomes, American Health Network is developing a program aimed at diabetes management. Community Hospitals operates an outpatient program for patients with congestive heart failure and an eight-year-old diabetes management program, and is launching a program for pediatric asthma. Other health care systems in Indianapolis offer or plan to offer similar disease management programs. However, few data are available concerning the impact of these programs on patient health outcomes or the number of patients they serve.

Virtually all of the health systems operate targeted clinical quality improvement programs, which typically are triggered by reviews of claims data, physician profiling information or quality assurance audits. For example, American Health Network and SpecialMed have care councils, groups of physicians who meet monthly to review utilization and quality assurance data. These councils provide a forum for discussion of clinical management issues. Community Hospitals has a clinical improvement team that reviews clinical processes and outcomes for major inpatient DRGs in all its affiliated hospitals, an approach that reportedly has produced quality improvements and cost savings.

The impact of these various attempts to influence clinical practice is still unclear. In many cases, implementation is in its early stages. More important, these efforts do not appear to be well coordinated within organizations, although some systems are taking steps to strengthen their coordinating mechanisms. In addition, attempts to influence clinical practice are not always coupled with supportive financial incentives or information systems. Considerable change may be expected in this area if PHOs increase the number of individuals they serve under global capitation contracts.

Care of the Poor

Respondents did not view care for the indigent as a major problem in Indianapolis. Two factors underlie this perception. First, the local economy is strong and the statewide rate of uninsurance is reportedly below the national average. Second, respondents believe the local system of safety net providers is effective and provides adequate access to services for people without insurance.

MEDICAID

The Indiana Medicaid program covers approximately 140,000 Indianapolis residents, or about 10 percent of the MSA population. Medicaid coverage is relatively limited, with AFDC income eligibility set at 51 percent of the poverty level for a family of three. Only seven states have more stringent criteria.[12] Medicaid reimbursement rates for physicians and hospitals were reduced substantially in 1994. This reduction, along with delays in provider payments that occurred when Medicaid switched to a new computer system, reportedly led a number of participating providers to withdraw from the program.

Indiana's first Medicaid managed care effort, Hoosier Healthwise, was a prima-

ry care case management (PCCM) program. In 1995, the state introduced a Medicaid HMO program in three geographic regions, including Indianapolis. AFDC recipients are automatically enrolled in either the PCCM program or an HMO option, depending on their choice of primary care physician.

Wishard Hospital, the Indiana University Medical Center and Methodist Hospital formed the Central Indiana Managed Care Organization (CIMCO), a not-for-profit managed care company, to engage in capitated Medicaid contracts in Marion County. St. Francis Hospital, five federally qualified health centers and a panel of 170 physicians also participate in CIMCO's network. Until recently, CIMCO was the sole risk contractor in Marion County, while Maxicare served the rest of central Indiana. As of November 1996, about 17,000 Marion County Medicaid recipients were enrolled in CIMCO. In late 1996, the state added a second HMO option, Maxicare, to its contracting program in Marion County. This second option is expected to increase Medicaid managed care enrollment in central Indiana because of the larger number of participating doctors.

Several issues have arisen with respect to Medicaid HMO enrollment. For example, the auto-assignment process sometimes splits family members among providers in different neighborhoods. In addition, some enrollees have become confused about which providers they may use. As a result, community health centers continue to treat these patients without reimbursement from Medicaid, and some have experienced shortfalls that have affected their ability to cross-subsidize indigent care.

CARE OF THE INDIGENT

Several providers located in central Indianapolis serve the community's indigent care needs. Wishard Memorial, the county's public hospital, is the principal source of charity care, followed by Methodist Hospital, the Indiana University Medical Center and St. Francis Hospital. James Whitcomb Riley Hospital is a major Medicaid and indigent care provider for children.

Indianapolis has two safety net clinic systems. The Marion County Health and Hospital Corporation runs five community-based neighborhood health centers, each of which serves about 17,000 patients annually, and manages the Citizens Health Corporation, a federally qualified health center that serves approximately 8,500 patients annually. Methodist operates HealthNet, a system of five federally funded clinics that see approximately 19,000 patients annually. The People's Health Center is the most recent addition to HealthNet, with a total user population of approximately 11,000. In addition to Marion County and HealthNet, the Gennesaret free clinic provides outpatient care to about 3,000 homeless persons. The St. Francis system also opened the St. Francis Neighborhood Clinic in February 1997 to provide primary care services for the uninsured.

Political support for Wishard Hospital is strong—in part, some respondents speculated, because other providers do not want to inherit its Medicaid and indigent care burden. Several years ago, under new leadership, HHC initiated a major reengineering of Wishard Hospital, using federal Medicaid disproportionate share funds to renovate the physical plant and institute a major consumer service initiative.

These changes have helped Wishard compete effectively for Medicaid patients. Wishard is now developing a "virtual HMO" model to manage indigent care more effectively. Uninsured patients who present at the hospital or affiliated clinics will be tracked by its information system, assigned to primary care providers and receive a membership card and handbook. This model is designed to improve the overall coordination of care for the uninsured population.

Issues to Track

A previous study examined the changes underway in the Indianapolis health system as of July 1995.[13] Comparison of findings from that last site visit and this one shows that changes in the health system generally are continuing in the same direction, but not at a rapid pace. The first report identified the dominance of hospital-based health care systems as an important market feature and focused on the developing merger activity involving these systems. However, one of the mergers anticipated at that time did not take place (a merger between St. Vincent's and Community Hospitals). The first report also identified several other market characteristics that remain today:

- the preference for POS and PPO products in the managed care market;
- the lack of a strong, coordinated purchaser influence;
- the limited role of public policy in shaping market changes;
- the key position of Wishard Memorial Hospital and affiliated clinics as providers of services to Medicaid and uninsured populations; and
- the relatively limited impact to date of clinical management efforts on the delivery of care.

Most change at the health system level appears to be taking place in the organizational arrangements of hospitals, while changes in other aspects of the system remain modest.

Most respondents expressed satisfaction with health care delivery in Indianapolis, and viewed health care costs as relatively stable and acceptable in comparison with those of other major metropolitan areas. They did not report reduced access to care for the general population or for the indigent population. Respondents said they believe health care provided in Indianapolis is of high quality, although there is little concrete information available concerning quality of care.

The dominance of the hospital-based health care systems, particularly in specific geographic service areas within Indianapolis, suggests that the Indianapolis market may evolve in a more orderly manner than many other large metropolitan markets. These systems appear to be focused on maintaining market share and control over local health care dollars. Some market participants expected St. Vincent's to merge with St. Francis at some point, possibly as the culmination of a variety of organizational linkages and affiliations over time. The timing of such a merger is difficult to predict; it depends in part on strategies adopted by the parent systems.

For-profit national health systems have had difficulty developing strong market positions in Indianapolis, as have large national HMOs. Medicare reimbursement rates for risk contracts are low, offering little incentive for these national

companies to enter the market. It is possible, however, that a for-profit company will try to acquire Community Hospitals. In addition, if Anthem, the area's largest insurer, turns its attention from national expansion to the local market, respondents predicted it could have a major impact. Its HMO enrollment has been declining, while its PPO product remains strong. Anthem's activities are closely monitored by others in the market.

The public policy front in Indianapolis is relatively quiet. Consumer-oriented managed care protection legislation may be submitted, but is unlikely to be highly restrictive. Nor does there appear to be any momentum to fund new programs for the uninsured. Mandatory Medicaid managed care enrollment would be a significant policy initiative. But even though such a move likely would stimulate new alliances between health systems and health plans to serve Medicaid recipients, it probably would not affect the fundamental market structure for either plans or providers.

One issue that bears watching is the impact on clinical practice of health systems' efforts to control the premium dollar by sponsoring health plans and using PHOs to negotiate global capitation contracts. This strategy creates incentives for the health systems to more closely integrate health care delivery and financing. The relative importance of this incentive and its impact on the health system ultimately depends on the number of patients served under global capitation contracts.

NOTES

1 The Indianapolis Project World Wide Web site, 1996 [http://www.indianapolis.org/unigov.htm].

2 Slater, C.M., and G.E. Hall, 1996 County and City Extra, 5th ed., Lanham, MD: Berman Press, 1996.

3 September 1996 Economic Trends Report, Indianapolis Chamber of Commerce.

4 Area Resource File as of February 1996, Office of Research and Planning, Bureau of Health Professions, U.S. Department of Health and Human Services. Data are a five-year average from 1988 to 1992.

5 Biannual Report, Marion County Health Department, 1996.

6 American Hospital Association, database of the 1995 Annual Survey of Hospitals. Figures do not include long-term care units in hospitals.

7 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.

8 Indianapolis Chamber of Commerce, 1996.

9 InterStudy Competitive Edge HMO Directory 7.1, March 1997.

10 Ibid. and interview respondents.

11 InterStudy Competitive Edge HMO Directory 7.1, March 1997.

12 Committee on Ways and Means, U.S. House of Representatives, 1996 Green Book, November 4, 1996.

13 Ginsburg, P.B., and N.J. Fasciano, eds., The Community Snapshots Project, The Robert Wood Johnson Foundation, 1996.