Health System Change in Phoenix, Ariz.

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Rapid, geographically dispersed population growth during the past three decades distinguishes Phoenix from most other large metropolitan areas in the United States and has had a significant impact on its health care delivery system. This growth has attracted several national, for-profit health care firms to the Phoenix area. However, most local hospital-based health systems have retained their independence, partly because of their strength in geographic sub-markets, where population growth has buffered them against the effects of lower per capita use of inpatient services. These local systems have attempted to solidify their dominance in these submarkets by developing physician-hospital organizations (PHOs) with their medical staffs, which they have leveraged with varying degrees of success in their negotiations with managed care plans.

In contrast, for-profit, national firms dominate the health plan market for commercial and Medicare enrollees in Phoenix. Some of these firms have been in the Phoenix market for many years, while others entered recently by acquiring health plans that were started by local providers. HMOs currently enroll almost 30 percent of the total population in Phoenix, including 100 percent of the Medicaid population.[1] Competition for Medicare enrollees has been particularly intense, and favorable Medicare reimbursement rates for risk contractors apparently have helped attract national managed care firms to the Phoenix market.

The most significant changes in the Phoenix health care market revolve around the organization of physicians. Until recently, the majority of physicians were in solo or small-group practices, but they increasingly are seeking new affiliations to negotiate managed care contracts. In addition to participating in PHOs, some specialists are forming specialty networks and pursuing capitated contracts with HMOs. Finally, a small but growing number of primary care practices are being purchased by national, for-profit physician management companies or other organizations.

Private sector purchasers, for the most part, have not played an influential role in shaping Phoenix's health care market, nor have other community organizations consistently exercised leadership in the health care arena. Health plans compete primarily on price for commercial enrollees and on benefits for Medicare enrollees. Little public information is available that compares health plans or health care systems in terms of patient outcomes or satisfaction.

At the state level, public policy has focused on the development and operations of the Arizona Health Care Cost Containment

System (AHCCCS), Arizona's alternative to traditional Medicaid. Launched in 1982, AHCCCS contracts with prepaid health plans through a competitive bidding process to serve low-income enrollees. These plans, in turn, contract with most of Phoenix's physicians and hospitals, providing access to "mainstream" providers for their enrollees.

At the local level, the deteriorating financial condition of the county hospital and its associated service delivery system is the dominant health policy issue. A proposal to privatize the county system as a solution to that problem has sparked intense public debate. Because eligibility requirements for AHCCCS are relatively strict, the county system is a critical safety net provider, and its failure could have a major impact on access to care for the uninsured.

The Phoenix Community

The Phoenix-Mesa metropolitan statistical area (MSA) covers nearly 38,000 square miles. It includes Maricopa County, with a population of 2.3 million, and Pinal County, which has a population of 126,000. Phoenix and its surrounding suburban areas, including Scottsdale, Sun City, Temple and Mesa, account for approximately 95 percent of the MSA's population. Known locally as "the Valley," Phoenix is one of the fastest-growing metropolitan areas in the U.S.; its population is projected to increase by nearly 3 percent annually for the next 15 years. Low unemployment and the availability of large tracts of undeveloped land outside the city will contribute to that growth.

Despite Phoenix's reputation as a retirement community, the proportion of residents over age 65 was only slightly above the U.S. average in 1995.[2] However, these data may not reflect the area's "snowbirds," retirees who spend only the winter in Phoenix. The average per capita income and income distribution in Phoenix are similar to national averages, but a higher proportion of Phoenix residents are educated beyond high school. Hispanics account for 17 percent of Phoenix's population, well above the national average.[3] The gross mortality rate was slightly below the U.S. average in 1994, but the infant mortality rate was above the national average for white and non-white residents.[4]

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THE HEALTH CARE MARKET

Phoenix has several distinct but overlapping health care markets. The central downtown region, east of Interstate 17 and north of Interstate 10, is home to the area's largest tertiary hospitals, including Good Samaritan Regional Medical Center, St. Joseph's Hospital and the Maricopa Medical Center. South Phoenix, directly below the central downtown area, has large concentrations of Hispanic residents and is served by Phoenix Memorial Hospital, Samaritan's Maryvale facility and Columbia HealthWest. The north Phoenix market, above the downtown area, includes John C. Lincoln Hospital and the Baptist Health System.

The most affluent areas of the Valley include Scottsdale and Paradise Valley, located northeast of downtown and are served by the Scottsdale Memorial Health System. Sun City, in the northwest corner of Phoenix, has a sizable retirement community and is served by the two-hospital

Sun Health Corporation. Mesa, Gilbert and Chandler are located east of I-17 and are among the Valley's most rapidly growing areas. East Phoenix is served by several systems, including the Lutheran Healthcare Network, Desert Samaritan Medical Center, Mesa General Hospital and Chandler Hospital. Tempe, southeast of downtown, is home to Arizona State University and St. Luke's Tempe Hospital.

The combination of rapid population growth, the absence of an allopathic medical school and a long history of managed health care has helped moderate health care capacity in Phoenix. The MSA has nearly 25 percent fewer hospital beds per 1,000 population than the U.S. average[5] and about 2 percent fewer physicians per 1,000 than the average for cities with a population of more than 200,000.[6] Nevertheless, the reach of Phoenix health care organizations extends beyond the MSA boundaries. Samaritan is a 50 percent owner of HealthPartners, an HMO with a statewide market, and the Mayo Clinic draws patients from the surrounding region.

LEADERSHIP AND DECISION MAKING

Respondents characterized the political culture at the state and local levels as anti-tax and anti-entitlement. The widespread perception is that the health care system is driven predominantly by individual decisions made by the market's many private provider systems and health plans, and that the system works well for most people. Perhaps as a result, many respondents noted a lack of community concern about health care issues. The government's role centers on financing and delivering care for the poor through the state's AHCCCS program and the Maricopa County health care system.

There was no consensus among respondents concerning organizations they considered leaders on community health issues. The state legislature, the county Board of Supervisors and the county public health department all influence health care, but they are not perceived as focal points for community health improvement efforts. Respondents noted the influence of the Arizona Hospital Association and Medical Association in the state legislature. They also mentioned that the Flinn Foundation, which focuses 75 percent of its grant making on Arizona health care issues, provides important health-related information to the community. Other groups identified with specific health care issues include the Catholic Diocese, the Arizona Latin American Medical Association, the Children's Action Coalition and the Area Agency on Aging. However, most respondents said health care advocacy at the grassroots level is limited. The lack of a strong community voice on health issues relevant to the Hispanic population was especially noteworthy.

External Forces Affecting the Health System

PUBLIC POLICY

Subsequent to the passage of federal Medicaid legislation in 1965, Arizona was the only state that did not develop a traditional Medicaid program. In 1982, stimulated by the pending bankruptcy of several rural county governments, the state instituted a demonstration program that enrolled low-income residents in prepaid health plans selected by the state through a competitive bidding process. This alternative to Medicaid, called the Arizona Health Care Cost Containment System (AHCCCS), continues today and is viewed nationally and locally as successful. In fact, a recent ballot initiative to expand eligibility for AHCCCS was supported by 75 percent of Arizona

voters. AHCCCS has played an important role in shaping Phoenix's health care system during the past 15 years, particularly the county-based system of care for the indigent. However, there is now considerable concern about the potential impact of federal welfare reform on AHCCCS and on the availability of health and social services for immigrants in Phoenix who do not quality for AHCCCS.

Except for those issues related to the financing and provision of health care for low-income individuals, relatively little public policy attention in Arizona has been devoted to health care. Last year, the legislature considered a "patient protection act" to govern HMO grievance procedures. Health plans opposed the initiative, claiming it would increase their costs, and a task force was appointed to negotiate a compromise measure. To date, Arizona has passed no "anti-managed care" legislation.

The state attorney general's office became concerned with the issue of for-profit conversion when Samaritan Health System considered an acquisition proposal by Columbia/HCA. But the acquisition did not materialize, obviating the need for specific policy actions.

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PURCHASING

Phoenix has enjoyed a prosperous economy during the past few years. Unemployment is approximately 5 percent, and during 1994 and 1995, Phoenix led the country in job creation among communities with more than 750,000 residents.[7] A substantial proportion of those new jobs were in the service sector. More than half of the area's employees work for companies with 200 or fewer employees. The largest private sector employers in Phoenix include Honeywell, Allied Signal, Motorola, America West Airlines and the local health care systems.[8]

Many large, non-health care, private sector employers are based outside the Phoenix area, and their health care purchasing decisions are strongly influenced by the policies of their corporate parents. Most of these employers contract with large, national health insurers, such as Cigna, Aetna, Foundation Health Plans and FHP. Managed care plans have been included in their health care offerings to employees for some time. These large employers typically pay 90 to 100 percent of their employees' health insurance premiums, and a smaller percentage for dependents. Some of these employers now expect contracting plans to be accredited by the National Committee for Quality Assurance and to collect and report performance data for the Health Plan Employer Data and Information Set (HEDIS). These employers also collect information on their employees' satisfaction with various dimensions of health plan performance. Large employers believe that their employees value provider choice and, as a result, health plans that offer broad provider networks and easy access to physicians are becoming more popular.

The Arizona State Retirement System, which includes all of the state's current employees and its retirees, is the largest public sector employer in Phoenix. It started using a competitive bidding process for its health benefits program in 1992, in response to a steep rate increase. The state makes a level premium contribution that is determined by the lowest-cost plan. Employees who choose a more

expensive option must pay the additional premium cost themselves.

Small businesses rely heavily on brokers to secure health insurance coverage. Price is the most important factor in their selection decisions, and they typically pay a much smaller proportion of the health insurance premium than do larger employers. However, choice and access to physicians are important to these purchasers as well.

As employers, Phoenix's health care systems play a major role in the area's economy. Most systems have adopted strategies to encourage their employees to seek health care from system providers. For example, Samaritan's employees represent a large source of enrollment for HealthPartner's Health Plan, which is partly owned by Samaritan.

There is little cooperative activity among Phoenix employers with respect to evaluating or purchasing health care. The Coalition for Affordable Health Care, which served as an educational and communication forum for employers, engaged in no joint purchasing decisions; in fact, it dissolved in late 1996. The only ongoing joint purchasing activity identified by respondents involves a group of grocers who are collaborating on the purchase of mental health benefits.

Organization of the Health Care System

Phoenix's rapid and geographically dispersed growth has supported the entry and development of multiple health plans and systems. In particular, several provider systems have been able to carve out strong positions in geographic sub-areas of Phoenix, although the local health care market as a whole is not highly concentrated at either the health plan or the provider system level. Health plans are perceived as powerful but not dominant in this market. Some provider systems view themselves as indispensable to plans because of their dominance in geographic sub-markets. Although respondents believed this situation to be relatively stable in the short term, many predicted increased consolidation among hospital systems and the emergence of more physician networks over time.

PROVIDER ORGANIZATIONS

Phoenix is home to 35 hospitals, including federal government, psychiatric and rehabilitation facilities, most of which are not-for-profit and locally owned. Phoenix's hospital market does not follow the "hub and spoke" configuration common to many older cities, where large tertiary care hospitals are located in the downtown area and the less technologically equipped institutions are found in the suburbs or surrounding communities. Although a substantial amount of tertiary and specialized care is provided in downtown Phoenix, many suburban hospitals also deliver tertiary care because of the market's large geographic size.

Samaritan Health System is the largest health system in the state and the most geographically dispersed system in the Phoenix area. Its flagship hospital, 582-bed Good Samaritan Regional Medical Center, is in central Phoenix, and it has three hospitals in the suburban areas:

- Desert Samaritan Regional Medical Center, with 331 beds;
- Maryvale Samaritan Medical Center, with 213 beds; and
- Thunderbird Samaritan Medical Center, with 221 beds.

The Samaritan system includes two rural hospitals (one owned and one managed by the system), two family health centers, two skilled nursing facilities and a variety of other programs and facilities. In addition, Samaritan operates three hospital-based ambulatory surgery centers and three free-standing ambulatory surgery centers in a joint venture with Columbia/HCA.

Samaritan has been the most active of the health care systems in developing health plans. It owns Arizona Physicians IPA, the largest AHCCCS contractor in Phoenix, and HealthPartners Health Plans, which serves 180,000 private sector enrollees statewide and is cosponsored by Tucson Medical Center.

Mercy Healthcare Arizona, which includes the 570-bed St. Joseph's Hospital and Medical Center and the nationally known Barrow Neurological Institute, competes with Samaritan for central Phoenix's tertiary care market. The next-largest hospital in central Phoenix, the 474-bed Maricopa Medical Center, is owned by the county and primarily serves the indigent population and AHCCCS beneficiaries. Its financial viability is uncertain.

Tenet/OrNda has the largest for-profit presence in the Phoenix hospital market, with four hospitals:

- the 289-bed St. Luke's Medical Center;
- St. Luke's in Tempe, with 102 beds;
- Mesa General, which has 145 beds; and
- the 75-bed Community Hospital.

Another national for-profit hospital system, Columbia/HCA, owns two hospitals in Phoenix and is attempting to increase its presence there. It participated in merger discussions with Samaritan Health Systems and reportedly has approached other hospitals with acquisition offers.

The Phoenix market is attractive to for-profit hospital systems, in part because of its growing population and the large number of independent hospital-based health systems located there. However, the proposed acquisition by Columbia/HCA of not-for-profit Samaritan generated substantial opposition from community leaders.

The physician market in Phoenix historically has been organized around solo and small-group practices, with only a handful of larger groups. Like the health system market, the physician market may be described broadly as a set of geographically separated sub-markets specific to individual hospitals. The formation of PHOs by hospitals and their physician staffs imposes an organizational structure on these physician sub-markets.

A small number of statewide physician groups exist in Arizona, including the Thomas Davis Medical Centers, which has 217 physicians, 75 of whom are in Phoenix; Casa Blanca, with 79 physicians; and Arizona Physicians Group, which has 35 physicians. These groups were formed and have expanded primarily to contract with managed care organizations.

The Mayo Clinic-Scottsdale, located in the northeastern Valley, is unusual in the Phoenix market. Mayo entered the Phoenix market in the late 1980s, attracted in part by the absence of large multispecialty group practices. In addition to the 145 specialists who practice at the main facility, Mayo employs 45 primary care physicians at six centers throughout the area. The Mayo Clinic's national reputation draws attention to its presence in Phoenix, but its impact on the local physician market has been limited. Its main facility is located in the far northeastern corner of the metropolitan area, its physicians constitute a relatively small proportion of Phoenix's 6,000 physicians and a signifi-

cant proportion of its patients come from outside Phoenix, primarily the southwestern United States and Southern California.

ORGANIZATIONAL CHANGE: PROVIDERS

At the time of the site visit, it appeared that health care in central Phoenix would be consolidated through a merger of Samaritan Health System and Mercy Healthcare Arizona. Prior to the Samaritan/Mercy merger agreement, Samaritan had engaged in merger discussions with Columbia/HCA and with the Tucson Medical Center. The latter discussions proceeded from the 1995 merger of the health plans owned by the two entities that created HealthPartners Health Plans. Samaritan sought a merger partner to help finance its sizable debt load. Competitors predicted that the merger process would be painful, because of culture conflicts between the two organizations and overlapping clinical service areas. However, they viewed the proposed merger as more favorable, from a competitive standpoint, than the purchase of Samaritan by Columbia/HCA. Subsequent to the site visit, the Samaritan/ Mercy merger was abandoned, apparently due to disagreement concerning how much control over the merged entity should be ceded to Catholic Healthcare West (Mercy Healthcare's parent organization) in return for the assumption of Samaritan's debt.[9]

While Samaritan's search for a merger partner is the most visible evidence of the potential for consolidation in the Phoenix market, it is unclear whether it is a presage of more system mergers or acquisition activities. Most systems in Phoenix have strong positions in well-defined geographic areas. They have pursued strategies, such as the creation of PHOs, designed to tighten their links with physicians and make them indispensable to managed care plans in their geographic sub-markets.

Health systems that succeed with this approach may feel less pressure to merge or seek contracting alliances with other provider systems. However, the effectiveness of PHOs as integrating mechanisms varies greatly. Many Phoenix physicians have been exploring other organizing approaches that do not include hospitals.

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Two emerging trends portend a greater degree of consolidation and practice integration among Phoenix physicians.

First, for-profit physician management companies are acquiring existing physician group practices. For example, Phy-Cor, a national physician management company based in California, recently purchased two physician groups, and FPA, another California-based physician management company, acquired the Thomas Davis Medical Centers. The Thomas Davis physicians subsequently became one of the few major physician groups in the country to unionize. Respondents predicted that physician management companies will use their acquisitions as a basis for expansion in Phoenix through the purchase of more practices. In fact, the Mayo Clinic has been steadily expanding its primary care

physician base through the purchase of primary care practices located throughout Phoenix.

The second emerging trend in the physician market is the development of single-specialty physician networks to contract with managed care plans and self-insured employers. For example, an orthopedic surgeons' network contracts with Cigna Health Plans to provide services to 220,000 individuals under a capitated payment arrangement. Similar physician networks exist, or are under development, for reconstructive surgery, cardiology and other specialties. These networks provide specialists with an organizational alternative to PHOs for contracting with managed care organizations and for developing practice guidelines, practice profiles and other educational efforts related to specialty care.

HEALTH PLANS

The Phoenix health plan market is highly competitive. Managed care enrollment has increased gradually since the late 1970s and, as a result, Phoenix residents are relatively accustomed to managed care. Population growth has supported the growth of managed care organizations; new residents establish links with their providers by choosing a health plan. Under the AHCCCS program, all Medicaid recipients are enrolled in prepaid plans. Together, HMOs and PPOs reportedly enroll about 60 percent of the commercial health insurance market. Ownership of the large health plans is split between national HMO firms and local providers or insurers.

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Cigna is the largest health plan in Arizona. It acquired a local plan in 1982. It offers staff-model and IPA-model HMO products, including a point-of-service (POS) product and a PPO option. Its staff-model plan employs 229 physicians and 65 other providers, primarily in the Phoenix area; its IPA is statewide. It is strong in the commercial, Medicare and Medicaid markets, because of its size, long-standing local presence and variety of product choices.

Intergroup is owned by a national, for-profit HMO firm. Intergroup was launched in 1980 under the sponsorship of two multispecialty group practices in Tucson that later merged; subsequently, the plan expanded into Phoenix. It was acquired by Foundation Healthcare in 1994. Recently, Foundation sold the founding multispecialty group, the Thomas Davis Medical Centers, to California-based FPA, a for-profit practice management company. Intergroup offers HMO, PPO and indemnity products, and manages self-insured plans for large employers. Its service area includes Tucson and Phoenix. It enrolls Medicare and AHCCCS beneficiaries, along with commercial members, and its Medicare plan reportedly has grown from 17,000 to 45,000 members during the past two years. The separation of Intergroup's health plan from its founding physicians, combined with the recent vote by these physicians to unionize, has raised questions about the plan's future.

FHP of Arizona is owned by a national HMO. Like Intergroup, this plan recently underwent a change of ownership; its new parent company is PacifiCare of Southern California. FHP offers an IPA-model

HMO, as well as an indemnity product with limited enrollment. It does not offer a POS product. FHP competes in the commercial and Medicare markets, with a particularly strong presence in the latter market.

Blue Cross and Blue Shield of Arizona, which competes statewide, has its enrollees in Phoenix distributed across HMO, PPO and indemnity products. Its traditional focus has been on the commercial and Medicaid markets, but the Blues plan recently won a multistate contract to serve CHAMPUS beneficiaries. Blue Cross and Blue Shield has drawn on several strengths: its brand-name recognition, database management capabilities and willingness to offer purchasers multi-year price guarantees.

HealthPartners Health Plan is owned jointly by Samaritan Health System and Tucson Medical Center. It markets both "gatekeeper" and "direct access" HMO products, a POS product and a PPO. HealthPartners competes for commercial and Medicare enrollees, and is perceived to be gaining strength statewide. With the recent sale of Intergroup, HealthPartners is the most visible remaining local, provider-owned HMO alternative in the Phoenix market.

A number of smaller HMOs operate in Phoenix, some of which are relatively new entrants sponsored by national managed care companies. These smaller plans have escalated price competition in the commercial and Medicare sub-markets, according to their larger competitors, because considerable overlap between their provider networks has forced these plans to differentiate themselves on price.

The Medicare market has been hotly contested in Phoenix, where the reimbursement rate for risk-based contracts is relatively attractive. Medicare beneficiaries in this market who choose a risk plan option typically pay little or no premium. Competition among plans is based primarily on benefits and provider choice. For example, Intergroup offers Medicare enrollees free transportation to their physician appointments. Intergroup and FHP both offer free health club memberships. Some respondents believe that competition for Medicare business is helping to hold down increases in the commercial market. To get risk-based contracts with Medicare, plans must enroll at least 50 percent of their members from the commercial sector. Some plans intent on increasing their Medicare enrollment may feel compelled to lower their commercial premiums to attract a sufficient number of enrollees to meet that requirement.

There appears to be tremendous variation among plans in their financial relationships with their contracting providers. Even within plans, reimbursement varies according to market type. Most health plans report that they reimburse at least some of their primary care physicians on a capitated basis. They generally pay specialists on a fee-for-service basis, and reimburse hospitals using a DRG or per diem payment methodology. However, there is a great deal of experimentation with payment approaches. For example, some plans reimburse specialists on a capitated basis but use a fee schedule for primary care physicians. In general, health plans are reluctant to negotiate global capitation contracts with PHOs because they prefer to maintain control of the premium dollar and keep whatever savings they can realize through cost-cutting measures.

ORGANIZATIONAL CHANGE: HEALTH PLANS

Competition among health plans in Phoenix likely will increase. Some national HMO companies are starting to make inroads. Respondents noted that these firms can draw on their corporate strength to underprice existing plans and build market share. The short-term effect of this competition may be to drive those plans already in the market to step up their experimentation with different products and provider arrangements. For example, the Mayo Clinic-Scottsdale has announced its plan to market an HMO in Phoenix, using its expanding primary care network. Although the Mayo HMO will not be a low-priced option in this market, it is expected that its strong brand-name recognition will attract enrollees from other plans.

Plans are adopting different strategies to secure a competitive advantage in the Phoenix market. In response to purchasers' perceived desires for broad geographic coverage, most plans are trying to expand their provider networks. For example, Cigna is broadening its staff-model option, and other plans are exploring relationships with additional hospital systems. Capitated contracts with specialty networks appear to be increasing, although these arrangements may restrict the number of specialists available to enrollees within a plan. Depending on how these contracts are structured, they may support health plans' efforts to develop products that offer consumers direct access to specialists.

The lack of a dominant health plan or group of plans and the expected entry of new plans suggest that the health plan market in Phoenix will undergo organizational change. Driven by competition for Medicare and commercial enrollees, Phoenix health plans will continue to redesign their internal organizational structures, provider networks and financial arrangements with providers.

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Clinical Practice and the Delivery of Care

Provider respondents report that attempts to influence clinical practice and the delivery of care—practice guidelines, case management, physician profiling, disease management programs, prevention and screening programs—are common among health plans and, to a lesser extent, among PHOs that accept global capitation from plans. However, two market factors have limited the prevalence and effectiveness of these practices.

First, physician alignment with plans is loose, with the exception of physicians in Cigna's staff-model HMO option and the Thomas Davis Medical Centers' historically close connection with Intergroup. It is relatively common for physicians to have a dozen or more plan and PHO affiliations, which minimizes any one plan's ability to influence an individual physician's practice.

Second, there is no coordinated purchaser pressure on health plans to make specific changes in care delivery. Lacking such pressure, health plans and PHOs have pursued various initiatives to influence physician prac-

tice, but little evidence is available concerning their effectiveness.

A few health plan respondents spoke of their plans' increased emphasis on prevention and health promotion activities. For example, HealthPartners is entering into a joint community health education effort with the Maricopa County Health Department. More broadly, the local association of HMOs participated in a statewide initiative with the county medical society, the state hospital association and the state Department of Health to improve the delivery and reporting of childhood immunizations.

Some health plans, medical groups and mature PHOs report using practice guidelines to help physicians address specific conditions. Case management and disease management programs also are relatively common among health plans. Disease management programs typically focus on asthma, heart disease and diabetes. Cigna reports that 28 formal disease management programs are available for its enrollees and describes 18 as very successful. Some health plans use case management programs developed by contracting hospitals. FHP, for example, has tapped John C. Lincoln Hospital for help in managing care for enrollees with chronic lung disease. In addition, FHP is shifting staff from traditional utilization review activities to case management functions.

The potential of these initiatives to influence care delivery is a matter of debate among Phoenix providers. There are few data concerning their effectiveness. Some providers said they believe that health plans have increased accountability for care delivery and that has improved the quality of care. Others were skeptical, however, saying that these practices are more likely to hinder physicians' efforts to provide good care. These opinions reflect conflicting views concerning the primary motive behind these efforts: cost control or quality improvement.

Care of the Poor

Under AHCCCS, all Medicaid recipients must be enrolled in organized prepaid health care plans. However, Phoenix also has a relatively large "notch group" population that does not qualify for the AHCCCS program but cannot afford to purchase health insurance. The central safety net provider for this population is the Maricopa County Health System, which consists of a 500-bed downtown teaching hospital, 12 primary health care clinics throughout the Valley, a substance abuse treatment facility and an AHCCCS health plan. The county Board of Supervisors has been considering proposals to privatize the system for the past two years. Recently, however, the Board voted not to go forward with the privatization initiative, leaving the future of Phoenix's health care safety net uncertain.

MEDICAID

Arizona's Medicaid eligibility criteria are restrictive; only 14 states set their AFDC income eligibility levels below Arizona's cutoff, 40 percent of poverty.[10] AHCCCS covers about 444,000 Medicaid recipients statewide, plus an additional 32,000 beneficiaries not covered by Medicaid, primarily through its state-funded medically needy, medically indigent (MN/MI) program.[11] In its initial years, AHCCCS encountered substantial operational problems with enrollment, systems, provider payment and the financial stability of the health plans. Since then, however, AHCCCS has come to be viewed as a

model for other Medicaid programs. A federally sponsored study concluded that average AHCCCS per beneficiary costs grew 6.8 percent between 1983 and 1991—well below the 9.9 percent average for traditional Medicaid programs.[12]

AHCCCS, Arizona's Medicaid program, uses a competitive bidding process every three years to select plans in each of Arizona's 15 counties.[13] Bids are evaluated using price and quality criteria for each enrollee category. Plans with lower bids are eligible to receive a higher proportion of unassigned enrollees. Competition to serve AHCCCS enrollees is increasing; during the most recent cycle, AHCCCS received 95 bids and selected 42 plans statewide. In Phoenix, nine plans were selected.[14]

A number of new commercial plans entered the AHCCCS market in Phoenix during the 1994 bidding cycle, including Cigna and Blue Cross and Blue Shield of Arizona. This competition reportedly has hurt the county health system. Enrollment in the Maricopa Health Plan declined from 45,000 in 1993 to about 22,000 in 1996.[15] Some respondents speculated that several plans submitted low-ball bids to enter the market or expand market share. They were skeptical that these premium levels were sustainable without cost shifting or deterioration in quality. Others suggested that the program's competitive structure controls costs and the state's extensive monitoring of AHCCCS health plans helps ensure quality. There is great interest in the outcome of the next bidding process, which starts in the fall of 1997.

CARE OF THE INDIGENT

Most respondents described the service population of the health care safety net as patients without health insurance or with special needs. The Maricopa Medical Center and its 12 family health centers are viewed as the dominant safety net providers in Phoenix, along with Samaritan, St. Joseph's Hospital and Phoenix Memorial Hospital in downtown Phoenix, and other clinics, including Clinica Adelante, which has three outpatient centers, the St. Vincent de Paul Clinic and the Mountain Park Health Center. Despite the large proportion of the Phoenix population that is Hispanic, there are relatively few Spanish-speaking providers. This fact, along with a lack of health insurance and limited resources to pay for medical care, reportedly leads many legal and illegal residents to seek attention from traditional health care providers in place of, or prior to, seeking care from mainstream providers.

The Samaritan System, Maricopa Medical Center and St. Joseph's Hospital accounted for approximately two-thirds of Maricopa County's uncompensated care for 1995.[16] On a cost basis, Maricopa Medical Center appears to provide the highest volume of uncompensated care. Both Maricopa and Samaritan provided between $30 million and $40 million of uncompensated care in 1995.[17]

Maricopa County and the Maricopa Health System have faced substantial budget pressures during the past several years. The health system's administrators are concerned about the stability of public financing and increased competition from private plans and providers for AHCCCS patients. It is difficult to determine the health system's financial performance because overhead expenses for the system and the county are intermingled. The health system's acute care budget is approximately $250 million, of which the county contributes about $28 million from general fund revenues. The system also receives about $10 million in federal disproportionate share hospital (DSH) funding and several million dollars in

funding from the state tobacco tax. The county subsidy reportedly has been declining during the past several years. Although DSH funds are paid directly to the county, the proportion of such funds allocated to the health system varies from year to year.

Some respondents are concerned that the county's financial pressures are affecting indigent patients' access to clinical services. For example, some community health centers reported seeing patients who claimed to have difficulty getting care through the county system or complained of high coinsurance rates.

In 1994, a health system board recommended privatizing the "deficit-plagued health system because government red tape keeps it from competing for revenue from . . . insurance companies in the private market."[18] The Board of Supervisors explored three methods of privatizing county health services:

- selling the health system;
- leasing it to a for-profit entity; or
- leasing it to a not-for-profit corporation.

The Samaritan system submitted a bid that included closing the county's inpatient facility and providing inpatient care through Samaritan hospitals instead, while continuing to operate the county's primary care clinics. Only one bidder, Health Providers, Inc. (HPI), agreed to keep the entire health system intact and negotiated with the county to operate the system as a franchise. In December 1996, the supervisors decided to delay their vote on leasing the county system to HPI because of numerous concerns about the company's financial resources and capabilities. The county's legal representatives concluded that individual supervisors could be held personally financially liable if HPI was not able to meet its financial commitments. The board subsequently rejected the privatization plan and entered into a one-year management contract with Quorum, a for-profit hospital management company, to operate the facility.

The future of the Maricopa Health System remains uncertain. Some respondents believe that reducing or closing the county facility will have only a moderate impact on indigent care, and that private providers will expand their safety net role. However, several respondents raised concerns that other providers cannot deliver the culturally competent care provided by the Maricopa system, and that the county's indigent care burden will be disproportionately shifted to a few downtown hospitals.

Issues to Track

Three features unique to Phoenix have shaped the local health care system, and they will continue to exert a strong influence. They are:

- sustained population growth;
- large geographic scope; and
- the strong influence of Medicare and Medicaid, versus private sector purchasing initiatives, on the health plan market.

The importance of Phoenix's rapid population growth during the past three decades as a force for health system change cannot be overemphasized. This expansion has precipitated entry of new health plans, contributed to the creation of new health care facilities to serve rapidly growing areas and provided a cushion for health care organizations to grow out of their "mistakes." While health systems in most other metropolitan areas have undergone periods of retrenchment and

consolidation to address overcapacity, health systems in Phoenix for the most part have been able to focus on geographic and product line expansions. These efforts have been facilitated by the geographic dispersion of Phoenix's population growth. The broad geographic area encompassed by the Phoenix market has helped health systems to develop geographically protected sub-markets and to implement strategies for defending them. Success with these strategies has further helped systems negotiate more effectively with managed care plans.

Health plans in Phoenix have benefited from the important role played by Medicare and Medicaid in creating an environment supportive of managed care. The AHCCCS program has accelerated the participation of physicians and hospitals in managed care arrangements and has created opportunities for local start-up plans. Medicare's favorable reimbursement rates for risk contractors in Phoenix have attracted national, for-profit managed care plans, which in turn have stimulated price competition for private sector enrollees. In the private sector, health plans compete with few regulatory restrictions and virtually no coordinated oversight by private purchasers.

Respondents reported that the uninsured population has increased since 1990, but that access to care has changed little. Health insurance premiums have been relatively flat, but some respondents questioned whether the premium savings enjoyed by employers have been shared adequately with consumers. Respondents were uncertain about the impact of recent market changes on quality of care.

Within this context, several trends in the Phoenix market merit tracking.

One major issue is whether Samaritan will be able to find a merger partner willing to assume its debt, which reportedly is approximately $350 million. Columbia/HCA and Tenet, two large for-profit hospital systems, have expressed interest in the Samaritan system but, in the past, community leaders have opposed the acquisition of Samaritan by a for-profit corporation. There was no clear consensus among market respondents on whether a Samaritan merger would signal the beginning of a major consolidation of hospital systems in Phoenix and an increasing role for national for-profit hospital markets in the market.

The financial viability of the Maricopa Medical Center is another important issue. If, despite the efforts of its new management, the Maricopa Medical Center cannot be saved, access to services for indigent patients may diminish, and other providers may face increased demands to serve this population. As the largest alternative providers in central Phoenix, Samaritan and St. Joseph's hospitals likely will bear the brunt of these demands.

In the physician market, where physicians historically have been weak and unorganized relative to health plans and systems, organization is underway. Practice consolidation is increasing, as is the role of national, for-profit practice management firms, which are purchasing primary care and specialty practices. Specialists are seeking greater participation in networks to contract with managed care organizations. Hospital systems are competing with physician management companies and specialty networks to form physician groups that can negotiate more effectively with managed care plans. This is the most unsettled component of the Phoenix health care system and merits close attention.

The Mayo Clinic's strategy to increase its presence in the Phoenix market may prove

significant. Mayo is purchasing primary care practices, marketing a health plan built on these practices and its own specialists and constructing a hospital in northern Phoenix. The strategy may affect Phoenix's hospital, health plan and physician markets, although the short-term impact on these markets will be minimal, with the possible exception of the localized market for hospital services in northern Phoenix. Even there, projected population growth will soften the impact.

In the health plan market, the dominance of for-profit, national managed care companies is increasing. The purchase of Intergroup, a locally owned HMO, by a national firm is the most recent example of this trend. Although acquisition possibilities are limited, market respondents expected that national managed care organizations will continue to increase their strength through enrollment growth and, possibly, market entry. However, possible changes in Medicare reimbursement rates, which currently favor risk contractors in Phoenix, could have a significant impact on the local health plan market.

Finally, it will be important to track whether competition among health plans, which currently turns on benefits in the Medicare market and on premiums in the private employee market, expands to focus on issues relating to the organization and delivery of care. It seems unlikely that this will occur in the near future, because of the lack of coordinated purchasing activity among Phoenix employers.

NOTES

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

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

3 *Ibid*.

4 National Center for Health Statistics, Centers for Disease Control and Prevention, March 1997, and Area Resource File as of February 1996, Office of Research and Planning, Bureau of Health Professions, U.S. Department of Health and Human Services.

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

6 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.

7 Greater Phoenix Blue Chip Economic Forecast, Economic Outlook Center, Arizona State University, August 1996.

8 Phoenix Chamber of Commerce, 1995-1996 Community Economic Report.

9 Snyder, J., "Hospital Chain Scuttles Good Samaritan Merger," *Arizona Republic*, July 16, 1997.

10 House Ways and Means Committee, 1996 Green Book.

11 Overview of the Arizona Health Care Cost Containment System, July 1996.

12 McCall, N., C.W. Wrightson, L. Paringer, G. Trapnell, "Managed Medicaid Cost Savings: The Arizona Experience," *Health Affairs*, Spring, 1994, pp. 234-44.

13 Beginning in 1997, the bid cycle was to be extended to a five-year contract period.

14 Government Accounting Office (GAO), Arizona Medicaid: Competition Among Managed Care Plans Lowers Program Costs, October 1995.

15 McClay, "Hospital of Last Resort? Safety Net Plans Pose Questions" *Arizona Republic*, December 8, 1996.

16 Lewin Group calculations based on Uniform Accounting Reports filed with the Arizona Department of Health Services.

17 Lewin Group calculations based on Uniform Accounting Reports and hospital income statement data.

18 *Arizona Republic*, December 8, 1996.