Health System Change in Syracuse, N.Y.

*Raymond J. Baxter **
Linda T. Kohn +
*Robin K. Omata **
*Loel Solomon **

**The Lewin Group*
+ Center for Studying Health System Change

The Syracuse community historically has featured a high level of coordination among its major health care institutions and mutual support among them, the business community and elected officials. Now the community is seeing the first signs of overt competition in health care, driven in large part by uncertainty about the end of the state's hospital rate-setting law, the prospect of new managed care companies entering the market and anticipation of mandatory Medicaid managed care.

The health system for the four-county Syracuse, N.Y., metropolitan area is dominated by Syracuse's four general hospitals, which traditionally have engaged in a high degree of cooperation around downsizing hospital capacity and meeting new community needs in ambulatory and long-term care. For the past 14 years, these institutions have operated in the highly regulated New York State health care environment, which set hospitals' payment rates, precluding much negotiation between purchasers and hospitals, and subsidized indigent care and graduate medical education. The insurance market has been decidedly fee-for-service, although a few local managed care organizations have sprung up during recent years in collaboration with local hospitals and physician groups. Physicians typically have practiced in small groups or in solo practices. However, larger multispecialty groups are beginning to emerge and to align themselves selectively with hospitals or health plans or both.

Until very recently, the Syracuse health system was largely insulated from and resistant to the competitive forces prevalent in many communities throughout the United States. Health care in Syracuse traditionally has been provided through locally owned, not-for-profit organizations that have worked together over the years with considerable business, community and political support. This cooperative spirit may be attributed to a number of factors:

- First, Syracuse is a relatively small community, with a limited number of significant health care organizations, which have developed close working relationships.
- Second, the community takes pride in the perceived quality of its health care system, particularly attributed to the state university's Health Sciences Center. This pride and the widely held belief that good health care institutions are an asset to the community and its economy have contributed to a strong working relationship among health care organizations, the business community and local political leaders.

- Third, Syracuse is not keen on making rapid or major changes to its health care system, preferring instead "to learn from other communities' mistakes" before embracing managed care or altering the nature of health care organization and delivery.

These factors, combined with a perception that local health care costs are favorable compared with those in other communities, have sustained the traditional fee-for-service insurance market and softened employer pressure to reduce costs, restrict provider choice or manage health care utilization.

But signs of change are emerging nonetheless, largely in anticipation of new state policies and the entrance of new health care organizations into the central New York market. Observers expect deregulation of hospital rates to ignite aggressive negotiating by health plans to reduce hospital costs and competition among hospitals to retain volume. The business community has pressed hospitals to examine the potential effects of policy and market changes on hospital capacity and medical education, and a group of large employers has formed a purchasing coalition. Anxiety about and anticipation of these changes appear to be the major driving forces behind newly competitive behavior and repositioning by local health care organizations. These activities are reflected in:

- the emergence of physician-hospital organizations (PHOs) and management service organizations (MSOs);
- efforts by hospitals to ensure referral flow and facilitate managed care contracting by tightening long-standing physician affiliations and acquiring physician practices;
- alliances among various combinations of hospitals, health plans, physician groups and other service providers; and
- the appearance of entrepreneurial physician-owned organizations, particularly in the suburban areas around Syracuse.

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An air of uncertainty prevails among providers, whose most commonly cited concerns about the future include:

- heightened price competition and discounting, spurred by the anticipated entry of national managed care companies into the local market;
- consolidation of the four principal Syracuse-based hospitals into two or three allied systems;
- reductions in graduate medical education and charity care, prompted by price competition and cuts in state reimbursements to hospitals; and
- increased power of physicians.

The Syracuse Community

Three-quarters of a million people live in the four-county Syracuse metropolitan area of central New York. They are generally well-off, compared with state and national averages. Poverty and unemploy-

ment are lower, although less so in the outlying suburban and rural counties. A significantly smaller portion of the population is non-white, compared with state and national averages; age distribution is comparable to these norms. Health status is similar to that of the rest of New York State (outside of New York City), except for higher mortality from respiratory diseases and lower mortality from homicide and non-motor vehicle accidents. A 1996 Onondaga County community health assessment identified several areas of concern, including adolescent health (gonorrhea, suicide and teen pregnancy); infant mortality, particularly among African Americans; communicable diseases (HIV, tuberculosis, enteric diseases and immunizations); and high cardiovascular disease and cancer mortality rates.

HEALTH MARKET

The Syracuse metropolitan area is a local, self-contained health market. Health insurance is dominated by local insurers, principally Blue Cross/Blue Shield of Central New York. Most HMOs are also locally owned and operated. Although Syracuse is home to branches of several large national employers that tend to make centralized health care purchasing decisions outside the region, many of these companies offer local HMO options along with their national fee-for-service or managed care plans.

Providers are also highly local. Syracuse's general hospitals provide tertiary care for the entire region, as well much of the area's general hospital care, because of their easy accessibility. The strong teaching orientation of several of these institutions, particularly the State University of New York (SUNY) Health Sciences Center and Crouse-Irving Memorial Hospital, contributes to a high concentration of specialist physicians in Onondaga County.

According to one SUNY respondent, 65 percent of SUNY-trained physicians continue practicing in the state after they complete their residencies, most of them in central New York. The supply of physicians in the surrounding three counties is uneven and varies considerably by specialty.[1] As a whole, the Syracuse metropolitan area has 9 percent fewer primary care physicians per capita than the U.S. average and roughly the same proportion of specialists.[2]

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Physician-owned ambulatory care centers, some cosponsored with hospitals, have started to appear in suburban areas north, east and west of Syracuse. The most comprehensive of these include large multispecialty clinics and outpatient surgery, urgent care and lab facilities. This trend seems to indicate a growing dispersal of non-hospital care into major suburban areas.

Outside the suburbs of Syracuse, five community hospitals are attempting to retain their traditional patient base in the face of mounting competition from the Syracuse hospitals. They complain that the Syracuse hospitals are "capturing" patients who are referred for tertiary care and providing subsequent ongoing care that historically was provided by these community hospitals.

Hospitals in Utica and Rochester, which are outside the Syracuse metropolitan area, draw a small portion of residents who need specialty care, and some respondents expressed concern that major tertiary centers in Vermont and Pennsylvania will soon begin competing for specialized care patients as well.

LEADERSHIP AND DECISION MAKING

Community attitudes play an important role in health system leadership and decision making. For example, the Syracuse community takes pride in its hospitals and in local self-sufficiency. These attitudes have bolstered the influence of local hospitals and fostered a collaborative and supportive community environment for them.

Many respondents spoke proudly of high-quality hospitals with state-of-the-art equipment and highly skilled physicians. While opinions varied about the efficiency and cost-effectiveness of locally provided care, most respondents said they viewed the health system as an asset to the region's economy, not as a cost burden. This belief is reinforced by a long history of cooperation by the hospitals, which are credited with reducing capacity as demand declined in past years. Recent studies, however, indicate a surplus of hospital beds that is likely to increase in the next few years.[3]

A preference for "solving our own problems" is reflected in pride over the community's success in reducing infant mortality,[4] and a distrust of managed care by important local businesses. In addition, the community relies strongly on the local political process to influence state policy, most notably in support of academic medical centers and indigent care. The dominance of a handful of large local enterprises in civic and political decisions, coupled with the fact that a number of large national companies manage their health care purchasing from afar, fosters comfort with longstanding arrangements and a collaborative style of health care decision making in the Syracuse area. Several influential, collaborative decision-making bodies initiate or weigh in on important community-wide health issues.

The Hospital Executive Council (HEC), which includes the leaders of the four Syracuse hospitals and the medical school, has long supported joint planning. The HEC is credited with helping achieve significant local hospital consolidation during the 1950s and 1960s. It also developed an ambulatory care center and nursing home to meet community needs and sponsored a seminal prepaid group practice. More recently, the HEC participated in a community-wide infant mortality initiative and collaborated with the influential Metropolitan Development Association in a study of excess hospital capacity and threats to graduate medical education funding. The HEC is exploring a proposal to consolidate laboratory services for the four Syracuse hospitals and is engaged in a collaborative initiative to develop clinical pathways for high-volume surgical procedures and medical diagnoses. However, some respondents have suggested that increasing competition among the HEC's member institutions may be eroding its effectiveness.

The Metropolitan Development Association (MDA), which represents Syracuse's major employers, has also played an important role in shaping health care delivery. As noted, the MDA influenced the HEC's decision to study hospital capacity and medical education financing this past year. The MDA wields substantial influence in the business community

and with state and local governments. Many of its member institutions are well represented on hospital boards.

The Purchasing Coalition of Central New York, which includes representatives of seven companies, emerged more recently. It has focused its efforts on identifying a single health plan to offer its members. Several large local firms, such as Welch Allyn, Inc., Niagara Mohawk and Agway, are among the coalition's leaders, but it has yet to achieve full support from the business community. Major national employers with substantial local operations (Carrier Corporation and Chrysler, for example) are now being recruited.

In contrast to the community-wide organizations that represent the interests of major health care providers and employers, institutional representation for consumers, vulnerable populations and other community interests is less evident. Most respondents were unable to identify an influential voice for consumers. Organizations that advocate for the poor (i.e., Legal Aid and the Salvation Army) and the elderly (the County Office on Aging) were mentioned occasionally, with the caveat that they were overwhelmed by large caseloads and program responsibilities.

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The Community Health Information and Planning Service (CHIPS) is a long-standing organization that supports health planning and offers technical assistance to smaller service providers and not-for-profit community-based organizations. For many years, CHIPS has been the vehicle for community and consumer participation in the state-sanctioned local Health Systems Agency planning process. It also provides a forum for the smaller not-for-profit health and human services organizations typically funded by the United Way. CHIPS's recent activities have included technical assistance to community service agencies in forming partnerships to cope with managed care; community planning around Medicaid managed care and federal-state block grants; and studies on physician supply and access to care.

Decision making at the community level is influenced by information from providers, in particular the HEC, although it is not clear how broadly providers'—or other—information is disseminated. Few respondents were aware of either the 1996 community health assessment conducted by the Onondaga County Health Department or the studies conducted by CHIPS. A number did refer to the county medical society's survey of physicians, which ranked HMOs on the basis of service and quality; this received considerable media attention, and was reportedly taken seriously by health plans. Health plans said that they were collecting HEDIS performance data, but few purchasers were aware of its availability, and some media representatives expressed frustration at lack of access to those data. Several purchasers complained about the lack of good data from insurers on cost, quality and utilization of services.

External Forces Affecting the Health System

Public policy and purchaser activities have affected the Syracuse-area health system. State policy before 1996 minimized competition through hospital rate-setting and community-wide planning, in conjunction with one of the country's most comprehensive certificate of need (CON) programs. Syracuse's powerful elected officials in the state legislature frequently have influenced state health policy. More recently, state policy has shifted to support a competitive marketplace and embrace managed care. In contrast, Syracuse-area private purchasers have been slow to embrace managed care and continue to seek state aid for academic health centers and indigent care.

PUBLIC POLICY

Four dimensions of public policy are of particular import to the Syracuse health system:

- the long-standing state hospital regulatory structure, which was radically altered in 1996;
- state university policy toward its academic medical centers;
- state law effectively prohibiting large, for-profit hospital companies; and
- state Medicaid policy.

Hospital regulation in New York State has centered for 14 years around the state's hospital payment system, the New York State Prospective Hospital Reimbursement Methodology (NYPHRM).[5] NYPHRM regulated hospital rates through a complex formula that set individual hospitals' rates, limiting the ability of insurance carriers other than HMOs to negotiate rates. This policy stunted the development of PPO plans in the state, because PPOs typically rely on discounted hospital fees to achieve market advantage.

NYPHRM also governed the state's funding of care for the uninsured and graduate medical education, and at times offered special adjustments to finance other policy goals, such as work force development and support for hospitals that served other objectives. NYPHRM was also part of the rubric for controlling service expansion and capital investment through a comprehensive health planning and CON process.

State policy before 1996 minimized competition through hospital rate-setting and community-wide planning, in conjunction with one of the country's most comprehensive certificate of need (CON) programs.

Changes in NYPHRM were imminent at the time of the site visit in May 1996, as the legislature actively debated the governor's proposal to replace the system with one in which nongovernment payers would negotiate inpatient rates directly with hospitals.

Health care organizations in the Syracuse area vigorously advocated for their interests and began positioning themselves to address the potential consequences of deregulation.

Hospitals set out to reduce costs in anticipation of lower negotiated rates and cuts in graduate medical education (GME) and charity care funding. To secure referrals and maintain volume in a more competitive environment, the hospitals initiated various physician-hospital organizational structures and affiliations. Both hospitals and doctors prepared for managed care contracting, and medical groups tried to increase their attractiveness to managed

care plans by highlighting centers of excellence. Teaching hospitals re-examined historic commitments to GME.

Physicians explored new alignments with hospitals and health plans. Health plans also anticipated significant changes, including more aggressive contracting practices as hospitals become more competitive.

Most of these activities involved more planning and negotiation than action at the time of our site visit. However, some actions, such as aggressive hospital acquisition of physician practices, were clearly competitive.

The New York Health Reform Act of 1996, with its anticipated rate negotiation system, was signed into law in September 1996. Special state funding for uncompensated care and GME was retained at a reduced level and in a somewhat different form. Health insurance for uninsured children was expanded.

The impact of the new law, which took effect in January 1997, is not yet fully clear. The first round of rate negotiations reportedly resulted in lower rates for Syracuse hospitals than under NYPHRM, but not as low as providers had feared. Some respondents attributed this to the relative inexperience of all the parties in negotiating rates. More aggressive negotiation is expected during the next round, which will begin as the existing contracts expire, most of them in early 1998. Although GME dollars in total are expected to fall by 15 to 20 percent, Syracuse medical centers believe that replacement of a statewide GME pool with regional GME pools will reduce what they have considered a transfer of upstate dollars to New York City teaching hospitals, and thus mitigate some of the impact on Syracuse teaching hospitals.

SUNY's policy toward its academic medical centers is closely related to the NYPHRM reform. During late 1995 and early 1996, it was feared that the new administration in Albany would support budget-cutting efforts by the SUNY Board of Trustees to close one or more SUNY medical centers. Such a proposal had been approved in October 1995 by the SUNY trustees. This move, combined with anxiety over the imminent NYPHRM reform, drove Syracuse's SUNY Health Sciences Center and University Hospital to re-examine the size and scope of their teaching program. With the HEC and the MDA, these two institutions explored alternative means for financing GME and sharing their training programs with other institutions in Syracuse. In mid-1996, the SUNY trustees dropped a plan to privatize its medical centers. The SUNY Health Sciences Center reportedly was able to negotiate acceptable rates under the new hospital payment law.

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The long-standing state law effectively barring out-of-state, investor-owned hospital companies from the New York State market is another important public policy. Respondents generally viewed this law as protecting existing hospitals from the

intense price competition that might accompany the entry of a for-profit hospital company, such as Columbia/HCA, to the central New York region.

Another important state policy that bears watching is the potential effect of Medicaid managed care in the Syracuse area, which could shift 56,000 covered lives into managed care plans,[6] increasing overall managed care penetration by more than 50 percent. This program has been implemented so far on a voluntary basis; mandatory enrollment will begin in February 1998.

PURCHASING

Purchasing approaches in the Syracuse area are sharply divided between the private and public sectors. Private purchasing favors employee choice, support for local health care organizations and, at least until recently, traditional fee-for-service insurance. Public purchasing, as reflected principally through the state Medicaid program, favors cost reduction and managed care.

Some employer representatives stated explicit concerns that excessive pressure on health care providers would hurt a vital part of the area's economy.

There are a number of health-related enterprises in the Syracuse business community; 11 of the top 40 service-related employers are hospitals or health-related firms.[7] SUNY, with 4,500 employees in its Health Sciences Center and University Hospital, is the area's single largest employer.[8] While direct employment in health care delivery represents just over 8 percent of the metropolitan area's non-agricultural work force, other significant health-related industries in the area include Welch Allyn, a major national medical equipment supplier, and the pharmaceutical concern Bristol-Myers Squibb.[9] These ties partly explain local employers' distinctive approach to health care purchasing.

It is also important to note that Syracuse's influential business community views health care not as a cost problem, but as a way to attract and hold quality workers. These employers believe that a high-quality health system, and particularly an academic medical center, improve the region's economy and quality of life.

• Private Purchasing

Private purchasers in the Syracuse area fall into two groups: local firms, which tend to have close ties to the area's local health care organizations, and "branch offices" of large national firms like Carrier Corporation, Lockheed-Martin and Anheuser-Busch, whose headquarters and health care purchasing decisions are centered outside the local community.

Historically, both groups have taken a relatively passive approach to purchasing. Locally based firms embrace the "community development" values already described, and the national firms make their purchasing decisions independent of local health care conditions in Syracuse. Local representatives for various employers typically voiced support for what they consider a high-quality local health system, and expressed the view that utilization and cost of services in and around Syracuse was not a particular problem, particularly when compared with New York City.

Some employer representatives stated explicit concerns that excessive pressure on health care providers would hurt a vital part of the area's economy. In addition, many employer representatives indicated that, until very recently, they had few incentives to offer managed care plans because the HMOs serving the area did not offer better prices than traditional fee-for-service insurers. Those firms that do offer managed care plans have tended to offer them side-by-side with a traditional insurance plan, with few financial incentives for employees to choose the HMO plan.

During the last few years, three factors began to influence a shift in employer purchasing approaches.

- HMOs became more price-competitive as new health plans, such as the national MetraHealth plan, entered the local market.
- At about the same time, traditional local plans and insurers became less competitive. One local plan, PHP, reportedly raised its premiums to absorb major capital investments, and both Guardian and Blue Cross/Blue Shield of Central New York raised their rates to cover higher-than-anticipated claims.
- Concern about the impact of state and federal policy on hospital payment focused more attention on excess bed capacity, raising questions about the traditional delivery system's efficiency.

In response to these factors, employers like Syracuse China Company have altered premium cost-sharing with employees to promote enrollment in managed care options. Other area employers reportedly have narrowed their plan offerings, citing the high cost of administering multiple health insurance options (especially while corporate human resource departments were "downsized"), and a desire to reduce "employee confusion."

The new Purchasing Coalition of Central New York, which currently represents seven companies with 10,000 to 15,000 covered lives, has attracted considerable attention. Views on its significance differ. Some observers have criticized the coalition for upsetting the customary collaboration among business and health care organizations; others view the coalition as a sign that business attitudes toward health care purchasing are changing. The coalition's principal initiative has been its solicitation for a managed care plan to offer its members. It issued a request for proposal (RFP) from competitive point-of-service (POS) plans with broad, nonexclusive provider networks to service its member companies. Twenty-two bids were submitted. The local managed care plan, PHP, was selected in late 1996, and in January 1997, six member companies began offering the plan to their employees. The coalition ultimately hopes to represent 14 large member companies with 50,000 lives.

• Public Purchasing

The movement of Medicaid toward managed care is the most important public purchasing development in the Syracuse region. Managed care penetration in the local Medicaid market (roughly 34 percent in Onondaga County and 0 percent to 17 percent in the outlying counties) is higher than in the commercial market. (MSA-wide commercial HMO enrollment is 24 percent.) There is virtually no Medicare managed care (0.1 percent in the Syracuse area versus 7 percent in New York State).[10]

Approximately 21,000 Medicaid enrollees in the four-county Syracuse metropolitan

area have voluntarily enrolled in Medicaid managed care.[11] However, under a demonstration program recently approved by the Health Care Financing Administration (HCFA) for selected counties in New York State, Onondaga and Oswego counties will begin enrolling Medicaid beneficiaries in managed care plans on a mandatory basis in January 1998. The two other counties that make up the Syracuse metropolitan area—Madison and Cayuga counties—will implement mandatory Medicaid managed care programs later, if HCFA approves a statewide waiver.

The waiver seeks to reduce state spending on health care services through mandatory enrollment in managed care for all Medicaid eligibles, except the elderly and disabled populations who receive nursing home and related long-term care services. Responsibility for executing enrollment and transition of recipients will remain at the county level. The four Syracuse counties have been working since January 1996 to restructure welfare and Medicaid eligibility and enrollment procedures, and plan to merge those processes into a single authority in each county.

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Organization of the Health Care System

Significant changes are underway in the organization of key health care functions in the Syracuse metropolitan area. Historically, Syracuse's four general hospitals and the SUNY medical school have dominated the system, in a comfortable relationship with traditional fee-for-service insurers, mainly Blue Cross/Blue Shield. Doctors typically have been organized in solo practices or small groups aligned with one or two hospitals,[12] and are often on the faculty of the SUNY Health Sciences Center. Over the years, the four hospitals were responsible for the joint development of an ambulatory care center, a nursing home and the area's first prepaid health plan. Nearly all health care organizations were locally owned and administered not-for-profit entities, except for the public SUNY Health Sciences Center.

A growing suburban population, the threat of reduced reimbursement from the new rate negotiation system and the entry of new managed care organizations have accelerated changes in the delivery and insurance sectors. Notable developments include the creation of integrated multispecialty clinic facilities, establishment of PHOs and MSOs to facilitate managed care contracting for physicians and hospitals, purchase of physician practices by hospitals and movement toward more exclusive relationships among doctors, hospitals and health plans.

PROVIDERS

Four Syracuse-based hospitals, all with deep local roots, are key to the area's health system.

Crouse-Irving Memorial Hospital, with 513 beds, is located downtown, directly adjacent

to the SUNY Health Sciences Center and its 350-bed University Hospital. Crouse-Irving Memorial was established 30 years ago through the merger of Syracuse Memorial Hospital and Crouse Hospital. It is a major teaching hospital, and is known for its neonatal and ambulatory surgery programs.

Next door, connected by a bridge, is the *SUNY Health Sciences Center*, a major academic medical center and tertiary care provider known for its trauma unit and a wide range of subspecialty services, including neurology and endocrinology. It is also a major provider of the region's uncompensated care.

St. Joseph's Health System, located north of downtown Syracuse, is owned by the local Franciscan order. The 431-bed facility is recognized as a premier "heart" center in central New York. It offers a major open-heart program and a family practice residency program.

Community General Hospital has 356 beds and is located south of the city. It is known as a strong community hospital with a favorable payer mix.

These four institutions have made up the core of the region's health care system for years. In addition, there are five community hospitals in the outlying counties:

- Auburn Memorial Hospital, with 306 beds, in Cayuga County;
- Madison County's 84-bed Community Memorial and 263-bed Oneida Healthcare Center; and
- Oswego County's 67-bed Albert Lindley Lee Memorial Hospital and 202-bed Oswego Hospital.

Physicians generally have been organized in solo practices or small groups. Specialists outnumber primary care physicians by significantly more than the national average.[13] This is not surprising, given the presence of the SUNY Health Sciences Center and the tendency of physicians to remain in the area after training.

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In the last five years, each of the four Syracuse hospitals has developed a PHO or comparable arrangement with its medical staff. These PHOs are designed to serve as vehicles for managed care contracting, but none currently has the authority to bind its members in contract negotiations. The most integrated of these arrangements appears to be the Crouse-Irving Memorial PHO, in which financial risk is shared for selected procedures.

To "lock in" referral networks and secure patient volume, hospitals have been aggressively purchasing primary care and multispecialty group practices. St. Joseph's and Crouse-Irving Memorial each has acquired about a dozen practices, and Community General has added three. But there has been a downside to this activity, according to respondents from some hospitals and independent practices, who say that the productivity of purchased practices has declined because of loss of physicians' financial incentives and less effective management.

Hospitals have also tried to cement referral relations with community physicians by offering to provide management support services, such as billing, clinical records management, benefits administration and office space. In a few instances, providers have linked with organizations that provide other levels of care. Community hospitals outside Syracuse own or manage home health agencies, and a major long-term care institution has been pursuing an exclusive contract with an acute care hospital.

There has been no consolidation among hospitals yet, despite repeated speculation about mergers or alliances among Syracuse institutions or between Syracuse and outlying community hospitals. Proposals for a dedicated children's hospital service and a merger between University Hospital and Crouse-Irving Memorial fell through. Informal bilateral hospital discussions are reportedly underway again. Physician groups have not consolidated much either.

Local plans are working to develop broader regional ties, spurred in part by the Central New York Purchasing Coalition's activities on behalf of large employers and the regional employment base maintained by many area companies.

The physician sector has witnessed an interesting development with the appearance of entrepreneurial physician-directed and physician-owned ventures. One such entity is AJM Management Services, the corporate parent of North Medical Family Physicians. Located in the suburbs north of Syracuse, this system includes a large multispecialty group practice that is licensed to bear risk as an HMO (in anticipation of future managed care activity), physician office suites and lab facilities, practice management services and urgent care and high-volume ambulatory surgery facilities. Hospitals have dismissed AJM as a minimal competitive threat. However, that company's attempt to establish a second such facility in another location was hotly contested by one of the hospitals, which filed a competing CON application.

INSURERS AND HEALTH PLANS

The insurance market in the Syracuse metropolitan area is still heavily fee-for-service and local. Blue Cross/Blue Shield of Central New York is the principal carrier; Aetna, Cigna and MetraHealth also play a role. In the self-insured market, two multistate third-party administrators (TPAs) that are headquartered locally—POMPCO and Risk Management Service Company (RMSCO)—control the bulk of the business; Blue Cross/Blue Shield recently introduced its own TPA product.

Managed care penetration has been modest, reflecting limited purchaser pressure and price competition until recently. PPOs are not a force because they have been barred from negotiating discounts with hospitals—a prohibition that ended with the reform of New York's rate-setting law. More than 16 percent of the population is enrolled in an HMO, compared with a U.S. average of close to 18 percent and a 24 percent average for large metropolitan areas.[14] Managed care's increasing price competitiveness is now beginning to erode fee-for-service plan enrollment. There is also some speculation that New York State's 1992 small-group insurance reforms, which required guaranteed issue and community rating in the small-group market, may have increased the cost of indemnity insurance.

HMOs in this area typically have been local "home-grown" plans, but outside organizations have now entered the market. The HMO with the longest history is PHP, which also has the largest share of HMO enrollees. PHP was established in 1972 by the four Syracuse hospitals and subsequently became an independent entity. In addition, there are two local IPA-model plans: HMO-CNY, a joint venture between PHP and the four-county medical society, and Patient's Choice, which was also sponsored by the medical society in 1985 and was acquired by HealthSource, a national HMO, in 1994.

The entry of HealthSource into the local market was followed by the expansion of the Utica-based, not-for-profit Mohawk Valley Plan into the Syracuse area, and the arrival of for-profit MetraHealth. The most recent national entrants are for-profit U.S. Healthcare and not-for-profit Kaiser Permanente, neither of which has made significant inroads in the Syracuse area market to date. At the same time, local plans are working to develop broader regional ties, spurred in part by the Central New York Purchasing Coalition's activities on behalf of large employers and the regional employment base maintained by many area companies.

Although HMO influence in the Syracuse area is growing, it remains quite limited. There is little capitation of providers; of the six HMOs that operate in the Syracuse metropolitan area, only one offers a capitated group practice model. The remainder are IPA-model entities that pay for care on a discounted fee-for-service basis.

Provider networks are typically large, loose and overlapping, reflecting purchasers' preferences. (The Purchasing Coalition's managed care request for proposals reportedly sought plans with broad, open panels that include most hospitals and a wide array of physicians.) Each HMO contracts with 60 percent to 80 percent of Onondaga County''s specialists. A smaller proportion of the region's primary care physicians are under contract with each HMO, but they frequently contract with multiple HMOs.[15] At this point, no commercial HMO has an exclusive hospital contract.

PHP is unusual for the Syracuse area in that it contracts with each physician-hospital organization, as well as University Hospital and its faculty practice plan, but it locks enrollees into their chosen primary care practitioner's referral network. In addition, PHP's wholly owned, 70-member multispecialty group practice, which refers 40 percent of its inpatient care to a single hospital, is one of PHP's principal networks.

Clinical Practice and Delivery of Care

Clinical decision making still appears to be in the hands of individual physicians in Syracuse, unlike other communities, where large medical groups, hospitals or insurers and purchasers exert greater influence. Providers do not appear to have explicit incentives (i.e., capitation or performance-based contracting) or information-based tools (guidelines, profiling) to initiate major changes in clinical practice patterns or the delivery and organization of care.

Retention of physician control over clinical practice stems from several factors, including limited HMO penetration and the "loose" nature of managed care in the Syracuse area. The overlapping structure of physician and hospital networks and

the absence of formal referral arrangements make it difficult for a single entity to impose standardized clinical practices. There are few strong financial incentives to direct clinical practice, because most arrangements are based on fee-for-service or discounted payment schedules.

PHP's contracts with the Crouse-Irving Memorial PHO and PHP's own Health Service Medical Group are important exceptions. They feature global capitation for professional services and inpatient risk pools. Under the risk pool arrangement, any surplus or deficit in pooled funds is shared among physicians. Risk-sharing is limited to 20 percent of the pool's value. It is not clear, however, whether this arrangement is affecting clinical practice patterns. Providers tend to describe the utilization review mechanisms imposed by health plans more as administrative "hassles" than as factors in clinical practice.

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The SUNY Health Sciences Center appears to exert an important, broad-level influence on clinical practice in the Syracuse area. Respondents said they believe the Health Sciences Center's role in training and employing physicians has contributed to the preponderance of specialists and the reputed high level of physician skill.

Many respondents said clinical practice guidelines are attracting more attention, particularly among health plans. PHP uses guidelines developed by Milliman & Robertson, among others, and it relies on a network medical director and physicians nominated by participating PHOs to promote acceptance and use of the guidelines.

Provider organizations also described guideline development activities. The Syracuse Community Health Center, the HEC, individual hospitals and PHOs all reported that they were developing protocols and guidelines. However described, the hospitals led some efforts more along the lines of standard quality assurance reviews than aggressive efforts to change care practices. The New York State Cardiac Monitoring Study, which reports hospital mortality rates for open-heart surgery, appears to have spurred the development of guidelines around invasive cardiology procedures.

In contrast to the development of guidelines to influence clinical processes, activity around outcomes evaluation appears to be much more tentative. Health plans report use of profiling systems for utilization management and to credential network providers. Hospitals and PHOs are interested in developing information systems that can link inpatient and outpatient clinical records with administrative data. Respondents said many of these initiatives are directed principally at administering and managing physician activities, while others are designed to improve clinical practice. Crouse-Irving Memorial recently formed a subsidiary to develop a data system to manage clinical and administrative data, and University Hospital has created a clinical outcomes analysis unit.

In a different vein, changing clinician roles may have an impact on care delivery. In particular, primary care practitioners appear to be gaining influence in several respects. Primary care physicians are

becoming increasingly attractive to hospitals and health plans, as evidenced by a skirmish between St. Joseph's and Crouse-Irving Memorial Hospital over family practice programs. St. Joseph's has housed SUNY's family practice residency and has long been aligned with family practice groups. A few years ago, Crouse-Irving Memorial purchased several family practices that had been aligned with St. Joseph's, in what many respondents refer to as "the opening shot" in direct competition between Syracuse hospitals. In the outlying areas of Madison, Oswego, Oneida and Auburn, providers acknowledged heavier reliance on mid-level practitioners.

Changes in referral patterns and patient use are unclear. A variety of less formal attempts are underway to direct referrals. Hospitals at least implicitly expect referrals from owned physician groups or from groups tied into management service contracts with hospitals, and there are in fact a few strong referral relationships between multispecialty group practices and particular health plans and hospitals.

Overall, integration of clinical care among provider organizations appears to be very limited.

Care of the Poor

Care of the poor is not generally described as a significant problem by community and health system leaders in Syracuse. Observers say that Medicaid services are widely shared among the principal hospitals, and they believe that Medicaid managed care will improve access to appropriate care. Similarly, they do not see service for the uninsured as a problem, mainly because of New York State's tradition of subsidizing hospitals' bad debt and charity needs. Hospitals say they share responsibility for charity care, but the burden of uncompensated care appears to be concentrated among University Hospital, St. Joseph's, Crouse-Irving Memorial and the Syracuse Community Health Center.

MEDICAID

Respondents generally viewed the planned introduction of a mandatory Medicaid managed care program in Onondaga County as positive. County representatives claim they are ready to move recipients into managed care, despite what critics have described as a lack of public education or provider education. Some advocates for the poor predict that inadequate preparation will result in service disruptions, increased use of hospital emergency departments and disenrollment of eligible recipients. In addition, advocates and community-based service providers have expressed some concern that managed care may reduce access to expensive therapies and mental health and substance abuse services. It is also unclear at this point what roles state and local government agencies will play in administering the program.

However, most respondents believe Medicaid managed care will improve access to primary care. One 1993 survey found that two-thirds to three-quarters of Medicaid beneficiaries had difficulty accessing office-based physicians and outpatient clinics.[16]

Hospitals that provide significant levels of Medicaid services expressed mixed views about the plan. Some respondents see Medicaid managed care as an important revenue opportunity, while others fear it will siphon off outpatient services to doctors' offices and free-standing ambulatory care

facilities. Syracuse Community Health Center, the area's principal community health center, has attempted to increase its competitiveness by creating its own Medicaid HMO, Total Care Choice, which is staffed primarily by its own providers. Despite this move, the center is concerned it could be undercut by large—particularly national—HMOs that can subsidize their Medicaid services from other revenue sources.

CARE OF THE UNINSURED

The proportion of uninsured persons in the Syracuse area is lower than average, particularly in Onondaga County,[17] compared with statewide and national norms. However, some respondents expressed concern that the number of uninsured would increase shortly, as transition benefits to employees laid off by two regional employers lapse. The bulk of indigent care is delivered by hospitals and subsidized through the state's uncompensated care pool. The community health center reports seeing more uninsured persons recently (as a proportion of its caseload) and has extended walk-in clinic hours to accommodate demand. Other funding sources include a mix of federal and state categorical funds, which are sometimes matched with local dollars. These sources provide for direct medical services and public health functions such as prevention programs.

The environment for health care organizations in the Syracuse area has shifted from one of comfort and cooperation to one of uncertainty and anxiety.

Issues to Track

The health system in and around Syracuse appears to be on the verge of change. Much of the change-related activity, however, has been anticipatory, and many of the events expected to drive or unleash change either have not occurred yet, or have been less disruptive than anticipated. For example, the termination of the state's comprehensive hospital rate-setting system has not yet produced the financial consequences originally expected. The threatened entry of national managed care organizations into the local market is occurring less precipitously than anticipated. Medicaid managed care enrollment will probably not increase significantly until January 1998, when mandatory Medicaid managed care enrollment will start to take effect.

There is little evidence that cost, access, quality of care or insurance coverage has been affected by the changing environment. Hospitals, health plans, community health programs and physician groups are all taking steps to survive—or prevail—in a deregulated, price-competitive environment. But these activities are tempered by a strong ethos of caution and resistance to "outside solutions" and the traditionally close working relationship of business and health and civic interests.

The environment for health care organizations in the Syracuse area has shifted from one of comfort and cooperation to one of uncertainty and anxiety.

High-cost teaching hospitals and providers that supply a large share of uncompensated and Medicaid care are vulnerable to the payment reductions associated with the demise of NYPHRM and the onset of negotiated rates and Medicaid managed care. Excess hospital bed capacity remains

and is likely to grow. Hospitals in the counties outside Syracuse are in a precarious position due to the dominance of the four Syracuse-based hospitals and the higher rates of uninsurance reported in those outlying areas.

In the health insurance market, four local HMOs face difficulty if they have to compete with large, well-capitalized national plans.[18]

The Syracuse Community Health Center depends heavily on the success of its Medicaid managed care product, and will likely face competition for Medicaid enrollees and rising uncompensated care demands. The local and state health and social services departments are also in the midst of reorganization and changes in responsibilities with regard to Medicaid and welfare reform.

The changes underway in Syracuse's health system are largely in anticipation of events that are still unfolding. Nonetheless, these anticipatory responses are likely to create other changes. For example, the implementation of PHO and MSO strategies and the purchase of physician practices may redefine referral patterns between doctors and hospitals. Advertising campaigns, the purchase of primary care practices and investments in sophisticated information systems may divert resources from patient care or increase health care costs in the short term. Increased risk assumption and contracting may alter patterns of care.

It will be important to track respondents' early perceptions to see whether predictions hold true over the longer run. Among the questions that bear watching:

- Will access to primary care improve for Medicaid managed care enrollees?
- Will the recent decline in HMO premium costs relative to indemnity plan costs continue, and will mandatory Medicaid managed care trigger a more widespread transition from fee-for-service to managed care in the commercial market?
- Will hospital consolidation and alignment between physicians and hospitals go forward?
- Will physicians gain greater power relative to hospitals and health plans, either in joint relationships or by initiating their own ventures?
- Will the historic collaboration of hospitals with each other and with civic and business leaders reassert itself, or will competitive or antagonistic forces prevail?
- Will the replacement of the NYPHRM hospital payment system with a deregulated market-based approach occur smoothly, or will it provoke more turbulence?

NOTES

1 Area Resource File as of February 1996, Office of Research and Planning, Bureau of Health Professions, U.S. Department of Health and Human Services; Community Health Information and Planning Service (CHIPS), 1993.

2 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.

3 Hospital Executive Council, 1996.

4 Although this rate for African Americans is still higher than other norms for this group, the county's health assessment notes a decline from the 1980s.

5 NYPHRM built onto a pre-existing rate setting structure that dated back to 1968. It is important to note that the earlier set of regulations applied only to Medicaid and Blue Cross rates.

6 New York State Managed Care Report, April 1996.

7 Syracuse Chamber of Commerce.

8 The largest public purchaser in the area is the regional Board of Cooperative Educational Services for Onondaga, Cayuga and Madison counties (OCM/BOCES), a consortium of three counties' local school districts that collectively contract with Blue Cross/Blue Shield of Central New York. Approximately 7,000 policy-holders are covered under that arrangement. Member school districts also contract with local HMOs independently.

9 Syracuse Chamber of Commerce.

10 New York State Managed Care Report, April 1996; Health Care Financing Administration, 1995.

11 New York State Managed Care Report, April 1996.

12 Faculty of the SUNY Health Sciences Center are organized in a new faculty practice plan, University Medical Associates.

13 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.

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

15 Estimate provided by Lacey & Cahill LLC, 1996.

16 CHIPS, Access to Medical Services, 1993.

17 Onondaga County Health Department, 1996.

18 These HMOs include Patient's Choice, which began locally, but is now owned by HealthSource.