Health System Change in Cleveland, Ohio

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The organization of health care delivery in the Cleveland area has changed dramatically during the past few years. These changes appear to have been driven by the actions of the private sector, particularly a few dominant hospitals, physician organizations and health plans. Cleveland is also characterized by a strong hospital safety net and a unique collaboration of employers and providers to evaluate hospital quality. The impact of these changes on the access, cost and quality of services is not yet known in any measurable terms. It seems likely that future changes will be driven by changes in public policy, most notably those that increase managed care in the Medicaid and Medicare programs.

Health care is an important feature of Cleveland's economic landscape. Indeed, Cleveland is recognized as both a regional and a national referral center, and the health care industry is a major employer there. Cleveland's hospitals historically have dominated the area's health care market. Of 43 hospitals in the Cleveland area, 17 are located in Cleveland, where the area's tertiary facilities are concentrated, and account for 56 percent of the area's hospital beds.[1] Until the last few years, most of these facilities had well-defined local geographic and service markets, and overall there was a high level of stability in the hospital sector. Foremost among the reasons for this stability are:

- a strong mission identification by the Cleveland area's religiously affiliated, not-for-profit hospitals;
- hospitals' overall financial success, despite significant excess capacity;
- Cleveland's strong public hospital;
- the preservation of market niches afforded by the state's certificate of need (CON) program; and
- the market power of Ohio Blue Cross & Blue Shield, which is the cornerstone of the prevailing fee-for-service/indemnity insurance market.

But this historical stability has been upset during the past two years, as local providers have begun reaching out to attract patients beyond their traditional geographic or service areas. At least three factors have contributed to this push to secure or expand market share:

- Legislation was passed that sunsets the state's CON regulations as of May 1997, permitting hospitals to enter lines of business that previously were rationed.

- Aggressive regional and national providers and insurance entities have entered the local market. These include two national for-profit hospital chains, one of which is attempting to enter both the hospital and insurance markets. This threat of competition has spurred efforts to secure or expand traditional markets.

- Public and private purchasers have increased pressures to reduce health care spending. In the public sector, the state began phasing in mandatory managed care for Medicaid in Cuyahoga County in July 1996. In the private sector, employers have switched plans readily for small premium decreases—spurring intense price competition among plans and, in turn, providers. These threats to revenue have reinforced hospitals' inclination to expand market share and to grow to achieve economies of scale and greater market power.

Providers and insurers have responded promptly to this new environment by attempting to lock in or expand their share of the market. They are reportedly accepting—even offering—prices at or below cost in order to gain market share. Hospitals and physician groups are merging or affiliating at a rapid pace and forming into large networks. Anticipating more extensive penetration of managed care, institutional providers are seeking to improve their market position by expanding the range of services they offer, purchasing physician practices to ensure volume and reorganizing to contract with managed care plans. Most respondents believe this process of change will continue for some time, eventually resolving into a regional health care system dominated by three or four large provider systems.

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The configuration of these evolving systems and the relationships and balance of power among the provider, purchaser and insurance sectors remain uncertain. A number of factors will shape the outcome, including:

- *The traditional dominance of a small number of organizations,* most notably the Cleveland Clinic, the University Hospitals and Blue Cross & Blue Shield of Ohio, in the Cleveland health care market.

- *The growth of managed care,* which to date has been modest but may be accelerated by changes in Medicare and Medicaid, and which likely will prove key to determining which systems succeed, because some systems are better positioned than others for managed care.

- *The evolution of employer influence on health care delivery.* Although many respondents feel that Cleveland's employers have not yet exerted a heavy hand on the health care system, recent activities signal a change. There are several broad-based business organizations focused on health care issues. One of these organizations recently initiated a direct contracting effort, and, as noted above, employers have demonstrated clear readiness to switch health plans frequently for modest economic gains.

- *The shakeout of several different system-building approaches* that are being pursued by Cleveland's providers. These models include ownership/acquisition, affiliation/contracting and horizontal inte-

gration and vertical integration among hospitals and health plans or between physicians and hospitals. Each major emerging system has shifted its strategy at least once in the last few years, and it is unclear which approaches will prevail.

- *The considerable surplus of hospital beds and physicians.* The concentration of providers through purchase and affiliation has not yet resulted in significant capacity changes. Following the effect of competitive pressures on capacity changes over time will be important.

As noted, the impact of these changes on the delivery of care and on its cost, quality and accessibility is not fully known. Changes in the respective roles of generalist and specialist physicians may be taking shape, and interest in data to guide or evaluate practice appears to be increasing. Premium costs reportedly have flattened out in response to widespread health plan and provider discounting, but it is not clear that underlying provider costs have changed significantly.

The community generally views the quality of care as high, citing hospital report card data published during the past few years as evidence that quality has not declined. Access to care is not seen as a critical issue, probably because of favorable perceptions of the area's safety net providers. Some observers believe that the advent of mandatory Medicaid managed care will improve access. At the same time, concerns have surfaced about the impact of the recent acquisition of not-for-profit safety net hospitals by national investor-owned chains.

The Cleveland Community

The Cleveland-area community comprises six counties in northeast Ohio, and includes 2.2 million people. It extends 100 miles along the Lake Erie shore and more than 40 miles inland. Nearly two-thirds of the area's population is concentrated in Cuyahoga County, Ohio's largest county, where the city of Cleveland is located. Another quarter of the population lives in suburban Lake and Lorain counties, and the remainder in the rural and suburban areas of Ashtabula, Geauga and Medina counties.

The population as a whole is somewhat older than the national average, with a larger proportion of minorities. The median household income and percentage of families living below the poverty line approximate national averages. The 1995 unemployment rate was lower than the national rate.[2] Nonagricultural jobs are predominantly in the service (76 percent) and manufacturing (20 percent) sectors. The health sector makes up 10 percent of the employment base.[3]

As a community, Cleveland has some significant health problems. Age-adjusted mortality rates for cancer and ischemic heart disease are 9 percent and 25 percent higher than the national average, respectively.[4] Infant mortality is significantly above the national average, and is higher in Cuyahoga County, where one in five live births occurred among women with no first trimester prenatal care.[5] Health services use and capacity are relatively high. The rate of admissions and days per 1,000 population are 24 percent and 21 percent higher than national norms, respectively.[6] The ratio of hospital beds to the population is about 22 percent higher than the national average.[7] Local estimates hold that the area is overbedded by 40 percent, although hospital occupancy rates are comparable to the national average.[8] The area has 25 percent more physicians per 1,000 people than the national norm (19 percent more primary care physicians and 31 percent more specialists), which is not surprising because it is a major center for medical education.[9]

THE HEALTH CARE MARKET

The market for health services is well-defined along geographic lines, with a distinct central core based in Cleveland and suburban-rural sub-markets to the east, south and west. The central core, encompassing Cleveland and nearby Cuyahoga County suburbs, has a high concentration of hospitals. Most of the city's hospitals are located in poor or working-class urban neighborhoods, and carry significant charity care responsibilities. Several hospitals are establishing new satellite clinics in strategic urban locations. Cleveland residents reportedly are loyal to their neighborhood hospitals, and the Cuyahoga River forms an east-west demarcation line around which the dominant hospital systems appear to be developing their strategies. Physicians on the east side typically are organized in large hospital-owned and -affiliated groups, while those on the west side are more likely to be in smaller private practices.

The suburban and rural areas to the east and west are also highly oriented toward Cleveland providers, with little pull from other urban centers. Much of the specialty care for these residents is provided either in Cleveland or, increasingly, in local suburban hospitals under contract with Cleveland hospitals. A number of the Cleveland-based hospital systems have established ambulatory and urgent care clinics on the periphery of Cuyahoga County to attract patients from outlying counties. Suburban and rural populations to the south are pulled between the Akron health market and Cleveland-based systems.

Interviewees almost universally believe that Cleveland has a high-quality health care system and that the quality of medical care has remained constant or improved in recent years. Much of this perception is tied to the prestige of several major Cleveland providers. In addition, the Case Western Reserve University Medical School, which is affiliated with five local hospitals and systems (as well as the Henry Ford Health System in Detroit), is considered one of Cleveland's health care assets. Case Western also has an agreement with the state to enroll a majority of Case Western's students from Ohio.

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In the past, health care costs were viewed as high, but these concerns have abated. According to American Hospital Association statistics, Cleveland's rank among large cities for average cost per admission dropped from 11 to 21 between 1990 and 1994,[10] and data from three employers showed 24 percent declines in premiums between 1991 and 1994.[11]

LEADERSHIP AND DECISION MAKING

Area political and business leaders play an active role in health care issues, which they view as important to the community. Business leaders are well represented on hospital boards and they take an active interest in health system issues through several organizations, including: Cleveland Tomorrow, a business roundtable of Cleveland's leading employers, the Health Action Council, representing large purchasers, and the Council of Small Enterprises (COSE), a purchasing cooperative of small and medium-size businesses under the auspices of the Chamber of Commerce.

In general, however, the Cleveland-area health market is driven by the city's leading hospitals and physician groups. These are powerful institutions that shape the community's perceptions of health care and market change.

In contrast, there appears to be some unease with insurers, particularly Ohio Blue Cross & Blue Shield, partly because of its historically dominant role and partly because of its attempted acquisition by Columbia/HCA, a national for-profit hospital company. Some interviewees believe that insurers are extracting dollars from an increasingly competitive health care market without adding value. This view has been underscored by press reports of the considerable personal gain that several Blue Cross executives stood to make from the Blues plans proposed sale.

Many respondents express hope that the Cleveland area may leap-frog the evolutionary phase that many metropolitan markets are experiencing, where price and the preponderance of a few large managed care plans are the driving factors. These observers say they would like to see Cleveland make a speedy transition to direct contracting between purchasers and large provider organizations. Few people, however, were able to cite concrete evidence to support that this will take place.

There is also a prevailing view that decisions affecting the health care sector are made informally by a small group of executive decision makers, such as hospital CEOs and business leaders who sit on hospital boards. It is widely believed that these influential personalities and their long-standing interpersonal relationships drive the emerging partnerships and competitive relationships.

A number of consumer advocacy organizations are active in the Cleveland area, but they do not appear to wield great influence on health care policy or the shape of the delivery system. Consumers do not appear to participate in their employers' health care purchasing decisions, but purchasers reportedly are reflecting their employees' preferences by selecting plans with broad, geographically appropriate provider networks.

Several respondents noted the absence of a consistent, collective voice for the public good on health policy issues such as excess capacity, for-profit health care acquisitions of not-for-profit institutions and the effects on clinical practice of financial incentives for physicians. The *Cleveland Plain Dealer* has reported extensively on issues related to the safety net, Medicaid managed care, quality of care and for-profit acquisitions. The emergence of a coalition of labor unions and other groups opposing Columbia/HCA's acquisition of Ohio Blue Cross & Blue Shield may presage greater advocacy activity, and a local council of consumers, providers and plans has been formed as an advisory group to monitor the implementation of mandatory Medicaid managed care in Cuyahoga County.

External Forces Affecting the Health System

PUBLIC POLICY

In contrast to the central role played by health care institutions and the business community, government policy and regulation does not appear to be a primary force for change in the Cleveland area. In general, Ohio's regulation of the health care industry is characterized as market friendly, and powerful Cleveland-based carriers and

providers are perceived as having great influence in the state capital. As noted, the state's CON program is being phased out, which will diminish the local health systems agency's influence on health planning. The state has laid a foundation of basic consumer insurance protections that includes restrictions on premium levels and guaranteed issue for the individual market. A statewide quality assurance initiative features new monitoring and enforcement powers for the state health department. The state has also established new solvency provisions for providers accepting risk. The State Department of Insurance rejected the proposed acquisition of Ohio Blue Cross & Blue Shield by Columbia/HCA as unfair to the policyholders and not in the public interest.[12] No major changes in state health policy are anticipated in the near future.

The transition to mandatory Medicaid managed care in Cuyahoga County holds the largest potential impact for the Cleveland area. This policy took effect in July 1996 for Aid to Families with Dependent Children (AFDC) eligibles (none of the other four counties in this area was subject to the July 1996 deadline). Enrollment, contracting and claims administration will be managed at the state level. Two local health plans dominated the Medicaid managed care market in Cleveland prior to this change, although they may be challenged by national organizations that are entering the Cleveland Medicaid market. It is interesting to note that most respondents do not expect providers to be significantly affected by these changes. They anticipate that patients will continue to be loyal to their traditional Medicaid providers, and they assume that these providers will be part of every Medicaid managed care plan's network.

Cleveland has a relatively strong safety net and indigent care system centered around the MetroHealth system and its clinics. Financing for safety net and public health functions is primarily county-based. The county subsidy to MetroHealth, the Cleveland public hospital, is approximately $15 million annually, generated through taxes and administered by the county commissioners. In addition, state and federal Medicaid funds from the disproportionate share program have helped subsidize care for the uninsured. The future of MetroHealth, which now operates three of the four community health clinics formerly run by the city health department, is viewed as quite positive. There is concern, however, that MetroHealth will have to shoulder more of the safety net burden it historically shared with not-for-profit hospitals, such as St. Vincent's Charity Hospital, which is now operated in a joint venture by Columbia/HCA, and Mount Sinai Hospital, now owned by Primary Health Systems.

The community health centers report that they are serving an increasing proportion of the uninsured and are implementing strategies to accommodate Medicaid managed care. For example, the oldest and largest community health center in the area, the Cleveland Neighborhood Health Services, Inc., developed a health maintenance organization (HMO) in the late 1980s that enables it to serve a growing share of Medicaid managed care patients. Other community health centers vary in their ability to contract with managed care organizations. They describe worsening financial pressures on their organizations, which they attribute primarily to serving more uninsured persons.

Public health agencies focus on population-based health activities, including immunization, epidemiology and environmental health. They typically provide little in the

way of personal medical services and are supported by per capita taxes and user fees. The one notable exception is the Lorain County Health Department, which spends about 40 percent of its budget on direct care, primarily on the uninsured and underinsured. Lorain County had operated a successful home care program, which is now being supplanted by competing hospital and proprietary agency programs.

PURCHASING

The largest employers in the Cleveland area are the federal government, Ford Motor Company, the Catholic Diocese of Cleveland, the Cleveland Board of Education, the Cuyahoga County government and the Cleveland Clinic Foundation. These and other government, manufacturing and health care employers, along with a heavily unionized work force, have the potential to exert considerable influence through their health care purchasing activities.

• Private Purchasing

So far, employers appear to have gotten what they want in terms of cost and quality. Employers have been highly sensitive to price differences. They have not had to demand premium discounts and price reductions, which have been initiated by plans (and, in turn, by providers) seeking to secure or expand their market share. Employers have shown little allegiance to specific plans and products, and appear to be jumping from plan to plan in response to lower prices. Because most plans use similarly configured, broad, overlapping provider networks, purchasers are able to get the networks they want without penalty for switching plans. With a few important exceptions, they have not pressed to increase managed care, nor have they made differentiation of quality a major aspect of their purchasing decisions. Despite purchasers' initiative in founding the Cleveland Health Quality Choice (CHQC) program, quality still appears to be defined principally by the reputation of the large physician and hospital systems. Purchasers and plans generally agree on which providers are considered high quality, based on history, community reputation, personal experience and their CHQC rankings.

Cleveland Health Quality Choice is a notable feature of the Cleveland health system. Established in 1988 as one of the first community-wide quality initiatives in the country, CHQC profiles participating hospitals along six dimensions, and reports the results to the public semiannually. The program was originally sponsored by the business community and was subsequently adopted by the hospital and physician communities, partly in anticipation that businesses might selectively contract with providers based on their participation and ranking in CHQC. The Greater Cleveland Hospital Association has played a central institutional role in the program, and all of Cleveland's hospitals were participating in mid-1996. The Health Action Council of Northeast Ohio, a coalition of more than 140 businesses representing some 350,000 covered lives, helped found CHQC and remains a key backer.

So far, CHQC appears to have had less effect on purchasers' decisions than on hospitals' concern for their internal practices and their reputations. Several hospitals reported instances in which they publicized good performance, debated the CHQC methodology when they felt it penalized them unfairly or used the results to guide internal quality improvement programs. The program has not been without controversy, most of which has centered on whether CHQC adequately adjusts for the

severity of illness in patients seen by tertiary referral centers. However, the CHQC initiative is unusual in its public reporting of results and the collaboration of purchasers and providers sponsoring it.

Despite lengthy discussion, it remains unclear whether employers will actually use CHQC data in their purchasing decisions. Even employers that have taken a more active and directive role in health care purchasing have made only limited use of quality data. Lubrizol, a chemical manufacturer that has its own point-of-service (POS) plan for Ohio employees, and Parker Hannefin, an industrial producer of aviation and other machinery that has developed its own preferred provider organization (PPO), have focused on general reputation and patient satisfaction surveys to evaluate plans.

The Health Action Council recently announced that it would selectively contract for certain specialty services (e.g., heart surgery, cancer care, transplants, joint replacements) based in part on quality demonstrated through CHQC performance. This direct contracting initiative represents a potentially important change in purchaser activity. First, it bypasses insurers and health plans—fueling providers' hopes that Cleveland will be able to avoid the dominance of managed care plans that has characterized other markets. Second, by using CHQC data to select providers, the council explicitly incorporates quality-of-care information into its purchasing decisions.

As noted, traditional fee-for-service insurance is still strong in the Cleveland market, although it is losing ground to preferred provider and POS products. The endurance of fee-for-service pricing is widely attributed to two factors:

- The heavily unionized Cleveland-area work force has placed a high value on freedom of choice and access in its collective bargaining negotiations.
- Employers have been able to achieve cost control through discounting.

Ohio Blue Cross & Blue Shield has dominated the fee-for-service market for many years by virtue of its large employer clientele, discounting practices and willingness to develop products geared to purchaser needs. The ability of private purchasers to achieve their cost objectives without significant changes in the delivery of care appears to have moderated a desire for managed care. Employers appear comfortable with current insurance products, and most recent enrollee growth has been in preferred provider and POS products. Staff-model and group-model HMOs have been less popular, although small and medium-size employers are showing more interest in them because they view them as less expensive and more stable than other provider network options.

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- **Public Purchasing**

In contrast to Cleveland's private sector health care purchasers, Medicaid and Medicare are actively pursuing managed care. New opportunities for managed care in these two programs are credited with attracting national carriers to the Cleveland market, including the recently merged Aetna/U.S. Healthcare company. Under the state's voluntary Medicaid managed care program, enrollment reached 56 percent in

Cuyahoga County and 31 percent in Lorain County.[13] Medicare managed care penetration is a modest 6 percent overall in the Cleveland area, but is reported to be growing rapidly. Health plans and providers see Medicare managed care as the next significant driving force in the delivery system, as new plan-provider alliances are formed to pursue a share of the Medicare managed care business. Medicaid and Medicare managed care plans generally appear to be moving toward more restrictive networks.

Organization of the Health Care System

Consolidation of health care organizations in the Cleveland area has accelerated during the past two years. Hospitals have been rapidly forming or joining hospital systems, and small systems are being acquired by or affiliating with larger systems. Many of these large new entities are aimed at a broader market—northeast Ohio or even multistate regions. It is expected that eventually all hospitals in the area will be aligned in one of three or four large systems. Physicians also have been joining larger groups, and these groups are aligning with the emerging hospital systems. Because large numbers of physicians in the area were already salaried employees of hospitals or large group practices, such close alignments are not a new phenomenon in this market. Many of the medium and large primary care practices that were once free-standing have been acquired by larger hospital-affiliated entities. Hospitals also have been creating and affiliating with health plans.

While most of this activity has involved local organizations, large national insurers and hospital companies have begun to enter the market during the past year, to the consternation of most local providers and some community interest groups. Still, most hospitals (except those recently purchased by national for-profit entities) remain under local ownership and are not-for-profit. A smaller number of the health plans are locally owned, while many are regional or national organizations.

PROVIDER ORGANIZATIONS

Three large provider organizations play central roles in the evolving Cleveland-area health system. They are organized around University Hospitals, the Cleveland Clinic and the Columbia/HCA-Sisters of Charity System. In addition, several smaller systems occupy particular geographic or service niches, and most of these are affiliated in some fashion with one of the three systems.

The *University Hospitals Health System* (UHHS) is centered around the 536-bed University Hospitals campus in Cleveland. It also includes the 122-bed Geauga Community Hospital and the 110-bed Bedford Community Hospital, as well as an extensive network of primary care and specialty physicians housed in two large physician groups, University MedNet, which was acquired in 1989, and University Primary Care Physicians, formed in 1994. In addition, UHHS has a managed care organization, QualChoice, with 87,500 members. All of these entities are owned by UHHS.

The *Cleveland Clinic's system* must be viewed through two lenses:

- the Cleveland Clinic and its owned entities and
- the Cleveland Health Network (CHN), a contractual organization shaped by the Clinic.

The Cleveland Clinic is a large multispecialty group practice of salaried physicians

with an international reputation for excellence. The Clinic is a physician-driven organization that owns a 921-bed hospital. It recently completed the purchase of Marymount Hospital and is finalizing a long-term lease with Lakewood Hospital. More recently, the Clinic announced plans to merge with two smaller hospital systems, the 769-bed Meridia System and the 602-bed Fairview Health System. The Meridia System, located in Cuyahoga County, was the result of an earlier merger of five area hospitals. Previously, it was closely aligned with Ohio Blue Cross & Blue Shield. The Fairview Health System encompasses Fairview Hospital and Lutheran Hospital and an array of ambulatory care satellites throughout Cleveland's west side.

The Cleveland Clinic was also the principal organizer, along with the public MetroHealth system, of the Cleveland Health Network, the most extensive provider network in the Cleveland area. CHN describes itself as a physician-driven, contractual affiliation of nine hospitals and their associated physician-hospital organizations:

- Cleveland Clinic,
- MetroHealth System,
- EMH Regional Health Care System,
- Fairview Health System,
- Marymount Hospital,
- Parma Community General Hospital,
- Southwest General Health Center,
- Summa Health System (Akron) and
- Children's Hospital (Akron).

The CHN is governed by a board representing its 18 constituent members and is designed to contract with managed care organizations and other purchasers.

The third evolving system is the *Columbia/HCA-Sisters of Charity system.* This includes the three hospitals involved in a joint venture between Columbia/HCA and Sisters of Charity—Timken Mercy, St. Vincent's and St. John's Westshore—as well as the recently announced purchase of St. Luke's Hospital. This group collectively constitutes 1,240 beds located in Cuyahoga and Stark counties.

Other systems include:

- the MetroHealth System, which consists of Cleveland's public hospital and its associated clinics;
- a new system assembled by national, for-profit Primary Health Systems (PHS) through its purchase of five institutions (Mount Sinai, Deaconess, St. Alexis, Laurelwood and Richmond Heights), which together comprise 1,054 beds; and
- the 327-bed system in Lorain County, which resulted from the merger of Lorain Community Hospital and St. Joseph's Hospital.

The principal physician groups are all operating with, owned by or aligned with the major provider systems. The Cleveland Clinic is an 800-member multispecialty group practice of salaried physicians. UHHS owns two major physician groups: the 140-member University Primary Care Physicians Group and the 115-member University MedNet multispecialty group practice. In addition, UHHS is affiliated with the 150-member University Suburban group. At MetroHealth, approximately 320 physicians are salaried. As noted, small practices still persist on the west side of Cleveland and in the suburban counties.

ORGANIZATION CHANGE: PROVIDERS

The considerable consolidation of the past three years typically has been initiated by providers and has had horizontal (i.e., hospital to hospital) and vertical (i.e., hospital to physician group) elements. Dominant providers have sought to strengthen their market power by purchasing smaller hospitals and physician groups. For example, University Hospitals acquired Geauga and Bedford Community hospitals and the MedNet physicians group, and the Cleveland Clinic acquired Marymount Hospital.

To a lesser extent, several smaller providers have sought to increase their market power by merging with each other. The Meridia System did this in 1984, as did Fairview and Lutheran in 1986 and, more recently, St. Joseph's and Lorain Community Hospital. Several of these systems subsequently formed partnerships with a larger system. For example, the Fairview and Meridia systems each negotiated separate deals with the Cleveland Clinic in 1996.

A third level of consolidation involves the entry of two for-profit hospital chains in the Cleveland market in 1994. As noted above, Columbia/HCA entered into a three-hospital joint venture with the Sisters of Charity system, and shortly thereafter added a fourth hospital. PHS has acquired five area hospitals.

This consolidation trend appears likely to continue. Some respondents speculate, for example, that PHS may seek additional hospital acquisitions. PHS, University Hospitals, Columbia/HCA and the Cleveland Clinic all reportedly tendered offers for the Meridia System in mid-1996 before its acquisition by the Cleveland Clinic was announced.

The alignment of most suburban and rural hospitals with one or another of the emerging large Cleveland-based systems is another important phenomenon. These affiliations span a wide variety of relatively nonexclusive agreements, typically around referral relationships that are designed to give the Cleveland-based sponsor greater geographic reach and to convey brand-name support via specialty referral networks for the suburban institutions. The suburban and rural hospitals are receptive to working with these large city hospitals because they believe they need these partnerships to participate in managed care and to survive in an increasingly competitive environment. So far, most of these alignments appear to be high-level organizational relationships that have not had significant effects at the clinical or operational level.

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Changes in the physician sector have occurred along two lines:

- aggregation of physicians into large groups and
- alignment of physician groups (via purchase or network affiliation) with large hospital-centered provider systems.

The Cleveland area historically has been characterized by large groups of salaried physicians, employed either by large multi-

specialty groups (the Cleveland Clinic, MedNet) or by hospitals (MetroHealth, University Hospitals). More recently, the large provider systems, as well as some less dominant hospitals, have been aligning with large numbers of additional physicians.

University Hospitals has actively pursued ownership of physician practices. The University Primary Care Physician group houses the primary care practices purchased by the system, and University MedNet is a 115-physician practice owned by UHHS. In addition, University Suburban is a large multispecialty group practice closely affiliated with but not owned by UHHS. The current head of University MedNet was recently named to the newly created position of senior vice president of system development to lead the further integration of these physicians into the UHHS clinical enterprise. Physicians in each of these groups admit many of their patients to University Hospitals.

Traditional fee-for-service plans are still strong in Cleveland's insurance market, with more recent growth in PPO and POS products. Overall, HMO penetration is about 20 percent.

As noted, the Cleveland Clinic has pursued development of the Cleveland Health Network (CHN), which is governed by representatives of the nine participating hospitals and their affiliated physician-hospital networks (PHOs). Described by some as a super-PHO, CHN identifies itself as a physician-led and physician-driven organization that was formed to contract with managed care plans. It is currently a highly decentralized organization.

Other provider groups, like Meridia, have also purchased physician practices. A number of observers commented that the price of physician practices has risen—beyond their value according to some—as demand has increased. Respondents also described a postsale pattern of declining productivity and older physicians cashing out. At least two hospitals reported losing medical staff to a larger system, which further diminished their competitive position and ability to align their medical staff with the institutions' strategy.

HEALTH PLANS

Traditional fee-for-service plans are still strong in Cleveland's insurance market, with more recent growth in PPO and POS products. Overall, HMO penetration is about 19 percent.[14] The largest and most influential health plans are: Ohio Blue Cross & Blue Shield, Blue Cross Anthem, Kaiser Permanente and United Health Care.

The number of plans has grown recently as large national carriers, including Aetna, Prudential and Cigna, have entered the market. Additional entrants are expected to pursue new opportunities in Medicaid managed care and Medicare risk-contracting. Cleveland is still a relatively high-cost, high-utilization market with opportunities for profit, and there are few policy or regulatory barriers to entry. The Medicaid managed care market is currently dominated by two local plans, Personal Physician Care and Total Health Care. Most plans offer a wide range of PPO, POS, HMO and indemnity products.

Managed care plans typically have loose, overlapping and geographically extensive networks that include 20 or more hospitals. Almost all networks include either University Hospitals Health System, the Cleveland Clinic or both. Networks also typically include one of the high-volume hospitals for

maternity care, such as Meridia Hillcrest or Fairview, as well as smaller acute care institutions. Provider selection generally consists of targeting a small subset of hospitals for exclusion rather than identifying specific institutions for inclusion. Providers are pressuring plans to include all components of the newly merged systems in their networks, rather than the individual components with which they previously contracted. Networks generally appear to be expanding rather than contracting, although at least one large plan is reportedly planning to begin deselecting physicians who are infrequently used by its enrollees. Discounted fee-for-service is still the dominant form of provider payment in the managed care market, and there is little risk-bearing by providers and limited capitation.

Although its share has declined in the past 10 years, Ohio Blue Cross & Blue Shield dominates the insurance market with a wide range of products. It is closely aligned with the Council of Small Enterprises. In recent years, Blue Cross has experienced financial difficulties and has crossed swords with University Hospitals and the Cleveland Clinic at different times. Blue Cross has been at the center of several major attempts at vertical integration of providers and insurers.

The attempted purchase of Ohio Blue Cross & Blue Shield by Columbia/HCA on the heels of the for-profit hospital company's joint venture with the Sisters of Charity system last year generated considerable controversy. This potentially powerful vertical integration, which presumably would have directed the care of large numbers of Blue Cross members to Columbia/HCA-owned hospitals, was opposed by a coalition of organized labor and other groups, and was reviewed by Ohio's insurance commissioner, attorney general and the courts. The national Blue Cross and Blue Shield sued Ohio Blue Cross & Blue Shield to disallow its use of the valuable Blue Cross shield trademark. In November 1996, a district court ruled in favor of the national association, and ordered the Ohio Blues to stop using the trademark immediately.

Anthem, a Blue Cross entity with a strong base in the Indianapolis and Cincinnati areas, entered the Cleveland market in the mid-1980s. Earlier this year, Anthem announced plans to expand by purchasing Blue Cross of New Jersey. Like other large plans, Anthem markets a wide range of products, including a PPO, POS, exclusive provider organization (EPO), HMO and a recently approved Medicare managed care plan. Anthem may receive a boost from the district court decision in the Ohio Blues case, and it is poised to step in as the bearer of the trademark shield in Ohio.

Kaiser Permanente is a mixed-model (group and independent practitioner association or IPA) HMO. Its core product is a closed-group HMO, although PPO and POS options were recently added. Kaiser has an exclusive relationship with the Ohio Permanente Medical Group of salaried physicians and recently affiliated with the Cleveland Clinic, where it leases beds, and began developing relationships with non-salaried community physicians.

ORGANIZATIONAL CHANGE: HEALTH PLANS

Health plans have been less involved than hospitals and physician groups with local ownership changes, with one important exception. Ohio Blue Cross & Blue Shield has explored vertical integration with providers on at least three occasions:

- In the 1970s, the Ohio Blues initiated a contract with the MedNet physicians

group to develop an HMO, a relationship it subsequently terminated.

- In 1995, Blue Cross entered a joint venture with the Meridia hospital system, known as Northeast Ohio Community Health Plan, but this attempt to vertically integrate provider and insurer functions was widely considered unsuccessful.
- In 1996, a much more sweeping possibility for vertical integration emerged with Columbia/HCA's attempted acquisition of Ohio Blue Cross & Blue Shield, as discussed earlier.

Clinical Practice and Delivery of Care

Despite significant changes in health care organization, there does not yet appear to be a high degree of administrative or clinical integration within these newly concentrated entities. Nor has there been any significant reduction in capacity.

Ownership models of consolidation generally convey a greater level of administrative integration. The University Hospitals Health System, for example, employs many of its physicians, manages budgeting centrally and is making significant investments in unified information systems. UHHS also plans to centralize billing, human resources and management information systems. The Fairview and Columbia/HCA-Sisters of Charity systems also centralize such administrative and financial functions. But a great deal of administrative integration still appears to be in the planning stages. In nonownership affiliations, such as the Cleveland Health Network, the organization is intentionally decentralized, retaining considerable administrative autonomy for the member organizations. For example, CHN members manage their own billing functions, but pass data on to the network for physician profiling and clinical guidelines development.

Clinical integration is also limited. Most systems describe plans for unified clinical data systems, clinical pathways development and consolidated clinical management of departments and ancillary functions. UHHS has consolidated radiology services and plans to integrate urology, cardiovascular and cancer services across its hospitals. The Fairview system has unified the heads of its departments and consolidated radiology and anesthesia services. Within CHN, MetroHealth staffs the emergency departments for the Cleveland Clinic and the Meridia System, and has an affiliation with the Cleveland Clinic to support its neonatology program. The Cleveland Clinic directs radiation oncology at Fairview and Meridia Hillcrest.

Additional consolidation and integration of clinical care was still being planned. For example, PHS was reportedly beginning to establish single-specialty departments across its four member hospitals, and the Meridia system was planning to reorganize clinical services into centralized product lines across its hospitals.

Respondents believe that physicians still control the course of day-to-day clinical practice in the Cleveland area. However, consumer expectations regarding health care services are rising as more information becomes available to them. Numerous anecdotes tell of patients who approach their providers with the results of their own Internet literature searches and print journal articles. More significant is the broadly shared view that information and involvement from parties outside the doctor-patient relationship are beginning to wield significant influence on individual clinical decisions.

Several factors are contributing to this increased involvement of third parties, including the migration of solo practitioners into group practices, where consistent clinical practice across physicians is expected. One is the increasing availability of practice guidelines, such as those disseminated by the federal Agency for Health Care Policy and Research. Several large group practices have adopted data-driven internal quality review processes and consensus standards for best practices, and local health plans and hospital systems reported increased reliance on practice guidelines. When pressed, however, most agreed that implementation of these guidelines is not yet fully operational.

Some health plans and large providers are trying to influence physician practice patterns through profiling activities that rely on data collection and feedback. In this manner, physicians can see how their practices compare with those of their peers. That objective is not always met, however. Physicians complained about receiving feedback data from multiple sources in different formats, which makes comparisons difficult. A few providers and most plans say they are making profiling a cornerstone of their approach to care management, and intend to make that information more accessible, consistent and credible. They emphasize that they are not interested in policing clinical practice, but in working collaboratively with clinicians to jointly identify best practices.

In general, physicians have not been subjected to tight utilization controls, strict practice guidelines or strong financial incentives to influence their clinical decisions. Despite considerable discussion about practice guidelines, there is little evidence of their use or impact on care. Utilization review activities are generally quite basic, typically focused on length of stay. The state is designing a new system of measuring quality and performance, but its precise shape and impact on physician practice is unclear. Health plans and provider systems talk about the importance of working with physicians as partners and staying out of their way. Scattered financial incentives are in use, but the lack of capitated arrangements and the large numbers of full-time salaried physicians limit their impact. One plan offers physicians a bonus based on individual performance in addition to their per-member-per-month capitation payments. Several groups and networks are offering equity ownership as a way of aligning physicians' interests with larger organizational objectives.

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Although many of the recent organizational changes have been expressly designed to shift or at least solidify referrals, there is little hard evidence that referral patterns have changed significantly as a result. Identified referral shifts typically involve the realignment of physicians from one hospital to another, or the opening of a new service. Some new ambulatory care sites are emerging, typically in Cleveland at urban churches and malls, and are geared to the Medicaid population. Some evidence was cited that generalist physicians are providing their patients with care that previously might have been referred to a specialist. At the same time,

specialists reportedly are providing more primary care or moving fully into generalist practice as their incomes drop. One large physician group described how it assigned generalist medicine patients to specialists to fill their time and improve productivity. Primary and specialist physicians say they will adopt a disease management approach to provide the full spectrum of care across an episode of illness or the course of a chronic disease.

Respondents cite an increase in health education and prevention activities, some of these by HMOs and Medicaid managed care organizations and some by employers. The rapid turnover of health plans by employers has limited this activity, and two county health departments cited the growing volume of patients seeking immunizations at public health clinics as evidence of a decline in preventive services provided in the private sector.

Issues to Track

The organization of the Cleveland health care system has undergone swift and considerable change. Ownership and influence are being consolidated in a small number of emerging large hospital-physician networks. The future direction of the insurance market is uncertain, given the attempted sale of Ohio Blue Cross & Blue Shield and the anticipated entry of several national managed care plans. However, any effects of these dramatic organizational changes on health care access, cost and quality are not yet apparent.

Most respondents believe that the numbers of uninsured have not changed measurably during the past three to five years. Although the shift in the region's job base from manufacturing toward service sector employment may have reduced or eliminated employer-based coverage for some workers, access to affordable health insurance for owners and employees of small businesses reportedly has increased as a result of COSE's activities. For the insured population, most observers believe that access to services has not changed appreciably. Health plan restrictions on access to specialists are few; the supply of primary care and specialty physicians is more than ample, and waiting times for appointments are described as reasonable. Networks tend to be broad and geographically extensive.

A few concerns were cited. Respondents said the use of generalists for management of chronic illness is inappropriately encouraged. Inadequate preventive care (i.e., immunizations) persists, they noted. Finally, respondents expressed concern that nonclinical personnel are used to make decisions about authorizing specialty care.

The consensus view is that premium costs have flattened or dropped in the last five years. But while purchasers are getting better deals from plans (and plans are getting better deals from providers), mainly through discounting, it is unclear whether these savings are being passed on to consumers.

The community at large and the health care sector believe that quality of care has been and remains high. As discussed earlier, the Cleveland Health Quality Choice initiative has focused more attention on quality of care. It is unclear, however, whether quality will become a more important factor in health care purchasers' decisions.

Significant questions remain about the shape of Cleveland's health system, and, in particular, about the balance of power among purchasers, providers and insurers:

- Will employers start to assert themselves more as purchasers and apply more pressure on health care organizations? Will they work with health plans to increase the presence of managed care, or will they seek direct contracting arrangements with major provider organizations? Will they use information on health care quality in their purchasing decisions?
- How will the implementation of managed care in Medicare and Medicaid affect the rest of the market? Will it drive a broader conversion to managed care? Will Medicaid recipients remain with their traditional providers or will they become the focus of intense competition?
- How will the entry of national for-profit hospital and managed care organizations in this market play out? What will happen to safety net providers that traditionally have cared for the poor and uninsured? What does the future hold for Ohio Blue Cross & Blue Shield, long the dominant insurer, and how will that affect insurers, providers and consumers?
- How will the three large emerging provider systems ultimately structure themselves: through ownership, contractual affiliation or through vertical or horizontal integration? Will there be a consolidation of current provider capacity and a reduction in underlying costs? Taking a broader view, will these changes affect clinical services and patient care? Will there be true integration of services at the clinical level, as many observers envision, or will consolidation remain chiefly administrative?

NOTES

1 American Hospital Association, *Guide to the Health Care Field,* 1995/1996.

2 *1996 County and City Extra: Annual Metro, City and County Data Book,* ed. Courtenay M. Slater and George E. Hall, Lanham, MD: Bernan Press, 1996.

3 *Greater Cleveland Fact Book,* Research Department, Greater Cleveland Growth Association, 1995.

4 National Center for Health Statistics, Centers for Disease Control and Prevention, March 1997. Data are for 1994.

5 Ohio Department of Health, Selected Vital Statistics by Race: Number and Rate, Selected Counties in Central Ohio, 1994.

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

7 *Ibid.*

8 American Hospital Association, *Guide to the Health Care Field,* 1995/1996.

9 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.

10 American Hospital Association Annual Survey of Hospitals as reported by the Greater Cleveland Hospital Association.

11 Respondent report.

12 *Cleveland Plain Dealer,* March 13, 1997

13 Ohio Department of Human Services, Managed Health Care Section. Data derived from the MMIS BORO 10EZ-R001 report, 1996.

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