THE HEALTH CARE SYSTEM OF ROCHESTER, NEW YORK

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ITS HISTORY AND ACHIEVEMENTS

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This study was written in late 1987, a time of transition in the national and local health care systems. The data presented was current only as of 1987, but the patterns and trends identified have largely continued in the intervening three years.

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

Tables

Figures

APPENDICES

INTRODUCTION: THE ARCHITECTURE AND ACHIEVEMENTS OF ROCHESTER'S HEALTH CARE SYSTEM

Rochester's hospital planning of the 1960s has "probably saved Rochester businesses hundreds of millions of dollars and significantly strengthened their competitive position in industry nationwide."

Business and Health June 1986

"Rochester, New York—a model health care system...For decades, Rochester has been known for providing quality health care at a reasonable price...The magic ingredient has been the willingness of the business community to listen to the reasons for containment of the size of the hospital system and then supporting it."

New York Alive May/June 1983

"The Robert Wood Johnson Foundation today announced the first grant awards under its $16.2 million Community Programs for Affordable Health Care." The model for these programs is Rochester, New York's community coalition of businesses, health providers and consumers.

Princeton, New Jersey July 8 1983

"In 1982...Rochester's Medicare bill was 27 percent lower than the national average, and the lowest of 30 metropolitan areas."

The Washington Monthly June 1986

A model for other communities. Rochester's health care system is well known to corporate benefits officers and health policy experts across the nation. High quality health care is available in many places in the United States, but few communities can equal Rochester's triple achievement of:

- providing high quality health care
- at a moderate cost
- with near universal access.

The Rochester region's widely admired health care system did not "just happen." It is the deliberate product of 50 years' cooperative crafting by business leaders, local government officials, health providers, health insurers, and health planners. Over the years, many outstanding individuals have made important contributions to the shaping of the system.* These individuals developed and helped to institutionalize a regional process for developing constructive solutions to regional problems in health policy, a process that is now being strained by local and national changes.

Role of business community. Rochester industry has historically been dominated by large, home-grown corporations, and the executives of these corporations have been exceptional in their active involvement in community affairs. Social scientists underscore the critical role played by corporate leaders in the creation and shaping of the Rochester area health care system—individuals like Kodak executive Marion Folsom and Joseph C. Wilson, founder of the Xerox Corporation. The personal involvement of business leaders such as these in creating a community-wide health policy is one of the critical elements that has set Rochester apart from other communities and made possible its record of achievements in health care.

Health care for a region. From early on, community leaders like Folsom and Wilson have seen that the best value for health care dollars is a regional system of health care. A regional care system can be designed to assure that care is of high quality, to provide access to all residents, and to be efficient. The Rochester area has come closer than most areas in the nation to creating a regional system of care, but it has not been easy. Since health providers are usually the single most influential force in shaping a region's health care system and can reasonably be expected to do this in ways that benefit their own self-interest, progress toward a regional system has often meant arranging incentives for the region's providers to move in a direction opposite to the rest of the country. Also, the region's community leaders have moved health care toward a regional system by organizing countervailing consumer forces, so that the interests of both providers and consumers are represented in health policy decisions.

In most other regions of America, consumer forces to counterbalance the interests of providers have been weak or nonexistent. In these regions, health care is like Topsy: "it has just growed," and supplies and costs of health care are largely the outcome of countless independent, uncoordinated decisions by individual doctors, hospitals, medical schools and other providers.

A sense of community and a spirit of cooperation. In understanding the dynamics of health policy in the Rochester area, it is important not to overemphasize the tensions between the various health care interests. Coexisting with the tensions between interests, there have always been a widely shared, deep sense of community and a willingness to take part in cooperative solutions to community problems. The origin of these attitudes is unclear, but it is certain that this pervasive orientation in Rochester's health care community sets it apart from others in the nation, and has given rise to a large number of innovative health care projects that are the cooperative creation of many community interests, including providers of care. Such projects are rare in other communities.

The foundation of the Rochester area's health care system was laid in the 1930s. The story of its construction and a description of its achievements are told in the following pages.

*Appendix I is a chronology of notable events in the development of the Rochester region's health care system. Some readers may find it helpful to refer to the chronology while reading this report.

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I. THE FIRST QUARTER CENTURY: 1935–1960
HEALTH IS A COMMUNITY AFFAIR

The Rochester area health care system is unmistakably an outgrowth of a region in which there is a widely shared sense of community. The health care system embodies the community's characteristic approach to the handling of community-wide concerns that was established by Rochester's business and corporate elite during the first quarter of this century (McKelvey). The essence of this approach—systematic and cooperative group action based on the best expertise and research available—is also to be seen in the United Way of Greater Rochester, one of the nation's best organized and successful United Ways, and the Industrial Management Council, the highly regarded employer organization.

As early as the 1930s, Rochester's community leaders were concerned about the availability of health care for all persons in the community. Characteristically, they dealt with this concern by supporting development of a non-profit organization that could rationally manage the reimbursement of health care services on a community-wide basis. In 1935, Kodak fostered the establishment of the Rochester Blue Cross Plan, and subsequently embraced it as insurer to its employees. Other local companies followed close behind and, by 1941, 44% of Rochester's population had health insurance coverage, at a time when only 10% of workers nationally had any health insurance (Smillie).

Civic leaders were also concerned about the affordability of health care. In part, their concern was to keep health insurance premiums affordable for their workers who, in those days, paid their own premiums. Another reason for their concern was that charity care for the uninsured was largely paid by business contributions.

To address these concerns about availability and affordability of health care, Rochester community leaders started in the 1930s to introduce a measure of public accountability into decisions about health services and facilities in the region. They invited national experts to Rochester to conduct objective studies of health care provisions. The kind of questions posed to these experts were:

> Does Rochester have enough hospital beds?
> Are Rochester's hospitals efficiently managed?
> Would there be economies in greater cooperation between hospitals?

One example of the recommendations made by these experts comes from the 1938 McComb Report to the Community Chest:

> "We recommend the reorganization of the independent voluntary hospitals into a hospital *system* which under central management will be able to promote better distribution of patients, consolidation of service facilities common to all, more intelligent planning of general and special hospital services, and eliminate competition, duplication and overlapping of hospital functions." (McComb)

Corporate executives and Community Chest directors used these study findings as the basis for their decisions on allocation of charitable contributions.

A. TWO CRITICAL DECISIONS

During the second half of the 1930s, Rochester's industrial leaders made two decisions important to Rochester's health care future. They agreed:

- that the local Blue Cross plan should be the principal health insurance carrier, and
- that all companies' health insurance would be community rated.

1. Blue Cross as the dominant insurer

From its start, Rochester Blue Cross was unusual in its links with local industry and business. The Rochester Blue Cross Plan was formed through the collaborative efforts of the chief executive of Strong Memorial Hospital and community business leaders. In most other regions of the country, Blue Cross plans were started by the hospitals as a means to guarantee payment of hospital bills, and most Blue Cross plans continued to give their primary loyalty to the hospitals at least until very recently.

The ability of Rochester Blue Cross to represent the business community's interests to hospitals and other health providers has been enhanced by its dominance of the regional health insurance market. As recently as 1980, the Rochester Blues' market penetration typically ran at about 80%, one of the highest market penetrations of a single insurer in any region in the nation. In regions where a number of health insurers divide the market, the business sector's collective interests in decisions affecting the cost and design of the regional health care system may go largely unrepresented since effective representation of their shared interests probably requires that employers create a regional organization, such as a business health coalition, to speak for them in regional health policy matters. Yet, as recently as five years ago, there were only a handful of business health coalitions in the nation. As a result, employers' shared interests were generally not well represented in decisions that shaped regional health care systems.

2. Community rating, with a community-wide risk pool

Community rating in Rochester. The decision of Rochester employers that all local companies' health insurance would be community rated meant that all local companies would be together in the same insurance risk pool—the community pool—and all companies' employees would pay equal rates for equal coverage. This decision which is still in effect today has given the term "community-rating" a different meaning in Rochester than elsewhere.

Community rating elsewhere. During the 1960s in other communities, many medium and large employers demanded experience rated insurance and withdrew from their localities' community rated pools. Only employers unable to purchase experience rated insurance were left behind in the "community rated pools." In effect, this turned the so-called "community rated pools" into "assigned risk pools." Companies in these pools tended to be small employers, many of whom had work forces with high health costs; the result was costly "community rated" premiums.

By 1970, this transformation of what had originally been genuine community risk pools into assigned risk pools was the norm for most of the nation. Today in most communities, the only employers in the community rated pool are those who cannot qualify for experience rated insurance. Larger employers either self-insure or have experience rated insurance for which they pay the actual cost of their employees' health care plus the insurance company's fee for administering the insurance contract. When these employers become concerned about insurance costs, they tend to focus on methods of shifting some of the costs onto employees such as incorporating deductibles and co-payments into their employee health plans. They are likely to ignore the causal factors discussed below which drive the regional level of health costs.

B. THE HISTORIC IMPACT OF COMMUNITY-WIDE RATING AND A COMMUNITY APPROACH

The decision in the 1930s that all Rochester businesses would be in the single community-wide insurance pool has had a number of important consequences. Most important for Rochester's health care future, it gave every company a direct interest in the shape and size of the region's health care system.

1. Early concern with cost-effectiveness in the health care system

When a company's insurance pool is region-wide, the company's executives can easily relate their health insurance premium rates to the region's per capita cost of health care. As a result, Rochester's business leaders were among the first in the nation to understand that:

- excess regional hospital capacity of any type increases cost without improving care;
- duplication of high cost, technologically sophisticated equipment needlessly drives up per capita health costs and wastes corporate and community resources; and
- simultaneous constraint of expensive forms of care and development of cost-effective substitutions holds down per capita costs and insurance premiums. Moreover, the sick persons thus served are able to receive care on the level most appropriate to their needs.

While corporations in other parts of the country remained almost oblivious to or puzzled by their rising expenditures for employee health care, Rochester's business community was already actively working within the community health planning process to influence the basic factors that drive health care costs. Rochester's affordable health insurance premiums are evidence of their success.

> "All our efforts in developing Rochester's health care system required community leadership. It would have been very hard to achieve this with business leaders who did not pay the same rates."
>
> Dr. Ernest Saward, Professor of Social Medicine, University of Rochester Medical Center.

2. Community rating appears to have widened access to health care by making health care affordable for more people

In the United States, health insurance is the admission ticket to health care. The insured have access to health care providers and facilities that are among the world's best. But the uninsured experience serious problems in obtaining timely health care of good quality even though the uninsured have more health problems, get less health care, and accrue an ever-increasing backlog of economic, social and health problems.

In 1984, 35 million Americans, including 2.4 million New Yorkers, had no health insurance (Bureau of the Census; Signalhealth). Moreover, lack of health insurance is an increasing problem.

- The number of uninsured New Yorkers increased 23% in just 4 years between 1980 and 1984 (Signalhealth)
- The number of uninsured Americans increased 22% between 1979 and 1984 (Bureau of the Census, 1984)

Contrary to the popular belief that the uninsured are mostly unemployed persons, the majority of the uncovered population are working or are from working families. Fifty percent of New York State's uninsured are workers who do not have employment-related health coverage, and 80% are part of families in which someone is working. Thirty percent are children (Signalhealth).

The workers who are more likely to be uninsured are middle aged and older single women, the low income, the uneducated, and minorities. Low wages and lack of employer group health coverage are causal factors in their lack of coverage. Another factor is prohibitive premium costs. In most communities, health insurers either experience-rate their employers or lump small employers and the self-employed into a "catch-all pool" analogous to the "assigned risk pool" in automobile insurance. The resulting premiums can escalate beyond the reach of employer or employee.

In Rochester, not only has Blue Cross maintained a

community-wide pool, but the four HMOs also have community rated premiums. As a result, in this region healthy employer groups pay somewhat more than their costs and high risk groups may pay a lot less. Also, it has been the long-standing policy of the Rochester Blues, and is now the policy of all local HMOs to provide opportunities for small employers (one person or more) and lower-paid, disadvantaged worker groups to obtain the affordable premiums of its community-wide risk pool. Blue Cross/Blue Shield and the Rochester HMOs do this by extending the community rate to the Chambers of Commerce in their service areas as well as to organizations of small businesses and self-employed persons. These organizations can then offer insurance at the community rated premium to the small employers and self-employed persons who are their members. The Rochester Area Chamber of Commerce advertisement shown below, which appears regularly in local newspapers, illustrates the wide availability of insurance in the community-wide risk pool.

Rochester Area Chamber of Commerce

—Membership Benefits—
For Businesses and Individuals
PER QUARTER

BLUE MILLION
$193.24 Single $443.95 Family

GROUP HEALTH
$191.95 Single $489.55 Family

RHN
$198.79 Single $502.69 Family

BLUE CHOICE
$182.86 Single $483.01 Family

PREFERRED CARE
$186.79 Single $485.95 Family

FOR INFORMATION CALL
PAT SARUBBI 454-2220
ROCHESTER AREA
CHAMBER OF COMMERCE

The differential impact on less advantaged groups of a community-wide risk pool versus "assigned risk" community pools can be seen in the cost of health insurance for small employers and the self-employed compared to larger employers in the Rochester area and in two Southern Tier communities where larger employers have experience rated insurance or self-insure. The group health insurance rates of local chambers of commerce are used to illustrate typical insurance premiums for the self-employed and small employers.

TABLE 1-1. 1986 HEALTH INSURANCE FAMILY PREMIUMS PAID BY REPRESENTATIVE SMALL AND LARGE EMPLOYERS IN ROCHESTER, CORNING AND ELMIRA*

Insurance Source	Region		
	Rochester	Elmira	Corning
Chamber of Commerce	$1,776	$2,497	$3,277
Large Employer**	1,776	1,710	1,823
Chamber of Commerce premium as percent of large employer premium	100%	145%	180%

FLHSA. December, 1986

From Table 1-1, it is evident that the self-employed and small employers and their employees in the Elmira and Corning areas pay sharply higher premiums than medium and large employers—from 145% to 180% more. The reason is that the Elmira and Corning self-employed and small businesses are in a separate risk pool from mid-size and large employers which either self-insure or purchase experience-rated insurance. In Rochester, large, medium and small employers and the self-employed are all in the same risk pool and pay the same premium.

Employees of small businesses often must pay part or all the cost of their health insurance. For many of these workers, the Rochester family premium of $1,776 may be difficult to afford. However, the Corning premium of $3,277 may be completely unaffordable.

Does the wider access in the Rochester region to moderately priced health insurance result in a smaller percent of uninsured, compared to other regions? Community leaders in the health care field have long believed this to be the case, and a recent report of the Health Futures for Rochester Commission provides some empirical support for this assumption. Using econometric modeling methods, the Commission estimates that between 11,000 and 40,000, 1.2% to 4.5%, more persons under age 65 are insured in the Genesee Region† than would be the case if experience rating predominated in region's health insurance industry (Health Futures for Rochester). Also, in preparing this report, FLHSA prepared an estimate of the number of uninsured persons in the Genesee region. The estimate was made by subtracting the number of persons known and estimated to be insured from the total population of the region. This estimate, too, appears to support the belief that there are proportionally fewer uninsured persons in this

*Fully covered inpatient days are 120 in Rochester area, and 70 days in Elmira and Corning areas.

**Rochester figure is Blue Cross/Blue Shield premium. These large Elmira and Corning employers self-insure.

†In this report, "Genesee region" refers to the six-county service area of Rochester Blue Cross and Blue Shield. It includes Livingston, Monroe, Ontario, Seneca, Wayne and Yates counties.

TABLE 1–2. ESTIMATED INSURANCE COVERAGE OF THE POPULATION UNDER AGE 65 IN SIX–COUNTY GENESEE REGION, NEW YORK STATE AND UNITED STATES

Insurance Coverage	Genesee Region[1] 1986 (percent)	New York State[2] 1984 (percent)	United States[3] 1984 (percent)
Uninsured	8.7%	15.8%	17.4%
Insured	91.3%	84.2%	82.6%
Employer & other private	82.6%	70.7%	
Public	8.7%	13.5%	
Total	100.0%	100.0%	100.0%
Population	888,600	15.4 million	195.6 million
Number of uninsured	77,350	2.4 million	30.3 million

Sources:
1 FLSHA estimate of the number of insured in Livingston, Monroe, Ontario, Seneca, Wayne and Yates counties in June 1986. See Appendix 3 for estimation procedures.
2 Signalhealth, *New Yorkers are Losing Their Health Insurance*. Calculations from 1984 *Current Population Survey*, Bureau of the Census.
3 ESRI Issue Brief, "Employer-Sponsored Health Insurance Coverage," calculations from 1983 and 1985 *Current Population Surveys*. Excludes persons employed in agriculture or the military and members of their families.

region than other regions.* The proportion of the population under age 65 without insurance is estimated to be smaller in the six-county Genesee region than in New York State or in the United States. Less than 9% non-elderly residents in the Genesee region are estimated to be without health insurance. Comparable percentages for New York State and the United States are 16% and 17% (Table 1-2).

There are an estimated 77,350 uninsured persons under age 65 in this region. This is a disturbing number of persons with no financial coverage for health care, but it should be noted that this national problem is of smaller proportion in this region than in other parts of the country. If the state or national rates of uninsured prevailed locally, the number of local persons under age 65 without health insurance would be doubled.

Insurance coverage of older residents. Almost all Americans age 65 and over have federal Medicare insurance. But because Medicare provides incomplete coverage for acute illness and physician services and provides no coverage for prescription drugs outside the hospital, nearly all elders who can afford it have additional insurance to supplement Medicare. Almost 94% of the Genesee region's elderly Medicare beneficiaries are estimated to have this extra protection: only about 6% are without it (Table 1-3). Nationally, the percent of Medicare beneficiaries without supplemental insurance is three times as large.

*The estimation procedure is described in Appendix III.

TABLE 1-3. ESTIMATED SUPPLEMENTAL INSURANCE COVERAGE OF ELDERLY MEDICARE ENROLLEES IN SIX-COUNTY GENESEE REGION AND UNITED STATES

Insurance Coverage	Genesee Region[1] 1986 (percent)	United States[2] 1984 (percent)
Medicare supplemental	93.7%	79.9%
Private	86.4%	67%
Medicaid	7.3%	13%
Medicare only	6.3%	20.1%
Total	100.0%	100.0%
Number of Medicare enrollees	119,950	25.6 million

Sources:
1 FLSHA estimate of insurance coverage in Livingston, Monroe, Ontario, Seneca, Wayne and Yates counties in June 1986. See Appendix 3 for estimation procedures.
2 Congressional Budget Office calculations based on the Survey of Income and Program Participation and the 1980 National Medical Care Utilization and Expenditure Survey, April 1984.

Some indirect evidence which tends to confirm the FLHSA estimate of a high proportion of insured persons in the Genesee region is the small amount of uncompensated hospital care provided in this region compared to other regions of upstate New York. This would be the expected result if an exceptionally high proportion of the Genesee region population is insured, relative to other regions. Newly available 1985 hospital data show that only 2.6% of hospital costs in the Genesee region were for care of patients without insurance or otherwise unable to pay the bills. This compares to 3.8% in the Syracuse area and 4.5% in the Buffalo area (see Table 1-4).

TABLE 1-4. UNCOMPENSATED CARE AS A PERCENTAGE OF REIMBURSABLE COSTS IN UPSTATE NEW YORK HOSPITALS BY HOSPITAL REIMBURSEMENT REGION, 1985

Hospital Reimbursement Region	Bad Debt and Charity Care as Percent of Reimbursable Costs[1]	
Western	4.5%[a]	
Utica	4.0%	
Watertown	4.0%	
Central	3.8%[b]	
Northeastern	3.1%	
Genesee region	2.6%	
Monroe & Livingston cos.		2.6%
Ontario, Seneca, Wayne & Yates cos.		2.7%

FLSHA

Data sources:

—Bureau of Health Economics, Division of Health Care Financing, NYS Department of Health, provided dollar amounts of the payment bases for the Genesee Region's two experimental payment projects and bad debt and charity care provision for regions other than the Genesee region.

—Bureau of Hospital Reimbursement, Division of Health Care Financing's worksheets for calculation of 1985 New York State bad debt and charity care pool add on are source of regions' total reimbursable costs for other than Genesee region.

—Genesee region bad debt and charity care provision is from 1985 submitted Blue Cross Supplements and 1985 I.C.R.s.

1 For Genesee region hospitals, the 1985 payment bases for the hospital payment experiments are used as proxies for total reimbursable costs.

a Does not include Roswell Park Memorial Hospital. a specialized cancer research hospital.

b Includes the seven hospitals of the Finger Lakes region's southernmost counties (Chemung, Schuyler and Steuben).

If the estimate is correct that proportionally more persons are insured in this region than others, it is likely that access to health care is also better in this region than others. This is because access to health care is heavily dependent on possession of insurance coverage (Davis and Rowland).

3. Hospitals have fewer uncollectible bills

For the wider community, the region's larger proportion of insured reduces the need to provide charity care. This means the region's hospitals and other health providers are not burdened with the provision of large amounts of uncompensated care—a burden which ultimately comes back to corporations in the form of higher premiums and to taxpayers in the form of tax increases.

C. FUTURE ISSUES RELATED TO COMMUNITY-WIDE RATING AND A COMMUNITY APPROACH

Community-wide rating. Health care organization and financing is in a period of rapid change both locally and across the nation, and some of these changes raise questions about the viability of continuing a community rated approach to insurance. Executives in charge of employee benefits are increasingly concerned about their immediate bottom line, and are often unaware of the long term benefits of community rating to their corporations and the community in which they are located. Up to the present, the Rochester Blue Cross and Blue Shield Plans have been able to convince local employers to continue their support of the policy of community rating for all. However, the Blues Plans are under almost continuous pressure from one or another employer to abandon the policy. Similarly, HMOs are being pressured to move away from the community rating of all premiums. In the long run, continuation of community rating for all employers may require a conscious recommitment to the policy by local industries.

Implications of the growing number of insurers. Initially, all of Rochester's HMOs were either entities or affiliates of Blue Cross and Blue Shield. However, the Preferred Care/RHN HMO is independent of Blue Cross, which is a desirable change to the extent it has introduced competition into prepaid health care in the region.

It is also a change that has implications for regional health policy making. As recently as 1980, Blue Cross could accurately claim to represent "the interests of all Rochester employers" in negotiations with the hospitals and other providers. With Preferred Care and RHN's increasing shares of the market, neither Blue Cross nor any other insurer can now make this claim. The future effects of this fragmentation of the region's insurance market on health policy making are uncertain. Up to the present, there has been cooperation among insurers in arriving at community solutions, as illustrated by the HMOs' continuance of community rated premiums. However, the segmentation of the insurance pool may increase still further through such initiatives as preferred provider organizations (PPOs). A number of observers believe this segmentation of insurers in combination with growing competition among providers will decrease the Rochester area's historic ability to develop regional health policies. These observers expect an increase in policy decisions that further provider, insurer, or sub-regional interests without consideration of possible adverse impacts on other interests and the regional health care system. On the other hand, community leaders in this region have time and again demonstrated a remarkable capacity to develop organizations in which all interests are represented and which are able to arrive at area-wide solutions. Perhaps they will do so again.

D. THE FIRST QUARTER CENTURY A SUMMARY

The foundation of the Rochester region's present-day health care system was laid in the 1930s. From the beginning, corporate leaders worked with the hospitals and physicians to develop accessible, affordable health care for area residents. For example, Rochester employers led the country in the 1930s in enrolling employees in group hospital insurance.

Public accountability. To address their concern that health care be accessible and affordable, community leaders started the practice of commissioning expert studies of Rochester's health care system. The public accountability which this practice injected into their decisions about size and shape of the region's health care system forms an important part of the foundation of Rochester's health care system.

Blue Cross. The creation and early dominance of the Blue Cross hospital insurance corporation is the second major pier in the foundation. Uniquely in Rochester, the founding of Blue Cross was a collaborative undertaking of the hospitals and the area's corporate employers. This was soon followed by the area-wide agreement of major employers to use the Blue Cross Plan as their insurer, making Blue Cross the region's dominant health insurance company. For half a century, this dominant position enabled Blue Cross to effectively represent the Rochester area business sector's collective interests in decisions affecting the cost and design of the regional health care system.

The special nature of Rochester's health care system is embodied in a series of organizational innovations. The first important organizational innovation was the relatively more important role of employers and more modest role of hospitals on the Rochester Blue Cross' board of directors compared to other Blue Cross organizations.

The community-wide risk pool. The third major pier in the foundation is the single community-wide risk pool. Participation in this broad health insurance risk pool has given every company a stake in the size and shape of the region's health care system, and led to corporate involvement in community endeavors to control health care costs. Also, the community-wide risk pool has given an exceptionally large proportion of the population access to affordable health insurance and has provided revenue stability for the region's hospitals.

In the 1960s, these three elements would provide a firm foundation for development of community health planning.

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II. THE DECADE OF THE 1960s MANAGING THE HEALTH CARE SYSTEM

All across America during the 1960s and the 1970s, health insurance companies were issuing "blank checks" to hospitals and physicians and passing on the soaring health care bills to America's corporations. Between 1960 and 1980, the nation's health care bill increased from 5.3% to 9.5% of the gross national product, and from $250 million to almost $250 billion. Much of the skyrocketing increase in health care expenditures could be directly traced to the unrestrained construction of more and more hospital beds resulting from the irresistible lure of easy access to capital. A hospital bed built was a bed filled; and the bills were paid by employers and taxpayers. Many regions saw their hospital capacity grow from 3.5 beds to 5.5 or more beds per 1,000 and their per capita health expenditures increase proportionally.

A. THE BIRTH OF HEALTH PLANNING

This multiplication of hospital beds never occurred in Rochester. In 1960, Rochester's seven hospitals proposed a number of expansion projects with total costs of about $30 million with each hospital expected to have the final word in determining its own size, configuration and location. But Kodak Vice President Marion Folsom, newly returned to Rochester from his post as President Eisenhower's Secretary of Health, Education and Welfare, was asked to chair the fund drive's allocation committee. Folsom accepted on the condition that the existing allocation committee be disbanded and a new committee formed. (The membership of the original committee was 12 hospital representatives plus the chairman.) According to one account, Kodak refused to donate to the Hospital Fund unless the hospitals agreed to Folsom's demand (Puskin).

Folsom then organized the nation's first community health planning council, carefully choosing as committee members persons of influence in the community and representative of all groups with legitimate interests in the community's health care system—consumers, hospital administrators, physicians, business, and government.

The new committee's first action was to ask for an objective assessment of the community's hospital needs. It requested an objective evaluation of the current use of hospital beds in Monroe County's seven acute care hospitals. By determining the proportion of hospital beds being occupied by patients who did not need hospital care, it would be possible to more accurately estimate the number of hospital beds needed in the future. This pioneering study was designed and directed by health researchers at the Council of Social Agencies* and the University of Rochester Medical School. The

actual evaluation of hospital inpatients was conducted by 28 physicians selected by the Monroe County Medical Society who found that 16% of hospital beds in the county were occupied by patients who did not require them for medical reasons.

With this supporting evidence, the planning council made a 70% reduction in the number of new beds to be built in the community and a 53% reduction in the campaign goal—from $30 million to $14 million (Conant).**

From their earlier experiences on Rochester Community Chest committees, many members of this first health planning council were probably already familiar with the cost and quality benefits when a community planning agency deals with issues of social need on an area-wide basis rather than attempting to deal separately with the multiple requests from facilities and agencies. In more recent years, the Industrial Management Council has periodically reminded its employer members of the benefits of dealing with health care issues from a community-wide perspective.

The structure and process which Folsom devised for community health planning became the model for this region and the nation. The structure is an independent, broadly representative council composed of payers, consumers and health care providers. The process is one of open decision-making on health policy issues, informed by objective research and giving consideration to all interests. The goal of this process is to develop community solutions which have broad support in all sectors of the community.

The Finger Lakes Health Systems Agency (FLHSA), the Rochester region's present-day health planning agency, is a direct descendant of that 1961 health planning council. In the intervening years, the health planning agency has gone through several name changes which have coincided with enlargements of the planning area and/or new state or federal health planning legislation. Each successive agency has incorporated its predecessor.

Folsom's original design for health planning has been widely copied. It has served as the model for:

- The 1966 New York State legislation
  - —requiring that proposed expansions and renovations of health care facilities and addition of new health care services be submitted to the state government for authorization, which is based on objective evaluation of regional need (the "Certificate of Need" law).
  - —and creating regional health planning councils in all regions of New York State (the "Folsom Law").
- The 1967 federal "Partnership for Health" legislation, which authorized federal funds to the states for comprehensive health planning.
- The 1974 Comprehensive Health Planning and Resource Development Act. This federal legislation created a national network of regional health planning agencies, and encouraged states to use objective standards of health care need to appropriately set the capacity of their health care systems.

B. ESTABLISHING A PERMANENT, INDEPENDENT HEALTH PLANNING AGENCY

During the 1960s, two local organizations shared and sometimes vied for authority over health planning: the regional hospital council and the community planning council created by Folsom. Finally, late in the 1960s, there was a prolonged struggle over the future of health planning in the Rochester region. Would it be controlled by a lay-dominated council or a provider dominated council?

Background. The effectiveness during the 1960s of the Folsom-created, lay-dominated Patient Care Planning Council and its immediate successor organization, the Health Council of Monroe County, derived in large part from Marion Folsom's personal influence and determined leadership. During the same time period, the Rochester Regional Hospital Council, a provider organization, held state designation as the regional review authority.

Marion Folsom held key positions in both organizations, and was usually able to gain the endorsement of the hospital council for the recommendations of the lay-dominated community planning council. But as time passed, Folsom became increasingly "skeptical of the efficacy of a hospital-based...organization planning for health facilities when it was basically a trade union for those same facilities" (Puskin). He was also concerned with the long term viability of a community planning agency whose authority derived largely from his own personal influence in the community. With others, Folsom worked to institutionalize this personal power in an organization with a legal mandate and a funding source.

The struggle between the hospital council and the community council for control of health planning crystallized in the competition for state designation as the new, and much more powerful comprehensive regional health planning agency. Folsom wanted an agency in which providers would have only minority representation. But significant hospital interests wanted to win the designation for the hospital council.

*For the first years of its existence, Folsom's community health planning council did not have its own planning and research staff. The council's staff work was done by the Health Division of the Council of Social Agencies, which was part of the Community Chest. In 1966, the Health Division was spun off from the Council of Social Agencies and became the planning and research staff of the county-wide health planning council.

**Other achievements of the first health planning council are described in Appendix I: Notable Events in Rochester's Health Care History.

"They maintained that only hospitals could plan for hospitals and that the most effective means of lobbying for hospital interests was to play a strong role in the planning process" (Puskin).

The battle for official designation was prolonged and so bitter that a special representative "Committee of 7" was formed through the auspices of the Monroe County Medical Society in an attempt to avoid public confrontation between the two agencies. Finally, the community council won offical designation. Although the actual decision-making was dominated by a few people in private negotiations which are not recorded, it is likely that Marion Folsom's great influence in Rochester's industrial and financial sectors was critical to the outcome.

Folsom's victory set Rochester apart from other regions of the nation. It has given lay representatives, supported by professional health planners, a continuing, influential position in the regional planning process. It has meant that consumers, and civic, financial, and industrial interests have been able to play an active role in shaping the regional health care system (Puskin).*

Corporate support. From its inception, community health planning has had the endorsement and support of Rochester's corporations. They view health planning as a systematic, rational process through which to assure that people in this community have cost-effective, quality health care in the measure needed and at an affordable cost to citizens and employers. One illustration of the support of Rochester's corporate community for health planning occurred in 1982 when federal funding cuts threatened severe curtailment of the activities of the Finger Lakes Health Systems Agency. The Industrial Management Council backed the establishment of a community health planning fund under the auspices of United Way as a continuing means through which to address the financial viability of the agency.

C. HEALTH PLANNING GOALS AND ACHIEVEMENTS

The community's 1961 health planning decision on the appropriate number of hospital beds to meet the needs of area residents was one of many community health planning decisions taken between 1961 and 1986 that have influenced the nature of the region's health care system. Health planning in the Rochester region has had four primary objectives.

GOAL 1: To keep health care affordable by limiting the region's hospital bed supply and many other specialized services to the capacity objectively needed.

In the topsy-turvy economics of health care, supply has long dictated demand. Almost without exception, a regional increase in the quantity and technological sophistication of health services results in increased per capita health costs and is directly reflected in insurance premiums. The substantial regional variations in insurance premiums across the United States are very largely due to regional variations in the capacity of the regional health care system and correlated utilization rates.

General Motors' health insurance premiums for identical benefit packages for its employees in different regions illustrate the range of this variation, with Rochester located near the bottom of the range (Table 2-1).

TABLE 2–1. GENERAL MOTORS—OCTOBER 1983
HEALTH INSURANCE FAMILY PREMIUMS
FOR HOURLY EMPLOYEES
Insurance Plans Rank Ordered by Premium Amount

Rank	Region	Annual Premium
1	CALIFORNIA (SOUTHERN)	5,028
2	TENNESSEE—MEMPHIS	4,504
3	ILLINOIS	4,457
4	MISSOURI (ST. LOUIS)	4,374
5	TEXAS	4,159
10	SOUTH DAKOTA	3,863
15	WEST VIRGINIA	3,863
66	NEW YORK—ROCHESTER	2,088
79	RHODE ISLAND	948

SOURCE: General Motors

When cost differences per employee of this magnitude are summed for all employees, they add up to very substantial savings for Rochester area employers.

A large part of these savings are the direct result of Rochester's low rate of hospital utilization. General Motors' employee hospital use rates and costs provide a clear illustration of this relationship.

—In 1983, General Motors' Rochester-area employees and their dependents used 451 hospital days per 1000 insured persons, at a total cost to General Motors of $3.4 million. This was a "savings" to General Motors of $3 million over its cost had Rochester-area employees and dependents used hospital care at the General Motors' national average rate of 845 days per 1000 insured persons (General Motors data; FLHSA calculations).

Quality. Quality considerations have priority in the health planning process through which the needed capacity of the region's health care system is determined. In a number of service areas, quality of care is significantly improved by checking unneeded expansion of service sites, for example, by limiting the number of hospitals performing complex surgical procedures for which quality is directly related to volume. This relationship can be illustrated with open-heart surgery.

Open-heart surgery, including bypass surgery, is much safer in high volume open-heart surgery units than in low volume units. Other things being equal, hospitals performing fewer than 100 coronary artery

*The Puskin monograph contains a detailed account of the struggle for control of regional health planning and is the primary source for this abbreviated account.

bypass procedures a year have mortality rates that are two to seven times as high as hospitals performing at least 300 of these operations annually (Klett).

In the Rochester metropolitan area, regional health planning has limited to two the number of Rochester-area hospitals authorized to perform open-heart surgery—Rochester General Hospital and Strong Memorial Hospital. Absent the planning process, it is likely that four and possibly five metropolitan hospitals in the Rochester area would perform bypass surgeries.

Since 1981, both Rochester General Hospital and Strong Memorial Hospital have performed more than 300 open-heart surgeries a year. In 1985, 714 adult open-heart surgeries were performed by the Rochester General Hospital's two open-heart surgery teams and 458 by Strong Memorial's open-heart surgery team. This volume level helps assure the quality of open-heart surgery in this region. Had these 1,172 open-heart procedures been divided up between four or five hospitals, there would be cause for local concern about the quality of cardiac surgery.

The Rochester region has also realized considerable cost savings from restricting open-heart surgery to two hospitals. A hospital's unit cost for open-heart procedures is volume-sensitive, falling as quantity increases as the result of spreading out the high fixed costs of construction, training and equipment purchase over increasing numbers of procedures. The cost curve flattens out at a volume of about 500 surgeries a year, with the unit cost of open-heart surgery at a hospital volume of 500 per year approximately one-half the unit cost at a volume of 100 per year (Finkler). Both of the Rochester region hospitals which perform open-heart surgery are at or above this cost-efficient volume level.

In marked contrast to Rochester's planned limitation of open-heart surgery units is the situation in Phoenix, Arizona. In mid-1985, there were nine open-heart surgery units performing a total of 2,125 surgeries per year in Phoenix, Arizona then repealed its certification of need law and, within a year, four additional hospitals had initiated open-heart surgeries, averaging 125 surgeries per year per hospital. Within one additional year, another three hospitals were expected to initiate open-heart surgery units *(Today In Health Planning)*.

GOAL 2: Keep health care affordable by developing safe and appropriate cost-effective substitutions for costly forms of care while constraining the supply of these costly forms of care.

The development and insurance of organized, high level home care in Monroe County illustrates the type of actions that have been taken to implement this goal. Today, home health care is a booming industry nationwide but in the early 1960s it was unevenly available across the nation and, when available, limited to low level visiting nurse services for obstetrical and elderly patients.

The seed that led to the early development of high level home care in Rochester was an incidental finding in the nation's first systematic study of the appropriateness of placement and the quality of care of the chronically ill—conducted in Rochester in the late 1950s for the Community Chest's Council of Social Agencies. The study found that a number of the chronically ill patients in hospitals could be cared for in nursing homes and, incidentally, it also found that a number of the acute care patients could be cared for at home if high level health services were available in the home.

This finding stimulated Blue Cross to consider establishing a program to provide such services. The community committee formed to explore the issue was chaired by the general manager of Eastman Kodak and its members included Marion Folsom and hospital, medical society, health insurance and home care service representatives. The committee report recommended:

- that the home acute care program should serve the whole community and be independent of the hospitals. (Since hospitals had an interest in keeping their beds full, hospital-based home care programs might not realize their full potential.)
- that the structure of this new home care program be a central community office which would contract with the established home nursing services to deliver the various needed services. Cases would be divided evenly between the Monroe County Visiting Nurse Service and the Monroe County Health Department Nursing Service. (This arrangement recognized the political impossibility of favoring one nursing service over the other.)
- that the basic Blue Cross contract be expanded to cover these services in order to provide financing for this less expensive alternative to hospital care. (This new revenue source was sufficient incentive to induce the home nursing services to add acute care services to their capabilities. It exemplifies the redirection of health care monies from hospitals to cost-effective alternatives.)

The new program's patients were those who required intensive home care services (usually three or more services), without which they would have to spend more days in the hospital (Puskin). Some of the first beneficiaries of the new program were children in full body casts for correction of spinal problems. Previously they had lain for months in hospital wards; with the new home care services, they were able to be at home.

It was through the initiative of Blue Cross and with the backing of local corporate leaders that the nation's first area-wide program of intensive home care services was created. There was no active opposition by the community's health providers to its creation, probably because of the participation of their leaders in the planning process and the strong support of industry, but it is unlikely that local providers would have created a coordinated

community program without the continued encouragement and support of industry. With that support, providers have fully participated in a program which has grown and prospered for 25 years.

GOAL 3: Improve access and assure the quality of health care for low income persons and the uninsured.

The United States is alone among the world's industrially advanced countries in not having a program of universal health insurance. Those without health insurance or with government-funded Medicaid insurance, and those in geographically remote areas have difficulty obtaining health care and, when obtained, the quality may be inferior.

The Rochester area has not eliminated the access and quality difficulties of the uninsured and underinsured which are rooted in national policy. However, through its strong community planning process, it has been able to reduce these difficulties. Examples of cooperative planning achievements that have improved the health care of low income residents are Rochester's five inner-city neighborhood health centers and the merger of its municipal hospital with the university teaching hospital.

a. Obtaining early care: Rochester's neighborhood health centers

Americans generally obtain preventive and primary care from physicians in private practice. However, because of what are perceived as excessive paperwork requirements and inadequate reimbursement, many private practice physicians refuse to treat patients who have Medicaid insurance and also refuse to treat those who cannot pay. Moreover, many low income persons are unwilling to ask physicians for charity care. Geographic factors also contribute to the difficulty of the poor in obtaining care: in cities, few physicians establish their practices in low-income, inner city areas.

During the 1960s, Rochester and other American cities were in turmoil as inner-city black populations demanded improved economic opportunities and living conditions. One Rochester response to these demands was that the leaders of the black community, other lay community leaders, the health planning agency, and concerned physicians and other providers worked together to develop a plan for meeting the health care needs of the inner city population. At about this time, federal funds became available for comprehensive neighborhood health centers.

> "In August 1967, Mrs. Dorothy Wadsworth, a leading figure in Rochester civic affairs, received a call from Marion Folsom asking her to head a committee of the Health Council of Monroe County to study health services in the inner city. Mrs. Wadsworth put together a six-member committee representing the industrial and civic establishment of the city, which was assisted by a 64-member advisory committee representing a cross-section of local community and health interests in the inner city.
>
> "After a year's hard work, the Wadsworth committee released its report. It recommended a 'network' of neighborhood health centers in the poverty area that would use group medical practice to assure continuity of coordinated family care, offer psychiatric and dental care and make emergency treatment available on a 24-hour basis. It further recommended formation of a non-profit management corporation to plan and coordinate the activities of the two existing health centers in the inner city plus four prospective centers to be set in other sections of the city so as to allow easy access to medical care throughout the inner city" (Puskin).

The management corporation and three of the recommended additional health centers were successfully established—bringing to five the number of federally subsidized, inner city health centers linked together in a managed network. These centers have now been providing quality health care to Rochester residents for almost 20 years.

Federal funding made the formation of the network of health centers possible. The ability of health care leaders to mobilize community support for innovation and then to translate this support into the development of a new organization made the network of health centers a reality. Here, as in other steps in the evolution of its health care delivery system, Rochester has seemed almost poised to design and implement innovations as soon as the national or state environment becomes hospitable to them.

From their beginnings, the neighborhood health centers have extended their services to a broad cross-section of their immediate communities. Their intent was to avoid institutionalizing a dual system of care—one for indigents and another for the working population—as a means to help assure the quality of care provided to the medically indigent. Their mainstreaming of health care for the poor distinguishes Rochester's neighborhood health centers from those in other cities which concentrate exclusively on serving the poor.

The role played by the neighborhood health centers in providing health care to low income city residents is illustrated by some recent data. In 1985, the centers provided health care services to 20% (48,000) of the city population. Fifty-one percent of those served were below 100% of the poverty standard; this compares to only 14.5% of the city-wide population which is below 100% of the poverty standard (RHN Data).

A recent national study contains further evidence of the important role of Rochester's neighborhood health centers in providing care for groups traditionally at risk of poor access to health care (Singer; Children's Hospital—Boston). Patterns of health care access and use among handicapped students were compared across five urban school systems: Rochester, New York; Charlotte-Mecklenburg, North Carolina; Houston, Texas; Milwaukee, Wisconsin;

TABLE 2–2. AVAILABILITY OF A REGULAR SOURCE OF CARE. LOCATION OF REGULAR SOURCE AND IDENTIFICATION OF A REGULAR PHYSICIAN BY STUDY SITE

Characteristic	Regular Source of Care		Location of Regular Source				Regular Physician	
	No	Yes	Doctor's Office	Hospital Clinic	Other Clinic	ER	No	Yes
All special education students	7%	93%	63%	19%	8%	3%	26%	74%
Study site								
Santa Clara County	2	98	85	9	5	0	14	86
Rochester	2	98	48	25	22	2	14	86
Milwaukee	5	95	59	29	3	3	27	73
Charlotte	12	88	63	16	6	4	37	63
Houston	15	85	55	17	6	3	37	63

Source: Singer, et al. Health care access and use among handicapped students in five public school systems. *Medical Care*, 24:1–13 (1986)

and Santa Clara County, California. The Rochester and Milwaukee school districts are relatively poor communities, Charlotte and Houston are somewhat more affluent and Santa Clara County is the most affluent district. Although this study deals only with the approximately 11% handicapped of the elementary school population, it is likely that findings would be similar in a comparable study of the whole school population.

Table 2-2 compares access to care for the five urban school districts studied. Both Rochester and Santa Clara had almost total access, with 98% reporting such a source, compared to 85% in Houston and 88% in Charlotte. The important contribution of Rochester's neighborhood health centers to this high level of access is seen in the "location of regular source of care." For 47% of the Rochester sample, the regular source of care is a neighborhood health center (termed "clinics" in the study); this compares to only 14% in Santa Clara, 23% in Houston, 22% in Charlotte, and 32% in Milwaukee with clinic/neighborhood health center as regular source of care. Also, only 7% of Rochester and Santa Clara children were without insurance coverage, compared to 27% in Houston and 12% in Charlotte.

Because health care access is strongly associated with socioeconomic, racial and ethnic characteristics in the whole study group, the authors investigated whether this differential access also obtained in the individual communities. Table 2-3 permits a closer look at this issue, using the availability of a regular physician as the illustrative issue of access. In all communities except Rochester, the sociodemographic differences remain: nonwhite, poor, near poor, and low-income children were all at least twice as unlikely as their relevant comparison group to have had a regular physician. In Rochester alone, the sociodemographic differences were not statisti-

TABLE 2–3. ODDS OF NOT IDENTIFYING A REGULAR PHYSICIAN BY SELECTED DEMOGRAPHIC CHARACTERISTICS WITHIN STUDY SITES

Demographic Characteristic	Study Site (% With No Regular Physician)					Adjusted Odds Ratio (95% Confidence Interval)
	Santa Clara, CA	Rochester, NY	Milwaukee, WI	Charlotte, NC	Houston, TX	
Race/ethnicity						
Nonwhite	22	16	36	49	43	3.6[a]
White	9	10	13	17	15	(2.7, 418)
Simple odds ratio	2.9[a]	1.7	3.6[a]	4.6[a]	4.4[a]	
Poverty status						
Poor, near poor, low-income	19	13	27	46	44	2.7[a]
Not poor	11	16	15	17	14	(2.0, 3.7)
Simple odds ratio	1.9	0.8	2.0[b]	4.2[a]	4.6[a]	
Mother's education						
Non-high school graduate	24	13	33	47	46	2.3[a]
High school graduate	11	10	19	27	28	(1.8, 2.9)
Simple odds ratio	2.5[c]	1.3	2.1[c]	2.5[a]	2.2[a]	

The simple odds ratio is computed by dividing the odds of not identifying a regular physician among those in the risk group by the odds of not identifying a regular physician among those in the reference group. For example, in Santa Clara, the odds of not identifying a regular physician among nonwhites are 0.22/(1–0.22) = 0.2821, among whites, the odds are 0.09/(1–0.09) = 0.0989. The odds ratio is thus 0.2821/0.0989 = 2.9, as written in the table.

a $P < 0.001$. b $P < 0.05$. c $P < 0.01$.

Source: Singer, et al. Health care access and use among handicapped students in five public school systems. *Medical Care*, 24:1–13 (1986)

cally significant predictors of access to health care. There are similar differences between communities in handicapped children's actual use of medical care, with sociodemographic differences having the least effect in Rochester and Milwaukee.

Another factor contributing to the better access in Rochester compared to other study sites is the broad eligibility in New York State's Medicaid program. The findings of this national study illustrate the achievements of the region's health care system in general and the neighborhood health centers in particular in making health care more accessible than in other communities.

b. Obtaining hospital care

In areas of the nation which have both private and public hospitals, the private hospitals sometimes discourage or refuse admission to the Medicaid-insured and the uninsured poor. The public hospitals then become the major providers of care for these populations. Frequently overburdened and sometimes underfinanced, some public hospitals are unable to deliver high quality care. The result is one level of hospital care for the insured working and retired populations, and a second level of care for low income persons. In Monroe County as in a number of other urban areas, this potential source of two classes of hospital care was eliminated by merging the city-supported public hospital with the university teaching hospital.

Under Marion Folsom's leadership, the region's health planning agency proposed and negotiated the 1965 merger of Rochester Municipal Hospital with the University of Rochester's Strong Memorial Hospital. The merger had benefits for both Strong Memorial Hospital and the City of Rochester, but the greatest benefit over the long term has been to Rochester's low income citizens. Today in Rochester, all persons in need of hospital care are hospitalized in the same hospitals, without regard to social class or insurance status, and the region's uninsured and Medicaid insured do not experience problems in gaining hospital admission.

The neighborhood health center network and the merging of the municipal and university hospitals exemplify early community achievements initiated in the health planning process to improve access and quality of health care for low income persons in the Genesee region. Comparable community initiatives continue up to the present.

GOAL 4: Improve access and assure the quality of health care in towns and rural areas.

—The Regional Medical Program—

During the first half of the 1970s, the health care available in rural areas around and to the south of Rochester was improved by the collaborative accomplishments of the Regional Medical Program and the regional health planning agency, both of which had federal funding. The program increased physician and hospital expertise in the provision of preventive, primary and emergency care for heart disease, cancer and stroke in outlying towns and rural areas.

Background. The federal government's Regional Medical Program (RMP), enacted in 1965, was intended to take research findings on improved medical care out of the teaching hospitals and into rural America. But in most regions of the nation and initially in the Rochester region, the primary beneficiaries of the Regional Medical Program were the university medical centers rather than the inhabitants of outlying areas. RMP funds were largely used to expand medical school faculties for educational outreach programming.

In 1970, Washington realized that Regional Medical Programs were not having the desired effects on health care outside metropolitan areas; and regional programs were told to redirect their initiatives or lose their funding. The Rochester Regional Medical Program was one of the few that was able to make this shift in direction. The Department of Preventive Medicine and Community Health in the University of Rochester Medical School took the lead in redirecting the Rochester RMP and, by so doing, saved its $1 million annual funding. This redirection was so well regarded in Washington that Rochester's RMP was funded until 1976, several years longer than the RMP of any other region.

Regional planning of health care services. In this redirection, the new board of directors of the Regional Medical Program was deliberately overlapped with the board of the regional health planning agency. This unified leadership was able to use the complementary strengths of the two programs to maximum advantage. The health planning agency had a wealth of data about the region; it knew where and what the health care deficits of the region were. The Regional Medical Program had technical expertise and funds to stimulate or develop services to fill these deficits. Also, both programs were independent of established providers. The two programs' staffs worked closely together. The health planners' objective assessments of health care needs in the region were used by the Regional Medical Program's staff to allocate the federal funds where they were most needed. This symbiotic linkage of the federally supported planning program and resource development program occurred only in the Rochester region.*

Some illustrative joint achievements of this linkage are:

—the start of several rural primary group practices and several satellite clinics in parts of the region which had few or no medical practitioners.

—use of grant funds to stimulate the development of organized home care in the rural counties surrounding Monroe County.

*There was little or no coordination of the two programs in other regions of the country, with the result that there was almost no relationship between health care deficits identified by the planning programs and the distribution of seed monies by the RMPs.

—creation of a region-wide Emergency Medical Service (EMS). The EMS developed a continuing education program for ambulance service volunteers which raised the qualifications of the region's volunteers from sub-standard levels to the national standard. The Emergency Medical Service also allocated funds for a 50/50 match with local communities for equipping their ambulance services with 2-way radio systems. 102 of the region's 108 ambulance services took advantage of this offer.

National significance. Through their collaborative achievements, the Rochester region's cooperating programs demonstrated the feasibility of planning and allocating funds for health care services and facilities on a regional basis which helps to maximize the health benefits from limited funds. The success of this demonstration inspired the federal government's National Health Planning and Resource Development Act of 1974, which combined regional planning authority with seed monies for resource development. However, because the resource development funds were never appropriated, the national potential in the unification of planning with funding allocation was never tested. Rather, the 1974 Act provided federal authority and funding for state and regional health planning from 1975 to 1986.

D. HIGHLIGHTS OF THE 1960s

From the perspective of 1987, it is apparent that 1961 was a turning point for the Rochester region's health care system. The decision to limit the area's hospital capacity started this region's health care system down a developmental track that diverged from the main pathway followed by most regions. The regions that followed the main pathway allowed their hospital systems to keep expanding and, once overbuilt, hospital capacity has been *extremely* resistant to downsizing and extremely expensive for payers.

The Rochester region, to sustain its historic decision to limit hospital capacity, developed an effective community process for making health care policy. Through this process, the region has been able to redirect "savings" from undelivered hospital care into cost-effective care alternatives. For example, during the 1960s, the region developed intensive home health care services and increased the number of nursing home beds, and the region's standard health insurance contract was amended to cover these newly available forms of care.

In the 1970s, the early establishment of health maintenance organizations with their focus on the substitution of outpatient services for inpatient services would move the Rochester region further forward in the efficient delivery of health care.

• • •

III. THE DECADE OF THE 1970s MANAGING THE DELIVERY OF HEALTH CARE

The health care system that had evolved in America by the end of the 1960s was both costly and inefficient. The predominantly independent providers were reimbursed on a piecework basis for each service delivered. They were under no fiscal pressures or incentives to perform in a cost-effective manner, either individually or collectively. Duplication of services; provision of unnecessary or inappropriate services; routine use of the most costly forms of treatment available—all could occur since third-party payers were willing to pay the bills, no questions asked.

The advent of Medicare and Medicaid into this environment in the late 1960s significantly expanded the demand for health services, and triggered an explosion in health expenditures. Annual rates of increase in national health expenditures went from a range of 7% to 9% to rates of increase exceeding 12%. By 1970, explosion in their health care expenditures had made federal and state health officials receptive to any innovations that might bring management skills to bear on the many inefficiencies in health care delivery.

Rochester was well positioned to respond to the call for a better system. Rochester's large employers had long-standing interest in cost effective improvements in the organization and management of health care and were active supporters of community health planning. Also, the community's providers, planners and payers had already started to accumulate experience in the planning and implementation of innovations in health care delivery and reimbursement.

Beginning in the 1970s, Rochester began to lead the nation in the design and establishment of management organizations which coordinate the activities of multiple providers to achieve cost-effective health care. The first generation of these integrating organizations was developed in the decade of the '70s and specialized in providing cost-effective care to individual patients. Earliest were the health maintenance organizations (HMOs) which at first provided health care only to employer group members. Later in the 1970s, organizations were developed to arrange and manage comprehensive home care services for two special populations: ill elderly persons who would otherwise need to enter nursing homes, and terminally ill persons who would otherwise be in acute hospitals or nursing homes.

A. HEALTH MAINTENANCE ORGANIZATIONS IN THE GENESEE REGION

Rochester was the first mid-size city in the East or Midwest to give birth to health maintenance organizations. Popular acceptance of HMOs came first in the Far West, during the post-World War II years, and was slow in spreading eastward. Until 1973 when the first Rochester HMOs opened, the only HMOs outside the West were one each in New York, Boston and Washington.

Physician opposition. Successful establishment of HMOs in Rochester was a hard won victory. In 1970, a majority of physicians in Rochester and nationally believed that the start of group practice HMOs would be the beginning of the end for the private practice of medicine. The group practice HMO, in which care is provided at a single health center site by salaried physicians and other health personnel, was an anathema to most physicians in office-based, fee-for-service medical practice. In Rochester and other cities, physicians fought hard to prevent the opening of such HMOs and in most cities, this physician opposition coupled with physician influence in Blue Shield plans made it impossible to start group practice HMOs in the early 1970s. In Rochester, physicians made it difficult to establish a group practice model HMO, but they were not able to prevent it. Moreover, Rochester physicians did not follow the pattern common elsewhere: they did not form a united front to oppose the introduction of HMOs. Rather, a part of the local physician community responded positively to the challenge of a group practice HMO by creating an alternative type of HMO, one in which care was provided by private practice physicians in their own offices.

Support of the president of the Xerox Corporation. Joseph Wilson, president of the Xerox Corporation, was the prime mover behind Rochester's early establishment of HMOs. During the late 1960s and up to his untimely death in 1972, Wilson was one of the most influential persons in Rochester and he had a deep interest in health policy. In Rochester, Wilson had a close aide who represented his views and kept him up-to-date on local health affairs. Outside Rochester, Wilson chaired or sat on a number of state and national commissions investigating health policy options. His personal investigation into the factors pushing health cost escalation had made him an advocate for the development of more HMOs "as one way to produce voluntary movement toward efficient, effective and more economical health care systems" (Governor's Steering Committee on Social Problems). Wilson's backing of HMO expansion in Rochester and nationally was concurrent with the growing concern in Rochester about health care costs. His intense interest in health policy coupled with his influence in the community were important and probably critical in the early establishment of HMOs in Rochester.

1. Corporate endorsement of the establishment of HMOs

Late in 1968, Rochester Blue Cross presented its 5, 10, and 15-year projections of health insurance costs to the local employer service organization, the Industrial Management Council (IMC). Shocked by the magnitude of projected escalations in costs, the IMC urged formation of a community task force to evaluate possible methods of restraining health care costs.

The task force was chaired by William von Berg, a senior executive of the Sybron Corporation, and had representatives from labor, business, Blue Cross, Blue Shield, the hospitals and the medical profession. From the outset, it was clear the task force would consider local development of an HMO as one way to contain costs. In 1970, this meant development of a multispecialty, prepaid group practice providing services from a single location, patterned after the Kaiser HMOs on the West Coast. At that time, this was the only HMO model with a proven track record in cost-effective delivery of high quality care.

The physician representatives on the task force made their support of the task force recommendation for establishment of a group practice HMO conditional on a second recommendation by the task force—the simultaneous start of an "independent physician association (IPA)" HMO sponsored by the Monroe County Medical Society. Like the group practice HMO, the IPA was to be underwritten by the Blue Cross and Blue Shield Plans of the Rochester area. The industry members of the task force reluctantly acceded to this demand as the price of reducing physician opposition to the health center-based, group practice HMO.

The task force also supported development of a third HMO, to operate in conjunction with the neighborhood health centers being established to serve low income, inner city residents. Local community endorsement for this HMO was a federal condition for funding the neighborhood health centers.*

In business terms, it was clearly a mistake to simultaneously open three HMOs in a community where most of the population had never heard of HMOs and lacked any understanding of the differences between conventional health insurance and membership in a prepaid health plan. Moreover, two of the HMOs, Health Watch and RHN, would utilize almost untested formats. But the decision to

*The group practice HMO would be called the Genesee Valley Group Health Association (GVGHA). The medical society-sponsored IPA would be called Health Watch. The HMO allied with the neighborhood health centers would be called Rochester Health Network, or RHN. Health Watch started operation in 1973 at the same time as GVGHA and RHN, and went out of business in 1976 when the premium levels required to cover its costs made it non-competitive (Sorenson, et al., 1980).

start with three HMOs was a compromise which, like many compromises, made better political than business sense. Rochester industrialists were divided in their attitudes toward formation of the new health plans.

> "Some industrialists favored the direct competition between the usual fee-for-service mechanism...and a single program of prepaid group practice. Some favored open support for the Medical Society's Health Watch. Other business leaders wanted to preserve the status quo, while some favored multiple new programs" (Sorenson, et al., 1980).

Those who supported the introduction of HMOs into Rochester agreed to this compromise in order to move ahead toward their goal.

The problems created by this first decision were compounded by a further decision of the Industrial Management Council that all three HMOs should be Blue Cross/Blue Shield ventures, to open on the same day with the same benefits and the same premiums and marketed by the same sales force. This was a strategy guaranteed to confuse the public about HMOs. "John Hostutler, general manager of the IMC...(later) observed: 'The cafeteria approach was a fiasco. It was an accommodation we felt forced to make'" (Sorenson, et al., 1980).

In hindsight, it is evident that these early decisions forced HMO development in Rochester along an unnecessarily tortuous path.

2. Overcoming physician efforts to prevent the opening of GVGHA

If the first stage in development of Rochester's HMOs was the process leading up to the corporate community's decision to support the establishment of three HMOs, the second stage was the battle between supporters of GVGHA, the group practice model HMO, and the group of physicians fighting to prevent its establishment. Because of the decision to place the Wilson Center on Rochester General Hospital (RGH) property, the most visible opposition to GVGHA was by the physicians on the RGH staff. The intensity of physician opposition to GVGHA is illustrated by a few incidents.

- **Obtaining the lease for land on which to build the Wilson Center.** RGH trustees initially followed the lead of the hospital's physicians who were unanimously opposed to leasing RGH land for the Genesee Valley Group Health Association's Wilson Health Center. This action of the trustees was reversed through the personal intervention of leading Rochester industrialists who called on the trustees to take a broader community perspective on this issue (Corsica-Guidici).

- **The Battle of Buell Woods.** The siting of the Wilson Health Center on RGH land was further complicated by environmental issues. Encouraged to investigate the issue by physicians, the Audobon Club contended that this siting would destroy Buell Woods, "site of the old Buell farm" and "the last virgin timber in Monroe County," and disturb the nesting place of the pileated woodpecker (Breo). This skirmish in the larger battle was won by GVGHA when expert forestry witnesses testified that the trees had already been doomed by construction of the expressway along the perimeter of the woods.

- **Physicians form a union.** A number of local physicians formed a physicians' union in order to have an organization dedicated to fighting initiatives of local industrialists and health planners which were seen as threatening physicians' professional autonomy. That physicians, a profession noted for its support of professional independence and autonomy, would take such a step in a community not renowned for pro-union attitudes is a measure of the depth of their antagonism to HMOs and other changes occurring in their professional environment.

These and other actions intended to stop GVGHA before it could start were finally unsuccessful, but they did delay its opening date.

3. Achieving financial viability

The third stage in the successful establishment of HMOs in Rochester was their achievement of financial viability. This was especially challenging in the Rochester environment with its low rate of hospital utilization. In general, HMOs are able to provide broader coverage of primary and preventive care with savings from reduced hospital utilization, and are still able to price their premiums to be competitive with Blue Cross. However, the Rochester region's low hospital utilization has kept Blue Cross premiums low. In order to remain competitive with Rochester Blue Cross at the same time that they cover more services, local HMOs must reduce hospital use rates below the already very low Blue Cross utilization rate.

In other cities experiencing major HMO development and growth, the health insurance market is different than in Rochester. In Minneapolis, for example, hospital utilization in 1978 was 800-900 days per 1,000, compared to Rochester's 560 days/1,000. HMOs in Minneapolis found it easy during the 1970s to reduce hospital utilization and strongly compete with Blue Cross (FLHSA Task Force on Prepaid Health Care).

By 1978, two of Rochester's original three HMOs were still operating, but neither had achieved financial viability. Also, expected enrollment levels had not been attained, and the rate of growth in enrollment had been declining for two years. To evaluate the local HMOs and develop recommendations for strengthening them, a major HMO study was undertaken by the FLHSA in 1978. At the time, this was the most comprehensive review that had been done of a single locality's HMO programs and the local environment in which they operate.

The Task Force on Prepaid Health Care stressed:

- the critical importance to the achievement of financial viability of lowering hospital utilization rates.
- the importance of strong business support for the HMO concept if Rochester was to be a strong market for HMO growth.

Hospital utilization rates. HMOs are able to lower hospital utilization rates below community-wide use rates by changing the mix of inpatient and outpatient care. (Appendix II shows some of the alternatives in levels of care and sites of care which make this possible.) Research shows that it has been easier for group practice HMOs to control hospital use rates than for IPA HMOs.

The HMO task force found that:

- GVGHA had been successful in reducing the hospital utilization rates of its members, and by so doing had reduced community expenditures for hospital services—by $1.3 million in 1978 alone.
- RHN had failed to control hospital utilization. In fact, its use rates exceeded comparable rates for Blue Cross. The task force developed detailed recommendations for bringing RHN hospital use rates under control. These recommendations proved useful to RHN as a guide to options for organizational and operational changes directed at improved control of hospital utilization.

Business support for HMOs. National HMO research has shown that strong business support is an important factor in HMO success. The Task Force on Prepaid Health Care characterized business attitudes toward HMOs in Rochester as "cooperative, but neutral" during the early years of Rochester's HMOs. Other observers have termed the attitudes of some major local corporations as being "on the negative side of neutral." This can be seen in their responses to the HMO marketing efforts which began in 1973.

> "Eastman Kodak Company—the largest employer in the Rochester region—did not give the marketing teams direct access to its employees until 1978, when they were permitted to approach a small portion of the work force. The Xerox Corporation and the University of Rochester—the second and fourth largest regional employers, respectively—did not offer enrollment until 1977 and 1976 because of employee contract constraints" (Sorenson, et al., 1980).

Since publication of the HMO task force's recommendation for stronger business support of HMOs, the attitudes of Rochester business toward HMOs have shifted markedly—to positive endorsement and support of HMOs. For example, early in the 1980s both Kodak and Xerox restructured their health benefits to encourage employee membership in HMOs (Altmeyer and Phillips). The results of this restructuring have been dramatic. In 1980, about 5% of employees in both corporations were enrolled in HMOs. In 1986, 55% of local Kodak employees and 75% of local Xerox employees were enrolled in HMOs. (Calculation by FLHSA, based on insurer data.) This type of employer support for HMOs has made a strong contribution to the growth and viability of Rochester's HMOs.

Financial viability of Rochester's HMOs in 1987. In 1987, HMOs are clearly "here to stay" in Rochester. Both GVGHA and RHN have improved their financial performance and the two newer HMOs, Preferred Care and Blue Choice, appear to have learned important lessons about controlling hospital utilization from the experiences of other Rochester IPA HMOs.

In 1987, there has been some corporate restructuring of Rochester's HMOs. GVGHA has moved into a closer relationship with Blue Cross and is now, like Blue Choice, a Blue Cross line of business. Preferred Care and RHN have signed a merger agreement which puts them in a stronger position to compete with the two Blue Cross HMOs.

4. Rochester HMOs in comparative perspective

Market penetration. Even though HMOs had a slow start in Rochester, it was a very early start relative to other Eastern and Midwest cities. As a result, Rochester has been a national leader in HMO penetration of metropolitan market areas for a number of years (Office of Prepaid Health Care).

By 1981:

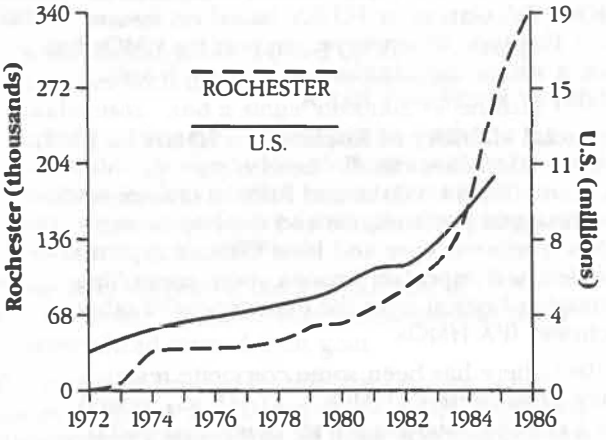
- Rochester had three functioning HMOs, while only half of the other 40 mid-sized cities in the nation had even one HMO.
- Rochester was one of only six mid-size cities with more than 5% of their population enrolled in HMOs. In 1981, Rochester's three HMOs were providing health care to 6.4% of the area's population.

Between 1981 and the start of 1986, HMOs multiplied nationally and HMO enrollments mushroomed. In January 1986:

- 88% of mid-size cities now had at least one HMO, and
- 63% of these cities had more than 5% of their population receiving their health care in HMOs.
- But only two mid-size cities, Rochester and Flint, Michigan, had more than 25% of area residents enrolled in HMOs.

The rate of growth in Rochester area HMO enrollments closely paralleled national trends up to the rapid growth spurt in Rochester enrollments beginning in 1984 (Fig. 3-1). By mid-1986, 45% of the Monroe County population under 65 years and 12% of the population 65 and over were enrolled in HMOs.

FIGURE 3-1. GROWTH IN HMO ENROLLMENTS. 1973 TO 1986, IN METROPOLITAN ROCHESTER AND UNITED STATES



Sources: Rochester HMOs and Interstudy, "National HMO Census: 1985"

HMO premium costs. The relative success of the Rochester area in containing health costs is apparent in its HMO premiums as well as in conventional indemnity insurance premiums. For example, for Xerox Corporation employees nationwide, HMO premiums in 1986 were lower in Rochester than in any other metropolitan area (Table 3-1).

- HMO premiums for Xerox employees across the nation ranged from a high of $3,197 in Boston to a low of $1,920 in Rochester, a difference of $1,277 per employee.
- The average HMO premium for Rochester Xerox employees was only 73% of the national average HMO premium for Xerox employees in 1986.

TABLE 3–1. HMO FAMILY PREMIUMS FOR XEROX EMPLOYEES JANUARY 1986

Area	Annual Rate	Percent of Average Rate
Boston	$3,197	122%
So. California	3,114	118%
Houston	2,836	108%
Philadelphia	2,739	104%
Washington, D.C.	2,705	103%
Pittsburgh	2,647	101%
NATIONAL AVERAGE	*2,630*	*100%*
Indianapolis	2,569	98%
Westchester County	2,425	92%
Seattle	2,419	92%
Minneapolis/St. Paul	2,363	90%
ROCHESTER	*1,920*	*73%*

Source: Xerox Corporation.

5. HMO enrollment of special populations

a. The elderly

In 1983, the Genesee Valley Group Health Association was one of 20 HMOs nationwide selected by the federal government to participate in trials of HMO health care for the older population insured by Medicare. The trial results were satisfactory and in 1985 the federal government began routine contracting with HMOs for enrollment of Medicare-insured elders. By mid-1987, all four Rochester-based HMOs had Medicare contracts and were enrolling Medicare elders.

HMO enrollment can be a good value for Medicare beneficiaries. It eliminates the burdensome paperwork of filing claims for every service. And, dollar for dollar, the additional fee for Medicare HMO membership buys more coverage than the Medicare supplemental insurance purchased by most elders and usually reduces seniors' out-of-pocket expenses for health care. HMOs can achieve this result through use of medical management techniques that reduce the high hospitalization rates of the 65+ population. They use the resulting cost savings to provide additional outpatient benefits.

However, many HMOs across the nation are finding it difficult to break even in providing care to this new group of members. Some of their difficulty is caused by Medicare's HMO reimbursement design which exposes HMOs to a risk of substantial loss from members with high cost care needs and penalizes HMOs located in communities with low per capita health costs.

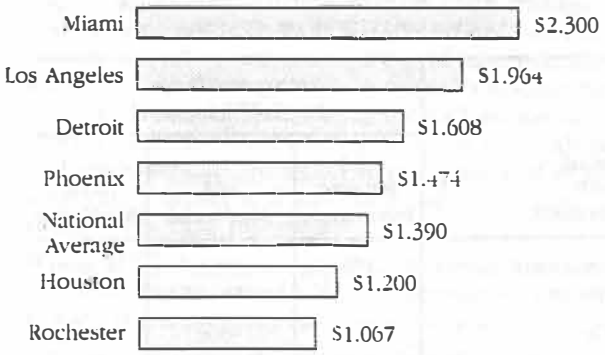
One problem with Medicare's HMO reimbursement is its flawed adjustment for insurance risk. In theory, an HMO's total Medicare payments are adjusted for the amount of care its Medicare enrollees will need, so that HMOs with sicker than average enrollees are paid more than HMOs whose enrollees are in average health or better than average health. In fact, the adjustment is crude and very imperfect so that HMOs are exposed to a risk of substantial underpayment. This risk is heightened by the extent to which Medicare expenditures are concentrated among a few costly enrollees, e.g., in 1982 Medicare's average per elder expenditure was $1,469 but, for the most costly 2% of enrollees, it was $23,818 (Riley). An HMO which happens to enroll even a handful of these costly care users could end up in the red on its Medicare business.

Medicare HMO reimbursement creates a special problem for HMOs in low cost communities. Medicare's HMO payment rate varies from one community to another, depending on the community's per elder health care costs. The payment rate per HMO member is calculated separately for every community in the country, and is based on Medicare's average per elder cost in that community. In communities with high average costs per Medicare elder, the HMO payment rate is high, and in communities with low average costs per Medicare

elder, the HMO payment rate is low. Because of the Rochester region's historic success in shaping a cost-efficient care system, Medicare's average per elder cost in Rochester is low and so, too, is the basic Medicare HMO payment rate in metropolitan Rochester.

These cost differences between cities are illustrated in a national study of Medicare's average per elder expenditures in 30 metropolitan areas in which the Rochester area ranked lowest (See Table 3-2).

TABLE 3-2. MEDICARE EXPENDITURES PER ELDER IN SELECTED METROPOLITAN AREAS, 1982*



Source: W. McClure and D. Shaller, "Variations in Medicare Expenditures," *Health Affairs* (Summer 1984).

*Adjusted for age and gender, and local variation in wages.

In 1981, the national average per elder expenditure was $1,390, ranging from a high of $2,306 in Miami to a low of less than half that ($1,067) in Rochester (McClure and Shaller). These very large differences between Medicare's per elder expenditures in high and low cost communities continue into the present and are directly reflected in the HMO payment rates. In 1986, Medicare's basic HMO payment rate in Miami's Dade County was $3,857 while the Monroe County rate, at $2,057, was little more than half that (*Federal Register*, January 1986).

This reimbursement method places Rochester HMOs in a difficult situation. To begin with, they must reduce hospital use rates for their Medicare enrollees below their area's already low utilization rate. If they succeed in this first challenge, they will have some savings to pay for the added outpatient care costs incurred in delivering a larger proportion of care in ambulatory settings. However, the absolute dollar amount of these savings will be much less than for HMOs in Miami and most other areas. Therefore, the second challenge to Rochester HMOs is to be sufficiently efficient to deliver the needed ambulatory care for this constrained dollar amount. This may be especially problematic for IPA-model HMOs which find it harder to control hospital utilization than group practice HMOs.

If the HMOs can successfully deal with these challenges and enroll increasing numbers of elderly, the impact on inpatient utilization may be substantial. In the limited experience to date, Medicare members of Rochester area HMOs are using hospital days at a rate per 1,000 that is 40% less than the rate for all Monroe County seniors (Table 3-3). Since approximately 45% of the region's acute hospital days are used by persons 65 and older, a significant increase in HMO enrollment of older residents has the potential to substantially decrease hospital utilization in the area.

b. The Medicaid-covered population

During the second half of the 1980s (1985-87), Monroe County has been the site of a Medicaid HMO demonstration project. Called MediCap, this was the largest of New York State's Medicaid demonstration projects. Because the Monroe County MediCap project broke a great deal of new ground, its successes were mixed with a number of problems and the demonstration was ended after two years. At least for the time being, HMO enrollment is available only on a voluntary basis for some Monroe County Medicaid eligibles.

There are a number of reasons for the problems encountered by the demonstration. One is that the MediCap design was very ambitious. For example:

- It was the only one of the New York State demonstrations with the goal of enrolling the entire Medicaid-eligible population of a county in HMOs, and the 48,000 Medicaid recipients actually enrolled in MediCap included certain client groups, e.g., the chronic debilitated alcoholic, which would predictably be difficult to manage and which no HMO in the country is experienced in managing.

- Goals of the MediCap program were to increase access and quality of care while containing cost and returning a 5% savings to the payers. It is questionable whether these goals were achievable during the initial years of this experiment, given the likelihood that a significant number of enrollees would have previously unidentified health problems and needs (Traska).

- Rather than starting slowly with a "break-in and debugging period" for providers and management information system people, MediCap enrolled many members in a short time frame. The resulting heavy workload made problems difficult to correct.

- The full range of Medicaid psychiatric and chemical dependency benefits were included in the managed care package during the initial years of MediCap. Methods of effective management of these benefits have yet to be developed; and virtually all insurers and HMOs nationwide circumvent problems in this area by strictly limiting this category of benefits.

Many of the problems experienced by MediCap have been experienced by other HMOs in their start-up years, by established HMOs undertaking care delivery to new population subgroups, e.g., of the elderly, and by other Medicaid HMOs (Hurley). These include the need for providers to learn effective case management within a capitated system of care; the difficulties in getting an information system up, running, and able to provide critical management information on a timely basis; and setting capitation rates which are fair to both providers and payers (Traska). All of these problems relate to the

financial feasibility of MediCap for the providers: some local providers' financial losses were so substantial that they opted to discontinue participation.

However, consideration of MediCap's problems should not obscure the several remarkable achievements of the demonstration. These include:

- The mandatory enrollment feature of the demonstration (48,000 recipients were enrolled), a radical shift from traditional Medicaid policy of free choice of provider, was implemented with little consumer dissatisfaction.
- The level of recipient satisfaction with care was apparently higher in the MediCap program than in the pre-MediCap period, based on a survey of MediCap enrollees (Monroe County MediCap Plan, 1987).
- Preliminary hospitalization data for the first group enrolled in MediCap suggest that a reduction of about 45% in this population's traditionally high hospital utilization rate was achieved (see Table 3-3).
- MediCap enrollees had a much wider choice of physicians than pre-MediCap when only a small proportion of private practice physicians in the county actively participated in the Medicaid program (Tempkin-Greener, et al). With MediCap's improved fees, the number of physicians willing to treat Medicaid patients substantially increased.

In retrospect, the MediCap demonstration was worthwhile both for its successes and its failures. Its successes were in important areas; its shortcomings yielded valuable information that can be used in designing the second round of MediCap demonstrations. The results of other Medicaid HMO demonstrations across the country, just now coming in, are similarly checkered (Traska). Though most health care providers remain convinced that capitated, managed care is a good care model for the Medicaid population, the results of the first round of Medicaid HMO demonstrations are illuminating the multiple challenges in providing managed care to this population.

6. The impact of HMO enrollment on hospital utilization in the Rochester area

Due in part to its low ratio of hospital beds to population, Rochester has had relatively low hospital utilization rates for many years. The hospital utilization rate of employer group HMO members has always been somewhat below the rate of those insured by the Blue Cross Plans; the growing HMO enrollment in the Rochester area is expected to further lower the region's already low hospital use rate. Preliminary data on the early experience of Medicare and Medicaid HMO members suggest that prepaid managed care has the potential for reducing their hospital utilization rates even more sharply than the rates for the privately insured population under age 65 (Table 3-3).

HMO expansion, along with a number of other system-wide changes in finance and medical practice, has brought a downturn in hospital use since 1982. As a result, the Genesee region now has a substantial surplus in hospital beds and, by conservative estimate, will have a 15% to 20% surplus by 1990. The operation of these surplus beds is an unnecessary system expense but, as discussed in the next chapter, it is difficult to close down excess hospital beds.

TABLE 3–3. ANNUALIZED RATE OF HOSPITAL UTILIZATION BY HEALTH INSURANCE TYPE AND AGE IN ROCHESTER AREA JANUARY–SEPTEMBER 1986

Type of Health Insurance	Hospital Days per 1,000 Insured		
	<65 Private Insurance	<65 Medicaid	65+ Medicare
Conventional insurance	478[a]	1,046[b] pre-MediCap	3,440[c]
HMOs	341[d]	580[e] MediCap	2,080[d]
HMO rate as percent of hospital use rate of conventionally insured	71%	55%	60%

Sources:

a Rochester Blue Cross; first 3 quarters, 1986.

b MediCap: pre-MediCap annual days/1000 recipients (3-year average) for Monroe County Medicaid's AFDC and Home Relief recipients. This population includes a disproportionate number of women of child-bearing age with a resulting high use rate for obstetric and neonatal care. Also those who are Medicaid eligible by virtue of being on home relief include many high users of hospital care for alcoholism treatment and mental illness.

c Calculated by FLHSA from RAHC data; Monroe County Residents 65 and older, 1985

d Calculated by FLHSA from data supplied by HMOs. Entry is average HMO utilization rate, weighted by the 4 HMOs differing member months for the first 3 quarters of 1986

e RHN: preliminary estimate for first 3 quarters, 1986.

B. OTHER INITIATIVES IN MANAGED CARE

1. Case-managed care in the community: an alternative to nursing homes

Health care expenditures tend to be heavily concentrated among a small number of people who are heavy users of services among the elderly as well as among other age segments of the population. For example, national Medicare data show that 11% of enrollees used 77% of Medicare's 1982 budget (Riley). Local data show that while only 8% of Monroe County's Medicaid population is in nursing homes, Medicaid expenditures for nursing home care amount to almost 50% of the county's Medicaid budget.

Given this pattern of health care resource consumption, it is understandable that in the early 1970s

community leaders in Rochester began design of a program to assist the elderly who are potential heavy users in management of their use of long term care services.

This program—the Monroe County Long Term Care Program's ACCESS project—became operational in late 1977. ACCESS performs a number of functions for its patients/clients. These include: arranging for assessment of care needs and development of a care plan utilizing family and community services; certification of the care plan and patient's level of care for Medicaid payment purposes (when patients are eligible for Medicaid); arrangement and coordination of care provision from a wide array of service providers; and utilization review and case management on a continuing basis, in order to update the plan of care as needed. As part of its function as a federal demonstration agency, ACCESS has gathered and analyzed data on its substantial caseload of long term care patients and has made them available, on request, for local planning.

While ACCESS was designed to maximize the use of non-institutional services as an alternative to nursing home care, it has also had the responsibility for management of long term care services for all Monroe County Medicaid clients, 18 and over, irrespective of their site of care (home, nursing home, hospital, etc.). For the period 1977-82, private paying patients could also make use of ACCESS' assessment, care planning and case management services without cost.

In 1982, ACCESS obtained Medicare demonstration waivers. These waivers expanded the amount and array of services at home and in the nursing home for which Medicare would pay. As a result of these expanded services in the home, some Medicare-eligible patients could be maintained longer at home, rather than having to be hospitalized or placed in a nursing home. Some nursing home patients were provided additional medical support in the nursing home that helped to prevent the need for hospitalization.

As ACCESS has developed its case management capability in this community, there has been increasing recognition that long term care patients have differing needs for case management. Some, such as those supported at home with skilled services, may require intensive case management services. Others, such as those who have been in nursing homes more than 90 days, may require only periodic utilization review evaluations. By designing its case management services in such a way that the appropriate intensity of case management is provided, ACCESS has been successful in:

- helping to maintain patients in the community, sometimes with complex care plans;
- complementing but not replacing family care providers with formal services; and
- keeping its case management costs very reasonable.

This targeting of both case management services and community long term care services to those most in need helps to hold down health care costs of a population which includes a number of high users of care.

2. Hospice: care management for terminally ill patients

Hospice care was developed to provide dying patients and their families with an alternative to acute care in general hospitals. Hospice programs meet the needs of the terminally ill patient/family by providing a program of palliative care services when active treatment is no longer medically indicated and desired by the patient. Hospice programs are responsible for organizing medical, nursing, social, and other appropriate health and human services. Most hospice services are provided in the patient's home and a member of the hospice team functions as a case manager of these services, both during the patient's illness and later during the family's bereavement process.

In 1978, the Rochester Blue Cross Plan was the first in the nation to cover hospice care in its standard contract and also in the Blue Cross "65 Plus" contract offered to Medicare beneficiaries. The Genesee Region Home Care Association's (GRHCA) home-hospice program started in 1977 as a 3-month demonstration for Blue Cross subscribers terminally ill with cancer and has continued as a regular program of GRHCA to manage the Blue Cross hospice benefit. GRHCA was one of the 26 national hospice demonstration sites for Medicare and one of 15 New York State hospice demonstration sites from 1980 to 1982. In 1985, GRHCA was formally certified as a hospice under New York State's new hospice licensure provisions. In mid-1986, GRHCA's hospice program was still the only one in the Genesee region.

C. HIGHLIGHTS OF THE 1970s

In the decade of the 1970s, community leaders with concerns about rising health costs supported the development of a new type of health care organization in the Genesee region, an organization which integrates the individual's care from multiple providers and which is at financial risk to be cost-effective in providing health care. The first of these organizations were the prepaid health plans, or HMOs, which began operation in 1973. Establishment of HMOs in Rochester was backed by many corporate leaders as a way to provide employers with the choice of a care delivery system which paid attention to rational organization and cost effectiveness.

By improving the management and coordination of services provided by individual health professionals, these organizations have contributed to the Rochester area's long-standing goal of providing a broad range of services at an affordable price. Just as the region's indemnity premiums are among the

lowest in the country, so too are the region's HMO premiums.

The experience gained by local health care managers and providers in establishing and operating care management organizations has been applied to increasingly diverse populations and to different types of health care services. Lessons learned in providing managed care for one population have been applied to other populations and by other types of providers until now the region has:

—four HMOs which, among them, enroll members drawn from the entire population—from welfare recipients to actively employed to retirees.

—ACCESS, the home health care case management organization primarily serving the chronically ill Medicaid population age 65 and over.

—the home-hospice program of the Genesee Region Home Care Association, serving terminally ill patients and their families.

Through the efforts of business and industrial leaders, the Rochester metropolitan area was among the first in the East and Midwest regions in which consumers and payers had an HMO option. And, as a result of the early establishment of HMOs, the area had the HMO capability and capacity to handle the large increase of HMO membership of this decade, with its attendant cost savings for consumers and payers.

• • •

IV. THE DECADE OF THE 1980s: COOPERATION OR COMPETITION? INTEGRATION OR PLURALISM?

Spending for health care consumes an ever increasing share of the nation's resources. By 1985, 10.7% of GNP ($425 billion) went into health expenditures which continue to increase (Waldo). This unremitting growth is despite years of concerted effort by government at all levels and, more recently, by business to contain health costs.

In many parts of the nation, payers' cost control measures are aimed at holding down their own costs without regard to effects on the costs of other payers or the total costs of health care in their region. This is the current policy of the federal government and of many large employers. In New York and some other states, government cost control measures are designed to hold down health costs for all payers, public and private. Providers on the receiving end of these cost containment measures find their activities increasingly subject to outside control and their future revenues unpredictable. If health costs continue to rise, the future for providers will continue to be unpredictable, for it is certain that payers will institute still further measures in their attempts to hold down costs.

Provider uncertainty about the future shaped by this multiplication of cost control measures is common to providers all across the nation. In addition, Rochester providers are likely to experience special problems from control measures designed to apply across the state or the nation. Because these measures often presume that all regions' health care systems contain a lot of fat, they can damage "lean" health care sectors such as Rochester's. This was certainly the case in the late 1970s when the state's stringent hospital cost control program was to put all Genesee region hospitals into the red.

The region's creative response to this danger to its hospitals was to develop the second generation of integrating organizations, with accompanying payment systems that recognized rather than punished the efficiency of the Genesee region's health care system. These new integrating organizations were limited corporations which brought together all hospitals in geographic subareas of the region for area-wide planning, coordination and budgeting. The background, design and substantial achievements of the two area-wide hospital consortia and their payment experiments are detailed in this chapter. The chapter also describes the difficulties in sustaining these cooperative, integrated hospital systems at a time when local problems and national trends are pushing hospitals in the opposite direction—toward competition and pluralism.

A. THE HOSPITAL CORPORATIONS AND THE HOSPITAL PAYMENT EXPERIMENTS

The two hospital corporations are the Rochester Area Hospitals' Corporation (RAHC), created by Monroe and Livingston Counties' hospitals, and the Finger Lakes Area Hospitals' Corporation (FLAHC), created by the hospitals of Ontario, Seneca, Wayne and Yates Counties. RAHC and FLAHC provided the administrative frameworks needed to develop and operate the community-wide hospital budgeting programs in their respective regions.

1. Background

The incentives in the hospital reimbursement system in general use across the nation during the 1970s encouraged each hospital to elevate, rather than contain, costs. Hospitals were reimbursed for costs and, usually, by the day for each day of a hospital stay. This reimbursement mode helped to perpetuate physicians' customary ways of using hospitals at the very time that an explosive growth in

complex medical technologies was getting underway. The interaction of these factors resulted in duplicative investments in expensive technologies in many areas. The reimbursement system also encouraged the building of excess hospital capacity.

By custom and rule, physicians can treat patients, admit patients and use equipment only in hospitals at which they have privileges. And, for reasons of custom and economy of time, most physicians have privileges and concentrate most of their admissions at one or two hospitals. They expect these hospitals-cum-physicians' workshops to be modern buildings equipped with state-of-the-art technology in their specialty. In general, physician expectations about the appropriate equipping of their own hospitals are unaffected by information that desired equipment is already available and underutilized in another hospital just 10 minutes' drive across town. In other words, the motivation for hospital acquisition of a new technology may be to provide physicians with convenient access to the tools of their trade, and not an issue of patient access to the technology.

At the same time, each hospital, so as to maximize occupancy, felt it must have a large diverse staff of physicians, and to attract physicians must have every modality of technology. The hospital boards couldn't say "no" to physicians, or the physicians would go elsewhere and low occupancy would create deficits. For many geographical areas, the interaction of the reimbursement mode, physicians' hospital practice customs and hospitals' goals resulted in regional redundancy of costly, underutilized equipment and excess hospital capacity whose capital and operating costs had to be borne by the area's third-party payers and ultimately by the region's residents.

In the early 1970s, Rochester Blue Cross, several industrial leaders, and staff members from the regional health planning agency started to discuss a new method of funding hospitals. Their aim was a locally controlled, efficient system of hospital care for the population within a geographically defined area. The core of the new method would be some mechanism for unifying the funding for the whole hospital industry of the region in order to put all hospitals on one single region-wide budget. These early discussions took place at a time when national health insurance seemed imminent; and a locally controlled, regional hospital system was viewed by some as a desirable model for use in implementation of a national health insurance program. It would have the important virtue of keeping control over major elements of the region's health system within the region.

Initially, the hospitals had little interest in this idea. Then, in the mid-1970s, New York State imposed severe limits on hospital reimbursement which were particularly punitive for the Rochester area's hospital industry. Because fewer persons per capita are hospitalized in the Rochester area than elsewhere in New York State, those who are hospitalized are sicker and more costly to treat, on average, than hospital patients in other areas. Reimbursement levels linked to average per patient or per day care costs in other areas of the state can be inadequate for this region.

A committee consisting of presidents of the boards of trustees, administrators, and physicians of the hospitals throughout the nine-county region served by the Finger Lakes Health Systems Agency (FLHSA) was formed to consider ways to deal with the dire fiscal situation that particularly affected hospitals in Monroe County. Their discussions moved to the development of a region-wide prospective budget for community hospitalization to be coordinated through one organization. (This description of the MaxiCap project is largely drawn from Sorenson, et al., 1982.)

2. MaxiCap

In the mid-'70s, the national Blue Cross Association received funding from the federal Department of Health, Education, and Welfare to select one site in the nation to create and experiment with a new hospital reimbursement program. Rochester Blue Cross in collaboration with the local hospital association and the FLHSA made the successful application to be the site and the experiment was called "MaxiCap". The MaxiCap staff and committees and the FLHSA developed a plan that linked financing with planning. The total dollar amount (i.e., the "cap" on both revenues and expenses) to be spent on acute hospital care by Blue Cross, Medicare, and Medicaid for the entire region would be decided by the MaxiCap board, which would include providers, third-party payers, health planners, industry and union representatives, and consumers. The nine-county area would be divided into three subareas, each with its own hospital organization for administering its own subarea's budget.

For many reasons, the full MaxiCap project never came to fruition. Principal among them was lack of interest among the hospitals in Chemung, Schuyler and Steuben counties. These counties are not part of the Rochester Blue Cross/Blue Shield service area, and their health providers have not shared the other six counties' experience in regional health planning and problem solving. But most MaxiCap planning participants from the six-county Genesee region, especially the hospitals, were convinced that a single source, "capped" financing program, was highly preferable to the stringency of the state reimbursement formula which was insensitive to the local situation and to the unpredictability of revenues. Under New York State's reimbursement program, the hospitals risked still further cutbacks in funding, irregular payment schedules which caused serious cash flow problems, and reimbursement regulations proscribing many beneficial reforms. The MaxiCap program would have provided hospitals with a predetermined, guaranteed annual budget, a constant revenue stream, and greater flexibility to deliver care in more cost-efficient ways without losing income. Also, the attraction of the "cap" experiment for the hospitals was enhanced by

its reimbursement formula which would significantly increase hospital revenues in the early years of the experiment. This would help the hospitals to deal with their immediate fiscal problems.

3. The hospital experimental payment projects—HEP and FLHEP

Although the full MaxiCap project was not implemented, its bold experimental design, tailored to smaller geographical areas, was put to the test starting in 1980 by all hospitals in Monroe and Livingston counties and starting in 1981 by hospitals in Ontario, Seneca, Wayne, and Yates counties. The Hospital Experimental Payment (HEP) Project in Monroe and Livingston counties and the Finger Lakes Hospital Experimental Payment (FLHEP) Project in Ontario, Seneca, Wayne and Yates counties are voluntary projects designed cooperatively by the local hospitals, the Rochester Blue Cross Plan, and county, state and federal governments.

Putting each area's hospitals on an area-wide budget required an agreement between the principal payers—Blue Cross, Medicare and Medicaid—and all the hospitals. The major payers agreed to provide the hospitals with a guaranteed annual budget, with funds paid into a unified area-wide hospital budget. The participating hospitals agreed to limit their future annual revenues to their costs in the base year (1978 for HEP, 1979 for FLHEP) plus an annual inflation adjustment. Payments to individual hospitals could be adjusted for changes in volume and costs associated with new equipment or facilities.

The Rochester Area Hospitals' Corporation (RAHC) and the Finger Lakes Hospitals' Corporation (FLAHC) are the integrating organizations created by their respective areas' hospitals to administer the payment projects. Participating hospitals work through their area hospital corporation's decision-making structures to develop area-wide plans, solve area problems, and adjust the allocation of operating funds among hospitals.

The two hospital payment experiments are the first national demonstrations of the community-wide hospital budget. In place for six or more years, the two experiments had positive results. Hospitals were able to preserve the high quality of care and, by operating more efficiently, to simultaneously contain costs and improve their financial well-being. These achievements are notable in part because they are the product of significant cooperation and collaboration of all affected parties. They are also notable because they resulted from voluntary local actions, and not from regulatory controls imposed by the state and federal governments.

In reviewing the regional hospital experiments, it is important to recognize that the national policy environment in which they took place was moving rapidly in a direction diametrically opposite to that embodied in the experiments. The regional hospital experiments were designed to increase the coordination of major payers and of hospitals and to continue the limitations on the capacity of the regional hospital system. However, by the time the experiments got underway, the federal government was actively reorienting national health policy; rather than promoting increased cooperation between major payers, it was intent on controlling only its own costs and it urged businesses and state governments to do the same. Also, the federal government abandoned interest in regulating the size of the health care system; rather it advocated increased competition between health providers, including hospitals and physicians, as the path to cost containment. Only a handful of states, with New York a leader among them, continued their policies of containing health cost through coordination of major payers and restraint of health system capacity.

Because the national policy environment changed so rapidly in the late 1970s and the 1980s, the regional hospital experiments were increasingly out of step with the rest of the nation, even though they were well-conceived and notably effective in a number of respects.

4. Inter-hospital planning and coordination

Judged against the minimal level of regional hospital planning and coordination which is standard in the nation, some of the achievements of the two hospital consortia were remarkable.

Closing an unneeded hospital. The Finger Lakes hospital consortium, through a long and careful planning process, was able to come to a decision that one of its member hospitals should be closed. The consortium came first to the decision that only one hospital was needed in a county (Seneca) which had two. It then decided which hospital was financially and clinically more viable and should be the one to remain in operation, and thereby decided which one should close. This hospital is now closed. Although the FLHSA and the State Health Department had several times identified Seneca Falls Hospital as "not needed," the local hospitals had never taken this position. The region's health planners believe this to be the first time a regional hospital council anywhere in the country has ever taken such an action.

Widening physician access to specialized technologies. In the Rochester area, the physician advisory council of the area hospital corporation has worked out two special physician access arrangements to overcome the access issue which is often an obstacle to the centralizing of expensive, low volume technologies at one or two hospitals in a multi-hospital area.

One special arrangement is for Rochester area urologists trained in the use of the kidney lithotripter. The lithotripter is the state-of-the-art technology in kidney stone treatment, and most urologists can be expected to want access to this technology. However, the Finger Lakes Health Systems Agency

calculated that a single lithotripter could serve a population two to three times as large as that in the nine-county planning area served by the FLHSA. Strong Memorial Hospital was given the certificate of need for the region's $2-1/4 million lithotripter installation. In return, the hospital agreed to grant restricted admitting privileges to qualified area urologists with appropriate training: these urologists can admit patients to Strong for lithotripter treatment.

A second arrangement gives limited privileges to area cardiologists whose patients have open-heart surgery in the area's only open-heart surgery units, at Strong Memorial Hospital and Rochester General Hospital. Cardiologists can obtain restricted privileges to provide post-surgery follow-up care to their open-heart surgery patients at these hospitals. This arrangement means they are able to keep their patients, rather than lose them to cardiologists with regular privileges at Strong Memorial Hospital and Rochester General Hospital. These two breaks with hospitals' customary methods of granting physician privileges are highly unusual, and are noteworthy for the rational solution which they provide to the physician access issue.

5. Hospitals' financial condition

During the Hospital Experimental Payment Project of the Rochester area, the financial condition of the area hospitals has improved even while hospital revenues were contained. In the late 1970s, most hospitals in Monroe and Livingston counties were operating at a deficit under New York State's stringent regulation of reimbursement. During the first four years of the payment experiment, from 1980 through 1983, hospitals in the two counties:

—increased their equity (fund balances) by 50%—from $119 million to $179 million, and

—improved their liquidity (cash and investment balances)—from $41 million to $81 million.

In 1983, the financial performance of hospitals throughout the Genesee region was among the best in upstate New York. Both the Central (Syracuse) and Genesee regions' hospitals had favorable low scores on a composite measurement of overall financial performance. Two regions—Western (Buffalo) and Watertown—had scores greater than 1.00, indicating weak financial performance. (See Table 4-1.)

On the negative side, however, the HEP and FLHEP reimbursement formulas have failed to reflect the uneven performance of the hospitals in sustaining high occupancy rates. As care has shifted to outpatient settings, occupancy levels in some hospitals have remained high and others have fallen sharply. However, the HEP and FLHEP formulas protected the low occupancy institutions from suffering corresponding losses of revenues. As a result, these hospitals may have been somewhat slow in coming to grips with the reality of their shrinking market shares.

TABLE 4–1. 1983 FINANCIAL PERFORMANCE OF UPSTATE NEW YORK HOSPITALS BY HOSPITAL REIMBURSEMENT REGION

Hospital Reimbursement Region	Financial Viability Index*
Central	.53**
Genesee	.67
Utica	.75
Northeastern	.91
Watertown	1.14
Western	1.44

FLSHA. December 1986

Source: Bureau of Health Economics, NYS Department of Health.

*This ratio combines a liquidity ratio, a capital-structure ratio, and a profitability ratio. Lower values for this ratio are favorable.

**Includes the seven hospitals in the Finger Lakes Region's southernmost counties.

6. Benefits to payers

Because hospital inpatient units are the most expensive site for health care, reduction in a geographic area's inpatient hospital use helps to hold down area health costs. During the 1980s, a number of factors have been operating to reduce inpatient hospital use in the Genesee region including, most importantly, the incentives in the area-wide hospital budget experiments to shift care from inpatient to outpatient settings and increasing HMO enrollments. The combined impact of all factors on inpatient costs to Genesee region payers is shown in Table 4-2. Between 1980 and 1984, the Genesee region's per capita hospital net inpatient revenues increased by only 33%, compared to a statewide increase of 50% and a national increase of 56%. As a result of the region's success in restraining the rate of increase, the 1984 per capita hospital net inpatient revenue in the Genesee region was only 70% of the state per capita amount and 78% of the national per capita amount. Although it is not possible with available data to determine the specific contribution of the two hospital payment experiments to the region's success in restraining expenditures for inpatient care, it is likely the contribution was a major one.

7. Cost containment and quality of care

From the outset of the experimental payment projects, area hospitals have been concerned that quality and access to care not be compromised by the cost-cutting incentives in the experimental payment method. Several studies of the availability and outcomes of care in Rochester area hospitals between 1980 to 1985 are underway, but no reports are yet available for publication.

Apart from the quality and access issues in the hospital payment experiments, certainly the question has been raised over the years as to whether quality of care in this region has been compromised by the focus on cost containment. A

TABLE 4–2. PER CAPITA HOSPITAL NET INPATIENT REVENUES: 1980 and 1984, AND PERCENT INCREASE: 1980–1984

Area/Region	1980 $s	1980 (% of NYS)	1980 (% of U.S.)	1984 $s	1984 (% of NYS)	1984 (% of U.S.)	Percent Increase 1980–84 Four Year Total	Percent Increase 1980–84 Average Annual Increase
Monroe & Livingston counties	$263	(60%)	(93%)	$349	(71%)	(79%)	32.7%	7.3%
Ontario, Wayne, Yates & Seneca counties	$239	(73%)	(84%)	$323	(66%)	(73%)	35.2%	7.8%
Genesee Region	$257	(78%)	(91%)	$434	(70%)	(78%)	33.5%	7.5%
New York	$328	(100%)	(116%)	$492	(100%)	(112%)	50.0%	10.7%
United States	$283	(66%)	(100%)	$441	(90%)	(100%)	55.8%	11.7%

FLSA, January 1987

Sources:

1980 and 1984 Blue Cross and NY State Supplement to ICR, p. 1, Col. 23, Line 300.

County, subarea and regional data reflect estimates of net inpatient revenue paid by or on behalf of subarea and regional residents, irrespective of where the care was provided. Patient migration adjustments are based on migration patterns reflected in Table 148 of the 1981 SPARCS Annual Report Series and the Robert Packer Hospital Annual Reports for 1981. NY State and United States data are based on gross inpatient revenue for all community hospitals less and estimated discount, bad debt, charity care, etc., allowance based on the differential between gross and net patient revenue as reported in Table 11, "Hospital Statistics," American Hospital Association, 1981 and 1985.

1980 US, NYS, and County population: 1980 Census.
U.S. population—1984: Current Reports, Series P–25, No. 704, Table 2, p. 22.
NYS and County population—1984: Econ. Development Board Population Estimates issued 1977.

review of general health status indicators for this region and other regions of the country that spend far more per capita on health care does not reveal significant differences between populations. Also, a number of studies have found that variations in physician practice styles and efficiency are important in explaining differences in per capita expenditure, independent of health status and quality of care (McClure and Shaller).

8. HEP capital expenditure budget

In 1985, the scope of the Rochester area hospital payment experiment was expanded to include capital expenditures. To live within the capital expenditure budget, area hospitals have had to come to an agreement on the relative priorities for the hospital capital investment requests of all the hospitals:

- which projects meet a community need of high priority and should be funded from the current year's community-wide capital expenditure budget?
- which projects would fill a community need of a lower priority and should not be funded in the current year?

The capital expenditure budget is a significant change from established practice, and one which policy makers believe may be critical to successful long-term control of health expenditures. Heretofore, New York and other states with certificate of need legislation have used an "absolute need" standard to judge proposed hospital investments: "Will the proposed investment fill a community need?" *All* proposals which meet this standard pass the "need" test, no matter how large an amount each year's approved proposals will collectively add to future health expenditures. In a world of finite resources where health care expenditures already consume almost 11% of the gross national product, policy makers are seeking some reasoned means through which to limit new hospital capital investments to an affordable incremental cost. The capital expenditure budget is one such means. Because living within the capital expenditure budget forces judgment of the *relative need* for proposed investments, approvals can be rationally limited to the most needed projects.

Both the Finger Lakes Health Systems Agency (FLHSA) and the Rochester Area Hospitals' Corporation (RAHC) played major roles in the experimental capital expenditure budget process. The FLHSA determined overall community need for beds and services in the Rochester area. Only hospital capital proposals which will fill a community need were approvable. The area hospitals, acting through their RAHC councils, had collective responsibility for determining *which* of the proposed and approvable capital projects would be authorized. They developed a proposed capital expenditure budget which listed the projects budgeted for authorization. This budget was subject to review by the FLHSA which had first-line responsibility for assuring that the RAHC hospitals fulfill the capital expenditure provisions of the experiment. During the first two years of implementation, the FLHSA and RAHC made substantial progress in elaborating their respective responsibilities in capital expenditure budgeting.

B. CURRENT POLICY ISSUES IN ACUTE CARE AND THEIR IMPLICATIONS FOR THE FUTURE OF THE ROCHESTER REGION'S HEALTH CARE SYSTEM

At the time of writing, the Rochester and Finger Lakes areas' hospital payment experiments are in their eighth and seventh years, respectively. Their cooperating hospitals have demonstrated the feasibility and the regional benefits of area-wide hospital planning and budgeting and, during the demonstration period, increased the level of integration in the region's acute care system. Also, the payment experiments have given local providers and other interested parties control over many decisions which would otherwise have been made in Albany or Washington.

Despite their achievements, it seems unlikely that the experiments will continue for much longer. There have been on-going tensions between member hospitals within both experiments which, by their very nature, require the participation of all major hospitals in their areas. However, hospital participation in the payment experiments is voluntary, and individual hospitals can decide whether they are better off in or out of the payment experiment.

In today's environment, contrasted with that of 1980, there are positive incentives to a number of area hospitals to opt out of the regional payment experiments. One powerful incentive is that some hospitals can increase their revenues from the federal government's Medicare program by withdrawing from their area's experiment. Another incentive is the increase in hospitals' freedom to compete with each other for patients.

Medicare. Medicare payments are a major source of hospital revenues, accounting for approximately 35% of local hospital revenues. Changes in Medicare's reimbursement methods made since the start of the regional experiment will increase the Medicare revenues of some or all local hospitals that withdraw from the payment experiments; and some hospitals believe their Medicare revenues would be substantially increased. (This revenue increase was an important consideration motivating the 1986 withdrawal of Clifton Springs Hospital from FLHEP.)

Competing for patients. For the first time ever in the Genesee region, the number of patients being hospitalized is substantially below the region's hospital bed capacity. Of the approximately 2,700 medical/surgical beds in the region, an estimated 400 to 600 (15% to 20%) will be surplus by 1990. Some local causes of this new and growing bed surplus have already been discussed: the more than tripling of local HMO membership since 1980, and the incentives in the hospital payment experiments to hospitals to shift care from inpatient to outpatient settings. Other causes are occurring nationwide: development of new, less invasive medical technologies and procedures, changing consumer expectations about the desirable site of care, cost containment efforts by business, and broadened utilization review mechanisms.

The region's bed surplus is spread very unevenly across hospitals. Some hospitals are operating at or near capacity while others are nearly half-empty if one does not count those patients who no longer require acute care and are awaiting the availability of alternate care. Those hospitals operating at or near capacity are concerned to maintain or increase their shares of this shrinking market. And low occupancy hospitals are under great fiscal pressure to find new means through which to increase inpatient admissions or else to downsize their acute hospital capacity, a problematic course because of its threat to their viability as general hospitals. Because surplus beds add unnecessarily to major payers' payments to hospitals, the state has instituted a new reimbursement policy that severely penalizes hospitals operating with low occupancies, and the federal government is determined that it will not contribute toward the operating costs of these excess beds. The stakes in this competition for patients are high, and the losers may not survive.

In today's national environment with its promotion of health cost control through competition and survival of the fittest, the development of a rational area-wide plan for reducing hospital capacity does not seem feasible. Rather, it seems likely that the area's hospitals will move to compete more aggressively for the decreasing number of patients. If this would only "undo" the advance in inter-hospital coordination of the 1980s, it might be an acceptable price for the region to pay for the needed reduction in hospital capacity. However, some local observers of the health policy scene fear this competition could damage the Rochester region's cooperative community approach to designing and operating its health care system and, in so doing, erode the region's achievements in access and affordabilty of health care.

C. INTEGRATING MENTAL HEALTH SERVICES

The Rochester area's most recent innovation in the financing and delivery of health care is the Monroe-Livingston Mental Health Demonstration. It brings together in a single project the two major strands of improved integration and management of health care delivery and financing developed in Rochester during the last two decades:

- the integration and management of health services to the individual patient, reimbursed on a prepaid, capitated basis, and
- the community-wide coordination of services, under an area-wide budget.

Background. During the 1960s, thousands of persons were discharged from mental hospitals across the country because they were judged not to need inpatient treatment. The deinstitutionalization of the mentally ill was rarely complemented by the

transfer of funding or the establishment of adequate community services to meet the continuing needs of these chronically mentally ill persons for social and health services. Services, when available, were usually provided by a multiplicity of independent organizations. Mentally ill individuals were left on their own to deal with a number of separate organizations to arrange for their income, shelter, nutritional and health care needs. The bag ladies and street people who sleep on the grates of Washington, D.C., and New York City symbolize the national and state failure to provide appropriate and integrated services to the deinstitutionalized mentally ill. Rochester's chronic mental patients, too, have suffered from the same lack of appropriate and integrated services.

The lack of funding and the fragmentation of services for individuals is also replicated among providers. In Monroe County the revenues of the mental health centers and agencies that finance subsidized care have been irregular and unpredictable. Community planning and coordination of services for the mentally ill has been limited, and has generally not included the major provider of services to the severely mentally ill, the state-operated Rochester Psychiatric Center.

Monroe-Livingston mental health demonstration. In 1979, directors of Monroe County's five community mental health centers learned that New York State monies were available to design and implement a demonstration project on area-wide coordination of financing and delivery of mental health services. The community's mental health center directors moved immediately to seize this opportunity, and within six weeks had prepared their proposal for the planning phase of the project. Research into the community's current problems, design of the demonstration and extended negotiations with all parties took eight years. In 1984, the project's governance board anticipated the start of service delivery in 1985, but drawn-out negotiations with the state and the counties pushed the start date into 1987.

The demonstration project has three major parts:

- the creation of Integrated Mental Health, Inc. (IMH), *a limited purpose corporation* of all mental health centers and agencies in Monroe and Livingston counties, the state mental hospital, and all major payers (the New York State Office of Mental Health, the counties of Monroe and Livingston, and the United Way). IMH will provide the structures for community-wide planning and coordination of mental health services, and has established the requisite management information services.

- *a contract revenue system*, in which the major funding sources for subsidized care contract to fund the area-wide annual budget for subsidized ambulatory mental health services. Each payer makes regularly scheduled payments. This replaces the uncertainty of "deficit funding" and give providers flexibility to replace expensive inpatient care with less costly outpatient care when this is appropriate. The contract revenue system began operation at the start of 1987.

- *case management* of services in the community for chronic patients discharged from Rochester Psychiatric Center. The system of prepaid case managed care for these chronic patients is a mental health analog to HMOs. For a prepaid, capitated amount, the community mental health centers undertake to case manage, and provide or arrange the whole range of health and social services needed in the community by chronic patients discharged from Rochester Psychiatric Center. This part of the project, which has the potential to turn Rochester into a national model of mental health management, is expected to start serving its first patients in November 1987.

D. HIGHLIGHTS OF THE 1980S

In each successive decade, health services and reimbursement in the Rochester region have become progressively more organized and integrated. In the 1980s, the most notable change has been in the regional organization of health care.

During the 1980s, there has been area-wide experimentation with increased integration of acute hospitals and hospital reimbursement. The acute hospitals in both geographical districts of the Genesee region began the decade by joining together in limited, area-wide hospital corporations. These corporations then successfully negotiated with their major payers to establish the nation's first experiments with area-wide hospital budgets. Working cooperatively within these experimental payment projects, the hospitals have planned together to increase the efficiency of area-wide hospital services and allocate the regional hospital budgets.

- This containment of costs was achieved without compromising quality and access to care.
- The increased flexibility in use of revenues provided in the payment experiment has enabled the hospitals to improve their financial condition even while revenues were contained.

The likelihood that the regional hospital payment experiments will soon end is not a measure of their failure, but rather of the increasing divergence during the 1980s between the roadways followed by the Rochester health care system and the health care systems in other regions of the nation. For advocates of an integrated regional system of health care system for the Rochester area, the lesson to be learned from the mounting pressure by local providers for an end to the experiments may be that the roadway traveled by this region's health care system cannot be bent too far away from the main track.

Implementation of another advance in regional integration of health service providers and reimbursement began in 1987 with the start-up of the Monroe-Livingston County Mental Health Project. This experiment will introduce partial regional budgeting

(for the subsidized portion of mental health services), increase coordination of the region's multiple mental health centers and agencies, and provide case managed, comprehensive care in the community to patients discharged from the state psychiatric hospital. This experiment is one more "national first" for the Rochester region's health care system.

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V. CONCLUSION

In a concerted community undertaking that began twenty-five years ago, Rochester area health policy makers have worked together toward the goals of a health care system that:

- provides high quality health care
- at a moderate cost
- with access for all.

Their ability to make substantial progress toward these goals is due in considerable measure to notable features of the regional arena in which health policy was developed:

—**The widely shared sense of community responsibility for the health care of all citizens** has facilitated the cooperation and willingness to compromise—between providers, and between providers and payers—that is central in many of the area's significant innovations developed to solve community problems.

—**Business involvement** in community health policy began in the 1930s, far earlier than in other regions. This early involvement gave Rochester's business leaders a much earlier appreciation that improved organization and greater efficiency in health care delivery could produce substantial economies without compromising quality.

—**A regional perspective on health care issues.** Local industry's decisions, in the 1930s, to make Blue Cross the principal health insurer and to community-rate all employer insurance gave both industry and their health insurer a direct stake in regional health costs. This stake led them to support the use of a "regional need" standard for evaluating provider requests to expand or renovate their facilities and develop new services. Applications of the "regional need" standard has been important in maintaining the affordability of health care in the region.

—**The regional health planning organization,** with its broadly representative councils and its professional staff, have provided the forum, the impetus, and the expertise for planning many of the programs and policies that have enhanced access and affordability of health care in this region.

In combination, these four elements have produced a highly unusual regional capability to deliberately shape the health care system. The result is a system that is more affordable and more accessible than most.

Today the Rochester region's approach to health policy appears to be at a junction point. It can move toward the main path followed by most areas of the country where the shape of regional health care systems is determined by the multiple decisions of independent providers competing for market share and profits. This would give increased freedom of choice to providers, including freedom to compete, or the region can continue to use a cooperative, rational approach to designing its health care system. Either path seems possible.

The Rochester region's cooperative regional approach to health care policy is under pressure from a number of disintegrating forces both from without and within the region. Payers, both nationally and locally, have increasingly come to believe their interests are best served by fostering competition among providers, rather than limiting the investment in the most expensive forms of care provision. Also, as Rochester businesses and industries are increasingly part of national and international corporations, they have less interest than formerly in preserving the region's social achievements. As part of the same trend, a growing proportion of executives are without local roots, but rather have come to work in the area for only a few years. As a result, they are less likely than their predecessors to share the region's historical values. Also, they are less likely to understand and support the system elements that lie behind the regional achievements in health care.

However, there are still many integrating features present in the health policy arena. Many of the region's health policy makers are accustomed and experienced in working together in a cooperative mode, and value the process and its achievements. Some of the health providers and executives who are new to the region have been attracted here by the region's values and achievements, and they may be a source of replacements for the retiring generation of "trustees of the community interest." The level of corporate involvement in regional health policy, even if somewhat diminished, is still far higher than in most areas of the country. And the regional health planning agency, though weakened by funding cutbacks, continues to organize a region-wide decision-making process which brings together all interests and to provide expert support for participants in this process. In short, all the principal elements of the region's special approach to health care are still present. But if they are to remain active and effective in the face of the disintegrating pressures upon the region's unique health policy process, there may well need to be a conscious recommitment of support to this process by health providers and the business and industrial community.

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INTERVIEWS

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John Hostutler. President, Industrial Management Council.

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Tom Swartz. Director of Planning, United Way of Greater Rochester.

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APPENDIX I
NOTABLE EVENTS IN ROCHESTER'S HEALTH CARE HISTORY

1914 Marion Folsom accepts a position in Rochester at Eastman Kodak. Folsom will become the chief financial officer of Eastman Kodak and one of Rochester's most active civic leaders. At local, state and national levels, Folsom will lead the development of health planning.

1918 The Community Chest Plan, one of first in country, is formed under the leadership of George Eastman who serves as its president from 1918 to 1928.

By the 1920s, the Community Chest's executive committee has already established the practice of reviewing requests for capital-fund drives.

1924 The Council of Social Agencies, supported by Chest funds and composed of its participating agencies, is established to supervise the expansion and integration of welfare services. Almost from its inception, CSA has a Health Division which focuses on hospitals.

1925 The University of Rochester School of Medicine and Dentistry admits its first class.

1926 The new municipal hospital and Strong Memorial Hospital are built adjacent to each other and physically connected.

1928 Kodak adopts a comprehensive annuity plan, one of the first companies in the nation to do so. This is the first of several programs which Kodak will institute to provide its workers with income security and protection against financial catastrophe.

1931 Fourteen major Rochester firms unite under the leadership of Marion Folsom of Kodak to begin voluntary unemployment insurance for their 26,000 employees. At this time, unemployment insurance was a new idea.

1930s (Early 30s) Six local hospitals begin to cooperate formally. Credit officers and administrators of the six voluntary hospitals meet formally during the year to discuss administrative problems.

1935 Rochester Blue Cross is formed through the efforts of the first administrator of Strong Hospital in cooperation with community business leaders. It is the 9th Blue Cross Plan in the nation. 23,000 members enroll in first year.

Rochester industrial leaders agree that the local Blue Cross Plan will be the principal health insurance carrier, and that all employer groups will pay equal rates for equal coverage.

1936 With more than half of Community Chest funds going annually to the hospitals, the Chest directors feel a need for expert assistance in planning and evaluating health care in the community. The Community Chest commissions a series of studies on care of the sick and aged in Rochester. These studies, done over the next five years, include:

—*Business Management of the Community Chest-Participating Hospitals of Rochester, New York,* by Carl E. McCombs, M.D., of the Institute of Public Administration, New York City, 1938.

—*Health Agencies of Rochester, New York,* by Wilson G. Smillie, M.D., 1940.

—*Care of the Aged in Rochester, New York,* by Mary C. Jarrett, 1940.

—*A Survey of the Facilities for the Care of the Sick of Rochester, New York,* by Wilson G. Smillie, M.D., 1941.

These reports are the first in the long series of objective investigations of health care in the Rochester region which will be carried out in the next half century.

1939 The Rochester Hospital Council is incorporated by six hospitals (Strong Memorial Hospital does not join the Council until 1946). This is the metropolitan area's first formal hospital council.

1940 44% of Rochester's population is covered by health insurance at a time when only 10% of people nationwide have health insurance of any kind (Smillie).

1946 Rochester surgeons organize the Rochester Blue Shield Plan, which uses the staff and management services of Rochester Blue Cross.

1946 The Council of Rochester Regional Hospitals is formed under a five-year grant from the Commonwealth Foundation to upgrade medical service and patient care in rural areas of the region. The Commonwealth Fund commits $200,000 per year for five years for improvement of hospital facilities in the 11-county region. Within the Council's programs, staff of the urban hospitals share their expertise with the administrators and health professionals of the rural hospitals.

1949 The hospital fund-drive raises $7 million. This assures new facilities for each of the five cooperating hospitals and provides for the construction of a new Northside Hospital (which later becomes the main hospital of the Rochester General Hospital) (McKelvey).

1950s (Early 1950s) To meet Marion Folsom's conditions for obtaining a Kodak contract, the Blue Shield Plan's member physicians agree to accept a relative value fee schedule as full payment for insured employees whose incomes place them in the position of the "average working man or woman." (The original income ceiling of this "service benefit" was $5,000. This service benefit is still in effect today, with a 1986 income ceiling of $36,500.) Blue Shield also meets a second condition set by Kodak: that the cost for combined Blue Cross-Blue Shield family coverage, which in those days was all paid by the employee, be no more than $5.00 per month.

1950s Rochester Blue Cross and Blue Shield continue to use a communitywide risk pool for setting employer group rates (community rating) when Blues in other markets are forced to base rates on the costs of each insured group (experience rating). This is possible because Rochester Blues penetration is so high, risk so widely shared, and community rates are low.

Rochester employers and Blue Cross and Blue Shield collaborate to expand health insurance benefits for retirees. Henceforth, retired employees have the same benefits at the same cost as active employees. Over 80% of the entire employed and retired population in the area are enrolled in Blue Cross—a national record.

1955 Marion Folsom is appointed Secretary of the Department of Health, Education and Welfare in President Eisenhower's Cabinet.

1955 Blue Shield splits off from Blue Cross to become an independent organization. In the years to come, the Rochester Blue Cross plan becomes a national leader in innovation, creating new programs of home care, chronic care, ambulatory surgery and HMOs. In particular, Rochester Blue Cross will support and encourage the regional coordination and integration of health services and financing.

1955 The Health Division of the Community Chest's Council of Social Agencies undertakes a series of planning activities in chronic illness and rehabilitation. The best known of these studies, the 1959 Todd Report, will provide an informed basis for the community's chronic care policies for a number of years into the future.

1959 The Rochester hospitals initiate a fund drive, asking for more than $30 million and planning to add 500 additional beds.

1960 Marion Folsom is asked to oversee allocation of the hospital drive funds. He agrees, but feels it is critical that the committee which will determine need should be independent of the hospitals and broadly representative of the community. To achieve this end, Folsom forms the Patient Care Planning Council to oversee the hospital fund drive. Council members include the health and welfare officers of the city and the county, the dean of the medical school, the president of the medical society, representatives of Blue Cross, Blue Shield, the Rochester Regional Hospital Council, the executive directors of the Council of Social Agencies and the Community Chest, a labor official, an industrial representative, a member of the city council, a representative of the Industrial Management Council and others. These representatives use their influence in the community to bring about implementation of the planning council's recommendations. In many instances, their collective influence enables the council to carry the day over the objections of health providers (Conant).

The Patient Care Planning Council evolves into an on-going community health planning council, and Folsom serves as chairman of the PCPC for its six-year existence. This is generally considered to be the beginning of independent, community-based health planning in the United States.

Since this beginning, the Rochester area has continuously had a health planning agency. The agency has gone through several name changes, which coincided with enlargements of the planning area and/or new state or federal health planning legislation. Each successive planning agency has incorporated its predecessor. The first two health planning agencies' scope of concern was Monroe County. The two most recent agencies have served multi-county regions which encompass urban, suburban and rural areas. The present-day Finger Lakes Health Systems Agency has planning responsibility for a nine-county region contained on the north by Monroe and Wayne Counties and extending southward to the Pennsylvania border.

Names and time periods spanned by the area's health planning agencies:

1961–1966 Patient Care Planning Council

1966–1969 Health Council of Monroe County

1969–1975 Genesee Region Health Planning Council

1975–date Finger Lakes Health Systems Agency

1961 In an early action, the Patient Care Planning Council commissions an objective evaluation of the use of beds in the seven short-term hospitals in Monroe County. Sixteen percent of general hospital beds were found to be occupied by patients who did not require them for medical reasons.

Using evidence from this local bed utilization study and from the New York State Department of Health, the PCPC obtains a 50% reduction in the hospital campaign goal—to $14 million—and a 70% reduction in the number of new beds, from the 500 beds requested to the 140 beds approved (Conant).

1963 The Ford Foundation makes a large grant to the Health Division of the Council of Social Agencies and the University of Rochester for the study of health care of the aged. Grant projects include the country's first systematic cross-sectional study of all aged persons in a community. This study included elderly persons at home and those in institutions, and estimated their optimal placement and care needs. This and related studies found a number of persons in institutions who could be cared for at home.

1960s Under the protection of the limited bed supply, Blue Cross is able to make a series of major inpatient and outpatient benefit expansions—resulting in the nation's most comprehensive basic contract.

Inpatient psychiatric benefits are made equal to all other inpatient benefits; outpatient surgical benefits are instituted; pre-admission laboratory tests are covered; coverage is extended to care in chronic and rehabilitation hospitals; hemophilia treatment and coverage are included in the contract; and hospital utilization committees are established.

An area-wide hospital-level home care program—a national first—is created through the initiative of Blue Cross, and Blue Cross coverage is expanded to cover the new home care services which can help shorten hospital stays.

1962 Folsom is appointed chairman of the joint commission on community health services of the American Public Health Association and the National Health Council's National Commission. The commission's report, *Health is a Community Affair.* is published in 1966.

1962 On the recommendation of the Patient Care Planning Council and through negotiations stimulated by Folsom, the city, the county and the University of Rochester Medical School agree to a merger of Rochester Municipal Hospital into Strong Memorial Hospital.

1965 The federal government enacts the Medicaid and Medicare laws. Medicaid provides state governments with federal matching funds for the health care of some of the poor and those whose medical expenses make them poor. Medicare is the federal health insurance program for the elderly and disabled. It provides fairly complete coverage for acute care, whether in hospitals, nursing homes or in the home, and for physician services. It does not cover prescription drugs or long-term chronic care.

1966 Monroe Community Hospital (County Infirmary) becomes affiliated with the University of Rochester Medical Center. This affiliation agreement was the result of four years' persistent, careful negotiations kept alive by Marion Folsom. It is one of the major accomplishments of Folsom and the Patient Care Planning Council. Both infirmary officials and the University Medical Center argued against the proposal, but Folsom was able to generate broad acceptance for the affiliation in the community at large. "Also, the arguments against the proposal were almost wholly in the private interests of the affected parties and as such were hard to support in public exposure of the proposal" (Conant). By the mid-1970s. Monroe Community Hospital had developed into one of the nation's best chronic care multi-level facilities.

1966 Patient Care Planning Council is merged into its successor organization. In addition to accomplishments of the PCPC described above, other important achievements include:

—start of the complete replacement of all old hospital buildings.

—move of the city's smallest hospital from Park Avenue to Greece. This move achieved two desired results: it provided the rapidly growing western suburbs with a new 200-bed hospital and it rid the city of a hospital too small to provide the quality and level of care appropriate in a metropolitan area. These results were the culmination of five years' work by Folsom and the PCPC to effect a solution to the problem of a hospital which did not meet minimum size requirements.

—Construction of a consolidated laundry.

—Abandonment of a proposal by one hospital to build a $1.5 million nurses' residence and a diploma nursing program.

—Inauguration by Monroe Community College of nursing programs to serve the entire community.

—Closing of the county tuberculosis sanitarium; patients were transferred to a nearby state sanitarium.

—Study of mental health in Rochester resulting in the following steps:

(1) Proposal for a small independent psychiatric hospital was abandoned.

(2) A local general hospital agreed to include outpatient and inpatient psychiatric units in its construction plans.

(3) Mental Health Council organized and staffed by the Council of Social Agencies to coordinate activities and planning of 40 agencies in the field.

—Stimulated the County Medical Society and hospitals to establish utilization committees in each hospital (Conant).

1966 Supervision of hospitals in New York State is tranferred to the State Health Department from the State Welfare Department. New York State enacts the "certificate of need" legislation to provide health planners with regulatory authority, and creates regional health planning councils within the state to assure that the health planning process will originate at the local level.

1967 The Wadsworth Committee, of the Health Council of Monroe County, is formed to study health service needs in the inner city. The committee report, issued in June 1968, recommends a network of neighborhood health centers that would use group medical practice to assure easy access, continuity of coordinated family care, psychiatric and dental care, and 24-hour availability of emergency treatment.

1967 The Regional Medical Program is created under federal mandate to improve the treatment of heart disease, stroke and cancer in rural areas and small cities and towns. From 1970 to the end of this federal program in 1976, Rochester's Regional Medical Program (RMP) worked in close collaboration with the region's health planning agency. The planning agency had the data and expertise to determine the deficiencies in health care in the region: and the RMP had the funds and the technical expertise to stimulate the development or upgrading of services to overcome these deficiencies.

Two examples of the joint achievements of the Regional Medical Program and the regional health planning agency are the establishment of primary care group practices and satellite clinics in rural areas lacking medical services; and the upgrading of emergency ambulance services throughout the region, including the introduction of two-way radio communication capability.

The productive collaboration between Rochester's Regional Medical Program and health planning agency was outstanding in the nation and served as the model for the federal Comprehensive Health Planning and Resource Development Act of 1976.

1968 John Hostutler becomes president of Industrial Management Council (IMC), the Rochester area's employers association. In subsequent years, Hostutler will play an important role in broadening and deepening the involvement of area corporate leaders in the formulation of community health policies. On repeated occasions, the IMC will make clear its support for the actions of the regional health planning agency's representative councils. In 1985, the IMC has 215 member companies and affiliates, employing approximately 155,000 persons.

1970 Joseph C. Wilson, founder and chairman of the Xerox Corporation, chairs Governor Rockefeller's Commission on health and hospital services and costs. The commission finds that inefficient and irrational organization and perverse reimbursement incentives are driving the escalation of health care costs. It advocates the development of more health maintenance organizations (HMOs) as one way "to produce voluntary movement toward efficient, effective and more economical health care systems."

1970 A community committee chaired by William Von Berg, president of the Sybron Corporation, recommends the establishment in Monroe County of three HMOs under Blue Cross/Blue Shield ownership or sponsorship. The implementation of this recommendation is actively supported by Joseph Wilson, Rochester's most powerful industrialist. Wilson's backing of HMO development in Rochester is a critical element in their successful foundation.

1971 The first awarding of the Schlesinger Award for Community Health Planning is made jointly to the Genesee Region Health Planning Council and its executive director. The most prestigious of national awards for health planning, the Schlesinger Award is made cooperatively by the American Public Health Association and the American Association of Health Planning.

1973 Three HMOs become operational in Rochester, either as entities or affiliates of Blue Cross and Blue Shield.

—Genesee Valley Group Health Association, a group practice plan modeled on the Kaiser Plan HMOs.

—Health Watch, the nation's first IPA-type HMO, is a line of business in Blue Cross and Blue Shield. Though it later fails, it is replaced in 1978 by Preferred Care another IPA which is independent of Blue Cross and Blue Shield.

—Rochester Health Network, originally a network of five neighborhood health centers providing ambulatory care for low income groups, becomes a network model HMO.

1976 Marion Folsom dies.

1976 The nine-county planning area of the Finger Lakes Health Systems Agency is selected by the United States government and National Blue Cross as the first place in the nation to demonstrate MaxiCap, a new method of paying hospitals by relating region-wide planning to a region-wide budget. After two years of organizational work by hospitals, doctors and community representatives, serious interest in the proposal is restricted to metropolitan Rochester's hospitals. These hospitals are all running deficits under New York State's stringent payment regulations, and see the promise of financial improvement in the payment experiment.

The Rochester Area Hospitals' Corporation (RAHC) is established to administer metropolitan Rochester's Hospital Experimental Payment project (HEP) which starts operation in 1980. When the hospitals in Ontario, Wayne, Seneca and Yates counties observe the financial benefits which HEP brings to the RAHC hospitals, they negotiate a similar payment experiment, the Finger Lakes Hospital Experimental Payment project (FLHEP). The Finger Lakes Area Hospitals' Corporation (FLAHC) is established to administer FLHEP, which starts operation in 1981. These two hospital corporations raise area-wide cooperation and planning by hospitals to a new level.

1977 An area-wide hospice program and an early discharge maternity program are created and administered by the Genesee Region Home Care Association. Blue Cross benefits are expanded to cover these new programs.

1977 The Monroe County ACCESS demonstration project is initiated with state support to enhance the community capability to maintain elderly patients in their own homes, and thereby postponing their entry into nursing homes.

1982 In a national study of 30 metropolitan areas, Rochester is found to be the lowest cost center for the 65+ population covered by Medicare, with a cost of 71% of the United States average (adjusted for age, sex, and local variation in wages).

1982 Federal revenues to the Finger Lakes Health System Agency are cut 60%, endangering the future of health planning in this region. A special task force formed by the Industrial Management Council recommends that Blue Cross provide a special grant to the agency for the current year and requests that United Way form a task force to devise a long term, locally implementable solution to the FLHSA's financial problems.

1983 Rochester is the inspiration and model for the Robert Wood Johnson Foundation's $16-million grant program to support the development in other cities of community-level coalitions that work to make health care affordable and available to all. This program will assist other communities to emulate the cooperation of Rochester business, labor, hospitals, health insurers and the medical profession in major broad-based, community health care projects. The Robert Wood Johnson Foundation is the nation's leading philanthropy supporting innovations to improve the affordability and access to health care.

1983 The executive director of the Finger Lakes Health Systems Agency receives the Schlesinger Award for Community Health Planning. For the first time in its 12-year history, the award is returned to a community previously recognized.

1984 The Rochester Blue Cross Plan and the Rochester Blue Shield Plan merge managements in order to better coordinate their activities.

1985 MediCap, a federal-state-county Medicaid demonstration project, starts operation. The MediCap program contracts with area HMOs to provide managed health care to Medicaid recipients on a capitated basis. At its peak, the MediCap project enrolls 48,000 persons in managed care programs.

1985 Blue Cross and Blue Shield start a new HMO-IPA, Blue Choice. A national record of over 40,000 are members on opening day.

1985 Responding to the 1982 recommendation of the task force formed by the Industrial Management Council, the community health planning fund is created to provide for local funding of the Finger Lakes Health Systems Agency.

1986 HMO enrollment in Monroe County reaches 45% of the work force, with over 300,000 members enrolled.

1987 Integrated Mental Health, Inc. (IMH), a joint demonstration project of the New York State Office of Mental Health, Monroe and Livingston counties, and the voluntary agencies in Monroe and Livingston counties, starts. IMH will integrate planning, financing and delivery of mental health services to chronic mentally ill individuals in the two-county area.

1987 Federal funding for regional health planning agencies is terminated.

1987 The boards of directors of Preferred Care and RHN HMOs vote to merge.

1987 Genesee Valley Group Health Association (GVGHA), the Kaiser model HMO, moves into a closer relationship with Blue Cross to become a Blue Cross line of business.

1987 The Monroe County MediCap demonstration project of capitated, managed care for the Medicaid population is ended.

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APPENDIX II
WHERE TO GET CARE: WHAT ARE THE OPTIONS?

Today, compared to 20 years ago, many more health care needs can be met safely and appropriately outside the acute hospital and other inpatient institutions. The widening of options in "where to get care" has come from a number of advances, such as:

—new medical technologies, e.g., CT scanners and micro-surgery instruments

—improved anesthesias

—new drugs, e.g., for managing heart disease and mental illness

—development of home health care programs

—development of new ambulatory treatment programs

It is increasingly possible in the Rochester area to obtain needed care in non-institutional settings when that is a safe and appropriate alternative for the patient. Consumer preference, HMO growth and insurer utilization control programs are helping to increase the proportion of care provided at lower levels of care and in non-institutional settings.

The table below shows some of the present-day options in care sites. In the Rochester area, the FLHSA has used its persuasive and regulatory powers to encourage development and wider use of cost-effective care substitutions like those shown in the table. This has not always been easy. Some providers have been difficult to persuade away from old ways, even when research has established the safety and efficacy of lower levels of care and care in non-institutional settings. Also, the smaller per case revenues from care delivered in non-institutional settings may sometimes be a factor in providers' reluctance to shift care to these sites.

ALTERNATIVE LEVELS OF CARE AND CARE SITES

SURGERY

Inpatient admission for surgery

or

Surgery in a hospital ambulatory center, or physician's office

ALCOHOLISM DETOXIFICATION

In an acute hospital

or

In a residential social detoxification program

or

In an ambulatory setting

MENTAL ILLNESS

Psychiatric unit of acute hospital or state mental hospital

or

In supportive living environment of a halfway house, in a part-time hospitalization program.

or

In the community, with a variety of needed health and social services arranged and managed by a professional case manager

ACUTE ILLNESS

In an acute hospital

or

In a skilled nursing home

or

At home, with high level home care

ALCOHOLISM TREATMENT

Inpatient treatment

or

Intensive outpatient treatment (group and individual therapy) combined with stay in a community residence

or

Individual and group therapy in an ambulatory setting

CHRONIC ILLNESS AND/OR DISABILITY

In a nursing home

or

At home, with needed care arranged and managed by a professional case manager, backed up by adult day care, meals-on-wheels, homemaker services, and transportation services

KIDNEY DIALYSIS

In a hospital dialysis center

or

In a free-standing center

or

At home

or

Continuously, during normal activities

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APPENDIX III
ESTIMATE OF NUMBER OF PERSONS WITHOUT HEALTH INSURANCE IN SIX-COUNTY GENESEE REGION: SOURCES AND TECHNICAL NOTES

The estimation is for a single point in time: June 1986. The basic method of estimation was subtraction of the number of persons with health insurance from the projected population. An extensive effort was made to ascertain the number of insured persons. For employer and union groups known to be insured but for which it was not possible to ascertain the number of insured, a conservative estimate was made using national and local parameters on health insurance coverage. Considerable care was paid to the avoidance of double counting.

As the subtraction method tends to underestimate the number of insured, it probably overestimates the number of uninsured. It is likely that the real number of uninsured is smaller than the estimate.

Data Sources:

- Projected population figures: Population Projection Series issued April 1985 by the New York Department of Commerce.
- Data on number of insured were provided by:
  - —Rochester Blue Cross and Blue Shield
  - —All four Rochester HMOs
  - —Employers and labor unions, through direct contact
  - —State of New York and Monroe County, for Medicaid
  - —Health Care Financing Administration, U.S. Department of Heath and Human Services, for Medicare
  - —Office of Personnel Management, for federal employees

Assistance with estimation procedures and parameters was provided by:

- Employee Benefits Research Institute, Washington, D.C.
- Industrial Management Council, Rochester, New York
- Rochester Blue Cross and Blue Shield
- Third Party Resources Unit, New York State Department of Social Services

Additional details on the estimation procedure can be obtained from the Finger Lakes Health Systems Agency.

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Taylor, Patricia.

The health care system of Rochester, New York