# Health System Change in Miami, Fla.

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The Miami health care market is characterized by intense competition and deal making that revolve around frequent buying and selling of health plans and hospitals and financial positioning across both sectors. Yet no one sector is dominating the market. For-profit national companies, having long played an active role in the area, are making decisions affecting the local level that are played out within the regional strategies of these organizations. At the same time, locally based hospitals and health plans are positioning to achieve market power and maintain relationships with historical constituencies. New organizations that align hospitals and physicians are also forming. The pressure of considerable overcapacity in hospital beds and physicians and the presence of a large number of health plans have created expectations and opportunities for closures and consolidations.

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The Miami area is culturally and politically complex. The majority Hispanic population is composed of people originating from many different countries. In addition, the area has a large African American community and large groups of new and established immigrants, many of whom are poor. It is a mix of cities, suburbs, ethnic neighborhoods and rural areas. Leadership emerges primarily from these ethnic areas and from broader ethnic constituencies, but with no dominant or controlling player.

The political dynamics in the Miami area are characterized by colorful and sometimes conflicting interaction among many diverse interest groups and varying but only sometimes successful efforts to address local problems. Moreover, corruption in the city of Miami and incorporation of the largely unincorporated areas of the county have contributed to recent changes in municipal and county government that may have significant implications for financing care for the poor, who have long depended on local taxes for services. Care for the poor has historically been concentrated in the large public hospital in Miami and ethnically oriented community health centers in the neighborhoods.

On the private sector front, the Miami business community is made up primarily of small businesses with a few large employers that do not play an active role in the health care market. Commercial premi-

ums have decreased, lessening the motivation for business to organize purchasing power. Health plans have historically been attracted to the market by high Medicare rates and relatively generous Medicaid rates, so public purchasers have had a major role in shaping competition. For example, the state has recently taken a more active purchasing role through its efforts to move more of the Medicaid population into managed care arrangements. Final awards resulting from the recent competitive bidding for Medicaid contracts may shake up existing arrangements in ways that cannot yet be determined.

Miami-area physicians have historically practiced independently in solo and small practices. Increasingly, physicians are considering physician-hospital organizations (PHOs) and independent practice associations (IPAs) to help them compete for patients. Little exclusivity is evident as yet, except where physicians are salaried. Similarly, few efforts to introduce global capitation or care management are evident, though some groups are actively preparing to take on risk and manage care.

Poor access to health care for at-risk populations, unemployment, lack of insurance and high rates of poverty reportedly contribute to high rates of premature morbidity and mortality.

## The Miami Community

This case study describes the Dade County area, which has a highly diverse and changing population of approximately two million people.[1] The North Dade area is primarily urban and includes the city of Miami, which makes up approximately 20 percent of the county's population and is home to many of the area's hospitals and physicians. The South Dade area, which is more rural, includes agricultural areas with a large migrant population and significantly fewer health resources. Much of the county consists of unincorporated areas that depend on Dade County for municipal services. The massive destruction caused by Hurricane Andrew, which occurred in 1992, continues to affect the area in the form of population and employment shifts, including the closing of a major military base.

The dominant population (approximately 50 percent) is Hispanic, followed by the African American community at 20 percent. As the major entry point from Central and South America, immigration into the region is constant, and includes both legal and undocumented individuals. Almost 15 percent of the population is over the age of 65, a lower proportion than the rest of the state, but 12 percent above the national average.[2] The annual per capita income in the county is $19,266, below the national average for larger metropolitan areas; however, there is considerable variation in income cutting across ethnic and racial lines.[3] An estimated 20 percent of the population is uninsured.[4]

The picture of health status in the market is mixed. Overall age-adjusted mortality is considerably higher than U.S. averages,[5] and there are significant disparities between white (non-Hispanic) and non-white residents. Poor access to health care for at-risk populations, unemployment, lack of insurance and high rates of poverty reportedly contribute to high rates of premature morbidity and mortality.[6] Despite these rates, however, infant mortality rates fall well below the national average, a situation widely attributed to concerted state and local efforts to increase access to prenatal

care.[7] Other major health problems remain, including high rates of HIV infection, AIDS, tuberculosis and problems of substance abuse and deaths related to violence, incidents that disproportionately affect different ethnic and racial groups. In addition, the constant influx of immigrants has resulted in the presence of a variety of infectious and communicable diseases that are not normally seen in other parts of the United States.

## THE HEALTH CARE MARKET

The Miami health care market is characterized by an oversupply of health resources and fragmented, rapidly changing business relationships in what may be called an "every-health-care-organization-for-itself" environment. The market has over 31 percent more hospital beds per capita than the national average[8] and 42 percent more physicians.[9] At the same time, major areas of the city of Miami and South Dade County are designated as medically underserved areas, where the large indigent population has limited access to care.

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Hospitals' and health plans' attempts to pursue a mix of regional and neighborhood/ethnic-based strategies have not succeeded in coordinating service delivery or creating accountability at the county level. Moreover, frequent ownership changes interfere with the formation and maturation of alliances among providers and plans that might lead to better coordination of service delivery, care management and attention to demonstrating quality. These issues, together with the constant deal making and lack of dominant players, make Miami's market dynamics difficult to predict.

Abundant health care resources are located throughout the county with physician offices located near hospitals and office buildings and in many strip malls. Specialty services and tertiary care facilities are heavily concentrated in the city of Miami and the surrounding area. Tertiary services and clusters of physicians tend to be located in and around the joint campus of the University of Miami Medical School and Jackson Memorial Hospital, the county's public hospital. Some of the community hospitals are located farther north toward Broward County and in ethnic enclaves in the northern part of the county. Baptist Health System is the dominant provider in South Dade, which is also served by a large, multipurpose, federally supported community health center.

Residents of Dade County primarily seek their health care from providers in the county, but the major hospital systems and health plans in the area view their market more broadly. The major tertiary hospitals in Miami proper draw patients from surrounding counties, including Broward and Palm Beach to the north and Monroe to the south. Jackson Memorial's service area includes the rest of Florida, as well as Central and South America, and the Caribbean. The University of Miami Medical School maintains referral relationships with the physicians it trains from other countries, particularly for specialized services not available in those countries.

Historically, the Dade County tertiary hospitals, specialists and some of the North Dade community hospitals have attracted in-migration, that is, persons coming into

the county for care, especially from adjacent Broward County. Two changes have occurred that are limiting some of this in-migration.

- Broward County has developed its own Level I trauma facilities, which are expected to limit travel to Jackson Memorial.
- A significant number of persons who had sought temporary housing in Broward after Hurricane Andrew have remained there and receive local services.

## LEADERSHIP AND DECISION MAKING

Leadership and decision making generally reside at a very local level, with limited county-wide activity and little accountability at the county level. The dominance of national and regional ownership in the health care industry, however, generally means that most decisions about local hospitals and health plans are made outside the area. Leadership at the local level is also often bounded by racial, ethnic or geographic divisions. In fact, neighborhoods and broader ethnic communities do not come together in any way that provides either collaborative or political leadership to the entire Dade County area on health care or any other issues. Efforts to solve broad community problems are limited, though at times such efforts may be more concentrated and effective within a specific neighborhood.

In many cases, the legitimacy local leaders do have comes from these communities of concern. Some healthcare providers, particularly community hospitals and long-standing community health centers, have taken on the responsibility for organizing and implementing programs within their own neighborhoods. The boards of these providers are made up of community representatives, including members of the business community, civic and religious leaders. For example, the Pan American Hospital, which considers itself accountable primarily to the Cuban community it serves, works directly with many community leaders and area businesses to assess and address the health needs of its community.

On a broader, county-wide level, task forces and committees established to address health and other human services issues generally focus on assessment of health problems and identification of potential solutions. However, none of these organizations—local or county-wide—has the legitimacy, authority or resources to influence or initiate action. A number of advocacy groups serve the interests of vulnerable populations, such as children, immigrants, refugees and persons with HIV/AIDS, but they also have limited influence. The business community, through the local chambers of commerce and individual efforts of area businesses, is involved in working with various community-wide initiatives such as school health, prevention and health promotion efforts sponsored by community groups and hospitals.

Many respondents feel that no one is accountable for the effective expenditure of county health funds, though several organizations are either designated or have the potential to improve accountability. These organizations include the Dade County Health Department, the Jackson Memorial Public Health Trust and the relatively newly authorized Public Health Authority. The County Public Health Department recently divested itself of its clinical sites to concentrate on community and public health issues such as teen pregnancy and sexually transmitted diseases. The state-funded Health Department serves as a convenor around

an issue, but cannot ensure that local action occurs because of limited local legitimacy and influence.

The Public Health Trust is the governing board for Jackson Memorial Hospital and its related enterprises and is charged with accountability to the "community." Made up of community representatives, the Trust is responsible for ensuring that efforts by Jackson Memorial and its clinics, especially in the use of county indigent care dollars, reflect the needs of the community. However, the Trust has been a source of some controversy and concern about whether it truly represents the community and is accountable. In response to these concerns, the Dade County Commissioners established the Public Health Authority, which began operating in November 1996. The Authority was set up to assess the extent to which the Trust was meeting community needs and to report its findings to the County Commissioners. Originally intended to act as an independent group, the Public Health Authority established a close working relationship with the Public Health Trust, leading respondents to question its ability to render independent judgment.

Miami's recent bankruptcy and accusations of corruption also raise questions about the future of the county governance in general and financing of indigent care in particular. Jackson Memorial receives a portion of its support from dedicated property tax millage. However, as unincorporated areas become incorporated, they must vote to retain millage. To the extent that newly incorporated areas do not do this, funding for Jackson Memorial could be affected. Many respondents hope that the new mayor of Dade County will address this issue, but his approach to health care financing is not yet clear.

## External Forces Affecting the Health System

### PUBLIC POLICY

The primary focus of state policy has been on access, insurance and Medicaid, with little focus until recently on improving access to health care and regulating the health care industry. Historically, the state provided limited support to improve access to care. Important steps have been taken in recent years, however, including: enhancements of special programs and services like the Florida Healthy Start Program, and expansion of Medicaid and other policies designed to expand insurance coverage, particularly for children and persons working for small businesses. For example, the Florida legislature established the Healthy Kids Corporation in 1990 to provide comprehensive health care coverage to uninsured children in 11 school districts across the state, including Miami's. The program now covers 20,000 children and will be expanded to include five additional sites covering 45,000 children by fall 1997. Fifty percent of the program is funded by state dollars; 33 percent by family premiums; and the remainder by school districts, hospital authorities, children's services councils and community groups. Healthy Kids Corporation uses school districts to define the client base and relies on the income criteria of the National School Lunch Program to set sliding-scale premium rates.

To expand coverage for employees in small businesses, the state established Community Health Purchasing Alliances (CHPAs), state-chartered, not-for-profit entities designed to enable small employers to purchase insurance. Launched in 1994, the purchasing alliances were organized geographically into districts. The state provid-

ed some initial seed money and continues to support some of the district CHPAs, though not the local one in Dade County. CHPAs serve as liaisons between employers and health plans and do not purchase insurance directly. If an employer wants to purchase insurance through the CHPA, the employer contacts the CHPA, and the CHPA in turn refers the employer to an authorized agent. The intent is for each district to be self-supporting.

Another initiative, the Florida Health Security Plan, was proposed to expand insurance coverage for individuals who are not currently eligible for Medicaid to 250 percent of the poverty level. The Florida Health Security Plan also proposed expanding the use of managed care. The federal government approved this request for a statewide Medicaid waiver under the 1115 authority but the state did not implement it due to a lack of enabling state legislation. However, the state is actively expanding its managed care initiatives under existing but more limited Medicaid waivers that include amendments to permit mandatory enrollment of Medicaid recipients who choose not to participate in the state's primary care case management program (PCCM).[10] State Medicaid policies have significant impact in the Miami area because Dade County has the highest concentration of Medicaid eligibles in the state with approximately 27 percent of the 1.5 million Medicaid eligibles.[11]

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Eliminating persistent problems of fraud and abuse is the major focus of the state's regulatory policy. The Miami market, in particular, has been the site of a number of Medicare and Medicaid fraud and abuse cases that have gained national attention. The 1980s' charges of fraud and abuse and eventual convictions of principals in a major Medicare health plan, and similar charges regarding Medicaid plans during the last few years, have caused the state to step up its regulatory efforts. In fact, recent Medicaid regulations are designed to eliminate earlier regulations that permitted plans to participate in Medicaid managed care without meeting existing HMO licensure requirements. The new requirements impose stricter standards for marketing, financing and care delivery to reduce charges of unfair marketing practices and poor quality of care.

Extending commercial HMO requirements to Medicaid plans appears to be having some impact as evidenced by state intervention in the recent proposed merger between Physicians Corporation of America, the major Medicaid plan, and Sierra, Inc., of Nevada, which was halted due to the unacceptable background of one of the Sierra principals. Moreover, legislators set new, tougher standards to include restrictions on Medicaid enrollment practices and use of competitive bidding for 1997 Medicaid contracts, efforts designed to reduce costs and improve quality of care. A new statute was also passed establishing locally based ombudsman programs to address consumer and physician complaints about HMOs. Whether these legislative initiatives will improve the quality of health plans remains to be seen.

The history of fraud and abuse in public programs has drawn special attention from

the federal Health Care Financing Administration (HCFA). A temporary field office was placed in Miami specifically to address fraud and abuse problems. Although originally planned as a time-limited effort, the office continues to operate. The current investigation of charges against Columbia/HCA related to its Medicare billing and other practices, including those in the Miami market, indicates that these problems have not yet been resolved.

## PUBLIC AND PRIVATE PURCHASERS

Miami is on the one hand characterized by a large publicly insured population whose programs have paid relatively high rates relative to commercial plans and have a sizable number of lives under managed care arrangements, primarily HMOs. The area's private purchasers, on the other hand, are represented by a primarily small-employer market (50 or fewer employees) that generally purchases health care through brokers and is most interested in premium costs. The large number of health plans and products in the market provides considerable choice for purchasers.

Relatively high payment rates, particularly for Medicare, have made both Medicare and Medicaid more attractive to managed care organizations than the commercial market.

### • Public Purchasing

The public purchasers include Medicare and Medicaid and government agencies, which employ a large number of people. The largest employers in Dade County are the Metro Dade Public Schools, Metro Dade County Government, the federal government and the state of Florida. The first three of these together represent approximately 8 percent of the work force in the county.[12]

Relatively high payment rates, particularly for Medicare, have made both Medicare and Medicaid more attractive to managed care organizations than the commercial market. Medicare's average adjusted per capita cost (AAPCC) rates established for all areas of the country are extremely high for Miami—approximately 60 percent above the national average.[13]

Medicare and Medicaid account for a large number of the county's population enrolled in HMOs. For Medicare, HMO enrollment is 30.5 percent compared with a national average of 12.6 percent as of December 1996.[14] Medicare HMOs have operated in the market for a long time, compete actively for enrollment and generally use generous benefit packages and large networks as their basis for competition.

The Medicaid population is rapidly moving into managed care because of new requirements for mandatory enrollment of recipients who do not choose voluntarily among a number of prepaid plans, HMOs or primary care case management. Dade County has the highest Medicaid managed care penetration in the state of Florida at 29.5 percent.[15] In 1996, approximately one-fourth of these beneficiaries were enrolled in Medicaid HMOs and other prepaid plans. The remaining beneficiaries participate in the state's primary care case management program. Respondents expect that all of the county's Medicaid population will be enrolled in HMOs and other prepaid plans in the future.

The 1997 Medicaid contracts change the rates the state will pay and the plans that can enroll Medicaid recipients. The state's Notice of Intent for contract awards was announced in February, and protests of the award process may delay the planned July

implementation. If implemented, the awarded 1997 contracts will reduce the capitation rates for Medicaid HMOs from 95 percent of the county's fee schedule to between 87 percent and 92 percent. The announced awards include 12 plans, each with a specific allocation of enrollees, dividing up the potential county capacity of approximately 400,000 Medicaid recipients. If the July rollout is postponed or overturned, the speed with which the Medicaid population will be enrolled in HMOs is uncertain.[16]

### • Private Purchasing

Relatively little organized private sector purchasing activity is underway, due in part to the prevalence of small employers, but also to the low cost of insured products, as a result of heavy competition among health plans. Health plans compete for commercial lives to get at least 50 percent of their enrollees from the commercial section to meet requirements of the Medicare program.

Purchasers have had a declining interest in mobilizing around purchasing in this market since the 1980s, when they experienced large annual increases in premiums. At that time, purchasers organized to share information. The South Florida Business Coalition, formed in the 1980s, served as a vehicle for many of the large employers in the market to share price information about different products. However, the coalition never developed a collective purchasing effort and many of the large employers pulled out. As health plans in the area had to lower their rates to get business, many employers were able to obtain lower prices. Consequently, fewer employers saw the need to organize around purchasing, and membership in the coalition declined.

Although some employers still offer traditional indemnity products, most offer and have greater enrollment in HMO, PPO and point of service products. Some employers offer multiple choices among HMOs that often involve different employee contributions. Employers such as Jackson Memorial Hospital and the University of Miami offer incentives to encourage enrollment in their own plans. Many of the larger private employers in the market are self-insured.

Only a limited number of small employers seek insurance products available through the Community Health Purchasing Alliance (CHPA). Most small employers offering insurance work directly with brokers. Respondents reported that overall participation in the state has only reached 2 percent of the insured population.[17] The District 11 CHPA includes Dade and Monroe counties and is supported by administrative fees, yearly employer memberships and some other private funds. The CHPA has increased the number of insured products available to small businesses but has not addressed the cost of those products adequately. Many small employers can obtain lower rates on their own for the same product. Approximately half of the plans offer the same rates to employers inside or outside the CHPAs (when membership and monthly fees are included), and in some instances the CHPA rates are higher.

The South Dade Chamber of Commerce developed another small-business effort that is reported to be more successful than the local CHPA in terms of participation by small businesses. By working with the John Alden Insurance Company to develop a PPO involving two hospitals, Baptist and South Miami, the Chamber is able to offer a PPO product with special pricing to its members.

## Organization of the Health Care System

The majority of Miami health care organizations are owned by for-profit national companies whose strategies often are driven from regional offices that have a focus somewhat broader than Dade County. These strategies may not take into account the character of the Miami community. Their influence is tempered by powerful not-for-profit, locally based institutions. The buying and selling of organizations dominates the environment, reflecting a strategy used by for-profit and not-for-profit entities. Hospitals have consolidated into three major health systems, leaving the future of the independent hospitals open to question. Consolidation has not yet resulted in any substantial decrease in capacity. Pressures from overcapacity and health plan demands for reductions in cost appear to be important factors underlying organizational change.

The Baptist system formed over the past year; the new Tenet/OrNda merged system developed over the last few months; and Columbia/HCA is continuing to purchase providers in the area.

The strategies of hospitals, health systems and health plans are focused on increasing market share.

- Two hospital efforts at plan ownership have emerged.
- Hospitals, hospital systems and plans are looking for ways to organize physicians to control referrals and insured lives.
- The emergence of new physician organizations appears likely in the near future.

Health plans have few barriers to entry and so they continue to enter and exit the market. Changes in Medicaid contracting with health plans will likely bring new players into the market, shifting the balance of business among the already large number of plans.

### PROVIDER ORGANIZATIONS

Most organizational change among providers has centered on ownership. Other types of change are emerging slowly, such as efforts to take on risk and manage care.

#### • Hospitals

Three major hospital systems in Dade County include 15 of the area's 24 acute care hospitals. Columbia/HCA owns five hospitals, has been in the market for the longest period of time and has a major presence in the state. Prior to the recent Tenet/OrNda merger, Columbia/ HCA was by far the largest of the systems, and its acquisition of Columbia Cedars Hospital provided it with a strong tertiary facility. The combined Tenet/OrNda now owns six, primarily community, hospitals. The local not-for-profit Baptist Health Systems owns four hospitals in the South Dade market.

The configuration of the hospital systems is relatively recent: The Baptist system formed over the past year; the new Tenet/OrNda merged system developed over the last few months; and Columbia/ HCA is continuing to purchase providers in the area. This pattern of rapid acquisition and system building reflects recent strategies to gain market power. Systems are just beginning to address more specific operational strategies to achieve some level of administrative, financial and clinical integration.

*Columbia/HCA*, a national for-profit hospital chain based in Nashville, Tennessee, has been in Florida since 1989 and now owns 55 of the state's 225 hospitals. Its Dade County, hospitals are part of Columbia's South Florida region that also includes Broward and Palm Beach counties. Columbia/HCA is a major player in the market, accounting for 22 percent of the acute care beds in the county.[18] The Columbia/HCA hospitals in Dade County include two hospitals in downtown Miami, where most of the area's tertiary facilities are located, Columbia Miami Heart Institute and Columbia Cedars Medical Center. Both hospitals provide a wide array of tertiary services and compete heavily with two independent tertiary facilities: Mount Sinai and Jackson Memorial. Cedars is also a major teaching facility for the University of Miami Medical School. The other three hospitals in the system are community hospitals, located in the southern and northern suburbs. Managed care contracting, marketing, home care and financial and administrative functions are handled at the South Florida regional level.

The *Tenet/OrNda* merger, in process at the time of the site visit, merges two for-profit, national corporations into a single entity whose combined area revenues will be close to those of the local Columbia/HCA region. Their combined network of Dade County hospitals will include three from the OrNda system: Parkway Regional Medical Center, Golden Glades Regional Medical Center and Coral Gables, and three from Tenet: Hialeah Hospital, Palmetto General and the recent acquisition of Northshore Medical Center, formerly a not-for-profit. Of these, only Northshore can be considered a tertiary facility. Tenet/OrNda hospitals are primarily outside the downtown Miami area, in the northern and southern parts of the county. The new system represents 19 percent of the acute care beds in the county.[19]

*Baptist Health Systems* dominates the South Dade area. Its hospitals, Baptist Hospital, South Miami Hospital and Homestead Hospital, contain most of the beds in this area. A fourth hospital, Mariners Hospital, is located in Monroe County. The merger of Mercy Hospital into the Baptist Systems is expected to further solidify the systems' position and help expand coverage in the Hispanic community, a niche for Mercy. Homestead, previously a city-owned facility, is located in a large rural section of South Dade, is the only facility in over a 20-mile radius and serves a large indigent population. Homestead Hospital works closely with Community Health Initiative of South Dade, a community health center, and admits some of its patients. The Baptist systems also owns diagnostic centers, home health agencies and physician practices, and has partial ownership of a health plan. The systems' dominance in South Dade gives it leverage with managed care companies that need to cover that geographic area.

**Consolidation of the hospital systems is expected to significantly increase competition among them. Each system is pursuing different strategies to ensure a strong presence in the market.**

Nine independent hospitals operate in the market, including two major teaching facilities—Jackson Memorial Hospital, the public hospital and major teaching facility of the University of Miami Medical School, and Mount Sinai. The other unaffiliated hospitals are primarily community hospitals, some of which have specific geographic or ethnic niches. The unaffiliated hospitals have

a variety of arrangements with the three health systems, and some are actively negotiating more formal affiliations.

Consolidation of the hospital systems is expected to significantly increase competition among them. Each system is pursuing different strategies to ensure a strong presence in the market. Baptist Health Systems is currently dominant in South Dade, where Tenet/OrNda and Columbia/HCA have some presence. Baptist is continuing to pursue acquisitions and affiliations to enhance its position. The system is also developing more comprehensive pediatric services to capture more business and reduce referrals out of its system to Miami Children's Hospital or Jackson Memorial. This strategy includes an expanded pediatric emergency facility and the opening of a neonatal intensive care unit.

Both Columbia and the new Tenet/OrNda systems have some weaknesses in terms of services and market coverage and are looking to further acquisitions and affiliations to address them. The Columbia system does not have pediatric services or transplants in its current network, and an affiliation with Jackson Memorial Hospital would enable Columbia to fill gaps in services. Tenet/OrNda has only limited tertiary services, and some believe it needs a "star" to compete effectively with both Columbia and Baptist. An interesting recent development is the announcement of plans by the Tenet/OrNda and Baptist systems to develop a joint arrangement to compete with Columbia/HCA for risk-based managed care contracts in the broader three-county market. This arrangement is based on Baptist's South Dade presence and the Tenet/OrNda, North Dade, Broward and Palm Beach hospitals.

At the same time, increasing pressure by health plans on hospitals to reduce costs continues to have an impact on hospital and system actions. Some respondents suggest that hospital rates are now lower than in some post-acute care facilities. Financial viability may dictate the need for increased emphasis on cost reduction efforts. For example, when the OrNda System purchased Golden Glades Regional Medical Center, the obstetric facilities were moved from Golden Glades to Parkway Regional Medical Center to centralize previously duplicative services. In addition, pre-merger, OrNda was moving toward consolidating departments and administrators across hospitals in Dade County.

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Little reduction of bed capacity and few hospital closures have resulted from the number of hospital acquisitions, despite the large oversupply of beds in the area. One reduction was the result of Columbia/HCA merging two of its hospitals, Columbia Heart Institute and St. Francis Hospital, and eliminating 250 beds. Reportedly, Mount Sinai and Miami Heart were the beneficiaries of additional patient volume as a result. Other hospitals have tried to transfer licensed beds from acute to post-acute status but have met with some resistance by the state and its certificate-of-need (CON) process.

Several key hospitals among the remaining independents are considering relationships with the systems, including potential mergers or other formalized relationships. These include: Jackson Memorial (which is the

only source of a variety of tertiary services); Mount Sinai (which has the greatest volume of adult open-heart surgery and adult cardiac catherizations); and to some extent, Pan American Hospital because of its special niche in the Cuban community.

Affiliation decisions by Jackson or Mount Sinai or both could considerably alter the current market position of the three hospital systems. Jackson Memorial Hospital is of special importance to the community because it is the county hospital and the sole hospital receiving funding for indigent care from a county tax assessment. In addition, its extensive tertiary services are provided to the nonindigent populations of South Florida, the rest of the state and internationally to South and Central America. This broad reach of the service area is attributed to some unique tertiary services and the reputation of some of the physicians and facilities. The Public Health Trust that governs the hospital also operates a large number of ambulatory clinics on the Jackson Memorial Hospital campus and at other sites, and owns a health plan, JMH Health Plan, two nursing homes and a home health agency. It is the primary teaching hospital and ambulatory care system for the University of Miami Medical School. Jackson Memorial is a high-cost facility, due in part to its emphasis on highly specialized services, its case mix and its use of the University of Miami Medical Group.

With a total of 707 beds, Mount Sinai Medical Center is the largest private, not-for-profit hospital in South Florida. It also has a teaching relationship with the University of Miami Medical School. Mount Sinai is Jackson Memorial's major competitor in providing open-heart surgery and cancer treatment. Mount Sinai is already engaged in active discussions regarding its future and has made selective arrangements in areas such as cancer services.

### • Physicians

Physicians in the area are reportedly worried about the changes they perceive in the market and the decreasing numbers of patients in their practices. Physician practices are primarily solo or small groups, with some larger single-specialty groups, often organized on an informal basis. A number of physicians report that they are considering moving to different organizational structures but have taken very little action. The major exceptions include the Cuban physicians and the University of Miami Medical Group, both of whom have established organizations. The Cuban physicians were directly involved in the establishment of one of the early HMOs, CAC/Ramsey, now owned by United HealthCare.

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Oversupply of physicians, particularly specialists, contributes to physician concerns. Originally attracted to Dade County by the large Medicare population, the climate and major population growth, physicians must increasingly compete for patients. To capture volume, physicians are signing up with every plan they can. Some physician respondents report growing dissatisfaction with low rates and increasing health plan intervention in the practice of medicine. Respondents further indicate that specialists, in particular, are seeing incomes decrease and some are leaving the area or retiring.

Physicians remaining in the area are exploring ways to organize, including single- and multispecialty group arrangements. Some

are selling their practices to physician management groups and hospital systems. While many view the goal of physician organization as creating networks of physicians and an organizational capacity to contract directly with health plans and take on risk, there is little evidence that this is occurring. One recent tri-county area attempt to start a physician-owned HMO was unable to raise the financing needed and is now planning to use its 1,000 physician-member network to develop a large multispecialty IPA to contract with HMOs. Currently the group, Primus Health Care of Aventura, is only offering its members discounts on malpractice insurance.

The largest practice group in the county is the 600-member faculty of the University of Miami, the University of Miami Medical Group (UMMG). University of Miami Medical Group handles contracting for most of its clinical faculty, although some specialty groups do their own contracting. UMMG has negotiated rates with health plans for primary care and specialty services. The faculty practice plan receives the payment, and pays the physicians a percentage, generally in the form of a modified fee schedule for specialty physicians and a capitated amount for office services of primary care physicians. Several UM subspecialty groups are doing their own contracting with other hospitals and plans apart from arrangements made by UMMG.

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### • Physician-Hospital Strategies

The hospital systems and the larger hospitals have been more aggressive in developing physician-based strategies to capture market share, although some are still in the early stages. Strategies include limited purchasing of physician practices and, more recently, development of PHOs and management service organization (MSO)-like organizations, assistance to physicians in forming IPAs and participation in the development of several managed care products. Hospitals and hospital systems base their strategies on their experience and their relationships with physicians.

Over the years, a group of hospitals has worked together with its physicians to develop various organizations that could help them compete more effectively. Baptist, Hialeah, Mercy, Mount Sinai, Northshore and Miami Children's hospitals joined together in the early 1990s to develop strategies to take on risk. Each of their physician-hospital organizations came together to form a super-PHO called the Dimension PHO. Two products were established: a PPO, and an HMO with John Alden Insurance Company as a partner. Dimension PPO is a highly successful product with an enrollment of more than 250,000. The HMO product, the Neighborhood Health Partnership, was developed as a 50/50 partnership between the Dimension PHO and John Alden. An existing HMO license held by Mount Sinai was transferred to this plan. Of the original six hospitals, Miami Children's dropped out of this arrangement because it was unwilling to accept risk for pediatric patients. Both Dimension organizations continue, although some of the participating hospitals have changed ownership and the Baptist Health Systems was formed.

Effects of these ownership changes on participating members, who now include the Baptist Health Systems and Tenet/OrNda (as the new owner of Northshore), and their independent activities are unclear.

Baptist Health Systems is pursuing additional strategies to align with physicians and take on risk. DadeWell is a new 700-person IPA being created by independent physicians as a 50/50 joint venture with the Baptist system. The goal is to create an integrated delivery system between the hospital system and the physician organization that can enter into full-risk managed care arrangements and can coordinate all components of health care delivery. Baptist expects to see greater contracting opportunities under the DadeWell arrangement.

Columbia/HCA's strategy to address relationships with physicians centers on development of a strong PHO, One Source Health System. Participating physicians are primarily those with admitting privileges at one or more Columbia/HCA hospitals. Exceptions are made when there is a need to expand a network for contracting. One Source is responsible for coordinating the marketing to health plans and self-insured employers on behalf of its participating physicians and the Columbia system. The system currently has risk contracts in addition to a variety of capitation, fee-for-service and exclusive provider organization contracts; it also contracts directly with employers.

Most of the independent unaffiliated hospitals have either physician organizations or PHOs, but few actually contract with plans. A major exception is the Pan American Hospital PHO, which contracts with CAC/Ramsay Health Plan and takes full-risk contracts. Pan American has also established an MSO to handle a variety of administrative and care management functions.

## HEALTH PLANS

Many health plans compete in the Miami area, but none dominates. The high level of HMO enrollment reported by a regional research group includes 33 percent of the commercial market, 38 percent of Medicare beneficiaries and 24 percent of people on Medicaid. The same research group indicates that 33 percent of commercial coverage is through PPOs.[20] The magnitude of managed care penetration has grabbed the attention of many national and regional plans. Competition varies by type of payer. In the Medicare market, competition is based primarily on offering some special benefit packages and ensuring a large and accessible network. In the commercial market and with the 1997 Medicaid contracts, price is the major competitive factor. In general, plans have benefited from high Medicare rates to support the lower rates they must offer to employers to be competitive. Competition is described by many as cutthroat and may contribute to the precarious financial position of some plans.

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Plans in the Miami area have mostly for-profit status, national or regional ownership and focus on Medicare and/or Medicaid. Twenty-three insuring organizations operate in Dade County including

17 licensed health plans. Indemnity products are offered, but cover a smaller percentage of the commercial market. In addition to HMO products, which predominate, PPO and POS products are offered by a subset of the plans. Of the 17 plans, 10 have either a statewide or national focus and include a number of publicly traded companies. Four of the 17 plans are not-for-profit, including two that are wholly or partially owned by hospitals. Many of the plans, including those that originally focused on Miami and Dade County, include broader market areas as part of their strategic development.

Some plans have specific market niches, either in terms of products or penetration of a specific payer group. Among the major plans are: Humana, with a sizable Medicare and commercial base; Blue Cross Blue Shield of Florida with products for all three payers; United HealthCare, also in all three markets as a result of recent acquisitions; Physician Corporation of America (PCA), the current major Medicaid plan; and AV-Med, which services the Medicare and commercial markets. Humana's recently announced intention to purchase PCA will expand Humana's operations into the Medicaid area and add a large number of insureds.

Among the four not-for-profit plans are two provider-owned plans: the Jackson Memorial Health Plan and Neighborhood Health Partnership (NHP). JMH Plan was established by the Public Health Trust in 1987 and has expanded primarily through acquisitions. It is still a relatively small plan, constrained somewhat by the high costs of Jackson Memorial Hospital and UMMG physicians, who make up the bulk of its network, and by administrative restrictions resulting from its being part of the Public Health Trust. NHP is a joint venture of the John Alden Insurance Company and the five-hospital Dimension PHO. Its primary membership is in Dade County and it offers Medicare, Medicaid and commercial products.

Even with a long history of HMOs, there is little differentiation of products, almost no exclusivity and limited capitation or full-risk contracting. Almost all HMOs are now IPA models, with the exception of the older staff-model CAC/Ramsey HMO, now part of United HealthCare. United has continued the CAC/Ramsey clinics, although the rest of the plan is an IPA model. All plans have relationships with multiple hospitals, specialty or subspecialty groups and independent physician practices in Dade, generally without distinct networks for different products. Differentiated networks are more likely for Medicaid, where plans try to contract with traditional Medicaid providers. Networks are rarely exclusive because plans and providers feel they would restrict contracting opportunities and be unattractive to purchasers. Even in those plans that are closely tied to specific providers, such as Neighborhood Health Partnership and the JMH Plan, competition forces them to develop broader networks. For example, while Neighborhood Health Partnership has a preferred but not exclusive relationship with the Dimension PHO, it must also selectively contract with providers outside of the Dimension PHO hospitals and physicians. Similarly, to ensure access to a

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variety of providers, as well as more competitive pricing, JMH must contract outside of Jackson Memorial and the University of Miami.

Health plans pay specialists on a largely discounted fee-for-service basis and may use a fixed rate of payment for primary care physicians, primarily covering office visits. A few exceptions to discounted fees can be found in the specialist and hospital arena, including the Dimension PHO arrangement and the Pan American Hospital arrangements with CAC/Ramsey (now United HealthCare). For example, Pan American accepts full risk for all services and, in turn, capitates both primary care and specialist physicians. Some movement toward capitated arrangements with specialists is also evident through plan contracts with IPAs and other specialty networks, which then pay the participating physicians on a discounted fee basis.

Respondents anticipate increasing consolidation in the plan market. Health plans continue to undergo ownership changes with a few recent notable entries and exits:

- United HealthCare made a major inroad to the market by purchasing and merging several plans.
- Health Systems International is entering the market through a merger with Foundation Health, a plan that entered the market through a health plan acquisition only two years ago.
- PacifiCare, which entered the Miami market in 1993 by purchasing another plan that was in receivership, is leaving Florida based on its analysis that remaining was not financially beneficial. The stiff competition for commercial lives has had a major impact on the size of PacifiCare's membership, and cuts in Medicaid reimbursement have further decreased its revenues.
- Physician Corporation of America (PCA) has had its merger plans with Sierra, Inc., thwarted by the state. If the recent announcement of the intent to purchase PCA by Humana is executed, it will represent a major step in plan consolidation.

The expansion of Medicaid managed care will provide the impetus for change in plan behavior. The expected move of 400,000 Medicaid recipients into health plans will increase the current level of enrollment fourfold. The expansion of contract awards to 12 plans includes some that have not had a presence in the market before and will provide opportunities for many to expand membership significantly. Currently only one HMO, PCA, has more than 40,000 Medicaid enrollees.

## Clinical Practice and Delivery of Care

There appears to be limited attention paid to the use of tools and techniques to influence physician practice patterns and delivery of care. Respondents report that the primary emphasis of deal making is on price, with limited attention to other factors. In addition, because plans contract with many providers, no single plan is important enough to a provider's practice, thereby decreasing the potential to influence the management of care.

Health systems and health plans are in various stages of developing and implementing clinical tools. Numerous utilization review and case management efforts have been put in place by hospitals using protocols and guidelines. Both health plans and hospitals are testing physician profile and

disease management tools and report different levels of development of information systems to support these efforts. For example, AV-Med is testing a physician profiling system that has been used to look at primary care physicians' referral patterns to specialists. Information was generated and shared with the physicians but has not been linked to any incentives. Disease management efforts are being used by Jackson Memorial for tuberculosis and diabetes, and AV-Med has a diabetes management program that works with the primary care physicians in its network.

Some changes in the delivery of care are evolving, mostly shifts from inpatient to ambulatory care, including development of more off-campus clinics by hospitals. Many hospitals report increased use of ambulatory care sites as a strategy to retain and/or capture patients. For example, Mount Sinai, in concert with several partners, is developing ambulatory care sites to attract more patients and to move some services away from the hospital. Columbia/HCA is actively buying more ambulatory care surgical facilities. Miami Children's Hospital owns and manages ambulatory pediatric practices. In addition, some of the community health centers and hospitals operate school-based health centers.

Health plans are beginning to redirect some of their volume, specifically low-risk deliveries, to lower-cost and non-tertiary facilities with the capacity to handle normal deliveries and only sending high-risk patients to Jackson Memorial. As a result, the number of Jackson deliveries has decreased from 17,000 to 7,000 in the past year. Jackson Memorial's response has been to try to gain back some of the deliveries by expanding hospital privileges to physicians at the community health centers and to other community physicians to increase Medicaid deliveries. The health centers view this as a major improvement in their ability to provide continuity of care for their patients.

## Care of the Poor

Care for the poor in Miami is currently being threatened by the weakening tax base that finances indigent care and the vulnerability of many traditional indigent care providers coupled with anticipated growth of the uninsured. There are an estimated 400,000 uninsured and 400,000 Medicaid eligibles in Miami.[21] These numbers, believed to include a number of the working poor, are expected to increase as a result of falling insurance rates among those employed by small businesses, the constant influx of immigrants into the area and the anticipated impact of welfare reform. Cultural views regarding the role of government may also contribute to the high uninsured rate. Respondents report that within the Central/South American culture, health insurance is viewed as the responsibility of the government; therefore, many Central/ South American employers do not offer health benefits to their employees.

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Providers serving these groups include Jackson Memorial Hospital and its network of nine community clinics as well as the federally qualified community health centers. Until recently, the County Health

Department also provided clinic services, but Jackson Memorial has taken over these clinics through a competitive bidding process. While there are a large number of clinics, there is considerable conflict and division between the Jackson Memorial system and the federally qualified health centers. The conflict goes back many years: the concentration of the indigent care dollars at Jackson and the more recent competition for Medicaid enrollees are the focus of current concern. Prior concerns that admitting privileges for center physicians limited their ability to keep their patients and provide continuity of care may be abating, but health center respondents continue to report difficulties in specialty referrals and in tracking patients once they are referred to Jackson programs.

The Jackson Memorial clinics are located in several neighborhoods and at the downtown medical campus, where all specialty clinics are based. Of the five community health centers, four are located in the greater Miami area and serve specific ethnic or racial groups. The fifth center, Community Health Initiative of South Dade (CHI) serves the largely rural South Dade area, including the migrant population. Located in their service areas for many years, the five community health centers have strong ties with local leadership. In addition to the JMH and community health center providers, a number of hospitals sponsor clinics, mental health clinics, substance abuse programs and other community-based services generally located in various neighborhoods. A variety of traditional public health and prevention services are sponsored by the County Health Department and community hospitals.

The two major financing mechanisms, the county indigent care fund and Medicaid, are both undergoing changes that may affect support for the delivery of care for the poor. The county indigent care fund, financed by a property tax millage and supplemental funds from the sales tax, primarily supports Jackson Memorial Hospital, its clinics and other services through the Public Health Trust. As a result of centralization of indigent care dollars, Jackson Memorial has been the only place where funds were available to pay for inpatient care as well as many specialty services. The other provider receiving dollars from the fund is one of the federally funded community health centers, Community Health of South Dade, due in part to the lack of JMH clinics in South Dade and the size of the uninsured and underserved population in that area. Other providers have been unable to receive county funds even though they serve indigents in the county.

The community health centers, in particular, report that they are experiencing major financial difficulties because of the lack of support for indigent care and decreased revenues from other sources, particularly Medicaid. In some cases, these facilities have reduced services and closed sites.

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closed sites. Medicaid has been a major payer of services for the poor, particularly those provided by community health centers. Centers report that high Medicaid payment rates under the old fee-for-service system helped the centers cross-subsidize services to the indigent. They indicate that as Medicaid has begun to enroll beneficiaries in managed care, they have seen a reduction in the number of Medicaid patients they traditionally served. To retain these patients, centers are being asked to accept various capitated arrangements from plans, which further reduces their Medicaid revenues. At the same time, they report an increase in the number of uninsured patients showing up at their centers. With the new Medicaid efforts to increase enrollment in health plans, they anticipate a further erosion of financial support for center services.

Providers seeing the poor are developing a variety of strategies to be more competitive in Medicaid managed care contracting. The individual centers are joining various plan networks to provide multiple opportunities for their patients to select the center as their provider. Several groups have organized for Medicaid contracting, and Jackson Memorial is trying to strengthen the competitiveness of its plan, the JMH Health Plan.

Health Choice is a provider network involving three Dade County federally qualified health centers, three mental health centers and a health center outside the area. To date, Health Choice has established a number of shared services, hired joint clinical chiefs of services and is developing a management service organization (MSO). It has also developed a primary care network to contract with health plans, and was included in several of the Medicaid proposals during the recent contracting cycle. Aurora is a for-profit provider network of community mental health centers that represents the primary source of mental health services for the indigent. It was organized to contract with health plans for Medicaid patients. To be competitive, it is integrating administrative functions to increase efficiency and lower operating costs. Alpha, a health plan developed by the Florida Association of Community Health Centers on a statewide basis, was successful in the recent Medicaid competition. Only one Dade County federally qualified community health center (FQHC) chose to participate in the plan. The success of these ventures may improve the competitiveness of participating providers in the Medicaid market.

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Expanded contracting within Medicaid is shifting Medicaid enrollees from obtaining their care almost entirely from the Jackson Memorial Hospital and health center providers to a broader set of providers in the private sector. This may have positive and negative effects on access to care. For the Medicaid population, the broadened provider base may improve access to care. For example, patients who once had to drive two hours from South Dade to Jackson Memorial may be able to

make a much shorter trip to a local provider. However, for indigent patients using traditional Medicaid providers, those providers may have reduced capacity to meet indigent care needs if their so-called paying population decreases or the payment for these patients is reduced.

Indigent care capacity in the county therefore faces several challenges, including:

- continued centralization of spending of indigent care dollars;
- incorporation of communities, which has the potential to alter support for county indigent care funding; and
- diminished capacities of other traditional safety net providers.

Current access problems, such as long waits for specialty appointments at Jackson Memorial, may increase as a variety of health centers and others reduce their number of sites and decrease hours of operation.

## Issues to Track

The *Miami Herald* depicted 1996 as "a feeding frenzy for health care firms in the state."[22] In Dade County this "frenzy" took the form of hospital chains aggressively purchasing hospitals to gain market share and lower costs, and ownership changes among the health plans including new entrants and departures. Events during the first part of 1997 suggest that this trend appears to be continuing as new deals are announced on a regular basis and consolidation of health plans may be taking off.

Considerable change in a highly competitive market was predicted by a study conducted 18 months prior to this site visit.[23] While consolidation of independent hospitals into existing systems was anticipated, neither the merger of Tenet/OrNda nor the rapid growth of the new Baptist Health Systems was envisioned. With the new systems emerging and potential cooperative strategies among them surfacing, the previously powerful position of Columbia/HCA may erode. Change of ownership among health plans and entry of new plans continues, but the anticipated consolidation and potential emergence of dominant plans has not yet occurred. Humana's planned purchase of PCA to expand into the Medicaid market may signal some greater movement toward consolidation. Among physicians, change is continuing at a fairly slow pace while the vulnerability of safety net providers is reportedly increasing as Medicaid patients shift to the private sector under expanding managed care arrangements. With premiums in the commercial market continuing to be held down due to competition among health plans, no new purchaser activities are emerging.

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The future shape and direction of the Miami health care system is not clear. How organizational changes and relationships will affect access, quality and costs of care are matters of some concern, but specific impact is not obvious. If commercial rates begin to rise, organized purchaser activity may be stimulated. On the other hand, an increase in the power of health systems may resist further erosion in payment levels. Potential alliances among any of the three health systems to

compete against the other may encourage increased alignments among other providers, particularly if the allied systems have adequate geographic coverage to successfully contract with health plans. Could such strategies lock one health system out of some plans? What will happen to the remaining independent hospitals, particularly Mount Sinai, Jackson Memorial and Pan American? Will the slow-moving organization of physicians accelerate?

The impact of changes in provider organizations on health plans should be watched carefully. Consolidation of health plans and increased cost pressures could lead to more direction of volume and efforts to influence and align physicians with plans. Increased alignment of health systems could lead to new provider relationships with plans, particularly to increased opportunities to add exclusivity into arrangements and obtain greater volume. Will providers assume more risk? If direction of volume increases, will health plans have more influence over physician practice and will they increase care management activity and monitoring?

The vulnerable system of care for the poor should be watched. Increased managed care in the Medicaid program may improve access to care for Medicaid beneficiaries, but erode the financial base for traditional providers of care to Medicaid and indigent patients. Will the strategies initiated by these providers be effective in strengthening their viability? Changes not yet implemented by Medicaid are expected to speed up managed care enrollment and reduce payment rates. Medicaid contracting will also affect the balance of business among health plans, potentially strengthening some and adding others to the mix. How will actions by local jurisdictions to incorporate affect funding for indigent care, and will the new county mayor assert leadership to protect this resource? As welfare reform unfolds, demand for indigent care is expected to increase and exacerbate the current fragility of the public hospital and clinics and the federally funded network of community health centers. Given the size of the Medicaid and uninsured population in the Miami area, continuing erosion of the safety net may have effects on the overall health system.

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