COMMUNITY SNAPSHOTS PROJECT

North Central Florida

Site Visit Report

Prepared by:

Alpha Center
Washington, DC

Authors:
Debra J. Lipson
Elizabeth Vieth

Debra J. Lipson is on the staff of the Alpha Center. Elizabeth Vieth is a consultant to the Alpha Center.
Reviewers included Carol Gormley of the North Central Florida Health Planning Council. The authors are solely responsible for the selection and interpretation of information in this report.

Overview

North central Florida, a 16-county area that includes the city of Gainesville, is a diverse rural health care market in the process of slow but steady change. The health care system shares some characteristics of other rural communities, including small struggling hospitals, a shortage of health care professionals, low commercial HMO penetration, and inadequate transportation systems. However, these disadvantages are mostly offset by the presence of large regional hospitals in Gainesville itself—notably Shands Hospital at the University of Florida, Alachua General Hospital, and North Florida Regional Medical Center—which dominate the region's health care system. The university is not only a major employer but draws significant resources and population to the area as a teaching and research institution. As a more urban center, Gainesville also has more managed care enrollment than other parts of the region.

The pace of change in the health care market in north central Florida has accelerated in the past year. In this period, competitive market pressures have increased. Purchasers and consumers have become more aware that health care prices in the region are above average for the state and have become more aggressive in driving hard bargains with insurers (and in a few cases with providers directly) to secure lower premium rates. As a result, insurers are competing more intensely to offer lower-cost products in all markets—commercial, Medicare, and Medicaid—and develop managed care products. A year ago, enrollment in health maintenance organizations (HMOs) and preferred provider organizations (PPOs) represented only about 10 percent of the total population. By this measure, interviewees familiar with other markets put north central Florida 6 to 7 years behind south Florida and 10 years behind Minneapolis/St. Paul. However, the near doubling of managed care enrollees in this area in the past year (current estimates put the managed care market share at 20 to 25 percent) indicates that change is occurring very quickly.

In response to these changes, hospitals, physicians, and other providers are under greater pressure to conform to managed care practices. They are trying to maintain or attract market share through consolidation and creating networks across levels of care. Competition among delivery systems for market share is, in turn, driving a trend toward mergers and strategic alliances between rural hospitals and regional centers in Gainesville. Unlike other rural areas, the rural hospitals in north central Florida have escaped severe financial stress or closure, largely due to a constant influx of low-income elderly retirees, which maintains hospitals' occupancy levels.

Although it is too soon to tell how these changes are affecting access to and quality of care, consumers recognize the trade-offs involved in the transformation from a predominantly fee-for-service system into one with more

managed care (albeit mostly in PPOs). Those with insurance notice a marked improvement in the year-to-year stability of premiums and better access to primary care providers. Those who converted to managed care plans were drawn by the lower out-of-pocket costs, but some are reportedly unhappy with a more limited choice of providers, especially when they have special needs or health care problems.

Meanwhile, in an area characterized by high poverty rates, both the number of uninsured people and concerns about their access to care are growing. State insurance market reforms aimed at improving coverage rates among small groups, primarily via community health purchasing alliances (CHPAs) have not afforded coverage to many uninsured people working for small firms in this area. Private physicians may be seeing more Medicaid patients due to the introduction of Medicaid managed care. But publicly supported providers say they still see the majority of Medicaid and uninsured patients. Community health centers and the university hospital are increasingly caught in a crunch between rate reductions for their insured populations and their obligation to serve the uninsured. These trends, in addition to the potential loss of funds under federal Medicaid block grants and reductions in other state and federal funds, are making many uneasy about the future.

▼ ▲ ▼ Community and Health System Background

Demographics and the Economy

The north central Florida area includes a 16-county region east of Tallahassee (the state capitol), west of Jacksonville (on the Atlantic coast), and north of Orlando. It shares a border with Georgia to the north. The major population center is Gainesville with 94,000 people, of whom about 15,000 are students at the University of Florida. Another 25,000 students are not considered permanent residents. Ocala, in the southern part of the region, is the other major population center.

In 1994, the population for the entire region was nearly 1.1 million, and census data shows a 43 percent increase from 1980 to 1990, nearly four times the national average rate of growth. Many of the new residents are low-income retirees who are drawn to the region for its low cost of living and recreational opportunities. The proportion of people in the region who live below the poverty level (16.5 percent) is slightly higher than the state average (13 percent), but pockets of the region have as much as double the region average.

Due to the region's large geographic size, one of the rural counties was selected for closer examination. Putnam County is located 50 miles east of Gainesville and has 70,000 residents including 10,500 in Palatka, the county seat. Between 1980 and 1990, the population of Putnam County grew by

nearly 29 percent. The population is predominantly white (75 to 80 percent), with African Americans at about 20 percent and other races less than 5 percent. About 20 percent of the population lives below the poverty level. Putnam County is less isolated than other counties in the region, being closer to major population centers—Jacksonville, St. Augustine, and Daytona Beach.

Employment in the area is heavily dependent on state and local governments and the health care industry. In Alachua County, the largest employers include the University of Florida, including Shands Hospital; the Alachua County School Board; and the state of Florida. Putnam County has two businesses with over 1,000 employees each—the Putnam County School Board and Georgia-Pacific Paper Company. About 96 percent of the private businesses in the area have fewer than 50 employees. The rural areas are dominated by the private timber reserves of Georgia Pacific and farms that primarily grow potatoes, cabbage, and ferns.

Health System History

The health care system in north central Florida is characterized chiefly by its contrasts—between an excess of resources in Gainesville; a dearth of facilities and providers in some of the most isolated, poor counties; and an adequate amount of resources in the less isolated counties. Insurance status of the population is believed to mirror closely that of the state as a whole: 41 percent privately insured, 22 percent on Medicare, 13 percent on Medicaid, and 24 percent uninsured.[2]

There are 21 general acute care and 11 specialty hospitals spread throughout the 16-county region, with at least half concentrated in the population centers of Gainesville, Lake City, and Ocala and the other half spread through rural communities. None of the rural hospitals are more than an hour's drive from one of these urban-based hospitals, and all are located within two hours' drive from the University of Florida, which offers specialized tertiary-level care. Because most Florida rural areas are located within 60 miles of a tertiary care center (though transportation is certainly a problem for many), there is intense competition for patients in the rural areas.

The competition is exacerbated by what many observers consider to be an overbedded system. This is the result of a medical arms race the major hos-

[2]These figures are rough estimates, based on certain assumptions: the proportion of the population over 65 is assumed to approximate the Medicare-covered population; numbers of Medicaid recipients are drawn from state Medicaid data; and both the privately insured and the uninsured are assumed to be the same as the Current Population Survey (CPS) estimates for the state in the absence of any other data to suggest otherwise. These figures are presumed to vary by county, however, depending on the demographic and economic composition of each one.

pitals in the region engaged in during the late 1970s and early 1980s. From the capacity to perform delicate surgical procedures to acquiring helicopter ambulances, each of the three Gainesville hospitals strove to be in the forefront. By the late 1980s and early 1990s, competitive strategies shifted toward reaching out to rural hospitals through outright acquisition, management service contracts, or clinical affiliations. Although many of the rural hospitals have turned over in ownership or use (e.g., converting from general acute care to rehabilitation), none has closed in the past 10 years, primarily because of the influx into the region of elderly people who use these hospitals.

With the increasing number of connections between Gainesville hospitals and those in the surrounding rural areas, the number of unaffiliated, independent hospitals is dwindling. Of the 21 hospitals in the region, only 3 are completely independent. One other remains separately owned but recently announced an affiliation with the University of Florida Health System that will bring university resources to the rural facility.

Although managed care penetration levels have been low, HMOs have been in the area since the mid-1980s when Av-Med began marketing in the region. Av-Med, which is based in Gainesville, dominates the HMO market, but other companies are gaining strength. Blue Cross and Blue Shield's Health Options HMO has been steadily increasing enrollment, primarily in the commercial market, and two other plans are strong in the Medicaid market. Av-Med Health Plan was the first HMO to initiate a Medicare risk contract in the area in 1993 and remains the only one to do so. PPOs are also growing in number and enrollment. The largest is the Blue Cross and Blue Shield PPO, which covers most of the 11,000 to 12,000 state employees that live in the area.

Except for Alachua County, with its high concentration of physicians, most counties in north central Florida are designated as medically underserved. Even in Alachua County, however, only 17 percent of the overall physician supply is in primary care fields. Access to primary care is especially poor for low-income people, whose alternatives are limited to the county health department, community health clinics (not available in all counties), and occasionally University of Florida-operated clinics.

Putnam County, the area of focus, has one major hospital, Putnam Community Hospital, which is currently owned by Columbia/HCA. Nearly 60 percent of its patients are covered by either Medicaid or Medicare. Due to a shortage of primary care physicians, it has been designated as a health professional shortage area by the federal government. According to some observers, commercially insured patients often leave the county for health services in urban areas because of the shortage of physicians. Others countered that "Putnam County is resource rich—unless you are poor."

Health care premiums in the region were reported to be as much as 20 percent higher than the statewide average, perhaps because of the presence of the university. Others believe the lack of competition has allowed prices to remain high.

▼ ▲ ▼ Health System Changes

Public Policymakers

State and national health care reform proposals and initiatives of two to three years ago played an important role in setting the stage for increased managed care and more affordable health insurance in the region, but they have had relatively little impact on the health care market. In 1992 and 1993, the state adopted health care reform legislation designed to encourage managed competition and increase coverage. The laws had two major components: (1) eleven state-chartered CHPAs and a set of insurance reforms intended to make insurance more available to small groups and low-income working uninsured people and (2) the Florida Health Security Program, a Medicaid Section 1115 waiver demonstration effort that was supposed to provide subsidized insurance coverage to low-income uninsured people and expand enrollment in Medicaid managed care plans. The state also provided a few rural areas with planning grants so they could develop networks to improve access to care.

The local CHPA has had very modest enrollment. Though the state obtained federal approval for its Section 1115 waiver, the state legislature has withheld authorization for the Health Security Program's implementation. Thus, expansion of coverage to uninsured people—estimated at about 24 percent of the region's population—remains on hold. And so far, the two rural health networks in the region have had no effect on access, a fact that has been attributed to low funding for the networks, few state requirements of the networks, and resistance by rural providers to collaboration.

The Medicaid managed care component of the reforms appears to have had greater effects on the region. In April 1993, the state embarked on a set of strategies to expand Medicaid enrollment in managed care plans. The state loosened the rules that Medicaid HMOs had to meet in order to qualify; for example, they gave Medicaid HMOs three years to meet licensing standards required of commercial HMOs, reduced reserve requirements to $250,000, and allowed direct marketing to eligible people. As a result, statewide Medicaid enrollment in managed care plans increased from 383,000

(22 percent of all recipients) in June 1993 to nearly 600,000 (30 percent) in January 1995.[3]

The introduction and growth of Medicaid managed care has brought more insurers and managed care plans into the region. Medicaid HMOs entered the north central Florida market in early 1994. Several plans operate in north central Florida, and nearly 30 percent of the eligible Medicaid population in this area is enrolled in a plan. Initially, there was considerable resistance to Medicaid managed care by some community providers, and as a result, members were sometimes enrolled before plans had developed local provider networks. Eventually, plans organized networks that now include hospitals, private sector physicians, community health centers, and county health departments.

The legislation Florida enacted in 1993 to ensure the viability of rural health care providers in a more competitive market has not yet had its intended effect. The legislation allocated funds for eight rural communities to plan and support rural health networks. The networks were to include both urban and rural health care providers and other organizational members, and their aim was to reduce duplication of services and strengthen rural delivery systems. Some also believed that the networks might evolve into health plans that could compete with urban-based groups that might move into rural areas, and the legislation included provisions for state antitrust exemptions if that proved to be necessary. Because the state guidelines for network organizational models and specific activities were so general, each of the rural health networks moved in very different directions.

The network in the Gainesville area—the Health Partnership of North Central Florida—included providers and other groups in Alachua County and five rural counties to the north and west.[4] After considering several alternatives for helping rural providers maintain their practices, the Partnership is seeking to develop a management services organization (MSO). It is also exploring other areas of potential collaboration, such as joint purchasing of services and supplies. According to one observer, one of the major barriers to faster or more substantial network development activity seems to be the reluctance of many rural physicians to give up their autonomy. The potential for antitrust exemptions has not been viewed as important, because the rural physicians are not considering any mergers, physician-hospital organizations, or other joint ventures.

[3]For a more detailed review of recent developments in the state's Medicaid managed care program, readers are referred to the south Florida (Miami/Ft. Lauderdale) site visit report.

[4]Another network was established adjacent to this one, encompassing counties to the east and south of Alachua along the St. Johns River. Ironically, Putnam County abuts both of these network districts but was not included in either one because major providers in Putnam were unwilling to cooperate.

Putnam County separately submitted an application for a rural health network development grant, but it was not funded. Developed by the Putnam County Health Care Authority—an advisory group on health issues that reports to the county board of commissioners—the proposal identified several critical problems, including inappropriate emergency room use, lack of community-based long-term care services for the elderly, teen pregnancy, and lack of communication and coordination among providers. Except for the need for community-based care for the elderly, the problems could not be resolved through linkages between rural and urban providers. Moreover, the proposed strategies were inconsistent with the legislation's goal of strengthening or improving the viability of rural health systems.

Purchasers

Over the past few years, the health care market has become increasingly sensitive to employers, public and private, who are seeking lower-cost health coverage options and stable premiums. In general, most employers would like to maintain comprehensive benefits for their employees as well. In the north central Florida area, large employers have driven the trends toward increased enrollment in PPOs and HMOs, lower premium increases, and slight modification of benefit packages. Large employers are shopping around, trying to reduce health care costs by increasing workers' cost-sharing (especially for out-of-network use) and negotiating discounts with HMOs and PPOs.

Small employers have had the opportunity to organize into CHPAs, and although small employers seem to be getting better deals as well, it is arguable how much the CHPAs are responsible. Most observers acknowledge that the power of the CHPAs—called "a toothless tiger" by one person—will continue to be weak unless they are allowed to negotiate directly with insurance companies.

The Gainesville market is particularly affected by the purchase of policies for state employees because of the high number of people in the area who work for state government or the university, which is a state institution. State, county, and local governments are the largest employers in the Gainesville area; they employ over 37 percent of all workers. Two state prisons are also located in the region. When the state announced earlier this year that the contract for administration of its self-insured plan for state employees—currently held by Blue Cross and Blue Shield—would be up for bid, the entire community watched with concern. The winning bid was awarded to a third-party administrator that will offer a PPO (UNISYS), ostensibly because of their lower offer. Although Blue Cross and Blue Shield is contesting the decision, it is widely expected that UNISYS will take over in January 1996 when the current contract expires. Through a subcontract with another company, which is a network organizer, UNISYS was "busy recruiting their Gainesville provider

panel" at the time of the site visit, according to one physician. The uncertainty during the interim period has raised concerns among employees about whether they will be able to maintain their current provider relationships.

In the private sector, large employers have spent more time exploring lower-cost options, and they appear to be making some progress. For example, Georgia-Pacific, a large self-insured employer in rural Putnam County, began investigating lower-cost options six years ago. It decided that PPOs might produce one-time savings but would not save a great deal in the long run because they do not manage care to any significant degree. The company also discussed a possible purchasing coalition with the local school board and a furniture company but abandoned this strategy when both groups encountered employee resistance to changes in their plans.

Instead, Georgia-Pacific, with the help of a consulting firm that specializes in setting up rural provider networks, decided to develop its own network of local primary care physicians that it would work closely with in order to change practice patterns in a way that would result in long-term savings. Employees must pay a much higher out-of-pocket copayment if they use providers outside this network. The company continues to act as a self-insured plan, but physicians contract with the consulting firm, which closely monitors utilization of each participating physician. Those that come in under a predetermined budget—agreed to by the doctors, the company, and union representatives—are entitled to a percentage of the withhold fund, and those who come in over it are subject to penalties (e.g., a contract with one physician was not renewed due to overutilization).

The impact has been dramatic for the company—from a 20 percent annual increase in health care costs before 1990 to flat or even lower costs in 1995. Long-term sick leaves have dropped by 30 percent. Twenty-five primary care physicians participate in the plan (including some in nearby counties where some employees live). Eighty percent of all eligible employees participate in the network plan; the remainder have stayed in an indemnity plan that has a broader choice of physicians but costs more in copayments and deductibles. According to the benefits manager, care is more accessible locally to employees, and the formerly high influx of specialists into the county has abated.

Because nearly 50 percent of the employers in the region are in the trade and service industries, which are dominated by small businesses with 50 or fewer employees, most firms could not organize as Georgia-Pacific has done. Indeed, nearly half of Florida's small businesses do not even offer health insurance to their employees.

Florida intended to increase the availability and affordability of health insurance to small employers when it authorized the creation of CHPAs for businesses with 50 or fewer employers. The eleven CHPAs throughout the state began offering health insurance plans in May 1994. CHPAs provide

information to their members on prices and benefits of all qualified health plans certified by the state, but they cannot negotiate premiums or contract with plans.

As of August 1995, the Gainesville area CHPA reported 1,100 lives covered in 320 organizations—less than 1 percent of the eligible firms or individuals in the area. The average number of enrollees per business is only 1.7 employees, which indicates that very small firms seem to be most attracted to the plans. One observer noted that CHPAs drew attention to insurance premiums and are thus given some credit for a reduction of 2 percent from the previous year. However, it was also reported that in some cases small businesses can negotiate better rates outside the CHPA, especially if they have low-risk employees. Although this may appear to violate the modified community rating requirements of the state's 1993 small group market reforms,[5] apparently the rate bands permit such differences.

In the rural areas, large and small employers alike are frustrated that they cannot squeeze out further savings. Though some have considered direct contracting with providers, in certain areas there is only one hospital and there are only a few physicians, which makes such a competitive strategy infeasible. However, if insurance premium prices start going up again, county governments might have more incentive to band together in order to organize their own provider network. They are also uncomfortable trying to wring deep discounts from providers, recognizing that this will cause access problems for the indigent, which in turn will increase hospital emergency room use and costs. Though quality does not seem to be an issue at this time, employers report more frequent use of data to monitor utilization and claims.

Insurers and Health Plans

During the past year or two, competition in the insurance market has intensified, due to (1) increasing efforts by large and small employers to reduce their health care premiums and (2) the entry of new insurance companies and products into the market. This is in contrast to three years ago, when insurer strategies were driven more by state health care reforms, such as modified community rating, which forced insurers to rely less on risk selection.

In response to pressures to lower costs, develop managed care products, and maintain or increase market share, insurers have pursued various strategies.

[5]The law, which applies to insurers selling to small groups (those with 1 to 50 employees) either through or outside the CHPAs, requires (1) guaranteed issue, without regard to health status, preexisting conditions, or claims history; (2) a 12-month limit on pre-existing-condition exclusions; (3) modified community rating with adjustments allowed only for age, gender, family composition, tobacco usage, and geographic location; and (4) availability of two standardized benefit plans.

These include (1) negotiating lower rates or discounts with hospitals and physicians or starting to capitate payments to primary care physicians; (2) developing new products, especially HMO point-of-service plans that permit patient choice if the patient is willing to pay more (even though most of the managed care market remains in the PPO sector); and (3) entering new markets, especially Medicare and Medicaid.

The north central Florida market is served by over a dozen insurers but those with significant market share are primarily Blue Cross and Blue Shield and Av-Med SantaFe. Other players, such as Century/PCA, Cigna, Principal Health Care, and HealthCare USA, have little overall market share but in some cases a large percentage of certain submarkets, such as Medicaid. There are also at least 15 PPOs operating in the region.

Insurers appear to have the upper hand when it comes to setting the prices they will pay providers. Insurers in the area generally pay providers at negotiated discounted rates, sometimes using Medicare rates as guidelines. In recent years, insurers have pushed for significant discounts, especially with specialty providers. One interviewee noted that anesthesiologists are faced with a potential 40 percent cut in rates. Some insurers are also benchmarking rates that providers are paid in other geographic areas to justify rate reductions.

Insurers are using their leverage to shift premium dollars away from inpatient care. Primary care providers are frequently offered incentives (e.g., percentage of withholds, bonuses) for holding down inpatient admissions or specialty referrals, and insurers are beginning to set capitated rates for primary care providers—at least those with a minimum of 100 of the insurer's enrollees—to provide an incentive to control costs. Some HMOs are also capitating certain types of specialists, such as allergists, podiatrists, and chiropractors. As a result of such strategies, one HMO executive claimed that in the past several years, 50 percent of that plan's premium dollars spent on health care were shifted from inpatient care to primary care, home health care, and pharmaceuticals.

Neither traditional insurers nor HMOs have pursued a strategy of vertical integration by merging with hospitals or integrated health systems. Few have bought physician practices or "rented" provider networks. Instead, the trend seems to be going in the other direction. Insurers seem to believe that to succeed in this market they need to concentrate on their core business—risk management—rather than becoming immersed in service delivery issues. An insurer that becomes too closely tied with any one provider or physician network is viewed as having too high a potential for conflict of interest with other providers with whom it might contract.[6] For example, Av-Med SantaFe,

the integrated health plan/health system based in Gainesville, decided early this year to sell its Gainesville hospital (Alachua General Hospital), three rural hospitals in the surrounding area, the home health care agency, and other service components.

Insurers are also developing new products, especially PPOs and HMO point-of-service (POS) plans, in response to employers who are increasingly concerned about reducing health care costs while maintaining some degree of choice for employees. The market has become so price sensitive that, according to one HMO representative, "people will walk for as low as $10 a month." One insurer noted that their HMO price increase over the past year was under 2 percent, while the increase for their PPO ranged from 8 percent to 20 percent . Thus, indemnity plans are being dropped in favor of PPOs or HMO POS plans, and restrictive staff-model HMOs are developing open-ended products. Most of the managed care market, however, is still in the PPO sector, and within it there is tremendous competition, as evidenced by the change in state employee carriers. Blue Cross and Blue Shield estimate they could lose about 8 percent of their overall market share in north central Florida if they lose out to UNISYS.

Managed care plans in the area are also jumping into the waters of Medicare and Medicaid HMO contracting, considered too risky before but increasingly seen as necessary for long-term survival. Two Medicaid-only plans moved into the rural counties of the area to capture this new market segment, although recent rate reductions may quell further interest by those not already in the game. There is only one insurer in the Medicare risk contract business, and according to that plan's representative, it can hardly absorb all the new Medicare enrollees into its risk contract fast enough. Another major insurer expects to enter the Medicare risk market by the end of this year. There are still questions about the profitability of such plans, however. HMO plans consider the adjusted average per capita cost (AAPCC) for this region to be low, and they have looked at the possibility of increasing the premium paid by Medicare enrollees.

As insurers have faced reduced revenues as a result of lower premiums, they have implemented a number of internal changes to reduce costs. One insurer reports significant investment in automated information systems with enhanced capabilities to monitor costs, referrals, and, potentially, patient records in order to assess outcomes. Others report increased efforts to work

[6]Note that this view benefits providers as well because nonaligned providers are better able to negotiate with several insurers and capture different patient markets that come along with them.

with contracted physicians to reduce emergency room utilization and efforts to educate members about when it is appropriate to use the emergency room.

Providers

Providers in the north central Florida area still have some choices to make. Because managed care is present but not dominant, providers can either choose to participate in the managed care arrangements that exist, prepare for the more demanding tasks required by managed care (e.g., information systems, capitated payment), or resist managed care encroachment. Although there are clearly examples of providers in each camp, most appear to be straddling the fence between the first two strategies. As one hospital administrator put it, "Providers can still ride the fee-for-service wave, but they better have a plan to play in a capitated system when that wave crashes on the beach."

Increasingly, rural providers are becoming part of horizontal provider- sponsored networks based in Gainesville or are organized by statewide associations of providers. Some that are unwilling to take the affiliation plunge are putting their toe in the waters by hiring outside management firms to strengthen their position if and when they decide to join a network. Others are joining PHOs to contribute to strength in numbers against "outside forces" that would take over their community.

However, there are still some fiercely independent doctors and hospitals who believe they can hold out against the managed care tide. For example, Putnam Community Hospital, owned by Columbia/HCA, apparently had not contracted with any HMO until just recently, preferring to wait until its PHO was in place. This delayed the entry of managed care into the county because HMOs generally do not want to start operations until they have cooperation between the sole hospital in a community and participating doctors.

Hospitals

For many years, the three major hospitals in Gainesville have been locked in a struggle to maintain or gain market share. As part of this effort, they bought smaller rural hospitals to serve as referral/feeder systems. The most notable recent example of this trend was a July 1995 announcement by Shands Hospital that it is negotiating to buy Alachua General Hospital, currently owned by Av-Med SantaFe. As part of the deal, Shands will also acquire three rural hospitals in the surrounding region, as well as a rehabilitation hospital, a psychiatric hospital, and home care operations. The deal is particularly beneficial to Shands, since the hospitals are located in high-referring areas for Shands.

Similarly, Columbia/HCA, which has as its hub the North Florida Regional Medical Center (NFRMC) in Gainesville, has four rural hospitals in its regional network. The Columbia merger with HCA two years ago netted the system two facilities in outlying areas, and since that time Columbia/ HCA has

acquired two more rural hospitals and expects to acquire more in the future. The regional network will make it easier to reduce duplication of technology and share marketing, offer regional contracting opportunities for managed care plans, and of course, facilitate referrals to the central hub.

Mergers or strategic alliances between rural hospitals and regional centers in Gainesville appear to be of great benefit to the rural hospitals, which gain management assistance and access to specialists. Specialists from Gainesville come to the rural community for regular clinics. Shands' affiliation linkages with hospitals in the region have benefitted the rural hospitals primarily by making the medical faculty's expertise available. Sometimes the affiliation benefits the rural hospital more than the urban hospital. For example, even though one of Av-Med SantaFe's rural hospitals sent very few referrals to Alachua General Hospital, the rural hospital became a stronger facility, a "primary care hospital" with 24-hour physician coverage and a focus on ambulatory care.

To assure more referrals, the urban-based hospitals have also been engaged in concerted efforts to develop their own physician networks. Shands has chosen to set up clinics in surrounding rural areas staffed by its own physicians. It is also planning to acquire a sizable number of primary care practices and create a management services organization to serve both UF College of Medicine faculty and affiliated physicians. Columbia/HCA, on the other hand, is pursuing a PHO strategy with its affiliated physicians, to strengthen their combined bargaining position with insurers and managed care plans.

These rural-urban connections explain in part why none of the hospitals in these rural areas has closed, in contrast to those in other rural communities. Networks with the three urban-based hospital systems have strengthened their ability to withstand the pressures that have beset other rural hospitals, especially those that are isolated from urban centers. However, these rural hospitals also benefitted from the influx of people moving into the area; the 16-county region's population grew by 43 percent between 1980 and 1990, in contrast to other rural areas, which have experienced population declines. Moreover, north central Florida's rural hospitals have been somewhat protected by the slow entry of managed care into the area.

That is likely to change as managed care contracts come to represent an increasing portion of hospitals' revenues. NFRMC reports about 30 percent of their revenues are from managed care contracts, mainly the Blue Cross and Blue Shield PPO, and Shands reports 16 percent. Hospital managers expect even more business from managed care contracts in the near future and may even have to assume risk via capitation payments. Some hospitals are preparing for this likelihood by strengthening their cost accounting capabilities in order to better negotiate managed care contracts. They are also improving their information systems in order to link clinical and financial data across numerous service delivery sites. Such proactive steps designed to make their

internal operations more efficient are likely to have spillover effects on their rural affiliates in the near future. The investment in new computer information systems in particular appears designed to facilitate sharing of data among satellite sites in outlying areas.

Hospitals are also trying to increase their attractiveness to managed care plans by offering a broader range of products, especially home health care, which they often acquire through purchase of other companies. Shands, for example, has acquired as many as 20 home health care sites throughout the state and expects to add another 20 home health care programs by 1998. As part of the pending deal with Av-Med SantaFe, Shands would also acquire other home care and rehabilitation operations.

Physicians

The increase in competition in the region and the growth of managed care are putting pressure on independent physicians to consider becoming part of a larger provider network. PPOs, HMOs, and hospitals are all recruiting physicians for their networks. When rural physicians refused to participate, some of the plans actually set up their own clinics and hired their own physicians. Gainesville-based providers are also setting up clinics in rural areas and rotating staff into rural communities to ensure referrals.

In Gainesville itself, physicians tend to be part of a group practice or on the staff of the university hospital. In rural communities, by contrast, physicians are more frequently in solo practice or on the staff of a community health center.

Physicians (mostly specialists) are responding to the pressure to join up by trying to play the game while maintaining their independence at the same time. For example, more physicians are participating in Independent Practice Association (IPA)-type networks, joining PPO panels, and discussing the formation of PHOs with their local hospitals to make sure they can serve patients no matter which plan they choose. Few are selling their practices outright. With an oversupply of specialists in Gainesville, it is not clear how well these strategies will work because managed care plans have plenty to choose from. Specialists in rural areas still believe they have a chance given their lower numbers. However, that situation is changing as well, because access to specialty care is increasing as Gainesville-based hospital staffs increase their rural presence.

Primary care physicians, who are fewer in number, appear to be in a stronger bargaining position. Thus, even if some of the rural providers' quality of care is questionable (as some insurers indicate), they have a greater chance of being able to negotiate good rates with insurers and in a few cases with self-insured employers. This is especially true for those primary care physicians and obstetricians that serve the Medicaid population. Primary care physicians in Putnam County were also successful in negotiating with Georgia-Pacific to serve their employees.

As physicians feel the pressure from managed care, they have become more concerned with financial issues such as maintaining their insured patient levels, constraining overhead costs, and negotiating adequate reimbursement rates. Obtaining rural health clinic (RHC) designation has been important for some rural doctors as a way to increase reimbursement rates from Medicare and Medicaid, although a number of them have decided against this based on their reluctance to hire such mid-level practitioners as physician assistants and nurse practitioners—a requirement for RHC designation.

Safety Net Providers

The entry of Medicaid managed care has forced publicly supported providers to get into the managed care game. At the same time, cuts in funding from both state and federal sources are prompting providers to improve their attractiveness to the insured population in order to increase reimbursements from private sources. In addition, the resurgence of tuberculosis (TB) and the rise in HIV cases in the area are putting pressure on public health agencies to respond in the absence of new or additional resources.

In Gainesville, the safety net providers include the University of Florida's Shands Hospital, although uninsured people go to the other two hospitals too (mostly Alachua General Hospital). Rural hospitals serve uninsured people as well. In the rural communities outside Gainesville, community-based primary care providers include federally funded community health centers (CHCs) and county public health units (CPHUs), which are technically branches of the state government but report to county commissioners. Because private physicians tend to limit their Medicaid patient loads, Medicaid patients as well as the uninsured are more likely to be seen in these two types of centers.

Relationships between CHCs and CPHUs, when they are located in the same county, are often strained. Eligible patients and services offered frequently overlap, funding sources are often the same, and philosophies of care are often different. In turn, relationships among the community-based programs and private physicians and hospitals are also difficult. Although these tensions were evident in Putnam County, the CHC and CPHU have made concerted efforts over the years to coordinate services. For example, the two agreed many years ago that the CHC would provide comprehensive primary care services except for obstetrics (OB) and the CPHU would provide OB care and such traditional public health services as WIC nutritional counseling and outreach to high-risk pregnant women. And though the CHC initiated a TB control program when the CPHU received a grant for a new TB outreach, prevention, and treatment program, the CHC turned over its clients to the county.

The entry of Medicaid managed care into Putnam County has upset these tenuous working relationships. Medicaid managed care came into the area in late 1993 when one of the plans approached the CHC and private providers about participation in their plan. The CHC worked out a deal with the plan,

as did some private physicians, but the hospital held out for a long time. The CPHU was not asked to participate, apparently because they did not have admitting privileges at the local hospital and would not provide 24-hour coverage. At the same time, because the managed care plan offered the private obstetricians rates higher than the regular Medicaid rates, the private physicians put pressure on the CPHU to stop providing obstetrical care. It was not until December 1994 that the health plan and the CPHU were able to negotiate a contract that covered minimal prenatal care services.[7] Two thousand of the county's 13,000 Medicaid recipients are now enrolled in the Medicaid HMO, and nearly all of them are served by the CHC.

Meanwhile, due to actual or anticipated cuts in state and federal funds, the CHC is trying to attract more insured patients. It is adding clinical staff at all sites, hiring new mid-level managers to perform utilization review, enlarging and renovating its facilities, training staff about managed care, recruiting more primary care physicians, and upgrading information systems. These efforts are viewed as critical not only to retain or attract new paying patients but to continue to serve the uninsured, who make up an increasing portion of the CHC's patient base. In some cases, however, such moves are regarded as threatening to private primary care providers, and this drives up the tension level in this rural community.

On top of these changes and pressures, the county health department has had a number of public health crises to confront. The county has always had higher morbidity and mortality rates than the state averages, and they have seen alarming rises in the rates of TB and HIV cases over the past four years. Putnam County has a number of "work camps" that house seasonal and year-round farmworkers, who are at greater risk of having HIV or TB. In response, three CPHUs in the region applied for and received a private grant, which allowed them to hire outreach workers who perform screening and directly observed therapy and transport patients to the local health department for diagnosis. As a result of their efforts, the percentage of farmworkers testing positive for TB has dropped from 60 percent to 35 percent. The county health department is also doing more outreach into the schools, where both TB and HIV, in addition to drug use and pregnancy, continue to be serious problems.

[7]It is not clear why the health plan pursued the CPHU. Some say the state puts pressure on Medicaid HMOs to contract with CPHUs, and others believe the HMO needed a source of prenatal care services, such as nutrition and psychosocial counseling, not available from private doctors. Media coverage of patients being turned away from the CPHU because they were HMO enrollees also prompted efforts to negotiate a contract between the two.

To strengthen the community's health infrastructure, health care providers and other citizens have formed an advisory group to resolve conflicts between providers and to educate county commissioners about health care issues. Apparently the commissioners, who were initially resistant to any managed care coming to their county, are now trying to identify ways that dollars saved as a result of Medicaid managed care can stay in their county. However, cooperation among providers continues to be a problem—one that managed care seems to exacerbate rather than help.

Consumers

Consumers and advocates who participated in a focus group conducted during the site visit report that consumers are deeply concerned and confused about changes in the health care delivery system. Although consumers recognize that the need to halt steep rises in health care costs is part of what's behind these changes, they fear that they will not benefit from the cost-cutting measures. They see the changes driven more by the bottom-line-oriented health care industry's concern for profits than by efforts to improve the quality of care. As a result of managed care's incursion into the north central Florida region, consumers are beginning to see an end to increases in out-of-pocket premiums, but some also perceive reduced quality and cuts in access to certain types of health care.

Consumers' concern about costs is certainly driving some of the changes. Employed people are more aware that increasing health care costs result in salary reductions and even job layoffs. Employers report that employees would rather face an increase in their deductibles than an increase in premium payments. A rural employer noted that because salaries are low, workers are more willing to accept limited choices than increased premiums. However, employers' cost concerns are still a major factor.

The changes have both good and bad results. In rural areas, consumers are pleased with what they perceive as an increase in access to care, especially primary care and prevention due to managed care and specialty care due to rotating specialists coming into their towns from Gainesville. But consumers are not always happy with managed care, particularly when they become seriously ill or need specialized services. They reported having trouble getting authorizations for specialty care, delays in getting care because of the gatekeeper process, and an increase in burdensome paperwork when they need additional services. Some elderly people in managed care are discharged from the hospital earlier than they used to be, which causes an increase in readmissions.

Some consumers believe that efforts to reduce costs increase the need to monitor and assure the quality of care being provided. Employers noted that

union representatives have a particular interest in quality, especially during contract negotiations. Quality concerns center around the increase in outpatient surgeries, lack of information about physician qualifications, and use of old equipment. They also wonder about the quality of various health plans; many expressed an interest in comparative data on quality indicators to help them make more informed choices. Right now, they note that employers rely primarily on physician licensing and insurance company credentialing standards alone, without examining outcomes of care.

The effect of Medicaid managed care on access and quality of care remains uncertain, because it has only recently been implemented in this area. However, there remain serious concerns about the marketing techniques used by the plans, and related concerns about the quality of care that these plans may be providing.

The state's efforts to improve access to prenatal care and to improve the prison health system were commended, but consumers are now concerned about recent cuts in services funded primarily by the government. These include mental health services in schools, primary care provided by public health departments, and services for special populations such as migrant farmworkers and people with AIDS. As a result of cuts, there are longer waiting times and fewer services available for people with no health insurance. Emergency room use remains high because of the state's failed efforts to expand coverage to the uninsured. Although there are a number of free, volunteer-staffed clinics in the area, they are not enough to serve increasing numbers of uninsured people.

▼ ▲ ▼ Future Developments

Though managed care and competition have been slow to come to this area, most predict that the future will bring changes at a faster pace than in the past. It is likely that the high cost of health care will still be the driving force for change in this area, given higher-than-average statewide costs, and will probably lead to (1) more managed care, especially in the commercial and Medicare market, with an accompanying increase in outpatient care; and (2) continued expansion of the major Gainesville hospital systems into the surrounding rural communities.

Managed care enrollment, particularly in HMOs, is expected to grow as consumers switch to these lower-priced plans. But how much growth, how fast, and how many plans can successfully compete in this predominantly rural area remain open questions. Some regard the Gainesville area as a "second- or third-tier market" compared to the more populous areas of the state where managed care can still grow substantially without the marketing and provider network difficulties encountered in rural areas. Intense competition may drive

some insurers out of the market. State cuts in contracts for Medicaid managed care may cause it to grow more slowly than in the past. Given how little participation there is now in Medicare risk contracts, and how many low- to moderate-income seniors there are, enrollment in Medicare HMOs could well increase the most in this area. Capitation of providers is likely to increase in the coming years as well.

Competition between the urban-based provider networks is expected to become even more intense. Indeed, the community is waiting and watching with great concern to see what occurs when the two "giants"—Shands and Columbia/HCA—start going head to head after Shands completes its purchase of hospitals and other provider systems from Av-Med SantaFe. At a minimum, this competition is expected to yield more closely aligned providers across levels of care (inpatient, outpatient, home health) and between urban and rural areas. If the competition results in greater exclusivity in provider affiliations, consumers may find that their choices are limited to one of two large vertically integrated systems. Some predicted that ultimately, both hospitals and physicians will be linked vertically with insurers, but there were no signals of this at present, so it may take several years to occur if it does at all.

The few remaining nonaligned rural hospitals will probably have to become aligned with one of the two urban hospital systems, or be increasingly vulnerable to financial problems. Those rural primary care providers not already in a "home-grown" network of their own will be extremely attractive to urban-based hospitals and insurers trying to capture the rural market. Specialists will face income reductions as managed care works to cut costs. And, though there are few exclusive arrangements between rural providers and Gainesville hospitals now, there are likely to be more, especially if there are only two major competing systems.

As a result of changes occurring now, it is expected that more patients will receive care in outpatient settings, which eventually may cause some hospital closings or a reduction in staffed beds, because of the oversupply of inpatient facilities in the area. One can easily predict an expansion of long-term care facilities, home health care, and rehabilitation services, given the continuing influx of retirees into Florida.

Given employers' interest in lowering health care costs, they may begin to implement some of the wellness programs they say they would like to expand. They have not reduced benefits, but employers anticipate needing to do so in the future as part of their effort to limit costs. Coverage of prescription drugs will most likely go down. But employers worry about declines in quality of care if they reduce payments more than they have already .

The future looks bleak for those with no insurance and those with Medicaid coverage. Major funding reductions at the federal level would hurt Florida, especially if the state is not compensated in some way for the

increasing numbers of poor and elderly people who rely on the state for their care. If these cuts do occur, access to health care "will get worse before it gets better," according to one public health official. Another warned that if the Medicaid block grant passes without some adjustment for high-growth states like Florida, it "would be the beginning of the end" for community health centers.