Advancing Payment Reform in Florida: Recommendations from the Tampa-Orlando Market Assessment and Implications for Statewide Uptake in Paying for Value

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Catalyst for Payment Reform

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EXECUTIVE SUMMARY OF FINDINGS

In 2020, Catalyst for Payment Reform (CPR) partnered with the Florida Alliance for Healthcare Value (the Florida Alliance) to conduct an extensive assessment of the local dynamics that impact the Tampa and Orlando health care markets. The goal was to determine where there are opportunities for reforms that could help to improve the quality and affordability of health care, and enhance transparency into prices and quality for Tampa and Orlando employers, other health care purchasers and their plan members.[1]

In Tampa and Orlando, health care providers appear to have a market-shaping role, as do large purchasers, especially those located in the Orlando market. Meanwhile, health plans have been slow to implement payment reform, leading other vendors and third-party administrators keen on disrupting the status quo to take interest in the region. The Florida Alliance has a history of organizing activities among employers and other health care purchasers and is poised to continue to lead purchaser activism, enabled by state legislation, that supports cost-containment strategies. However, there is a lot in flux as health systems rapidly expand their footprints, providers merge, and the regulatory environment – both at the federal and state level – goes through major overhauls. Taking these dynamics into consideration is critical in determining next steps for improving the value (price and quality) of health care for employers, other health care purchasers and their plan members in Tampa and Orlando through payment reform and other means.

CPR recommends the Florida Alliance and its employer-purchaser members take these next steps to move payment reform forward:

Build on purchaser momentum by drawing upon the state statute offering purchasers technical and strategic assistance with health care cost-containment strategies.

Rationale: As fiduciaries responsible for health care spending and costs, purchasers need to embrace the call to action to be activist buyers. This duty is particularly true for public sector purchasers who rely on taxpayer dollars to fund their employee benefits.

Stay active in policy forums to ensure a more functional marketplace.

Rationale: Policy changes, regulations and state initiatives, such as the possible expansion of Medicaid, could both help or hinder purchaser activities in payment reform.

Urge providers to move from upside-only payment reforms to downside risk arrangements that hold them accountable for meeting quality and cost targets.

Rationale: To create meaningful incentives for improvement, providers need to have a business case to reduce unnecessary care while achieving high-quality standards for the services they provide.

Implement benefit designs to encourage consumers to seek higher value care.

Rationale: Influencing and incentivizing employees to seek care from high-value providers is essential to controlling health care costs.

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[1] For the purposes of this report, the broader term "purchasers" refers to employers (fully insured and self-insured) and other health care purchasers, such as public sector organizations, and multiple employer welfare arrangements.

While CPR assessed the Tampa and Orlando markets, the findings have implications for efforts to advance paying for value statewide. The vertical and horizontal provider consolidation and integration in Tampa and Orlando reflect both broader national trends which could occur at the state level in Florida, with similar effects. Consolidation typically results in higher prices regardless of the quality of care.

Additionally, some of the recommendations in this report can be applied to all of Florida. The Florida Alliance is a statewide employer-purchaser coalition that leads collective action to benefit purchasers throughout Florida, as well as in key markets like Tampa and Orlando. These activities include keeping a pulse on local and state regulatory reforms and leveraging the collective weight and voice of employer-purchasers in policy forums to ensure a competitive marketplace and advance purchaser interests.

INTRODUCTION

Catalyst for Payment Reform (CPR) is an independent non-profit organization working to catalyze employers, public sector purchasers, and others to implement strategies that produce higher-value health care and improve the functioning of the health care marketplace.

The Florida Alliance for Healthcare Value (the Florida Alliance) is an employer-led research and education organization that brings together benefits leaders and health care stakeholders to develop and implement innovative improvements in health care cost, quality, transparency, and safety in Florida.

For the purposes of this report, the broader term "purchasers" refers to employers (fully insured and self-insured) and other health care purchasers, such as public sector organizations, and multiple employer welfare arrangements.

In 2020, CPR partnered with the Florida Alliance to conduct an extensive assessment of the local dynamics that drive the Tampa and Orlando health care markets. The goal was to identify optimal strategies for improving quality, affordability, and transparency for Tampa and Orlando purchasers – principally through payment reform[2] as a means of aligning the incentives of those who use and pay for health care with those who deliver it.

CPR developed its proprietary Market Assessment Tool to establish a structured process for assessing the local characteristics and dynamics of a specific market to determine which payment reform strategies to implement. While many variables affect which payment reform options might be best suited to a particular market, experts agree that health systems, hospitals, and other provider organizations (**providers**), employers and other health care purchasers (**purchasers**), and payers or carriers (**health plans**), have the greatest impact and can each take on a *market-shaping* or

[2] For the purposes of this report, payment reform refers to a range of health care payment models/methods that use payment to promote or leverage greater value. For a payment model to be considered payment reform under CPR's definition, payment must be tied to quality.

non-market-shaping role. Developed through primary and secondary research with stakeholder groups and more than 35 national experts, the CPR Market Assessment Methodology identifies where the locus of market-shaping power resides in any given market, then categorizes the market into one of eight distinct types. These describe whether the market-shaping role lies with providers, purchasers, health plans, or some combination of these. Each market type corresponds with a set of reform initiatives with the greatest prospects of effectiveness and feasibility.

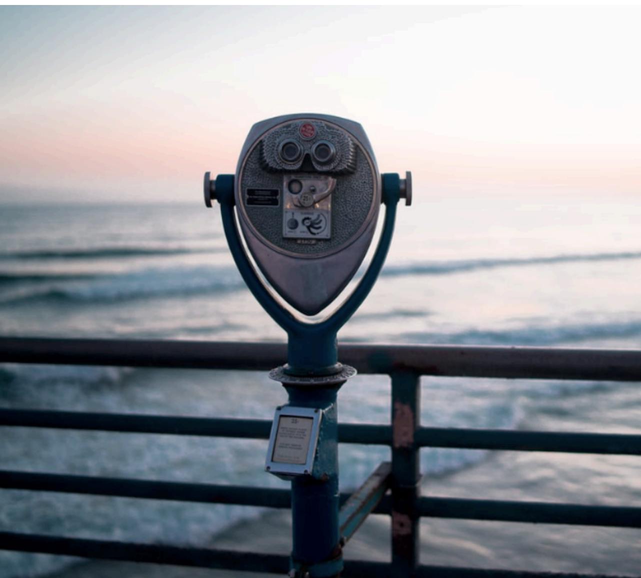
Local market conditions have implications for which payment reform options may work best and which may produce unintended negative consequences. As stakeholders work together to implement change, the market assessment contributes to a shared, data-driven understanding of the market and the best options for payment reform and improving value.

This report has four sections. Section 1 describes the landscape of the Tampa and Orlando health care markets. Section 2 covers an in-depth analysis of the three stakeholder groups that most shape payment reform opportunities in each market, using insights and perspectives from online surveys and primary interviews. Section 2 also has a spotlight on behavioral health, including views from providers and health plans regarding the Psychiatric Collaborative Care Model (CoCM). Sections 3 and 4 use these insights to classify Tampa and Orlando among the eight market types and create a Tampa and Orlando-specific list of reform opportunities based on market dynamics, public-private partnership opportunities, and the legislative environment.

METHODOLOGY

CPR undertook a four-pronged process to collect data for its assessment of the Tampa and Orlando markets.

First, CPR gathered publicly available structural data about providers, health plans, and purchasers in both markets, as well as the local mix of insurance coverage.



Second, CPR invited various provider, health plan, and purchaser representatives of the Tampa and Orlando health care markets to share their views in a stakeholder-specific online survey about the dynamics in the market and opportunities for payment reform. The survey asked respondents to identify whether they would be responding for the Orlando market, the Tampa market, or both. The onset of the COVID-19 pandemic delayed and transformed the online survey process. CPR and the Florida Alliance fielded the survey between July and November 2020 instead of April to July 2020 as originally planned. In total, 34 stakeholders out of 128 invited (27%) responded to the online survey. Of the 34 stakeholders, 13 respondents completed both surveys, while the remaining stakeholders responded for only Tampa or Orlando.

Questions referring to statewide policies only appeared once. Additionally, CPR added four follow up questions to the survey, asking respondents to react to how COVID-19 may impact topics of interest such as stakeholder engagement, payment reform, and balance of power. Aside from the COVID-19 specific questions, the survey instructions asked participants to respond with a "pre-COVID-19 perspective." Additionally, at the request of the Florida Alliance, CPR added survey questions about the CoCM. CPR included these questions only for health plan and provider respondents.

Third, CPR conducted interviews with 11 key informants. Interviewees represented the same stakeholder groups – providers, health plans, and purchasers – as the online survey process.

Finally, CPR reviewed state laws related to quality and price transparency, health insurance benefit design, provider network design, provider payment, and provider market power to understand how Florida's legal and regulatory environment enables or constrains payment reform implementation.

With information from these four main sources, CPR classified the Tampa and Orlando markets using the Market Assessment Tool.

SECTION 1: DETAILED FINDINGS ON THE TAMPA AND ORLANDO MARKETS

Introduction to Florida Regions & Insurance Landscape

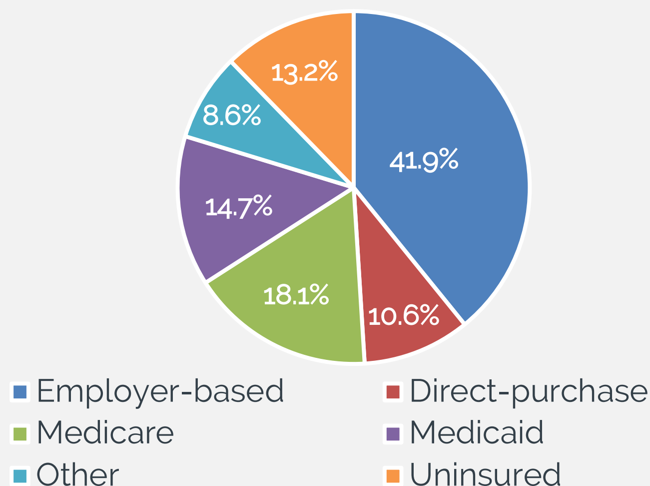
The Tampa region surrounds Tampa Bay on the west coast of central Florida. Tampa is the largest city (population 400,000) in the region, followed by St. Petersburg, Clearwater, Lakeland, Brandon, and Spring Hill. Five counties make up the greater Tampa area. Hillsborough County is the largest in the region with a population of 1.5 million, but Pinellas, Polk, and Pasco counties are each home to 500,000- 1 million residents. Hernando County, in the northern part of the region, has a population of less than 200,000. Most (59.8%) of Tampa region's residents are working age (18-64 years), while 20.1% of the population are under 18 years of age, and another 20.1% are over 65.

The Orlando region is also located in east central Florida to the northeast of Tampa. Orlando is the principal city (population 287,000), while the rest of the Greater Orlando region is made up of suburban towns with populations of 60,000 or less. Four counties make up the Orlando metropolitan statistical area. Orange County with a population of close to 1.4 million is the largest, while Lake, Osceola, and Seminole counties each have populations between 3-500,000 according to the 2019 American Community Survey. Of these Orlando-area residents, 63.2% are working age (age 18-64 years), while 21.7% are under 18 years of age, and 15.2% are over 65.

Insurance Coverage

Florida is known as a retirement destination, which accounts for the higher-than-average proportion of the state population aged over 65 years. As a result, Medicare is the second-largest source of health insurance in the state after employer-based plans. The state of Florida has not expanded Medicaid eligibility under the Patient Protection and Affordable Care Act, which leaves Medicaid as the third-largest source of health coverage in the state at 14.7%, followed by the 13.2% of Floridians with no health insurance coverage.

Figure 1. Insurance by Type, Florida[3]



Most counties in the Tampa and Orlando regions have uninsured rates similar to the state average. The exception is Seminole County, which has a lower rate at 9.1%.

Tampa Counties:

- Hernando County – 11.8% (lower)
- Hillsborough County – 13.1% (lower)
- Pasco County – 12.9% (lower)
- Pinellas County – 11.4% (lower)

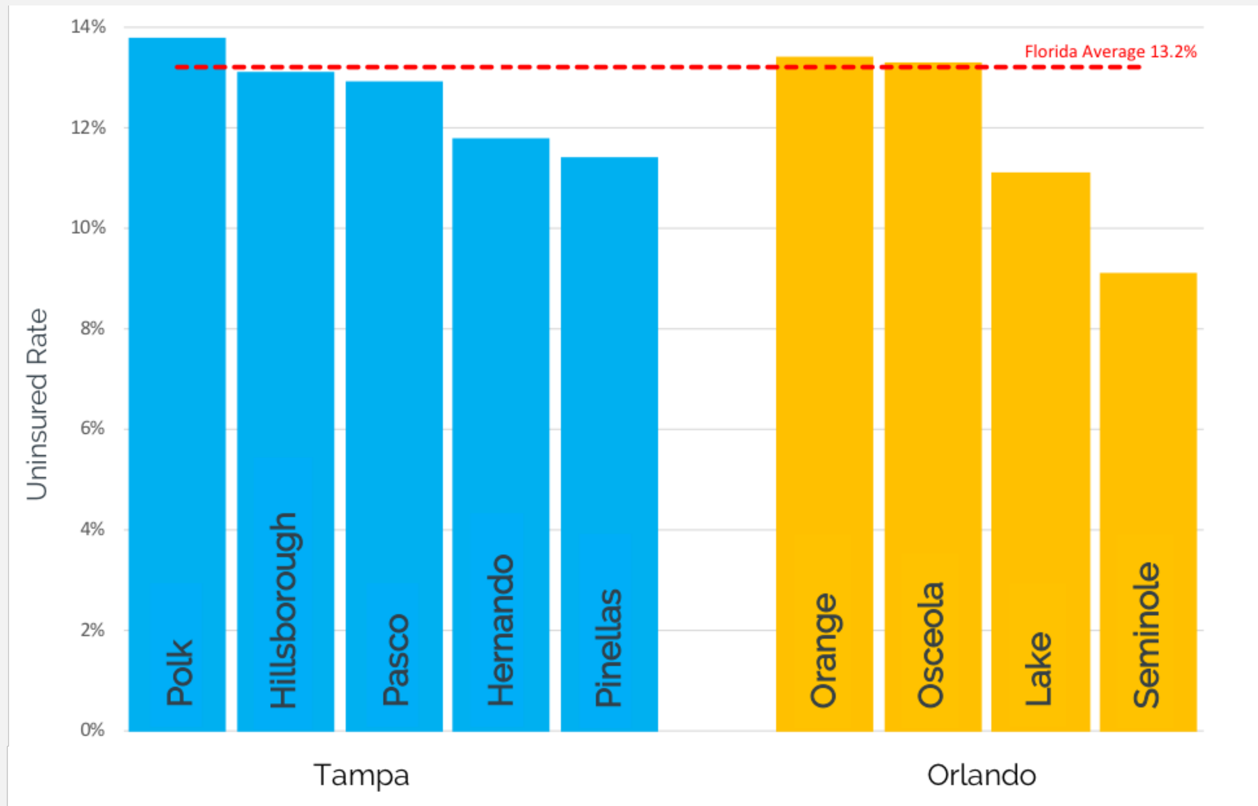
Orlando Counties:

- Lake County – 11.1% (lower)
- Orange County – 13.4% (higher)
- Osceola County – 13.3% (higher)
- Seminole County – 9.1% (lower)

It is important to note that these rates are from 2019 and do not reflect the impact of COVID-19. CPR was unable to locate county-specific uninsured data for 2020. However, given widespread reports of job losses and increases in unemployment rates, it is reasonable to conclude that the current uninsured rates are likely higher than the 2019 data suggest.

[3] American Community Survey, 2019

Figure 2. Uninsured Rate, Tampa and Orlando Area by County[4]



Regional Economy

The COVID-19 pandemic has impacted several large industries in Florida including tourism, hospitality, and transportation. Following a brief shutdown at the beginning of the pandemic, Florida's government pushed aggressively to re-open most businesses, including Governor Ron DeSantis' order on September 25, 2020, which prohibited Florida local governments from enforcing mask mandates, restricting restaurant capacity below 100%, or restricting any business capacity below 50%. Despite loose restrictions, a loss of revenue from out-of-state tourism and caution among the general public has had a significant negative impact on Florida's economy.

In Tampa, the pandemic has not affected the economy to the same degree as it has in Orlando, as Tampa's largest employers are essential services, such as health care, grocery stores, schools, and the military. The Super Bowl was played in Tampa in February 2021, which prior to the pandemic would have generated an economic boom for the region. Instead, economic gains were smaller than in previous years due to reduced capacity in the stadium.[5] Unemployment in the Tampa area was 5.7% as of November 2020, with 56,400 jobs lost in the previous year. Median household income in Tampa was $57,906 in 2019, below both the state median ($59,227) and the national median ($65,712).

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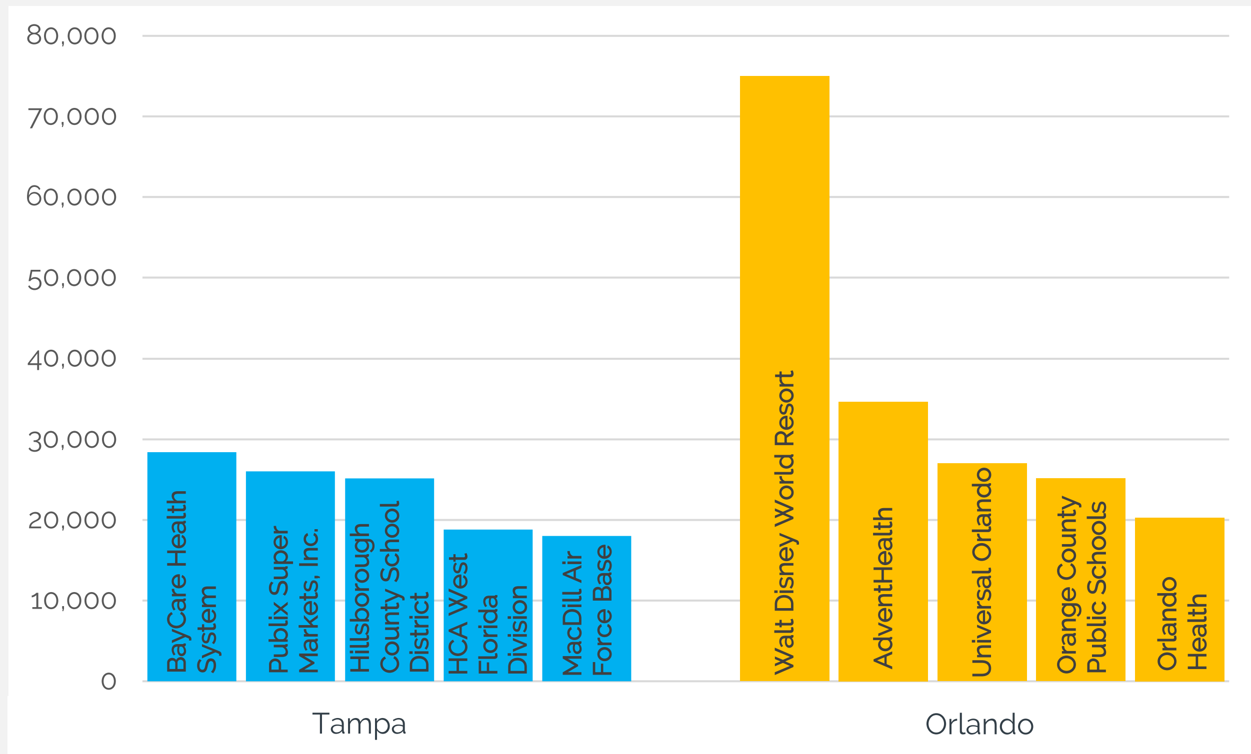
[4] American Community Survey, 2019
[5] Tampa Bay Times

Figure 3. Tampa and Orlando Metro Top 10 Private and Public Sector Employers (by Count EE's)[6]



On the other hand, the pandemic has strained the heavily tourism-based Orlando economy. Prior to COVID-19, Disney World, with an estimated 77,000 workers, was the largest single-site employer in the United States; however, in the wake of the pandemic, Disney World's workforce has yet to return in full force as it implements its recovery plan. The restaurant and hospitality industries that benefit from Disney World guests have also suffered.[7] While Disney World re-opened in July 2020, it has elected to keep parks operating at 35% capacity to maintain proper social distancing.[8] According to the Bureau of Labor Statistics, the unemployment rate in the Orlando area was 7.7% as of November 2020, and the area has lost about 125,000 jobs since November 2019. The median household income in Orlando in 2019 was $61,876, which is higher than the state median ($59,227) but lower than the national median ($65,712).

Health Care Market Dynamics in the Orlando and Tampa Markets

Provider Consolidation

Compared to Orlando, there is slightly less consolidation in the hospital market in Tampa; however, that may be changing as providers in Orlando expand their footprint into Tampa. The largest Tampa hospital, Tampa General, accounts for only 9.6% of inpatient discharges in the area. The largest hospital system in the Tampa region is BayCare, which operates several of the region's larger

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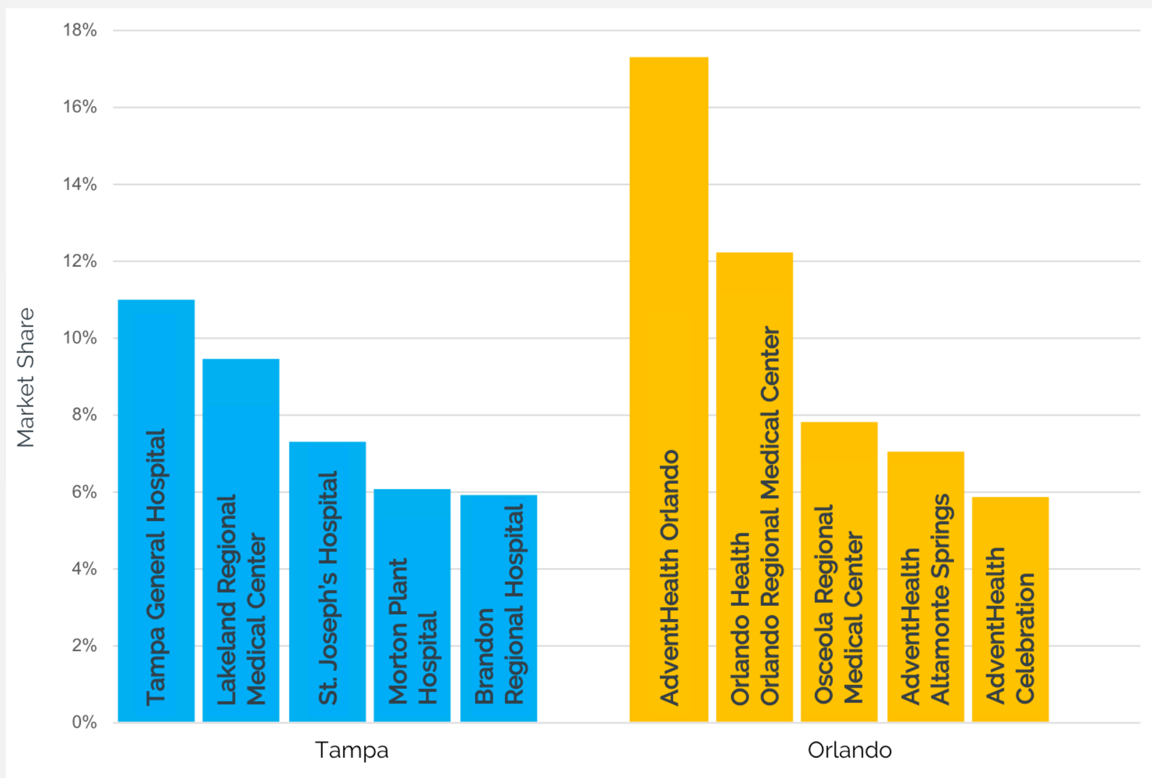
[6] Tampa and Orlando Business Journal Book of Lists
[7] Orlando Sentinel
[8] News: Disney Earnings Call

facilities, including St. Joseph's Hospital and Morton Plant Hospital. Additionally, two health systems dominant in the Orlando region, AdventHealth (formerly Florida Hospital) and Orlando Health, have moved into the Tampa area. AdventHealth operates AdventHealth Tampa and AdventHealth Carrollwood, and also has regional locations in Brandon, North Pinellas, and Wesley Chapel. The Herfindahl-Hirschman Index (HHI) is a commonly used measurement of market competition, calculated as the sum of the squared market shares of each individual firm in a defined service area.[9] Using the HHI methodology, CPR determined that in the first half of 2020, the Tampa market had a HHI of 2,176.13, indicating a *moderately concentrated* market.

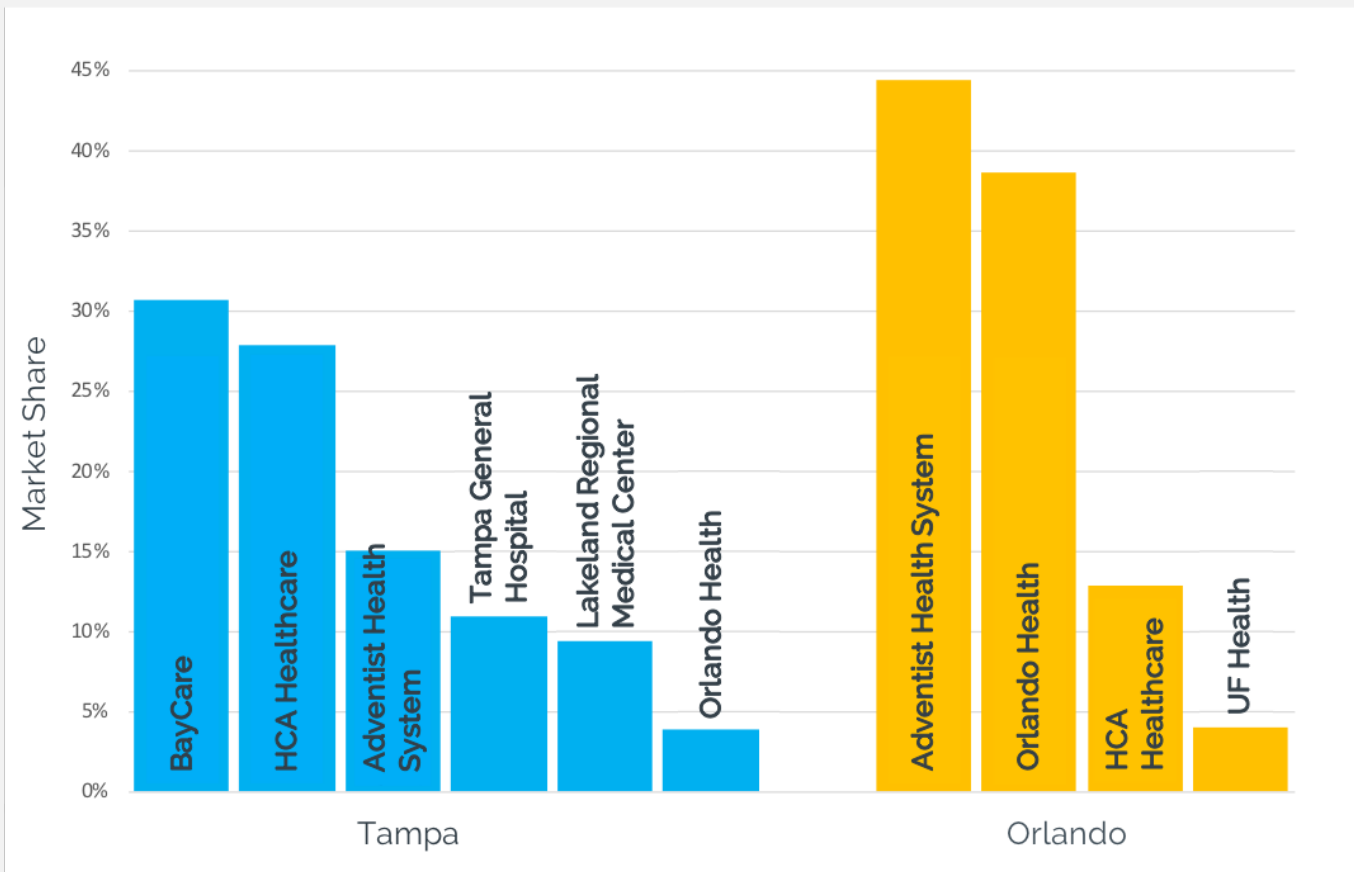
In Orlando, AdventHealth controls much of the market. Flagship facility AdventHealth Orlando is one of the five largest hospitals in the nation, accounting for about 15% of inpatient discharges in the region.[10] AdventHealth operates additional locations in Altamonte Springs, Apopka, Celebration, East Orlando, Kissimmee, Tavares (Waterman), Winter Garden, and Winter Park. The other major health system in the area, Orlando Health, operates its flagship location – Orlando Regional Medical Center – in Orlando, as well as the Dr. P. Phillips Hospital, Arnold Palmer Children's Hospital, and Winnie Palmer Hospital for Women & Babies. Orlando Health also operates regional locations in St. Cloud, Ocoee, and South Seminole. In 2020, the Orlando market had an HHI of 3,681.99, indicating a *highly concentrated* market.

Figure 4. Individual Hospital Market Share in Tampa & Orlando by 2020 Inpatient Discharges[11]



[9] The Herfindahl-Hirschman Index ranges from 1 (least concentrated) to 10,000 (most concentrated). The 10,000 figure comes from a theoretical scenario where there is only one company operating in the industry, with 100% of the market share. The Department of Justice considers markets in which the HHI is between 1,500 and 2,500 points to be moderately concentrated, and considers markets in which the HHI is in excess of 2,500 points to be highly concentrated.
[10] Becker's Hospital Review
[11] Florida Health Finder

Figure 5. Health System Market Share in Tampa & Orlando by 2020 (Q1 & Q2) Inpatient Discharges[12]



Vertical and Horizontal Integration Through Acquisition

When health systems, hospitals and/or physician groups merge, competition is reduced. Hospital mergers and acquisitions have become common in recent decades. In many situations a merger may seem like a "win-win" situation – a large provider expands its footprint, while the smaller provider is able to stay open and serve its patients. However, evidence suggests that these mergers drive prices higher due to a lack of competition and that the brunt of these increases are borne by purchasers and patients. Some reports also suggest that quality of care decreases after hospitals merge.[13]

The State of Florida has had a Certificate of Need (CON) program in place *(FL Stat §§ 408.031 through 408.7071 — Health Facility and Services Planning: Certificate of Need requirement)* since 1970, which requires health systems intent on merging or acquiring another hospital to submit merger plans for government approval. Generally, CON laws and regulations are intended to ensure hospital growth is sustainable within a region and that there is no under- or overcapacity in any given market. The CON laws can also limit the ability of new hospital entrants to move into the marketplace. However, state regulators are in the midst of reshaping this program after a repeal of

[12] Florida Health Finder
[13] New York Times

the law in 2019.[14] Furthermore, in 2020, the state legislature created an avenue for mergers and acquisitions *(FL Stat §§ 408.18 through 408.185 — Health Facility and Service Planning)*. The statue means that health care stakeholders, including licensed providers, insurers, networks, purchasers, and other participants, may ask the Attorney General's office to review their proposed business activity and essentially receive pre-clearance through an "antitrust no-action letter."

Mergers within the health system reflect a larger change in the Tampa and Orlando areas. As the population and suburbs expand, the region has begun to take the form of one large metropolitan area spanning all of central Florida. This expansion is demonstrated by the Orlando-based health systems moving into the Tampa market. In October 2020, Orlando Health made its first acquisition on the west coast of Florida, purchasing the struggling 480-bed Bayfront Hospital in St. Petersburg.[15] Additionally, Orlando Health acquired a large piece of property in Polk County and broke ground for a new facility in Osceola. Finally, on March 1, 2021, the University of Central Florida's College of Medicine and for-profit hospital chain HCA opened the UCF Lake Nona Medical Center, with the hopes of becoming an academic teaching hospital.[16] As the two markets become one, more mergers and acquisitions between the two areas are likely to occur.

The authors of this report recognize that the RAND 3.0 Hospital Price Transparency Study **may lack data from many large, self-funded, Florida-based employer-purchasers, thus producing data that may not be representative.** While national employers contributed data to the Study, it is unclear whether any of them have a large concentration of employees in the Tampa-Orlando area. T**he number of claims are relatively small, and** the claims costs may be based on an out-of-network fee structure, which could inflate the prices reported.

It is also **difficult to differentiate claims data for individuals who live in the area** from those for people who vacation or spend winters in Florida.

Ultimately, more Florida-specific information is needed in future RAND studies to draw definitive conclusions.

High Cost of Care

In 2020, RAND released the third version of its hospital pricing study examining hospital prices for inpatient and outpatient settings at the state, health system, and individual hospital level. By comparing the rates commercial insurers paid to the rates Medicare paid, the Study showcases the variation in prices among different hospitals, even within the same health system or city.

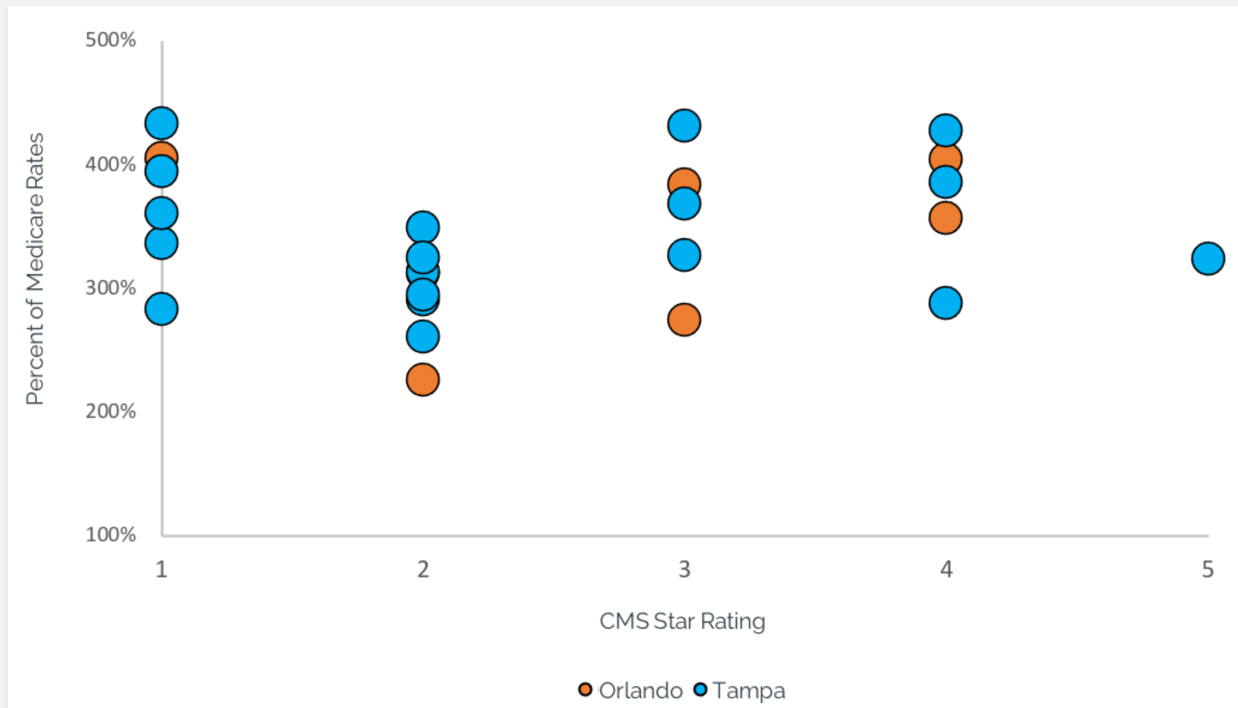
Notwithstanding the caveats in the call-out box to the left, in Florida the average inpatient hospitalization for a patient with commercial insurance costs 316% of the amount Medicare pays, and the average commercially insured outpatient visit costs 339% of Medicare. Together, inpatient and outpatient costs average 326% of Medicare for patients with commercial plans.

This difference is more noticeable in the Tampa and Orlando markets. In Tampa, some large hospitals' prices are more than 380% of Medicare rates for inpatient and outpatient services, while the largest Orlando hospitals charge more than 350% of Medicare. Both are well above the state average. Prices do not seem to be correlated to the quality-of-care patients receive when examined

[14] Health News Florida
[15] Tampa Bay Times
[16] Orlando Sentinel

by Centers for Medicare & Medicaid Services (CMS) star ratings from the same year (2018) or by the Leapfrog Hospital Safety Grades these hospitals earned in Fall 2020. For instance, two large Tampa hospitals, Morton Plant Hospital and St. Joseph's Hospital, each received an A grade from Leapfrog, but the former charges 385% of Medicare, while the latter charges 323%. Moreover, Lakeland Regional Medical Center in Tampa is charging 336% of Medicare and received a grade of C, while Tampa General is charging 260% and received a B.[17]

Figure 6. Hospital Rates & Quality (Inpatient & Outpatient), 2018



Finally, the data show that health costs in Florida remain too high for the region's residents. According to the Altarum Health Costs Consumer Survey, nearly half (46%) of Central Florida adults reported financial barriers to accessing needed health care in the previous year, and more than one third (35%) of Central Florida adults struggled to pay medical bills.[18] Regardless of the comparison to other parts of the country, individuals in the Tampa and Orlando areas feel the burden of high hospital prices, and the high costs they are paying do not correlate with higher quality of care.

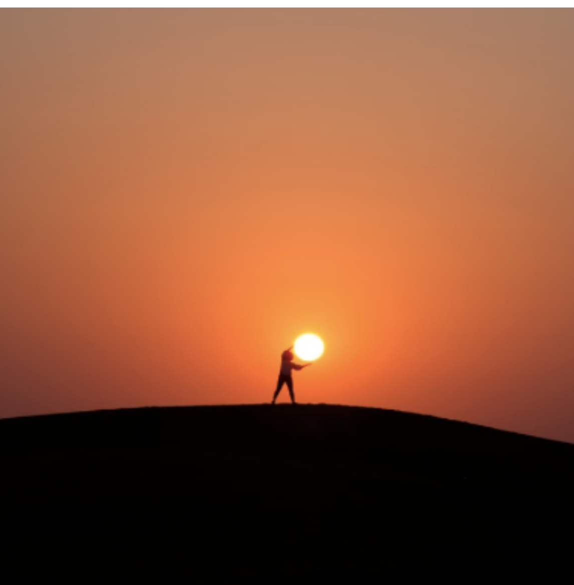
Health Plan Dynamics

There is a lack of competition among health plans in Florida. In 2018, the large and small group insurance markets in Florida were highly concentrated, with the largest insurers controlling 47% and 40% of the market respectively.[19] The lack of competition was even more pronounced in the

[17] Leapfrog Hospital Safety Grades, Fall 2020
[18] Altarum Health Care Value Hub
[19] Kaiser Family Foundation, Large Group Insurance Market Competition

individual market where only two health plans had greater than 5% of market share and the largest health plan (Blue Cross Blue Shield of Florida, DBA Florida Blue) accounted for 68% of the market, with over 1.8 million enrollees.[20] Oscar Health entered Florida's individual market in Orlando in 2019 when it enrolled 30,000 people, compared to Florida Blue's 1 million enrollees.[21] That same year, Oscar Health filed a lawsuit against Florida Blue's "exclusive agent clauses" that prohibit brokers from selling non-Blues insurance policies. Oscar Health ultimately dropped the lawsuit in February 2021 without explanation.[22]

For self-insured purchasers, the largest health plan in the state is Florida Blue, which covers approximately 5 million Floridians.[23] For state employees, Florida Blue is the only preferred provider organization (PPO) network insurance product available.[24] In 2012, customers filed a lawsuit against the Blue Cross Blue Shield Association, of which Florida Blue is an independent licensee, charging the Association with stymieing competition. A tentative settlement was reached in September 2020 which would allow for more competition among associated plans.[25] That same year, the Competitive Health Insurance Reform Act of 2020 became law, which allows the Justice Department to conduct more antitrust enforcement of health insurance companies.[26] Such federal activity is especially important in contrast to state regulations which, as cited earlier, allow health plans in Florida seeking mergers and acquisitions to receive a pre-clearance, anti-trust, no-action letter.



Despite the challenges, there are some bright spots for consumers and employers in Florida's health plan marketplace. Florida's Office of Insurance Regulation reviews yearly rate increases, which attempts to keep premiums in check.[27] Additionally, in 2020, one health plan – Cigna – demonstrated its ability to push back against private-equity backed provider network, Envision, which has a history of not agreeing to in-network rates and exposing employers and consumers to out-of-network bills.[28] Finally, the arrival of new third-party administrators like Centivo, Imagine Health, and others means self-funded employers have more options independent of traditional health plans as partners to administer their benefits.[29] The Orlando Health Network Value Report 2020 makes special note of the emergence of such third party administrators, or "network convenor organizations."

The report says, "Many network convenors have approached the health system with the intent of designing Orlando Health Network (OHN)-concentric network offerings to employers and progressive health plans." The report continues to say that these new partnerships will offer

[20] Kaiser Family Foundation, Individual Insurance Market Competition
[21] HealthInsurance.org
[22] Law 360
[23] Florida Blue
[24] State of Florida MyBenefits
[25] New York Times
[26] United States Department of Justice
[27] Kaiser Family Foundation, Rate Review Processes in the Individual and Small Group Markets
[28] Health Care Dive
[29] Centivo

employers and plans the benefits of "immediate higher quality care and long-term, sustainable cost savings."[30]

Momentum from Florida's Legislative and Executive Branches of Government

The State of Florida has policies in place to create a more competitive health care marketplace, especially for increasing the transparency of prices and provider quality. Under the DeSantis administration in 2019, Florida rolled out the consumer-facing Florida Health Price Finder, providing Floridians with price information for 44 common non-emergent health procedures.[31] The price transparency website is operated by the Health Care Cost Institute (HCCI) and uses data from the Florida Center for Health Information and Policy Analysis, an all-payer claims database created through state legislation (FL Stat § 408.05). A second transparency website, Florida Health Finder, went live in 2005 and was updated in 2019. This website provides consumers with licensing and quality performance information for the state's hospitals. Due to the implementation, updating, and availability of these two websites, Florida's grade in CPR's Report Card on State Price Transparency Laws rose from an F in 2017 to a C in 2020.[32]

In 2019, the DeSantis administration made transparency of cost and quality data a priority by launching the Governor's Health Care Transparency Award for hospitals and ambulatory surgical centers. This honor will be awarded to facilities that have exceeded the regulatory standards and are actively providing accessible and understandable data about their pricing, financial policies, and performance to current and prospective patients. The COVID-19 pandemic delayed the roll-out of the Governor's Transparency award.

There is momentum in Florida to control health care spending by importing pharmaceuticals from Canada. In 2020, the State of Florida entered into a contract with a company to purchase drugs from Canada for its state health programs, including Medicaid and the Department of Corrections, but the program still requires approval from U.S. Department of Health and Human Services.[33]
In November 2019, Governor DeSantis directed then Secretary Mayhew of the Agency for Health Care Administration (AHCA) to engage Florida's business community in aligning efforts toward value-based health care, as codified by Stat § 408.09. This statute stipulates that AHCA can assist employers and other health care purchasers requiring technical assistance on cost effective purchasing strategies, as well as with developing cost containment strategies. According to the Florida Alliance, the statute intends to leverage the collective purchasing power of the state of Florida and private employers to drive greater accountability for improved health outcomes through value-oriented payment reform programs. The Florida Alliance had been in discussions with Secretary Mayhew's team on moving forward with an initial focus on implementing payment reforms for maternity care and treatment for substance use disorders. However, due to the departure of Secretary Mayhew, as well as the onset of the pandemic, progress between AHCA and the business community is paused.

In general, the state's legislative and regulatory activity supports payment reform and other innovative purchasing strategies to improve health care value in Florida. However, there are mixed signals. For example, the Florida legislature acknowledges in Florida statue § 456.053 that:

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[30] Orlando Health Network Value Report 2020
[31] State of Florida
[32] Catalyst for Payment Reform
[33] Health News Florida

"…referral of a patient by a health care provider to a provider of health care services in which the referring health care provider has an investment interest represents a potential conflict of interest. ***The legislature finds these referral practices may limit or eliminate competitive alternatives…may result in overutilization of health care services, may increase costs to the health care system, and may adversely affect the quality of care.****"* [emphasis added]

Yet this same statute indicates that it might be appropriate for a provider to refer to facilities in which it has an ownership stake with "appropriate safeguards." It is unclear whether the safeguards outlined in the statute will be sufficient to protect consumers from more limited options and increased costs.[34] Furthermore, the repeal of Florida's certificate of need law reduces state oversight of hospital mergers and acquisitions, which can result in higher costs for Floridians.

Orlando Health and Bundled Payments

Orlando Health's most recent "Value Report 2020" notes that it started participating in CMS's Bundled Payments for Care Improvement Advanced (BPCI-A) in January 2020 for 11 episodes of care.

In the earlier version of the program, Orlando Health generated over $20 million in cost savings to CMS. The report continues to say "Ultimately, patients have and will reap the benefits of these better processes through lower costs and improved health outcomes."

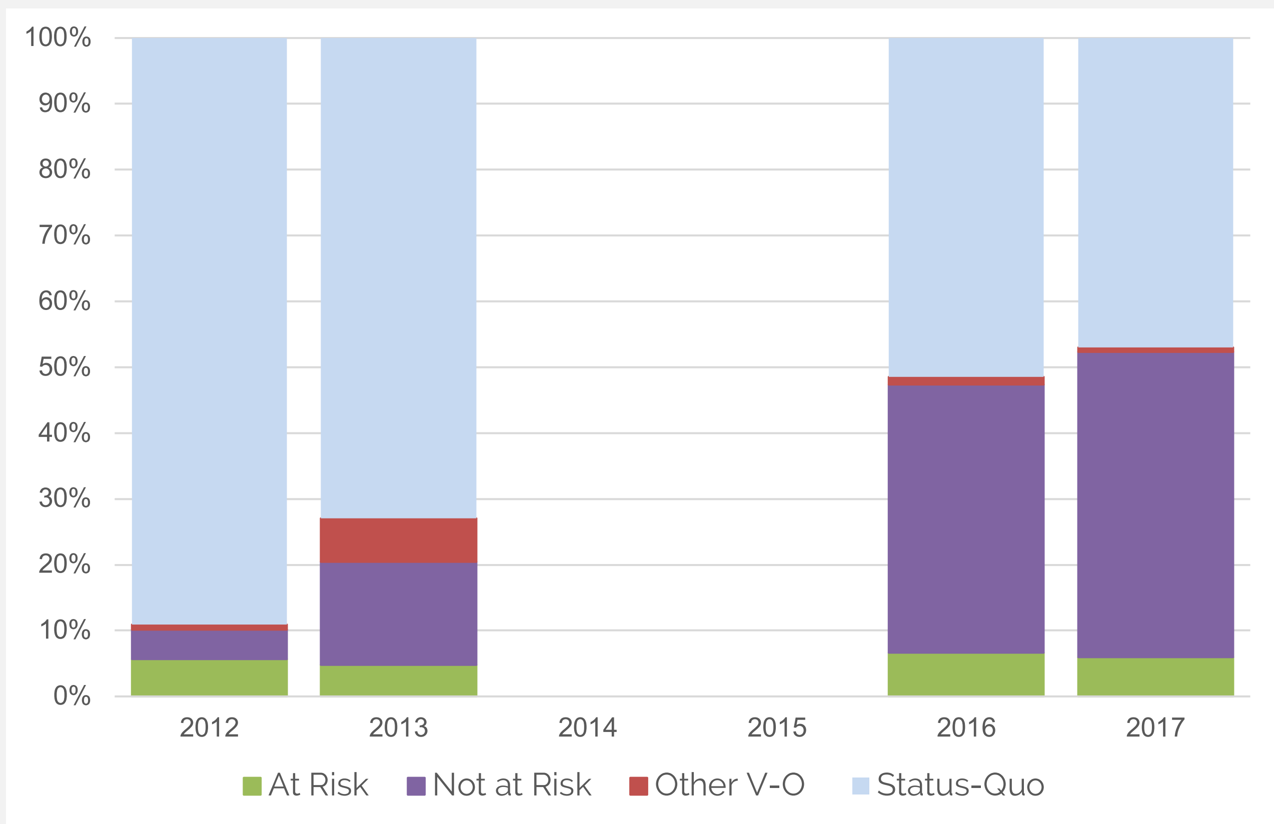
This program requires organizations to bear financial risk based on cost and quality performance. Orlando Health's participation in this at-risk program is a signal that it may engage in such programs in the commercial market.

Payment Reform in Florida It is challenging to say whether payment reform has gained traction in Florida as there is no baseline from which to track progress. National data, however, may provide a proxy for Florida. In 2019, CPR collaborated with the National Alliance of Healthcare Purchaser Coalitions to use data collected through its eValue8 health plan survey, an annual request for information (RFI) to commercial health plans. The RFI is a voluntary survey and is not designed to ensure a representative sample of health plans, but it is one of the largest national surveys of health plans. CPR and eValue8 analyzed commercial data on value-oriented payments for 2012, 2013, 2016, and 2017, and found that payments tied to quality increased from almost 11% in 2012 to over 53% in 2017. The national health plans represented in the 2017 eValue8 data are likely comparable to the plans conducting commercial business in Florida. National data collected by the Health Care Payment and Learning Action Network (HCP-LAN) shows a more modest increase, yet also provides a benchmark. The HCP-LAN's most current commercial data show that 44.3%[35] of payments flowed through methods that include quality in 2018.[36] While imperfect, it is reasonable to deduce that commercial payment reform implementation in Florida is within the ranges identified in the 2017 CPR/eValue8 national data and the 2018 HCP-LAN national data.

[34] State of Florida Legislature
[35] HCP-LAN
[36] The HCP-LAN tracks payments using the LAN Framework and LAN goals. The LAN only counts payments in Categories 3 and 4 toward meeting the LAN goals. For the purposes of the Florida analysis, CPR combined Categories 2, 3, and 4 in the commercial and Medicaid markets to determine the total percentage of payments tied to quality.

While payment reform implementation has increased rapidly since 2012, adoption of arrangements that put providers at financial risk has not gained much traction. Since 2012, of the payment methods that put providers at financial risk (e.g., shared risk, bundled payment, capitation), no *single* at-risk payment method accounted for more than 4% of total payments, and when combined, at-risk payments did not account for more than 6% of the total. It is worth noting that in Florida, there is significant provider participation in Medicare's Bundled Payments for Care Improvement (BPCI) and Bundled Payments for Care Improvement Advanced (BPCI-A) programs. Therefore, as a percent of total health care spending in Florida, it is possible that at-risk payments are higher than 6%. While participation in a Medicare program that includes downside financial risk does not directly translate to more downside financial risk in Florida's commercial market, it could be an indication that providers are willing to take on financial risk.

Figure 7. Value-Oriented Payments that are "At Risk," 2019[37]



Self-funded employers may be wary of adopting two-sided risk arrangements because the savings under these arrangements may only accrue to the health plan administrator and the provider, unless otherwise specified in a contract. If health plans offer both upside savings and downside risk arrangements to providers, they often do so for their fully insured business only, meaning that the

[37] National Scorecard on Payment Reform 2.0

savings accrue only to the plans and providers. Self-funded employers may only benefit from any savings in a shared risk arrangement by contracting directly with providers or with a third-party administrator explicitly committed to sharing any savings. In response to this dynamic, a new crop of vendors – including Signify Health, spotlighted below – has entered into the health care marketplace offering to convene or facilitate the adoption of downside risk contracts between employers and local, high-quality providers.[38]

Spotlight on Signify Health's partnership with the Florida Alliance

In early 2018, the Florida Alliance for Healthcare Value (then the Florida Health Care Coalition), partnered with Signify Health (then Remedy Partners), **to assist Florida Alliance members in the education, development, implementation, and administration of bundled payment programs.** The initiative served as a learning process for employers, providers, health systems, and health plans. The program started with cardiovascular bundles in Orlando and then expanded across the state to include additional bundles.

Signify has contracted with 15 hospitals in Tampa/Orlando to provide care at fixed bundled prices. **Since the beginning of the partnership, Signify has helped payers/employers representing several million plan members implement bundled payment programs covering dozens of conditions and procedures.** The Florida Alliance and Signify also worked to implement expanded bundles, called episodes of care. Participating purchasers have seen on average 10% savings per episode of care.

While Florida's Medicaid program is not known for provider payment reform, it does contract with comprehensive, risk-based managed care plans to provide care to at least some of its Medicaid beneficiaries.[39] Again, the HCP-LAN national Medicaid data can be instructive. In 2019, the HCP-LAN reported that approximately 34% of Medicaid dollars flowed through payment arrangements tied to quality.[40]

To date, Florida has not expanded its Medicaid program and expansion in 2021 is unlikely. In October 2020, the Florida Hospital Association selected Mary Mayhew as its Chief Executive Officer. Ms. Mayhew had led Florida's Agency for Health Care Administration, which oversees Florida's Medicaid program since 2019 and was a vocal critic of the Affordable Care Act's Medicaid expansion.[41] However, the negative financial impact of COVID-19 on hospitals has led many to entertain the idea of supporting Medicaid expansion to cover more uninsured patients. It is possible that Florida hospitals or the hospital association might take a similar stance.

[38] Catalyst for Payment Reform
[39] Kaiser Family Foundation
[40] HCP-LAN
[41] Kaiser Health News

Purchaser Perspective on Market Dynamics

To understand the viewpoint of health care purchasers in the Tampa and Orlando markets, CPR surveyed eleven private and public sector employer-purchasers and conducted follow up interviews with six of them.

The Impact of COVID-19
Employer-purchasers in the Tampa and Orlando markets believe COVID-19 has been a catalyst for change in many ways.

- **Telehealth is booming.**
- **A renewed focus on the importance of prevention**: COVID-19 may encourage greater focus on prevention and care management because it poses high risks to individuals with underlying conditions.
- The financial impact of the pandemic creates **pressure for change –** and more consumer cost sharing is off the table – so there is a need to get creative to contain costs.

Despite being in markets with significant provider consolidation and limited health plan options, self-insured purchasers in both Tampa and Orlando expressed confidence in their own ability to shape the market during payment reform negotiations with providers and health plans. This perception was stronger in Orlando, where five of eight employer-purchasers surveyed identified purchasers as holding the market-shaping role, compared to just two of eight respondents who identified providers as the market-shapers. In Tampa, employer-purchasers were evenly divided between whether they or providers hold the market shaping role (2 respondents for each). Only one purchaser, who is familiar with both Tampa and Orlando, identified health plans as holding the market shaping role in these markets.

Interviews revealed the perception that large purchasers in Orlando have been able to implement advantageous programs – whether with health plans or through direct arrangements with providers – but that those arrangements are not available to Tampa purchasers. In general, Tampa and Orlando suffer from a common issue: both areas are home to employees of national companies whose headquarters are outside of Florida and therefore, may not be as engaged in Florida-specific health care cost issues and reforms.

During the interviews, public sector purchasers described a lack of political will to lend their purchasing power to payment reform initiatives. Despite their significant volume of covered lives, the state and local government purchasers CPR interviewed said they are more limited in their ability to innovate and make quick changes than private purchasers. Benefit managers representing local city and county governments offered the following reasons for their wariness to innovate:

- Administrative barriers that government infrastructure poses (e.g., contracting processes)
- The need to provide rich benefits as a value add for employees (e.g., broad choices and low co-pays)

- Low tolerance for making bold changes that could have unintended consequences, negative optics (e.g., a government agency steering to particular providers) or cost or quality ramifications for employees and their families.

These hesitations are notable in contrast to public sector purchasers in other parts of the country who are among the most innovative purchasers due to their pressure to spend tax-payer dollars extremely carefully.

Example of Public Sector Purchaser Innovation: Metro Nashville Public Schools

Metro Nashville Public Schools (MNPS) purchases health care for 18,000 covered lives and spends $100 million annually. With a high concentration of reproductive-age female members, MNPS pays for about 250 deliveries annually. Facing increasingly high health costs, MNPS conceptualized a system of bundled maternity care, contracted directly with one provider (Vanderbilt University Medical Center). MNPS provides **one upfront payment per delivery, which covers everything from prenatal visits, enhanced services like patient navigator support, the hospital delivery, and care through three months post-partum - all with zero out-of-pocket costs for the member.** Since the program launched at the beginning of 2020, MNPS has incurred $3,500 savings per episode and seen a 25% reduction in cesarean deliveries, along with a Net Promoter Score of 88. The success of the program has led MNPS leadership to plan for bundled payments in other areas in 2021 and 2022.[42]

In the survey and throughout the interviews, purchasers highlighted ways that providers and health plans exert considerable influence in the health care market. For example, they noted in the online survey that providers in Tampa and Orlando moderately or very much hold “must have” status, or the ability to use their name recognition and market share to demand their inclusion in a health plan or purchaser provider network. Additionally, they noted that health plans and providers leverage each other’s market power through anti-competitive contracting practices such as anti-steering/anti-tiering provisions. Finally, purchasers observed dominant health systems leveraging their network status raise prices for purchasers and health plans in Tampa and Orlando, leading to ballooning prices and the continued dominance of fee-for-service.

Purchasers also expressed a need for increased quality transparency to push reforms, noting that health plans and hospitals should be more transparent on efficiency and quality data so that purchasers can evaluate whether initiatives like pay-for-performance are working. However, it is important to note that Florida Alliance employer and health care purchaser members request all hospitals in Florida to participate annually in The Leapfrog Group’s Hospital Survey. This continued pressure has significantly increased the number of Florida hospitals participating in the Survey over the past several years. In 2015, 129 hospitals – 60% of those invited – participated. In 2019, 182 hospitals – 81% of those invited – participated.

[42] Metro Nashville Public Schools’ Direct Contract Bundled Payment Program

Sutter Case Provides Roadmap for Other Markets

In Northern California, Sutter Health acquired a vast number of hospitals and medical practices leading to significant provider consolidation. **The challenging environment and resulting high prices so alarmed employers and other health care purchasers that a health benefit trust brought an antitrust suit against Sutter Health.** Then Attorney General of California, Xavier Becerra, also joined the suit. Both groups sought financial damages and to require Sutter to allow for health insurance options built on price and quality transparency.

In December 2019, the parties arrived at a settlement, including Sutter's agreement to pay $575 million to employers and health benefit trusts affected by Sutter's past conduct, and to cease their anticompetitive practices. **Purchasers across the country will be watching to see if the Sutter case will serve as a warning to other dominant providers** and as a roadmap to create more competitive health care markets.[43]

Purchasers view a hospital's participation in the survey as a signal that it is willing to disclose its performance.

When asked to describe the biggest opportunities for payment reform in Tampa and Orlando, employers and other health care purchasers pointed to accountable care organizations (ACOs) that are able to deliver high-quality and cost-effective care. They also expressed optimism around using benefit design and communications to steer plan participants away from high-cost providers, specifically hospital outpatient centers or hospital-affiliated freestanding emergency rooms, which are very expensive for plan participants.

Provider Perspective on Market Dynamics

To understand the viewpoint of health care providers in the Tampa and Orlando markets, CPR surveyed eleven providers, representing hospitals and health systems, and conducted three follow up interviews. Six of these provider representatives responded for both Tampa and Orlando markets; one representative responded solely for the Tampa market, and three responded solely for the Orlando market. Some survey respondents did not answer every question.

Based on the survey and interview data, CPR identified a range of provider perspectives about which stakeholder group shapes the Tampa and Orlando markets. In Tampa, the majority of providers surveyed (four out of six) stated that their group holds the market-shaping role when it comes to payment reform. In Orlando there was less consensus, with four out of seven respondents selecting purchasers as having the market-shaping role, two out seven selecting providers, and one selecting health plans. During the interviews, providers again pointed to large private purchasers as having greater market power than providers or health plans, especially in Orlando. However, the explanations seemed to be forward-looking. For instance, one provider representative noted that the cost pressures faced by purchasers might reach a tipping point when they and their plan participants finally reject high-cost providers, at which time providers will need to pivot from fee-for-service to payment reforms that help solve the "affordability crisis."

[43] Implications of Sutter Settlement

While the providers CPR interviewed and surveyed expressed a desire for and openness to payment reform, it was clear that they have not implemented much of it. Providers affirmed the lack of contracts with payment methods requiring them to accept financial risk. All six provider respondents in Tampa categorized only 0-10% of contracts as requiring shared risk, as did four of the six Orlando provider respondents. Meanwhile, providers in both markets acknowledged widespread upside only payment arrangements. Two respondents in Orlando identified pay-for-performance to be present in 50-100% of contracts with health plans. Similarly, three Orlando providers noted that shared savings is present in 26-50% of health plan contracts. Only one respondent to this question in Tampa estimated the same proportion of contracts with shared savings in that market. In interviews, providers acknowledged that fee-for-service has been a profitable model for a long time, which means low motivation among providers to adopt payment reforms.

The provider representatives who CPR surveyed and interviewed said they viewed health plans as posing barriers to payment reform. In their view, health plans displayed the least innovation among major stakeholders and have contributed to cost inefficiencies in the market. When asked about health plan involvement in payment reform, all seven surveyed Tampa providers responded that health plans are only moderately or marginally involved, as did all but one of the surveyed Orlando providers. During interviews, provider representatives pointed out that negotiations between health plans and providers are challenging due to a real and/or perceived lack of trust between the parties. Some of the mistrust appears to stem from the fact that health plans are acquiring physician practices and other segments of the care delivery system, thereby blurring the lines between health plans and the delivery system. From the provider point of view, health plans are only moderately ready and capable of implementing new forms of payment (three of six Tampa providers selected this response, as did five of seven for Orlando).

The Impact of COVID-19
Providers in the Tampa and Orlando markets believe the overall impact of COVID-19 on payment reform has been low; however, its long-term economic impact may speed underlying trends, including:

- Purchasers increasingly looking to value-based models of care and payment.
- Providers accelerating on their path to reform.
- Health plans realizing "the old ways" will not work anymore and beginning to look for success with providers on value-based-payment (e.g., shared savings).
- Telehealth becoming essential in any payment reform model.

All provider respondents to the survey said that the balance of power among health plans, purchasers, and providers would remain unchanged by the pandemic. However, provider interviewees were split as to whether COVID-19 would impact the level of involvement in payment reform among health plans, purchasers, and others. One provider respondent to the Orlando survey explained that due to the pandemic, "health systems see value in diversification of revenue streams and will be more amenable to payment reform efforts." Multiple respondents noted that the significant adoption of telehealth would likely spur more involvement in payment reform by the different stakeholder groups. Survey respondents lacked consensus about whether COVID-19 would impact how much providers in Tampa and Orlando would participate in payment reform. In Tampa, three provider respondents said their payment reform participation will increase, while another three said it would stay the same. Similarly, in Orlando, four providers predicted an increase and another three predicted participation levels would stay the same.

Providers identified upside only payment models as promising payment reforms. For instance, providers highlighted the CMS Medicare Shared Savings Program and the opportunities it provides to form ACOs. Providers noted successes of existing ACOs under advanced alternative payment models (APMs) and that some of these ACOs are on the track toward downside risk. There has been significant ACO activity in Tampa, mostly in Medicare Advantage, led by independent physician groups forming independent practice associations. Based on this activity, providers in Tampa believe independent physician practices are well-positioned to embrace non-fee-for-service payments.

Health Plan Perspective on Market Dynamics

To understand the viewpoint of health plans in the Tampa and Orlando markets, CPR surveyed five health plans, four of which crosscut both markets and one that serves only the Tampa market. CPR then conducted interviews with two health plans.

In general, health plans in both the Tampa and Orlando markets perceived providers and purchasers as having the greatest power and influence over payment reform. Health plans noted that their negotiations with providers are often challenging due to the market dominance that providers hold. When asked to identify the biggest barriers to payment reform in both markets, health plans cited: "Providers feel decreased payment levels that they have not budgeted for" and the low likelihood of

both parties agreeing to lower rates. In the interviews, health plans emphasized that providers were a major barrier to advancing payment reform.

If health plans truly lack leverage, it should not be a surprise that most payments they make to providers are fee-for-service. In their survey responses, health plans almost unanimously reported a dearth of APMs in their contracts with providers in Tampa and Orlando and said that providers, particularly hospitals, are only minimally or marginally able to accept new forms of payment. Notably, most of the health plans CPR surveyed for this effort are national health plans. Three of the plans operating in Tampa (one health plan did not answer this question) and one of the plans operating in Orlando acknowledged that their organizations have not customized APMs for providers in these two markets.

The Impact of COVID-19
Health plan interviewees reported believing that their organization's pace and appetite for payment reform will either stay the same or increase due to COVID-19.

The surveyed health plans predicted (three of four for Tampa and all four in Orlando) that providers' capabilities to accept new forms of payment will remain the same as before.

While health plans have been slow to make progress with payment reform, they have actively used consumer-facing mechanisms to shape the market. All five of the surveyed health plans indicated that their organizations use provider quality and cost transparency as tactics to drive change in member behavior. The majority of health plans surveyed use wellness initiatives to change member behavior (four of five health plans in Tampa and three of four in Orlando have moderately or largely used this tactic). Finally, four of five surveyed health plans in Tampa and three of four in Orlando reported using tiered and narrow networks on a moderate or large scale.

A Spotlight on Behavioral Health: The CoCM

Most providers indicated moderate activity and familiarity with the CoCM. Of note, AdventHealth and Concert Health are currently implementing the CoCM with 400 providers and, among providers in general, there is active interest in innovative approaches for behavioral health care. Among providers familiar with the model, some are working with both local and national companies implementing it and enabling billing under the CPT codes (99492-99494) promoted by the model. For patients to have increased access to these services, providers felt they needed to work with a third-party vendor because these codes are not currently in health plans' commercial fee schedules.

Among interviewed health plans, there was some familiarity with the CoCM. Health plans expressed support for this initiative and for billing and paying based on the CPT codes promoted by the model, but also underscored the importance of ensuring that these CPT codes truly capture the payments needed to enable the integration of behavioral health and primary care. For instance, will payment for these codes cover a behavioral health professional to be embedded in a primary care office? Is there enough participation in the program to support the model long-term? CPR identified a general sentiment among health plans that the CoCM is a great idea that needs a solid implementation plan spelling out the operational details about how it will work on the ground.

Purchaser surveys and interviews did not include questions regarding the CoCM; however, the Florida Alliance has met with Concert Health to develop an implementation plan for providers, health plans and purchasers.

SECTION 3: MARKET TYPES AND PAYMENT REFORM OPTIONS

Based on the combination of the online stakeholder survey and interview findings as well as structural data about the market, CPR categorized providers, health plans, and employers and other health care purchasers as *market shaping* or *non-market shaping*. The interplay of who has power in the market – who "calls the shots" – may make all the difference in determining which payment reform options are viable or the best options for making progress. Most changes to payment fall into one of three categories: (1) upside only for providers, (2) downside only for providers, and (3) two-sided risk (both upside and downside for providers). The right and left side of the schematic below separates markets into those in which providers are shaping the market (left) and those in which providers are not market-shaping (right). The top and bottom of the schematic divide markets into those in which purchasers are shaping the market (top) and those in which they are not (bottom). Then within those two purchaser categories, there is the added dimension of the role of the health plan in shaping the market, which further distinguishes the four main quadrants into eight separate and distinct market types.

Figure 8. Market Archetypes[44]

PURCHASERS		PROVIDERS: Market-Shaping	PROVIDERS: Not Market-Shaping
Market-Shaping	HP +	1 Purchasers, providers and health plans are market-shaping	2 Purchasers and health plans are market-shaping, providers are not
Market-Shaping	HP –	3 Purchasers and providers are market-shaping, health plans are not	4 Purchasers are market-shaping, providers and health plans are not
Not Market-Shaping	HP +	5 Providers and health plans are market-shaping, purchasers are not	6 Health plans are market-shaping, purchasers and providers are not
Not Market-Shaping	HP –	7 Providers are market-shaping, purchasers and health plans are not	8 Purchasers, providers and health plans are not market-shaping

[44] Derived from Catalyst for Payment Reform's proprietary Market Assessment Tool. For the purposes of this report, the broader term "purchasers" refers to employers (fully insured and self-insured) and other health care purchasers, such as public sector organizations.

More than 35 leading payment reform implementation, academic, and research experts in the country provided input to CPR on which payment reform types are best suited to the eight different market types. However, each market is unique and there are micro-markets within larger markets that deserve analysis. CPR will continue to build the knowledge base for such recommendations over time based on further expert input and, most importantly, iterative experience. Furthermore, the characteristics of markets are not static and can change over time. As a result, appropriate recommendations for a specific market are also likely to evolve.

SECTION 4: TAMPA AND ORLANDO MARKET TYPE AND PAYMENT REFORM RECOMMENDATIONS

Based on CPR's market type identification system, CPR considers Tampa and Orlando a ***market-type 3***, where providers and purchasers are market-shaping, and health plans have limited market-shaping abilities. Benefits of a market-type 3 could be willingness of providers to participate in shared savings programs, which in turn encourages coordination and integration of care delivery. However, if this integration leads to mergers and acquisitions that increase providers' market dominance, this could result in providers demanding price increases from relatively weak commercial health plans. To counterbalance the influence of providers, purchasers will want to work together to advance payment reform in the Tampa and Orlando markets. CPR's recommendations are as follows:

Continue Building on Purchaser Momentum

The Florida Alliance should continue to lead collective purchaser action, including shining a spotlight on exorbitantly high commercial prices in the state and holding low-quality hospitals accountable. To do so it can continue its Regional Leader role with The Leapfrog Group and being vocal about excluding poorly performing hospitals from provider networks. Most importantly, the Florida Alliance should urge its employer-purchaser members, as well as its audience of purchasers statewide, to take full advantage of the state statute offering purchasers assistance with health care cost-containment strategies.[45] While engaging large purchasers able to push the market is critical, the Florida Alliance should also continue to engage its small to mid-size employers and other health care purchasers in its collective agenda; extending reforms to all size purchasers creates greater awareness and alignment on the need for reforms to overcome the unsustainable status quo.

Finally, the Florida Alliance should focus on helping public sector purchasers like city, county, and state employee and retiree organizations flex their muscles and influence as large purchasers of health care. There is a growing movement among public sector purchasers across the country; many are taking bold actions to reduce health care costs and improve quality.[46] Montana provides a strong example of how public sector purchasers can use their fiduciary responsibility boldly to

[45] Florida Statutes Chapter 408 Health Care Administration
[46] Catalyst for Payment Reform

address unsustainable health care costs.[47] While the culture in Florida has made public sector purchasers averse to taking bold action in health care, the Florida Alliance could educate them and enable and empower these purchasers to implement proven strategies. Not only would their plan participants benefit from lower out-of-pocket costs and better quality, but taxpayers are also likely to benefit from reductions in spending.

Two years ago, the Florida Alliance developed "rights" for employers and other health care purchasers (below) to serve as guideposts to empower public and private purchasers in their health care purchasing efforts. These rights should remain a focus for the Florida Alliance and its employer-purchaser members.

The Florida Alliance for Healthcare Value
Employer / Health Care Purchaser Rights

Employers and health care purchasers
have the right to:

Right #1 Advocate for better value in the health care they purchase for their employees.

Right #2 Transparency of the costs and quality of the care they purchase.

Right #3 Be proactive and empowered purchasers of health care, seeking out innovative ways to generate value for their employees and their families.

Right #4 Use their health care data to support new partnerships made in an effort to accelerate value.

Right #5 Expect that quality is measured in a meaningful way.

Right #6 Ensure that plan members have the best patient care imaginable.

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[47] Tradeoffs

Stay Active in Policy Forums for a More Functional Marketplace

As described earlier, the regulatory environment that impacts Florida's health care marketplace is shifting rapidly. Employers and other health care purchasers should track how the certificate of need law evolves to help ensure that new provider facilities do not inundate the market, and that additional mergers and acquisitions do not continue to tip the scales away from purchaser interests.

While Florida has made substantial progress in making price and quality information publicly available, there is still more work to be done. State regulators could build out their website to help purchasers make the case for addressing unwarranted price variation (see how the New Hampshire transparency website[48] provides tools specifically for benefit managers). Another potential improvement would be to require more accurate price and quality reporting for freestanding emergency rooms and hospital outpatient facilities owned by large health systems. Without specific regulatory guidance, price and quality reporting for these facilities may be wrapped up in the reporting for the health system at large, potentially hiding facilities that have higher prices, with equal or less optimal quality performance. This practice will also make it difficult for purchasers to analyze these offerings and use benefit design to steer plan participants away from low-value sites of care.

Florida could follow the lead of Colorado, which passed the "Health Care Provider Unique Identification Per Site Or Service" bill in 2018 to address this issue. The act requires an off-campus location of a hospital, such as a freestanding emergency room, to use a unique national provider identifier (NPI) on claims for reimbursement for services provided at that location. In addition, all Medicaid providers must supply a unique NPI on their claims as well, identifying both the site of service and the provider type.[49]

Finally, purchasers interested in more payment reform may want to be open to supporting Medicaid expansion in Florida. Medicaid agencies and the managed care organizations that serve Medicaid enrollees have substantial experience in implementing payment reforms and could help build the momentum necessary for local providers to rely less on fee-for-service.[50] Moreover, researchers have identified many shared benefits to expanding Medicaid coverage, including the significant economic benefits to all stakeholders of reducing the number of uninsured patients in the state, helping sustain providers with a broader base of insured patients, and improving the health of patients.[51] Finally, Medicaid expansion has been shown to reduce racial health disparities in health coverage and outcomes significantly, a shortcoming of the current health care system laid bare by the COVID-19 pandemic.

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[48] NH HealthCost
[49] State of Colorado Legislation
[50] Catalyst for Payment Reform
[51] Princeton University State Health and Value Strategies

Urge Providers to Move from Upside Only Payment Reform to Downside Risk

As previously discussed, there is some payment reform activity happening in Florida, but in the commercial market, it is concentrated in upside only arrangements, like pay-for-performance. However, downside risk models are associated with better cost and quality performance by providers, and purchasers should make it known that they would like providers to enter into these arrangements.[52,53] There are inroads in Tampa and Orlando moving in that direction, especially among providers participating in Medicare initiatives like BPCI and BPCI-A. The influx of vendors like Signify Health and Carrum Health is also a promising sign, as these vendors may advance downside risk arrangements and have a stronger business case than traditional health plans to pass savings directly to purchasers. A March 2021 study in Health Affairs found that self-funded purchasers using Carrum Health captured approximately 85% of the savings, or $3,582 per episode (a 9.5% relative decrease), garnered through an episodes-of-care model.[54]

Given providers' market leverage in Tampa and Orlando, purchasers and their health plan or vendor partners will need to figure out how to make the case to providers to enter into two-sided risk arrangements. Supportive benefit designs could play a key role.[55] Purchasers and payers can also reduce providers' administrative burden in return for their acceptance of two-sided risk. For example, health plans can remove, or greatly reduce, requirements for prior authorization.[56] Multi-payer alignment on performance measurement and care redesign could further reduce provider burden.

Benefit Design and Consumer Shift

While employers and other health care purchasers in Tampa and Orlando face unfavorable conditions with consolidated provider markets, they have an important ace up their sleeves: benefit design strategies that shift where plan members seek care. If purchasers play this card successfully, they can combat the market dominance held by providers. The building block for many benefit design strategies is sufficient information about provider cost and quality, as described above.

To steer plan participants to high-value providers, benefit managers should implement benefit designs that strategically use cost sharing differentials or other financial incentives, as research shows that providing cost and quality information is not enough to ensure that patients will choose the highest value provider.[57,58]

[52] Integrated Healthcare Association
[53] NEJM Catalyst
[54] Health Affairs
[55] NEJM Catalyst
[56] Managed Care Magazine
[57] Health Affairs
[58] Health Affairs

One such incentive strategy is the use of *tiered or narrowed networks*, in which consumers have lower premiums and cost sharing if they choose providers designated as higher quality and lower cost. Another is *reference pricing (also called reference-based benefits)*, which establishes a standard or reference price for a drug, procedure, service or bundle of services, and generally requires plan participants to pay the difference between the allowed amount and the reference price. A third incentive strategy involves *centers of excellence*, and establishes a complementary payment and benefit design specific to a particular clinical area. This approach works well for non-emergent procedures, like joint replacement surgeries, and pairs well with the bundled payment strategies that Florida employers and other health care purchasers are eager to embrace.

A fourth strategy voiced during the interviews that is particularly attractive to purchasers in the Tampa market, is offering an *ACO led by an independent physician practice* as an insurance option for plan members. This ACO option would be similar to a narrow network or HMO insurance product, but built on an integrated data and payment strategy that incentivizes participating providers to deliver high-value care, including strong preventive care and telehealth consultations. Research shows that hospital-led ACOs are not as successful in reducing total cost of care or improving quality as ACOs led by independent physician practices.[59,60] Individual purchasers can implement these approaches at their own initiative, or with the help of an administrator partner.

While these strategies can be effective, purchasers tend to be wary of implementing health care options that disrupt plan participants who are accustomed to a traditional broad provider network. To mitigate this issue, purchasers can use a thoughtful communications strategy to encourage plan participants to select high-value health insurance options that limit provider choice, while still giving plan participants the option of a traditional provider network.[61] In some cases, benefit design may not be enough to change where plan participants seek care. If necessary, purchasers can develop a public-facing campaign in Tampa and Orlando to build awareness about how some providers prices are much higher than others, which would help plan participants understand the appeal of a more restrictive, but less expensive health plan.

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59 Integrated Healthcare Association

60 NEJM Catalyst

61 How to Communicate to Employees About High-Value Health Care

CONCLUSION

Catalyst for Payment Reform is pleased to present this assessment of the Tampa and Orlando markets to the Florida Alliance for Healthcare Value in support of their work to mobilize employers, other health care purchasers and other stakeholders to create a more efficient and effective health care market. In 2018, the Peterson Center on Healthcare made a grant to CPR to support the adoption of performance-based health care purchasing strategies by purchasers to improve outcomes for workforces and reduce the cost of care. Given the Florida Alliance's potential to steward payment reform strategies in these markets, CPR is confident that this assessment and its recommendations can help the Alliance find a path forward on reforms that could improve the affordability and quality of health care in central Florida and perhaps statewide.