

# Health Care in New York City: Service Providers' Response to an Emerging Market

Joel Cantor  
Kathryn Haslanger  
Anthony Tassi  
Eve Weiss  
Kathleen Finneran  
*The United Hospital Fund*  
Sue Kaplan  
*New York University*

*Occasional Papers*



Assessing  
the New  
Federalism

*An Urban Institute  
Program to Assess  
Changing Social Policies*



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Joel Cantor

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The Urban  
Institute

2100 M Street, N.W.  
Washington, D.C. 20037  
Phone: 202.833-7200  
Fax: 202.429-0687  
E-Mail: [paffairs@ui.urban.org](mailto:paffairs@ui.urban.org)  
<http://www.urban.org>

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This report is part of The Urban Institute's *Assessing the New Federalism* project, a multi-year effort to monitor and assess the devolution of social programs from the federal to the state and local levels. Project codirectors are Anna Kondratas and Alan Weil. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, Inc., the project studies child and family well-being.

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# Assessing the New Federalism

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**A** *ssessing the New Federalism* is a multi-year Urban Institute project designed to analyze the devolution of responsibility for social programs from the federal government to the states, focusing primarily on health care, income security, job training, and social services. Researchers monitor program changes and fiscal developments. In collaboration with Child Trends, Inc., the project studies changes in family well-being. The project aims to provide timely, nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute's Web site. This paper is one in a series of occasional papers analyzing information from these and other sources.



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# Executive Summary

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**H**ealth care delivery in New York City is changing dramatically. Managed care and market competition are on the rise in New York as they are in many other areas of the nation. In New York the shift to market-oriented health care is being accelerated by significant public policy changes. Most notably the New York Health Care Reform Act of 1996 deregulated the long-standing hospital rate-setting system while retaining significant public subsidies for indigent care, graduate medical education, and other public goods. Even as the state has remained committed to funding services for the uninsured and other vulnerable populations, significant reductions in revenue are anticipated, driven by the rapidly growing role for managed care and federal efforts to slow the growth of Medicare spending.

To examine the impact of the changing health care policy and market environment on providers of care in New York City, we conducted semi-structured interviews with 30 senior executives in 17 health care facilities. Hospitals and community health centers were systematically selected to represent the broad range of experiences in the boroughs of Manhattan and Brooklyn. Selected sites included both large facilities that were known leaders in health system network formation and other facilities oriented more to their local community, including facilities that serve mostly low-income populations. Interviews were conducted between October 1996 and February 1997.

We found that the health care delivery system in New York entered the current period of change with a strong history of support for the care of low-income and other vulnerable populations. The executives of many of the facilities we visited expressed a deep sense of institutional mission, which had been and continues to be bolstered by a supportive policy environment. Nevertheless,

many of these facilities were reported to be under increasing stress from diminished reimbursement streams, competition from other facilities, and changing patient referral patterns. The recent fluidity of policy changes and uncertainty about future changes compound these stresses, especially for community health centers and smaller hospitals.

All of the facilities we visited were in the process of significant change, both in their external orientation and internal management. External changes included mergers and network affiliations among facilities, new linkages between facilities and physicians and managed care organizations, new community outreach and marketing activities, and the establishment of new ambulatory care sites. Changes within the facilities included significant cost cutting, staff downsizing, and efforts at increasing productivity and enhancing revenue flows.

The interviews represent a snapshot taken at a time when hospitals and health centers were experiencing change on many fronts—and when there remained considerable uncertainty about the financial incentives and competitive forces that would be in play for the foreseeable future. Nevertheless, some early conclusions are possible. Growing competition does not seem to have fundamentally altered the charitable mission of a core of health care providers in New York, although many facilities reported struggling to maintain an open door for the uninsured while still running financially sound institutions.

The new competitiveness has spurred a welcome new orientation of health care institutions to their communities and to the primary care infrastructure. Hospitals and health centers are working to organize traditionally solo-practice physicians into networks that can interact more effectively with managed care organizations, setting the stage for improvement in service quality. Hospitals and health centers are also working to upgrade their facilities to attract patients and physicians. Amenities once reserved for the middle class are now finding their way into the clinic setting. Only as this market evolution continues will evidence emerge about whether these changes will benefit low-income patients as much as patients whose business is more remunerative to the facilities.

Competition also appears to be leading to more efficient facility operations. While it is not yet clear to what extent institutional mergers will lead to sustained efficiencies, most facilities are doing more with less. But already a downside to efficiency has emerged. Thousands of jobs have been lost in the hospital sector, jobs that have traditionally carried relatively favorable wages and benefits. Ironically, hospital downsizing may exacerbate the growth in the demand for uncompensated care, creating further stress for some institutions.

Not all facilities are equal partners in the new health care economy. The future of a vigorous core of academic medical centers and other large teaching hospitals seems assured: these facilities are the “network makers” vying for

position with purchasers of health care. The emerging networks are also courting other community-based facilities, the “network takers” that have attractive payer mixes or can serve as sources of referrals. But there are many hospitals and health centers that serve predominantly low-income communities that may ultimately be left out of the emerging organizational structures. New York’s unique experiment to blend market competition with significant public goods financing will test whether the populations served by these facilities will maintain access to care.



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# Health Care in New York City: Service Providers' Response to an Emerging Market

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## Introduction

**N**ew York's health care delivery environment is undergoing a dramatic transformation fueled by changes in public policy and the health care marketplace. During 1996, the state enacted legislation encouraging market competition by deregulating the 14-year system of hospital rate setting and establishing the legislative framework for mandatory Medicaid managed care enrollment. These measures fueled a transformation already under way toward a greater role for managed care and a hospital industry positioning itself for a competitive health care market.

Despite its shift from a regulated payment system toward hospital price competition, New York retained broad-based public financing of the care of low-income populations and other public goods such as graduate medical education. Even with recent belt-tightening, New York's Medicaid program is among the broadest and deepest in the nation, covering 15.6 percent of the state's population, higher than 47 other states.<sup>1</sup> Moreover, New York is the only state to directly subsidize both indigent care and graduate medical education beyond funding through the Medicaid program.

As managed care, market competition, and government program downsizing become the dominant paradigms on a national level, many analysts are

concerned that the web of explicit and implicit subsidies that have supported the care of the poor and uninsured is beginning to unravel. New York's experiment with a new blend of policies that encourage competition and efficiency while providing state financing for public goods could prove a model for other states or the federal government. The first leading indicator of whether New York's new policy approach is having its desired effect will be the response of its providers of care. Will policy and market change lead to improved responsiveness to patient needs and greater efficiency, or will the new pressures on providers reduce access or quality of care? Specifically, how will the infrastructure of care for uninsured and Medicaid populations fare under New York's brand of subsidy-enhanced competition?

In this report we seek to assess the effect of the changing policy and market environment on health care providers in New York City. We summarize the responses to semi-structured interviews of selected hospital and community health center executives in the boroughs of Manhattan and Brooklyn. The picture that we present is a snapshot taken between October 1996 and February 1997, a rapidly changing but critically important time. We define and explore the roles of mission and market position, and we consider the implications for the emerging market organization for health care providers in New York City and the vulnerable populations that they serve.

The report is divided into four main sections. First, we set the stage for understanding the provider viewpoint by summarizing major policy changes affecting health care delivery in New York during 1996 and 1997. Second, we describe our research approach and methodology. Third, we present findings from the interviews with health care executives. We close with a discussion of the implications of our findings for the future of health care in New York and nationally.

Our presentation of findings begins with a discussion of the institutional traditions that are the context for responses to the evolving environment. In many of the institutions we visited, the interviews revealed a deep sense of mission in support of the care of vulnerable populations that has been bolstered by a traditionally supportive public policy environment. Among those institutions most committed to serving the poor, mission was seen as the yin that plays off against the emerging yang of market competition.

We found that health care providers are transforming themselves from independent organizations focused on interacting with public-sector-driven reimbursement systems into increasingly interdependent, networked organizations focused on responding to private-sector purchasers of health care. At the time of the interviews, some executives were positioning their hospitals or health centers for true consolidation with other institutions, but most network and even merger activities were still functionally loose confederations between still mostly independent institutions. Nevertheless, repositioning and affiliating was foremost on the minds of the executives we interviewed.

From the time of this snapshot, institutions may be seen as evolving toward one of two (or perhaps three) positions: academic medical centers and some other large teaching facilities were becoming network makers and more community-oriented facilities were becoming network takers. Also, facilities serving almost exclusively nonremunerative populations (the uninsured and Medicaid beneficiaries) may be left out of network formation in the end. There are no clear signals yet as to the fate of these facilities, but some may be absorbed into larger networks or even closed.

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## The Context: Changing Environment, 1996–97

In recent years, New York City’s hospitals and health centers have been forced to confront dramatic changes in health care policy and financing occurring at the federal, state, and local levels. At the state level, the most significant of these changes has been the deregulation of New York’s hospital rate-setting system. With the enactment of the New York Health Care Reform Act of 1996 (NYHCRA), New York ended one of the most comprehensive rate-regulated hospital-based reimbursement systems in the country, a system through which the state supported access to medical care and the stability of hospitals in poor communities. From 1983 through 1996, the foundation of New York’s regulated system, the New York Prospective Hospital Reimbursement Methodology (NYPHRM), was an all-payer inpatient reimbursement system (Medicare was excluded from state rate setting in 1985) with payer surcharges (averaging 5.5 percent of hospital payments) paid into a pool. Pool revenues were distributed to hospitals based on reported losses from charity care, bad debt, and outpatient department deficits. Voluntary (i.e., not-for-profit) hospitals shouldering a greater burden of uncompensated care received distributions covering a higher proportion of their costs. Systemwide, voluntary hospitals recovered about 40 percent of their uncompensated care losses through these payments, and the public hospitals and a limited number of facilities qualifying as financially distressed received payments for a much larger share of their losses. In addition, in the latter years of NYPHRM, community health centers received a small portion of the pool for charity care. Through a rate-setting formula that paid higher rates to teaching hospitals, NYPHRM also played a crucial role in supporting graduate medical education in New York.

Under NYHCRA, the new system that went into effect January 1, 1997, New York no longer funds public goods through hospital reimbursements, but instead relies upon assessments of a broader base of providers and third-party payers to contribute directly to public goods pools. NYHCRA established three such pools—for indigent care, health care initiatives, and graduate medical education (GME)—with each pool offering a choice of payment methodologies to third-party payers. Uncompensated care funding through the indigent care pool has been significantly restructured. Outpatient department deficits are no longer factored into the reimbursement formulas, and additional bad debt/



charity care payments and provider tax exemptions for financially distressed hospitals are being phased out. The total amount of pool funding for health centers has increased modestly under NYHCRA.

At the same time that the state is restructuring direct hospital subsidies, New York City has almost eliminated its tax levy subsidy of the public hospital system, which stood at \$333 million as recently as 1994. During 1995, the city put 3 of its 11 acute care hospitals up for sale. Today, the city's hospitals have been taken off the market, and serious negotiations for the long-term lease of one are stalled. Nevertheless, the city's recent efforts to privatize its health care facilities raise doubts about its long-term commitment to the public system.

The continuing push toward increasing Medicaid enrollment in managed care also generates pressure for providers. Planning for the transition to managed care has been complicated by the uncertainty surrounding the implementation of the state's waiver request, which was filed with the Health Care Financing Administration (HCFA) in March 1995. During the period of this study, approval of the waiver had appeared imminent for many months, but without approval of the waiver it was unclear what the state's policies in regard to Medicaid managed care would ultimately be.<sup>2</sup> What has long seemed certain, however, is the continuation of substantial decreases in Medicaid rates to institutional providers.

Medicare reforms will have a similar effect on provider revenue. With a goal of saving \$116 billion over five years, the 1997 Balanced Budget Act aims to draw more Medicare recipients into managed care and reduce payments to providers for outpatient services, medical education, disproportionate share, and capital investment.<sup>3</sup> As a greater proportion of Medicare beneficiaries enroll in managed care, providers can anticipate some loss of revenue.

Decreases in Medicare funding for GME will obviously affect the finances of New York's teaching hospitals, which are also being hit hard by the changes in state funding for GME under NYHCRA. While GME funding previously had been covered in the state's rate-setting formula, under NYHCRA funding for medical education is partially raised through assessments on insurers and distributed by region. It is estimated that this change in methodology will decrease GME funding by over \$400 million (about 20 percent) in its first year, with the state expecting to recover the balance through negotiated rates with insurers.<sup>4</sup> The extent to which that expectation will be met depends on the relative market strength of payers and hospitals. State GME payments are also partially tied to incentives to reduce the total number of residents, increase the proportion that are training in primary care, improve the quality of training programs, and increase minority representation.

In response to anticipated reductions in GME funding, the Greater New York Hospital Association proposed and received approval from HCFA for a GME demonstration project. Under the GME demonstration, teaching hospitals will shrink resident training programs by 25 percent while increasing

emphasis on primary care training. In exchange, the participating hospitals would maintain their current levels of Medicare GME payments for one year and then receive reduced “hold harmless” payments over the next five years, with the goal of phasing out the payments. The hold harmless payments are aimed at assisting in the transition to smaller residency programs, including the cost of reconfiguring services and funding replacement personnel strategies required by downsizing. While the demonstration project is considered a major accomplishment for New York’s academic medical centers, it underscores the very real cuts these institutions will experience in the coming years.

Growth in the ranks of the uninsured creates additional pressures on providers serving low-income neighborhoods. As employer-based coverage shrinks, the number of the uninsured has grown twice as fast in New York as in the rest of the country, and nearly 25 percent of New York City’s nonelderly residents are uninsured. With the enactment of federal welfare reform and immigration law changes, these providers may face a substantial increase in the number of persons seeking care who cannot qualify for Medicaid and do not have other insurance, particularly since new immigrants will be barred from the welfare program for many years. (More than a quarter of New York City’s residents are foreign born.)

Hospital payment deregulation, reduced public program payment streams, and the growing role of managed care have dramatically changed the environment in which New York’s health care providers operate. Recent regulatory and market changes have launched what could be the most dramatic changes in New York’s health care infrastructure since the implementation of Medicare and Medicaid. In the remaining sections of this report we present the methods and findings of a study of selected hospitals and community health centers designed to illuminate those changes.

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## Research Methodology

To assess the effects of the forces of change on providers of health care, we conducted interviews with 30 senior executives from 17 health care facilities (11 hospitals and 6 ambulatory care facilities) in Manhattan and Brooklyn. In each facility we interviewed the chief executive officer and/or other top executives. In addition, most of our interviews also included one or more other senior managers, such as the chief medical officer or the senior corporate planning executive (Appendix I lists persons interviewed). In addition, to test the generalizability of our observations from the interviews, we conducted a formal discussion group of primarily midlevel managers from health care facilities and related organizations around New York.

The 17 facilities were selected systematically to represent a broad range of experiences and circumstances. We began by selecting hospitals to ensure a mix based on size (total revenue), payer mix (high versus low Medicaid rev-



enue), ownership (voluntary or municipal), network status (whether the facility is a leader in network formation), and historical financial condition (whether the facility is designated by the state as financially distressed). After selecting candidate hospitals based on the above criteria, we made our final selection by including hospitals that share catchment areas, either in northern Manhattan or central Brooklyn, or have a close affiliation with hospitals in those geographic areas. In that way, we ensured that our sample included both cooperators and competitors. Finally, we selected health centers that serve large low-income populations in the same areas of the city. Health centers were selected to ensure a mix of publicly owned and voluntary facilities and facilities with and without strong hospital affiliations. All facilities selected agreed to participate, and interviews were conducted between October 1996 and February 1997.

Tables 1 and 2 show selected characteristics of hospitals and health centers in New York City overall, those located in Manhattan and Brooklyn, and those selected for the interviews. Table 1 shows that our hospital sample represents large and small facilities compared to citywide and borough average hospital operating revenues. Because of our interest in changes to facilities serving low-income neighborhoods, the sample overrepresents facilities with high Medicaid

**Table 1** *Selected Characteristics of Hospitals in NYC, Manhattan, and Brooklyn and Those Selected for Participation in New Federalism Project Interviews*

Hospital Name	Operating Revenue (Million \$) <sup>1</sup>	Percent Medicaid Discharges <sup>1</sup>	State Pool Distribution Class <sup>2</sup>	Formal System or Network Affiliation <sup>3</sup>
New York City Average	287.7	40		
Manhattan Average	349.2	33		
Bellevue Hospital Center	421.7	65	Public	Health & Hospitals Corp.
Beth Israel Medical Center	604.2	46		Greater Metropolitan Health System
Columbia-Presbyterian Medical Center	747.8	36		New York & Presbyterian Hospitals Care Network
Harlem Hospital	301.9	59	Public	Health & Hospitals Corp.
Mt. Sinai Medical Center	755.5	29		Mt. Sinai Health System
North General Hospital	113.1	72		
St. Luke's/Roosevelt Hospital	642.8	42		Greater Metropolitan Health System
Brooklyn Average	228.2	50		
Brooklyn Hospital Center	292.4	49		New York University Medical Center Affiliates
Coney Island Hospital	227.0	61	Public	Health & Hospitals Corp.
Maimonides Medical Center	386.2	26		Mt. Sinai Health System
St. Mary's Hospital of Brooklyn	183.5	70	Fin. Distress	Catholic Medical Center

1. Source: New York State Institutional Cost Reports, 1995.

2. All of the study hospitals are eligible for state pool distributions for indigent care and graduate medical education. Public hospitals and state-designated financially distressed facilities receive special treatment under the indigent care pools.

3. Source: Greater New York Hospital Association, "Health Systems in the Metropolitan New York Region: A Preliminary Listing," April 1997.

**Table 2** Selected Characteristics of Community Health Centers in NYC, Manhattan, and Brooklyn and Those Selected for Participation in New Federalism Project Interviews

Health Center Name	Operating Revenue (Thousand \$)	Percent Medicaid Visits <sup>1</sup>	Percent Self-Pay Visits	Center Type <sup>2</sup>	Formal Hospital Affiliation
New York City Average	9,110.5	58	19		
Manhattan Average	12,320.7	52	24		
Ambulatory Care Network Corp.	1,886.9	81	15		Presbyterian Harlem Hospital
Renaissance Health Network	24,473.2	38	51	HHC	
Settlement Health Center	2,801.4	35	22	FQHC	
William F. Ryan Community Health Center	11,522.9	32	27	FQHC	
Brooklyn Average	6,924.6	62	15		
Cumberland Diagnostic and Treatment Center	25,818.5	41	31	HHC	
Bedford-Stuyvesant Family Health Center	4,212.6	38	9	FQHC	

Source: New York State Ambulatory Health Care Facility Reports, 1995.

1. Excludes managed care visits (data unavailable).

2. HHC = New York City Health and Hospitals Corporation, FQHC = Federally Qualified Health Center.

shares. Our sample of community health centers is relatively small (six), but table 2 shows that we have represented the major types of centers in the city.

Our interviews lasted from one to one-and-a-half hours at each of the 17 health care facilities. We asked open-ended questions based on protocols developed in collaboration with Urban Institute staff (interview protocols are given in Appendix II). In this report we draw conclusions from the patterns that we observed, rather than reporting on individual institutions. In addition, to preserve the confidentiality of the interviews, we do not attribute specific quotes or facts to individual interview subjects. Some of the quotations have been modified or paraphrased to preserve confidentiality and ensure clarity. In each case, however, we endeavored to capture both the meaning and tone of interviewees' responses to our questions.

## Findings

### The Starting Point: A Sense of Mission

The long tradition in public policy and service delivery of support for the health care of low-income populations and for graduate medical education has built a set of institutions with a deeply rooted sense of mission. Many of the hospital and health center executives we interviewed described their struggle to balance a historic commitment to serving vulnerable populations and training new doctors with the imperatives of an increasingly competitive environment. The nature of this commitment varies, both in terms of the array of services provided and the population groups considered central to the mission, but expressions of pride of mission were universal.



Many of the hospitals and health centers we visited are located in communities with large poor and immigrant populations, and many are located in areas officially designated as medically underserved. Health centers or hospital clinics are the only option for care for low-income populations in many neighborhoods of the city. The incidence of disease is also quite high in many of these areas. Forty-four percent of one borough's AIDS cases are in the service area of one of the health centers we visited, and 42 percent of that health center's patients receive care for HIV, substance abuse, or mental health problems. Several health centers are located within or near public housing projects, which provide a steady flow of Medicaid beneficiaries.

Most of the centers seek to provide a broadly defined set of primary care services. Several executives echoed the words spoken by one: "We are committed to providing continuity of care, from primary care to meeting the social needs of low-income, uninsured, and immigrant populations in our community." Most view their role as a primary care provider to be broader than simply providing medical care to their patients. One medical director described the mission of her health center as providing "broad-based social, mental, and spiritual support to the community." For many of their patients, the interaction with the health center provides an important opportunity for intervention on other levels. As one executive stated, "The more you do primary care, the more you see the whole social continuum. If housing isn't there, you get upper respiratory problems. Malnutrition leads to other health problems. . . ." Many health centers are staffed with social workers who help link patients to community organizations that assist with housing, child care, education, counseling for domestic abuse, and other social services. Thus, despite market pressure to streamline and reduce costs, most health centers are resistant to cutting services they see as critical to the health of their communities.

Many of the hospital executives we interviewed expressed a commitment to serving the local community and, like the health centers we visited, most of these facilities are located in neighborhoods with high numbers of immigrants and of uninsured and poor residents. Some hospitals, however, have a more constrained view of their role in caring for the uninsured, noting, in one case, a primary commitment to the surrounding middle-class community and, in another, the hospital's inaccessibility by public transportation. The executive of one large hospital stated that his facility was committed to serving as a safety net hospital, but only for nearby neighborhoods.

Other hospital executives perceive caring for poor and immigrant populations as a central element of their mission. The head of one academic medical center, one of the largest Medicare providers in the country, sees the academic mission as totally compatible with and supported by the mission to provide high-quality care to the surrounding population, largely poor and immigrant. This institution's long-standing challenge has been to make staff physicians "less hostile to community-based foreign medical graduates, to care about the community, and to see the community as an asset and as a natural lab for interventions." Other institutions have focused on defined populations with spe-

cial needs. For example, one of the teaching hospitals operates a large methadone maintenance and treatment program (MMTP). To the executive of this institution, the MMTP is an important expression of the institution's founding mission to provide care for poor and impoverished populations.

## **Perceptions of the Changing Environment**

### ***Declining Rates***

New York's hospitals and health centers are highly dependent on revenue from public sources. For example, Medicaid funds 40 percent of discharges from hospitals in the city (table 1), compared with only 14 percent of discharges nationwide.<sup>5</sup> Not surprisingly, Medicaid payment rates were foremost on the minds of all of the executives we interviewed, and their clear expectation was that declining rates will be a feature of the environment for the foreseeable future. One hospital executive warned that if the Medicaid cuts proposed by the governor in early 1997 were enacted, the only question left for his institution would be: "Who do we give the keys to?" Most executives were reasonably confident that such large cuts would not be enacted (a premonition that subsequently became reality with the defeat of the governor's proposed cuts); nevertheless, they still reported having to "waste" considerable time lobbying. Other recent policy changes brought about through the enactment of NYHCRA and welfare and immigration reforms (through reduced Medicaid eligibility) together with the prospect of mandatory Medicaid managed care were expected to add additional and substantial financial pressures.

### ***Uncertainty***

Many executives viewed the current policy and market environment as marked by rapid, sometimes unpredictable change. One health center director, for example, remarked with frustration that his center had gone through several strategic plans in recent years:

We planned to move into Medicaid managed care in a big way, then the City banned direct provider enrollment and reduced capitation payments. Then we looked to enroll private and Medicare managed care patients, but the Health Care Reform Act imposed new taxes on private plans and opened indigent care pools to 330 centers. Now self-pay patients are not as much of a financial drag as they were before. [For the future, we are] assuming that Medicaid managed care will become mandatory . . . and fee-for-service rates will decline; we are planning to sign new Medicaid managed care contracts.

The perception of uncertainty is more pronounced among the smaller institutions. Larger facilities have more resources to plan systematically and to ride out uncertainty. Executives from the larger voluntary hospitals, for instance, said that they had been preparing for the growth of managed care for the past five or more years. This statement is consistent with data on length of stay



and patient days, each of which declined about 2 percent per year between 1992 and 1996.<sup>6</sup>

### ***Future of HHC***

Individual institutional circumstances are also important for understanding the executives' views on the effects of specific environmental changes. The range of views on the role and future of the Health and Hospitals Corporation (HHC) illustrates this point well. Those hospitals with relatively lower shares of service to low-income populations see the HHC problem as one of excess capacity. As one executive put it, "Closing these places makes tremendous sense economically. . . . The reality is that there is almost always another hospital available within 7 to 10 minutes by ambulance. People will still have access if some institutions close."

The executives of voluntary hospitals that serve a substantial number of uninsured and other special need populations do not share this view. Without a new source of funding, they do not believe that voluntary institutions would shoulder the full burden of caring for uninsured or special need patients if there were to be a significant further loss of capacity in HHC. The CEO of one voluntary hospital that is situated geographically near both a public facility and another major voluntary medical center stated this view clearly: "If HHC decreases volume further, to what extent is it going to generate changes in utilization in neighboring voluntary hospitals? It is unlikely that patients will want to go to [our neighboring voluntary hospital]. . . . Even if these patients become more attractive financially, one just can't turn hospital philosophy [about treating low-income patients] around." Accordingly, executives of voluntary facilities that appear to be competing most directly with the city's HHC facilities expressed the most apprehension about the potential downsizing of the public system. As one nonprofit hospital executive put it, "We serve the uninsured, but HHC really serves the uninsured." With the uninsured numbering 1.8 million and growing in New York City,<sup>7</sup> it is not hard to understand why even those institutions with the strongest commitment to a social mission would fear being overwhelmed by a large number of complex yet nonremunerative patients.

### ***Enactment of NYHCRA***

Views of the effect of recent policy changes, most notably the enactment of NYHCRA last year, were also dependent on the role and position of the facilities in which we conducted interviews. Executives of academic medical centers (AMCs) and other major teaching hospitals expressed perceptions very different from those of more community-based hospitals and the community health centers. At the time of our interviews, the major teaching centers were focused on the financing of their GME programs. NYHCRA entailed a 20 percent cut in state GME funding, and these facilities were planning and negotiating their par-

ticipation in the Greater New York Hospital Association-led GME demonstration program. Both NYHCRA and the demonstration program provided significant financial incentives to teaching hospitals to reduce the size and change the emphasis of their GME programs. Although teaching hospitals have a large amount of revenue at risk through the GME reforms and were anticipating making major institutional changes, the executives expressed enthusiasm about their overall direction. As one CEO put it, “We’re delighted with the GME changes; they put AMCs on a more level playing field with other hospitals,” because most teaching costs do not have to be recouped through charges to insurers.

Views of the NYHCRA pool funding for indigent care were also dependent on hospital position. Although, as noted above, the overall level of indigent pool funding remains the same, allocation formulas were changed in significant ways. Most notably, executives from financially distressed hospitals expressed concern about eventual revenue losses resulting from the phasing out of their special subsidy status and exemption from provider taxes. Other hospitals viewed the NYHCRA indigent pool distribution formulas with some relief, describing them as “fair” or having a “minimal adverse effect.”

Another major policy change embodied in NYHCRA, hospital rate deregulation, was generally embraced by all hospital executives as necessary—or at least inevitable. To the executives, all indications were that managed care was growing and would come to dominate the market, and most executives were eager to seek competitive advantage in the market. All of the hospitals in the sample were engaged in rate negotiations with insurers and managed care companies. In general, no hospital executive saw his institution as well positioned in negotiations yet, and many commented that payers had the upper hand in rate negotiations at this early stage. In particular, executives of hospitals with large teaching programs expressed frustration with payers’ unwillingness to pay what they saw as a fair share of teaching costs. As one executive put it, “We are willing to split the difference [of the 20 percent cut in GME funding under NYHCRA], but the big payers are being greedy.”

## **Institutional Responses to Change**

The hospital and health center executives interviewed described a range of dramatic institutional responses to policy and market changes. Among hospitals, the responses varied due to objective differences among their institutions (e.g., public versus voluntary, teaching status, financial condition) and according to their traditional mission (e.g., national center of excellence, community-based safety net hospital, training institution). The executives also expressed clear ideas about where they wish to take their institutions in the future. Common themes emerged in respondents’ efforts to position their institutions in response to a more competitive market, but what they were positioning themselves *for* varied considerably across institutions, from capturing the Medicare risk market to simply surviving another year.



Because the market and policy changes are interrelated and cumulative, it is hard for specific actions taken by hospitals and health centers to be understood in terms of a response to a single development. Rather, health care providers can be seen as reassessing their entire operations as well as their positions in New York's health care environment. In the remainder of this section we examine institutional changes, first in relationship to the external market and then with regard to internal operations.

### ***Looking Outward: Network Development, Managed Care, and Marketing Activities***

The hospitals and health centers told us of significant changes in the ways they relate to their communities, competitors, and payers. Four main themes emerged: mergers, physicians, managed care, and marketing. Perhaps the most visible of the responses to change can be seen among the city's hospitals that were engaging in a flurry of merger and affiliation activities at the time of the study. Other less visible changes were also under way. The way that hospitals, physicians, and health centers interrelate was the subject of significant activity among the institutions we visited. These affiliation agreements, in turn, were part of the facilities' strategies to establish favorable terms in managed care contracts. The ways in which hospitals and health centers were acting to define their public image and to market themselves were also the focus of a great deal of management attention.

#### ***(1) Hospital Mergers and Affiliations***

At the time of our interviews, there was an unprecedented level of activity and discussion surrounding hospital mergers and other affiliations. Table 3 catalogues the merger and affiliation activities chronicled in New York's newspapers between January 1995 and October 1997. The table highlights the volatility of the market, enumerating the initiation of no fewer than 19 merger or affiliation negotiations as well as the failure of 3. The academic medical centers and large teaching hospitals led these activities, but most institutions were involved in some sort of network affiliation. Only a few facilities, largely those with the poorest payer mix (i.e., mostly the uninsured and Medicaid beneficiaries), appear to be at risk of being left behind in network formation. In our interviews, the views of emerging network makers differed dramatically from those of network takers or potentially marginalized institutions.

The network makers—the large academic medical centers and some other large teaching hospitals—listed three main expectations in their pursuit of merger and affiliation strategies: building market power, ensuring a steady stream of patient referrals, and achieving efficiencies. Perhaps the main goal cited in embarking on the merger course was to gain market power and clout in negotiations with insurance and managed care companies, even though most did not expect this clout to materialize for some time, even for several years. Clout is a function not only of the number of beds and affiliated physicians but also of prestige. As one executive explained, the merger between his institution and another large academic center would mean that “no employer in

the city could even contemplate contracting with a managed care plan” that did not include his network’s facilities.

Consolidating referral patterns was the second goal cited for merger and affiliation activities. Most of the mergers were designed to capture broad geographic swathes of the New York region. For instance, one network offers inpatient capacity from Manhattan to Long Island, while another has targeted New Jersey and the counties immediately north of New York City.

The final frequently cited reason for mergers and affiliations was to achieve economies of scale or functional efficiencies, initially through consolidation of administrative and ancillary services (e.g., laboratory services, laundry, joint purchasing) and later by combining clinical functions. A smaller number of executives saw the need for critical mass, a large enough base to support the academic mission or to assume insurance risk; the Medicare market is of prime concern to teaching hospitals. Executives from HHC hospitals, already part of a major network albeit undergoing fundamental transformations, talked of alliances with voluntary hospitals as a possible way to meet specific strategic needs. Upgrading information systems and administering teaching programs were cited as examples.

Hospital executives were by no means unanimous regarding the wisdom of mergers. One executive talked of valuing flexibility over security, preferring to go it alone and remain nimble, small, and “politically smart,” without ruling out the possibility of some form of association down the road. Some executives viewed mergers with an open mind, as one among many options being considered; but others were more openly skeptical. In the words of one executive, “You can’t merge two behemoths and expect to get a gazelle.” Concerning the need to change how institutions do business, this executive thinks that megamergers are more distraction than help. Also, within hospitals, many staff talked of mergers as carrying substantial administrative costs. Our discussion with midlevel managers from a broad range of health care institutions illustrated this development. The managers lamented that finance and planning offices across the city were spending virtually all of their time analyzing potential deals and paying less attention to day-to-day management activities, while also increasing the administrative burden on clinicians as more administrative staff are shifted into these external activities.

Merger skeptics most often expressed doubts about whether efficiencies would ever materialize from mergers of clinical departments. They cited strong vested interests of medical schools and individual department chairs and clinical heads as long-term obstacles to change. (It is noteworthy that the executives who expressed these doubts were most often referring to their competitors’ merger activities rather than their own.)

Smaller community hospitals can be viewed as network takers. Executives of these facilities expressed the most concern about the merger and network affiliation trend. Many see these activities as exogenous forces that do little



**Table 3** *New York City Hospital Mergers, Affiliations, Acquisitions, Closings, and Sales: 1995–1997*

Date	Mergers, Affiliations, Acquisitions, Closings, and Sales
Feb. 1995	Mayor announces city's plans to sell three of its public hospitals.
April 1995	City's largest municipal union considers offering a bid to buy two of the three public hospitals for sale.
June 1995	Two academic medical centers (Columbia-Presbyterian and New York University) reported to be informally discussing a merger.
July 1995	Academic medical center (Columbia-Presbyterian) reported to be in discussions with two other academic medical centers (New York Hospital and New York University) for possible merger.
Aug. 1995	Two medical schools (Cornell University and Columbia University) reported to be negotiating a possible merger.
Sept. 1995	Mayor announces that the city will lease rather than sell three of its public hospitals.
Oct. 1995	City unveils its offering of three public hospitals for long-term leasing (99 years) to bidders. One Manhattan-based academic medical center (New York University) and one Brooklyn-based teaching hospital (Maimonides) explore leasing the Brooklyn-based public hospital being offered by the city.
Nov. 1995	Manhattan-based teaching hospital (Beth Israel) and Queens voluntary hospital (Peninsula) announce intent to sign an affiliation agreement.
Dec. 1995	Manhattan-based academic medical center (Mount Sinai) reported to be leading bidder for the two Queens-based public hospitals being offered by the city.
Jan. 1996	Academic medical center (Columbia-Presbyterian) and voluntary hospital (St. Luke's-Roosevelt) announce they are actively negotiating a partnership.
March 1996	Manhattan-based academic medical center (New York Hospital) submits bid to lease all three of the public hospitals being offered by the city. Another Manhattan-based academic medical center (Mount Sinai) withdraws from the bidding process after pursuing a bid for the two public hospitals in Queens.
May 1996	Mount Sinai Medical Center reenters the bidding process for the two public hospitals in Queens.
June 1996	The boards of two Manhattan academic medical centers (Mount Sinai and New York University) approve an agreement to combine their medical schools, hospitals, affiliated institutions, and regional health systems to create the largest academic medical center in New York and one of the nation's premier medical schools.
	The city names a private enterprise (Primary Health Systems of Pennsylvania) as the winning bidder for one of the three public hospitals being offered by the city (Coney Island Hospital in Brooklyn). A winning bidder is not named for the two Queens public hospitals.
	The Archdiocese of New York and the Sisters of Charity announce the formation of the Catholic Health Care Network, comprising 31 hospitals and nursing homes and more than 9,000 beds in Manhattan, the Bronx, Staten Island, and seven counties outside New York City.
July 1996	A Manhattan-based teaching hospital (Beth Israel) and a Queens-based voluntary hospital (Long Island Jewish Medical Center) sign a memorandum of understanding to merge.
	Two Manhattan academic medical centers (Columbia-Presbyterian and New York Hospital) announce plans to merge.
Aug. 1996	Two Manhattan academic medical centers (Mount Sinai and New York University) sign a letter of intent to merge with the North Shore Health System of Long Island, resulting in the largest health care network in New York state.
	The city reopens the bidding process for its two Queens public hospitals, extending bidding opportunities to for-profit companies.
Sept. 1996	Long Island Jewish Medical Center joins forces with four Catholic hospitals in Long Island.
	A Manhattan-based academic medical center (Columbia-Presbyterian) announces plans for a corporate consolidation with a community hospital in New Jersey.

**Table 3** *New York City Hospital Mergers, Affiliations, Acquisitions, Closings, and Sales: 1995–1997 (Continued)*

Date	Mergers, Affiliations, Acquisitions, Closings, and Sales
Nov. 1996	Two academic medical centers (Columbia-Presbyterian and New York Hospital) announce the formation of a single parent board that includes 14 trustees from each institution.
Dec. 1996	<p>Manhattan-based academic medical center (New York Hospital) closes two community hospitals in Queens that it had acquired through its network expansion.</p> <p>Long Island Jewish Medical Center and the North Shore Health System in Long Island are reported to be discussing a merger.</p> <p>A teaching hospital (Beth Israel) located in downtown Manhattan’s east side and a voluntary hospital (St. Luke’s-Roosevelt) located in Manhattan’s upper west side announce their agreement to create a single parent corporation.</p>
Jan. 1997	The State Supreme Court rules that the sale or lease of any of the city’s public hospitals would require a change in state law, extensive public review, and the approval of the New York City Council. The mayor announces he plans to appeal the ruling.
Feb. 1997	Two academic medical centers (Mount Sinai and New York University) abandon their plans to merge, citing failure to agree on the terms of combining their medical schools.
April 1997	Manhattan-based academic medical center (Mount Sinai) announces its agreement to affiliate its health care network with the largest health care network in New Jersey.
June 1997	<p>The city’s deal to lease one of its public hospitals (Coney Island Hospital) to a private enterprise (Primary Health Systems) is reported to be in jeopardy due to “labor and court disputes, changes in tax regulations, and possible financial problems facing the buyers.”</p> <p>The Department of Justice challenges the merger of Long Island Jewish Medical Center and North Shore Health System of Long Island on antitrust grounds.</p>
Aug. 1997	<p>The mayor announces plans to build a \$147 million, 200-bed hospital to replace one of the Queens public hospitals being offered for long-term lease by the city. With the city’s privatization plan stalled by the court and the city unable to find buyers for the aging hospital, the president of the city’s Health and Hospitals Corporation said that a new hospital may be easier to sell than an old one. The mayor stressed that the move to build a new hospital did not signal a retreat from the city’s plan to privatize the public hospital system.</p> <p>The boards of two Brooklyn voluntary hospitals (Maimonides and Lutheran Medical Center) vote to form a single parent corporation.</p> <p>Manhattan medical school (Mount Sinai) signs an academic affiliation agreement with a hospital in New Jersey.</p>
Sept. 1997	Two academic medical centers (Mount Sinai and New York University) resume negotiations to merge. Previous merger negotiations were abandoned in February 1997 because of failure to agree on terms for combining the two institutions’ medical schools. The medical schools will not be included in the new negotiations, which will involve a merger of the hospitals only.
Oct. 1997	<p>Two recently partnered Manhattan hospitals (Beth Israel and St. Luke’s-Roosevelt) buy a 49 percent minority ownership in a Medicaid managed care plan run by the city’s oldest and largest community health center.</p> <p>Two recently partnered Manhattan academic medical centers (New York Hospital and Columbia-Presbyterian) enter into discussions with a Bronx-based voluntary hospital to join the New York-Presbyterian Hospitals Care Network.</p> <p>Two academic medical centers (Columbia-Presbyterian in Manhattan and Montefiore Medical Center in the Bronx) announce plans to build children’s hospitals.</p> <p>A Brooklyn voluntary hospital (Brooklyn Hospital Center) enters final stages of negotiations to join the network of two recently partnered Manhattan academic medical centers (Columbia-Presbyterian and New York Hospital).</p> <p>Federal court approves the merger of Long Island Jewish Medical Center and North Shore Health System. The merger had been challenged by the Department of Justice on antitrust grounds.</p>

Sources: *Crain’s New York Business, Newsday, New York Daily News, New York Post, New York Times, Wall Street Journal.*



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more than add to the uncertainty of their operating environment. In one instance, for example, a community hospital saw its prospects for affiliation fade simply because a merger of two academic medical centers had the side effect of bringing this hospital's major competitor into its prospective network. Nevertheless, many executives from the smaller institutions were anxious to join networks so as not to be left behind. They generally view these affiliations as a way to increase their own facility's prestige (e.g., by linking with a teaching hospital), to help them gain access to capital, and, ultimately, to give them strength and leverage in negotiations with insurers and managed care companies. Although these executives see mergers and networking activities as key to their survival, they fear that more powerful institutional partners will "suck them dry of patients."

### ***(2) New Relationships among Hospitals, Physicians, and Health Centers***

Hospital executives universally identified relationships with physicians as key to securing their institutions' future. Many of the executives see the physicians in New York City as unorganized and poorly positioned to deal with the new realities of a competitive marketplace dominated by managed care. Consequently, most of the institutions were actively engaged in organizing and attracting physicians. A number of institutions had been committing considerable resources to developing physician-hospital organizations (PHOs) or medical service organizations (MSOs). Many hospital officials spoke of offering community-based physicians a broad range of inducements to admit patients to their facilities, and most described efforts to improve operations in order to make the clinician's job more pleasant and efficient. For example, efforts were made in many hospitals to improve physical appearance and to streamline administrative functions. Most of the hospital and at least some health center executives emphasized their ability to assist physicians in navigating the managed care world as a comparative advantage and a selling point.

Wooing and organizing physicians, while universally viewed as central to success, has its difficulties. In their efforts to forge more stable relations with community physicians, teaching hospitals reported encountering the age-old tensions between academic-based and community-based physicians. Executives reported that hospital-based physicians often view community-based doctors as less qualified or proficient. One executive described "hand-to-hand" combat over academic appointments for community doctors. Additionally, physician affiliation efforts were not taking place in isolation; some managers reported that the physicians view hospital efforts to expand ambulatory care capacity (e.g., contracting with health centers or opening new group practice sites) as direct competition for their own patients. Hospital responses to this concern varied; some moved to offer more attractive financial inducements, and one hospital offered community physicians leadership roles in its newly formed PHO. One hospital simply tried to convince the physicians that competition for their patients is inevitable and that affiliating with new group practices to keep this hospital strong was the lesser of evils.

Hospitals reported considerable efforts to affiliate with community-based ambulatory care sites (both medical group practices and community health centers). In areas that are deemed desirable by the hospitals, they are also establishing new practice sites. Attracting and integrating physicians and ambulatory care practices is viewed by hospitals in terms of locking in a current or potential patient base (i.e., revenue stream), making inroads into another hospital's market area, or fending off other institutions' placing of physicians in their area. These ambulatory care affiliations define the battle lines in hospital competition for market share. Therefore, one hospital's attempt to integrate with a health center or group practice was often viewed as a threat by another facility, concerned that providers with historical ties to their institution might refer to a different hospital.

Health center executives reported being actively and sometimes aggressively wooed by several hospitals at the same time, and some directors expressed ambivalence about the rising interest of hospitals, fearing loss of institutional autonomy. Some community-based centers look to affiliation with each other as an alternative to joining a major hospital network. Many of the health centers we visited reported arrangements with other ambulatory care facilities. Several are part owners of Medicaid managed care plans with other centers, others are part of a formal ambulatory care network, and one has small-scale coordinated activities with other facilities (e.g., joint purchasing), which its director hopes to expand into more extensive networking activities. Several centers reported an emphasis on developing satellite facilities, including school-based health centers. Others were developing linkages with community-based organizations to expand their geographic reach and ties to the community and to place services where people need them. Several health center directors also mentioned mobile units.

From the hospitals' perspective, affiliating with health centers is not without its perils. Uninsured patients make up a large share of many community health centers' clientele. In addition, safety-net-oriented public policies sometimes make health centers less attractive partners. For instance, the state's Prenatal Care Assistance Program (PCAP) represents a particular challenge because, in addition to enhanced reimbursement for prenatal care providers, it also allows women to deliver in the hospital of their choice irrespective of whether the provider has admitting privileges. Therefore, establishing close links with prenatal care providers, an important activity in the context of Medicaid managed care, may not prove to be financially rewarding for the hospital.

In addition to—or in some cases as an alternative to—establishing linkages with existing health centers and physician practices, most of the larger hospitals were investing in establishing new off-site medical practices. In some cases, these investments were substantial and long term. In one case, a major teaching hospital had built a large and modern ambulatory care facility in Manhattan. In another, the hospital had a strategy of building a series of smaller group practice sites. In this latter case, the hospital owns and provides the



administrative infrastructure and staffing at each facility, entering into contracts with independent group practices to provide patient care. Arrangements such as these provide hospitals with considerable control over the siting of practices and long-term referral affiliations.

### ***(3) Strategies to Develop Managed Care Arrangements***

New affiliation arrangements among hospitals, and between hospitals and physicians or health centers, serve not only to consolidate referral arrangements but also to position hospitals and networks to negotiate with managed care organizations and other insurers. The organization that can establish a strong network of ambulatory care and hospital facilities with desirable geographic coverage will be in the strongest bargaining position. Additionally, vertical integration among health care providers can position institutions to form managed care plans or, at a minimum, to accept full capitation from plans or employers who wish to contract directly. Indeed, even though at the time of our interviews managed care accounted for a small percentage of overall hospital revenue, most of the hospitals we visited were aggressively seeking out managed care contracts and expressed the desire to take on financial risk through capitation.

Medicaid managed care (MMC) was becoming very important for most of the institutions.<sup>8</sup> Health center executives reported using a variety of strategies to respond to MMC, most by pursuing a number of contracts simultaneously to maximize their covered lives and to establish strategic advantage over places that might be tied to few plans. However, the opposite strategy was being pursued in several places where executives viewed their future in Medicaid managed care as tied to the ability of the dominant plan in their area to enroll all of their current patients. In most cases, these facilities had an ownership interest in the dominant plan.

As with other aspects of their overall strategy, executives in both hospitals and health centers viewed their own activity in Medicaid managed care as a way of staving off competitors who may be forming plans to capture their patients. One hospital executive whose own facility would soon launch a plan put it like this: “We don’t want other Medicaid plans coming into our neighborhood and skimming off all the healthy patients.” Interestingly, ownership interest in a plan did not preclude hospitals and health centers from contracting with other plans.

Most executives expressed fears that managed care plans would divert “their patients” to other facilities and therefore saw the need to maximize managed care enrollment. Nevertheless, Medicaid fee-for-service reimbursement was still seen as better than managed care, presenting them with a dilemma. These executives generally agreed that jumping into Medicaid managed care will be essential sometime in the near future, but in the interim they straddle two radically different sets of incentives. The teaching hospitals were more concerned about Medicare managed care than Medicaid, and these institutions reported taking steps to develop programs in this area such as provider-

sponsored plans in anticipation of federal authorization of Medicare provider-sponsored organizations.

#### ***(4) New Emphasis on Marketing, Outreach, and Image Building***

In addition to the horizontal and vertical affiliation activities and managed care efforts described above, the providers we interviewed reported extensive new marketing, outreach, and image building efforts. These activities were directed at multiple audiences, including patients (current and prospective), physicians, plans, and the competition, and were intended to build and consolidate each facility's patient base and strengthen its position in managed care negotiations.

To gain the loyalty of new patients, hospitals and health centers were marketing themselves in a variety of new ways, many engaging in aggressive community outreach. A number of executives mentioned organizing speakers' bureaus offering staff to address health care topics at community sites, using mobile units to provide ambulatory care or shuttle bus transportation for senior citizens, and participating in health fairs. Health center executives also described offering specific services, often as loss leaders, to attract new patients (e.g., dental care and prescription drugs).

Marketing and outreach activities included developing relationships with the local ambulance company, which, according to one executive, can yield growth in admissions. Additionally, one center reported "in-reach" activities to market to the families and other individuals who accompany patients to the clinic and remain in the waiting area. Other efforts to expand the patient base included staffing with bilingual and "culturally competent" personnel and reaching out to immigrant communities, in part by developing appropriate signs and written materials and by making translation services available. One hospital that serves a high percentage of new immigrants from one ethnic group reported plans to follow this population as it migrates within the city and open a site within the boundaries of the expanded community.

"Image transformation" is another strategy used by hospitals and health centers as part of their effort to become more attractive to physicians, plans, and patients. These strategies often involve cosmetic improvements, such as reducing the number of beds in each hospital room, painting their facilities more frequently, placing artwork on the walls, and improving the external appearance with new signs. All of the managers we interviewed were convinced that the quality of care at their institutions was fine, they simply needed to work on patients'—and perhaps more importantly, physicians'—perceptions in order to attract them and then retain them.

Not only were executives spending considerable time and effort to attract new patients, they were equally concerned with fending off competition for their current patients. One hospital executive expressed what a number of his peers had implied when he said that the core of their general strategy is to project an image of strength and growth, to make the other guys think twice about moving



into their area. This image of strength and growth was also viewed as key to enhancing relations with physicians and attracting new referrals.

Lastly, a number of institutions stressed the importance of developing or solidifying community ties, not only as a source of patients and physicians but also as a political buffer against the harsher effects of market competition. Working with churches was mentioned not only by denominational hospitals but also by nonsectarian institutions whose executives recognize the political and social importance of the religious base in their area. The executives believe that this religious base will not only be helpful in recruiting community physicians but also help them block other hospitals from placing ambulatory care practices in their service area. Furthermore, support from community leaders is crucial to gaining access to, and leverage with, political leaders on the local, state, and federal levels. Political affiliations are viewed as a source of protection by some institutions and an integral part of their strategy to respond to competitive threats.

### ***Looking Inward: Cutting Costs, Increasing Productivity, and Raising Revenue***

Regardless of how executives viewed the pressures from policy changes or competition, all were responding by taking significant steps to cut operating costs, increase clinical productivity, and maximize patient revenues. Hospitals have moved aggressively and successfully to lower inpatient lengths of stay, and they planned to continue their efforts. A number of hospitals we visited were also closing beds.

#### ***(1) Cutting Costs and Consolidating Services***

Virtually all of the institutions we visited were seeking to “trim the low-hanging fruit,” looking to save money through relatively easy measures such as joint purchasing and shared laundry contracts with other institutions. Some institutions also reported efforts to reduce, eliminate, or consolidate programs and services. For example, one community health center director reported laying off social work staff, and a hospital system executive reported a failed attempt to consolidate obstetrics services across two facilities. Some providers, especially hospitals, told us of strategies to downsize while securing their patient base by defining a set of core competencies. A number of facilities told us of plans to become geriatric centers of excellence, in part to increase their share of Medicare patients. One hospital serving a very low income area of the city was seeking to be seen as a center of excellence in treating gunshot wounds and caring for low birth-weight infants.

Layoffs have taken place in nearly all of the institutions we visited, and employee benefit reductions and wage freezes were made by some as well. Most executives preferred to reduce their workforce through attrition, but layoffs had been common and reportedly will continue within many institutions. While some institutions had cut their staff significantly (e.g., one hospital reported a 15 percent cut in the past two years), others felt constrained in altering their

cost structure by the presence of a heavily unionized workforce. This perception was perhaps strongest within HHC facilities, where work rules and wage agreements are negotiated at the city level. Managers at these institutions also must consider civil service rules and central office requirements. Nevertheless, HHC executives were implementing some of the most substantial changes in operations of all the institutions we visited and had significant cost reductions to show for their efforts. Many of the executives in both HHC and voluntary institutions noted that the unions generally recognize that big change is needed throughout the health care sector and that they are becoming more realistic in their participation in restructuring efforts.

## ***(2) Increasing Productivity***

Some executives reported that they had gotten all they could from implementing basic operational changes and layoffs and had reached the point at which further staff cuts would be counterproductive. For example, one executive reported that further reductions in the budget and staffing of his radiology department would put upward pressure on length of stay because the radiology service would take longer to turn around cases. Another hospital executive remarked that “virtually everyone” in the hospital had been cross-trained to maximize job flexibility.

Most hospital and health center executives reported a new emphasis on increasing physician productivity. HHC hospitals were in the process of renegotiating their affiliation agreements with the academic medical centers that provide the house staff to include financial penalties for not reaching specific productivity targets. One teaching hospital was looking for specific ways to increase productivity among attending physicians, starting with a thorough examination of “what they’re doing when they aren’t teaching.” This same hospital was also in the process of trying to recruit “hospitalist” physicians as the most cost-effective means of providing physician care to inpatients. Health centers are also taking steps to reengineer their operations and staffing to support higher clinical productivity. Some had introduced requirements that their physicians achieve a high standard number of patient visits.

Changing the skills mix of their clinical staff was cited by a number of executives as a way of maximizing productivity, although no clear pattern of changes was apparent. Hospital outpatient settings were mentioned as areas for improvement, where ambulatory care technicians could safely be used in place of nurses. However, substituting lower-skilled professionals comes at a price, and some executives said that paraprofessionals are more likely to be “clock watchers” and have less dedication to the institution. Likewise, lower-skilled professionals cannot handle the workload of a physician, lack the judgment of a senior clinician, and can’t offer advice or mentoring to other clinicians, according to another health center director. Therefore, several executives described a strategic approach to calibrating the most effective skills mix in their institutions. One health center medical director even reported plans to hire more experienced physicians in the future, because physicians directly from training programs, many of whom are engaged in ser-



vice programs to pay back medical school debt, are less productive and take too long to train.

### ***(3) Increasing Patient Revenue***

Most executives were seeking new sources of patient revenue as part of their strategy to deal with financial pressures. One facility, studying a possible expansion, projected that they would be able to remain solvent only if they limited their charity care to approximately 15 percent of patient visits, down from the 25 to 30 percent they were providing at present. Some executives reported more aggressive collection of sliding-scale fees. As the number of self-pay patients edged above 50 percent in one health center, its director told of how his center was forced to suspend its sliding fee scale for a period of several months. Others reported more careful financial screening of patients, turning away those who were members of health plans not in that center's network. Patients were also being billed for some items formerly included in the clinic visit, such as off-site complex laboratory services and "exotic" diagnostic procedures, such as bone density scans. Another common strategy has been to introduce nominal copayments (i.e., \$1 to \$10) for items such as prescription drugs.

Many of the executives interviewed saw enhancing revenue streams from existing patients as a strategy with limited potential. One executive of a municipal health center pointed out, "We have an increasingly savvy patient pool that says, 'You have to see me,' even if they have no money to pay for care. In this case, the sliding scale is of no use." The executives of the facilities that see themselves as safety net institutions spoke proudly of their mission to deliver care "no questions asked" and were very reluctant to try to collect more patient revenue. This reluctance was almost always tempered by concern for institutional survival, as the executives anticipate the demand for uncompensated care rising.

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## **Discussion**

Health care in New York City is at a watershed. Hospital rate deregulation on January 1, 1997, marked a transition point to a market-driven health care system, and evidence of vigorous competition is clearly emerging. Strong mission-oriented health care facilities and a continued role for public policy in supporting health care for the poor bode well for vulnerable populations in New York. It is too early to judge, however, whether New York's unique experiment blending competitive forces with government support for indigent care and other public goods will ultimately result in the desired balance of efficiency and equity in service delivery. Our interviews with senior health care executives in New York City in late 1996 and early 1997 provided considerable insight about institutional responses to changing incentives and opportunities.

On the positive side of the ledger, our interviews revealed that growing competition does not seem to be fundamentally altering the charitable mission of

New York's health services providers. In keeping with their mission orientation, health care providers played a central role in shaping the system of state subsidies that accompanied rate deregulation this year, even as they accepted rate deregulation as a natural evolutionary step for public policy in New York.

Competition also appears to be encouraging positive changes in the organization and delivery of health care. Linkages between hospitals and physicians and ambulatory care facilities are growing stronger. Hospitals and health centers are working to organize New York's traditionally atomized, largely solo-practice physician community. These efforts may lead to increased ambulatory care capacity in many previously underserved neighborhoods and could build a stronger organizational base for quality improvement and increased productivity.

All of the hospitals and health centers we visited were also struggling with ways to improve their cost structure. Mergers and network affiliation among hospitals may be the necessary precursors to a more cost-effective delivery system. Even though few of the executives we interviewed could identify examples of large-scale efficiencies resulting from mergers, most felt that the many small efficiencies would be cumulatively meaningful and that their institutions were positioned to take larger steps toward efficiency through reorganizing clinical services.

There was also evidence that the system is becoming more customer oriented. Without question, the increased attention to primary care capacity that managed care brings has spurred hospitals and health centers to develop new practice sites and to make existing ones more attractive. Amenities that middle-class patients take for granted are making their way into clinic settings. Most institutions were focusing more on patients' needs—how to attract them and better satisfy their needs—and most facilities were focused anew on appealing to physicians. The impulse of hospital managers to attract and retain patients and physicians is leading them to invest in information systems, improve physical plant, and create stronger linkages to community-based organizations. This increased orientation toward the patient and community could have significant benefits. To the extent that facilities use these outreach encounters to extend their understanding of what patients need and want and to tailor their services to the needs of New York's diverse population, patient care may become more responsive and patients may face fewer barriers to access.

Even as our interviews identified positive dimensions of competition, they also suggested areas that bear close observation as the market transition continues. Universally, the organizations we visited were bracing for substantially reduced revenue from private and public sources. Moreover, most hospitals and health centers had already undergone substantial belt-tightening, and their executives expressed concern that further cuts could harm access to or quality of care. The uncertainty of the changing regulatory and market incentives further compounded these concerns by making strategic planning difficult.



These fears were in sharpest focus among the executives of facilities located amidst the greatest concentrations of Medicaid beneficiaries, immigrants, and other uninsured residents; such executives described their struggle to maintain an open door while still running financially sound institutions. These executives reluctantly described recent steps geared toward managing their payer mix through intensified financial screening, more stringent catchment area definitions, or higher financial contributions by patients.

Competition may be spurring efficiency, yet with inpatient beds superseded by ambulatory services, the casualties of these efficiencies may well be the jobs representing the “hotel” functions in the health care sector. Hospitals have traditionally been a significant source of jobs with comparatively favorable wages, benefits, and a measure of job security, which the growing ambulatory services sector is unlikely to replace. And while attrition has been hospitals’ preferred strategy for workforce reduction, layoffs have been extensive, and both strategies bring dislocation and stress to workers, particularly those who see few alternatives in the labor market. Ironically, hospital downsizing may exacerbate the problems faced by facilities as large numbers of workers lose their health benefits.

While we heard a great deal about community responsiveness in our interviews, it was unclear whether community outreach activities will amount to more than efforts to increase market share among paying patients. In general, we did not hear about facilities modifying policy or developing new services in response to community demand. It may be that community outreach and marketing activities are simply putting an attractive veneer on enterprises that are downsizing and therefore have less ability to respond to community need.

Limiting access of the uninsured, either by aggressive patient registration policies or careful geographic placement of ambulatory care sites, means that New York’s most vulnerable communities are least likely to benefit from the new attention to primary care. Growing demand for primary care providers stemming from growth of managed care for commercially insured populations may also exacerbate facilities’ difficulties in recruiting and retaining well-trained primary care physicians to practice in low-income communities.

What does the future hold for health care in New York City? The new health care market in New York is becoming dominated by an elite group of network makers, largely the academic medical centers and a few other large teaching hospitals. Executives of the other, mostly more community-oriented hospitals expressed frustration that they have little influence over their fate. Some even suggested that the emerging network hubs would be likely to attract remunerative patients away from community hospitals, making it more difficult for them to serve the large Medicaid and uninsured populations left behind. Whether by virtue of their location, tradition, or public sponsorship, some institutions define for themselves a more central role in the safety net than others do. These facilities are not the dealmakers in network formation or the prestigious must-haves with leverage over insurers in rate negotiations. They are among the city’s more

vulnerable providers, and if they close, other facilities are not inclined to pick up their load. Even as hospitals are focusing on strengthening their ambulatory care networks, there are warning signs that access is becoming more difficult (or at least more expensive) for immigrant and other uninsured populations.

The recently reaffirmed policy in New York state of substantial public funding of care of the indigent is intended to counterbalance the primacy of ability-to-pay in competitive markets. New York's experiment in blending competition with public financing programs will test whether services will continue to be available to low-income populations in the face of competitive forces. Perhaps New York can have both the efficiency and responsiveness to consumers that distinguish competitive markets as it achieves equitable access to care.





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## Notes

1. C. Winterbottom, D.W. Liska, and K.M. Obermaier. *State-Level Databook on Health Care Access and Financing*, 2nd ed. Washington, D.C.: The Urban Institute, 1995.
2. On July 15, 1997, the federal government approved New York's Medicaid waiver application.
3. The Balanced Budget Act was not enacted until after the period of this study, but its general provisions were widely anticipated in the provider community.
4. Under NYHCRA, GME payments are funded by assessments on Medicaid and private health insurance covered lives. The Medicaid GME assessment in 1997 will raise about the same level of revenue as the previous year, but the private-payer assessment will raise about 55 percent of previous payments. The net impact of these changes is a reduction of about 20 percent in revenue for GME in New York City.
5. Part of the reason that the New York percentage is higher is that the Home Relief (i.e., General Assistance) population in New York has been thought of as covered by Medicaid, an uncommon practice among other states. Until the July 1997 approval of New York state's Section 1115 waiver, the Home Relief population was not considered when calculating federal financial participation.
6. United Hospital Fund. "Trends through June 1996." *Hospital Watch*, March 1997, vol. 8, no. 1, Exhibit 2.
7. Based on tabulations of the March 1997 Current Population Survey, Bureau of the Census.
8. Approval by the Health Care Financing Administration of New York state's Section 1115 waiver request to make managed care enrollment mandatory for most Medicaid beneficiaries was not assured at the time of the interviews, but approximately one in four beneficiaries was enrolled voluntarily.





## Appendix I

# Hospital and Health Center Officials Interviewed

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Ronald C. Ablow, M.D.  
President and Chief Executive Officer  
St. Luke's-Roosevelt Hospital Center

Frederick D. Alley  
President and CEO  
The Brooklyn Hospital Center

Lisa Alvarenga  
Vice President, Planning  
North General Hospital

Alexander S. Balco  
Executive Vice President for Finance  
and Administration  
St. Luke's-Roosevelt Hospital Center

John Ballow  
Associate Executive Director,  
Fiscal Services  
Coney Island Hospital

Roberta Berrien, M.D.  
Medical Director  
Settlement Health

Stanley Brezenoff  
President  
Maimonides Medical Center

Howard C. Cohen  
Consultant and  
former Executive Director  
Coney Island Hospital

Linda Curtis  
Executive Director  
Cumberland Neighborhood Family  
Health Care Center

Raoul DeOcera  
Chief Financial Officer  
Bedford-Stuyvesant Family  
Health Center

Barry R. Freedman  
Executive Vice President  
Mount Sinai Medical Center

John Glendening  
Deputy Executive Director  
Coney Island Hospital

Thomas J. Hayes  
Executive Vice President,  
Corporate Affairs  
Beth Israel Medical Center

Gregory M. Kaladjian  
Executive Director  
Bellevue Hospital Center

Ulysses S. Kilgore, III  
Executive Director  
Bedford-Stuyvesant Family  
Health Center

Gayle Lewis  
Chief Operating Officer  
Renaissance Health Care Network:  
Sydenham Neighborhood Family  
Health Care Center

Eugene L. McCabe  
President  
North General Hospital

Enid B. McCoy  
Executive Director  
St. Mary's Hospital of Brooklyn

Walid Michelen, M.D.  
Medical Director  
Ambulatory Care Network Corporation

Barbra E. Minch  
Executive Director  
William F. Ryan Community Health  
Center

Robert G. Newman, M.D.  
President and CEO  
Beth Israel Medical Center

Cesar A. Perales  
President  
Ambulatory Care Network Corporation

Ric Plaisance  
Executive Director  
Settlement Health

David Sklar  
Associate Director/Director of  
Reimbursement  
Coney Island Hospital

William T. Speck, M.D.  
President and CEO  
The Presbyterian Hospital  
Columbia-Presbyterian Medical Center

Monica Sweeney, M.D.  
Medical Director  
Bedford-Stuyvesant  
Family Health Center

David Tanneholz  
Vice President, Operations  
Coney Island Hospital

Ana A. Taras  
Director of Planning and Development  
William F. Ryan Community  
Health Center

Linnette Webb  
Senior Vice President and  
Executive Director  
Northern Manhattan Network  
Harlem Hospital Center

Roslyn Weinstein  
Executive Director  
Ambulatory Care Network Corporation

## Appendix II

# Hospital and Health Center Interview Protocols

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## NYC Hospital Interview Protocol

### General Background on the Hospital

There is no need to ask about basic characteristics or payer mix, as we have good sources for that information. On the remaining questions, we would ask for updates/verification.

- The recent Greater New York Hospital Association survey reported that your hospital was part of XXXXX network(s). Is that information still accurate? Have there been other major changes in the hospital entity in the past two years (e.g., acquired, merged, etc.)?
- [If applicable, ask:] How has network affiliation changed the day-to-day operations of your hospital?
- What types of arrangements exist between the hospital and physicians (e.g., PHOs, ED is leased to physician group)?

### Federal, State, and Local Policy Questions

How has the hospital been affected by *Medicaid* changes (including rate cuts, provider taxes, and managed care)?

How do you anticipate that the changes passed by the NYS legislature this year as part of the Health Care Reform Act (NYHCRA) will affect your hospital (i.e., rate deregulation, changes in indigent pool distributions, GME financing)?

- How are uncompensated care pool revenues used by the hospital? Do you fund specific services or use the funds more generally to offset expenses? How would a reduction or elimination of funds for uncompensated care affect this facility?
- [If not already covered, probe financially distressed facilities] How do you expect that the change in pool distribution formulas for financially distressed hospitals (i.e., that you will not be able to recover 100 percent of losses in the future) will affect your facility?

**How has the hospital been affected by *Medicare* policy (GME and DSH payments, Medicare managed care)?**

**Other than pool distributions, does the hospital receive other special grants or funding from state or city government agencies? Do those sources represent a significant source of funding?**

- Is the funding for designated programs or is it used to offset general uncompensated care?
- [For HHC facilities] What role has city funding of HHC played in the hospital? How have reductions in those funds affected your operations?

## **Market Forces**

**How has the hospital been affected by market forces, including the general growth in managed care and the trend toward hospital mergers? (If not covered above, ask about Medicaid managed care as well)**

- How have these changes affected the hospital's overall financial health?
- What are the major types of private payers that the hospital deals with (i.e., HMOs, PHSPs, PPOs, indemnity plans)? Which specific major insurers do you deal with? What types of arrangements does the hospital have with those insurers (e.g., discounted DRG or per diem rates, etc.)?
- How many managed care plans does the hospital contract with? How many cover commercial patients, how many cover Medicaid patients?
- [If missing from Hospital Watch data] What percentage of the hospital's inpatient and outpatient revenues come from managed care plans? Do you work directly with large self-funded plans, and if so, about what percent of your revenues come from such plans?
- Does the hospital have its own HMO/health plan? Has the hospital formed relationships with other hospitals or with any physician groups for the purposes of jointly offering services to employers or insurers?
- How has the hospital been affected by the trend toward network formation and mergers in the market?

## **Hospital Response to Policy and Market Changes**

**How has the hospital responded to market or policy changes? Have there been changes in staffing, service or patient mix, charges, or capital investment decisions?** (Note: We will have data on financial status changes and beds from external sources.)

**Have relationships with insurers, physicians, or labor unions changed?**

(Other than what we discussed earlier) **Have there been efforts to merge with or acquire other institutions?**

- What are the major policy or market factors contributing to changes in the hospital's bottom line?
- What has happened to waiting times in the ED, waiting times for elective surgery, services offered, specialty mix?
- Do you currently have any problems gaining access to capital? How have major policy or market factors affected your access to capital?

## **Safety Net Issues**

**How would you describe your facility's role in providing care to low-income and uninsured populations? Do you see your role changing? How and why?**

- [Ask only if unavailable from Hospital Watch] What percentage of uncompensated admissions come through the emergency department?

**What are the major vulnerable populations served by the hospital (e.g., uninsured, psych, HIV, etc.)?**

**How much care does the hospital provide to immigrants (legal or illegal)?**

- Does the hospital offer special social services for vulnerable or immigrant populations?
- How do you think that current state proposals to implement the federal welfare reform would affect the hospital? What would happen if the state ultimately decides not to cover immigrants under Medicaid?

## **Market-Level Assessment (ask if time permits)**

**What were the main policy, budgetary, or market forces that have affected hospitals in your service area in the past few years? How have hospitals in your service area responded (e.g., mergers, closures, changes in governance, downsizing, staff cuts, etc.)?**

- [If not previously covered] To what extent do you see NYHCRA affecting hospitals in your service area in the next few years, and in what way?



- [If not previously covered] To what extent do you see the expected changes in HHC affecting hospitals in your service area in the next few years, and in what way?
- [If not previously covered] In the next few years, do you see the provision of uncompensated care changing in your service area? Are some of the hospitals in your area likely to decrease provision of uncompensated care and others to increase? Which ones? How will the role of HHC change?

**Documents:**

Ask for any reports that would inform us about staffing or service changes in addition to what Hospital Watch provides us. Ask whether they would permit access to data reported to AHA.

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# NYC Health Center Interview Protocol

## Facility Role and Mission

**What is your facility's role or mission in your local area** (i.e., the local market in which you operate)?

- What are the main patient populations that you serve? Do you serve specific immigrant or other vulnerable populations?
- To which hospitals are your center's patients generally admitted for inpatient care? Do your physicians have admitting privileges?
- Are there other providers (e.g., physician groups, home health agencies, mental health centers) with which you have significant referral arrangements?

## Service Area Characteristics

**In your service area, has access to care of low-income and uninsured populations changed over the past two years? In what ways?**

**In your service area, what are the other main ambulatory care facilities? Have the number of providers or mix of services they provide changed within the past two years? Do you expect changes over the coming year?**

- To what extent are private physicians or small groups an option for patients in your service area?
- How have (or will) changes among other providers of ambulatory care in your local area affected the way your center operates? [If necessary, probe for changes in services provided by HHC facilities in their area.]
- How will the recent or anticipated changes in the inpatient facilities in your area (e.g., mergers, network affiliations) affect your center and your patients?

## Status of the Facility

**How would you characterize your center's financial status and its prospects for the future?**

- Have the major sources or levels of funding changed over the past two years? Has the funding distribution by service changed? Why? How has the center responded (e.g., patient or service mix)?



- Have there been any significant changes in patient volume, service mix, or staffing within the past two years? Has the number of immigrants using your services changed?
- Are changes anticipated within the next year? If so, why?
- With which Medicaid, Medicare, and other managed care plans do you contract? (If the list is long, ask for types of plans, i.e., PHSP, non-profit HMO, for-profit HMO.)
- [If multiple health plans, ask:] Do payment rates or arrangements vary among managed care plans? How so?
- How do managed care plans deal with enabling services such as translation, social services, etc. (i.e., plan or health center responsibility, built into rates)?

**Has Medicaid managed care influenced your Medicaid patient volume (increased or decreased)?**

**[If no:] Is it likely to change your Medicaid patient volume in the future?**

**[If yes:] Have you lost Medicaid patients to private physicians or other facilities because of managed care? Which type, and why** (e.g., patients prefer private physicians, other facilities are more aggressive marketers, health plans push patients to private docs)?

**Has Medicaid managed care affected your revenue? In what way?** If revenue has declined, how is the center faring financially?

**Does the center actively monitor indicators of access to or quality of care? If so, what indicators** (e.g., waiting times for appointments, waiting times for clinics, changes in services ordered, etc.)?

**Based on the above measures or indicators, how has the center's provision of care to Medicaid beneficiaries and the uninsured changed in the past two years? How has quality changed?**

- What factors have contributed to those changes? Were Medicaid or other state or local policy factors relevant? How so? What was the center's response to those policy changes?
- How would you assess the current level of access and quality of care of the populations that you serve? On what indicators do you base your assessment?

## **Future Policy Environment**

**What policy or market changes do you anticipate over the coming year? Do you have a strategic plan to address these changes, what does it involve, and how will it affect your capacity to serve low-income and uninsured populations?**

- How do you anticipate that immigration and welfare policy changes will affect your facility?
- [For voluntary facilities:] How do you anticipate that changes in HHC may affect your facility?





# About the Authors

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*Joel Cantor* is director of the research division of the United Hospital Fund. He also serves as a research associate professor at New York University's Robert F. Wagner Graduate School of Public Service. His current work focuses on health care financing and delivery in New York. Prior to joining the staff of the United Hospital Fund, Dr. Cantor was director of evaluation research at the Robert Wood Johnson Foundation.

*Kathryn Haslanger* is director of the United Hospital Fund's Division of Policy Analysis. She is responsible for developing and managing the Fund's policy agenda and identifying, developing, and managing program opportunities in the areas of home care, primary care, and managed care. Before joining the Fund in 1990, Ms. Haslanger served as deputy commissioner for community care and senior services at the New York City Human Resources Administration.

*Sue Kaplan* is an associate professor at New York University's Robert F. Wagner Graduate School of Public Service and associate director of the Health Research Program. Her work has focused primarily on issues surrounding the provision of primary care and safety net services to low-income populations in urban areas. Before coming to NYU, she was the vice president for planning and director of special projects and policy at the New York City Health and Hospitals Corporation.

*Anthony Tassi* is a health policy analyst with the United Hospital Fund. His research and analysis focus on Medicaid managed care in New York City. Previously he worked on national health reform legislation as a staff member for U.S. Senator Edward M. Kennedy, then chairman of the Labor and Human Resources Committee.

*Eve Weiss* is a research analyst at the United Hospital Fund of New York, where she participates in research on the transition to Medicaid managed care and on primary care services in New York City. Ms. Weiss manages the Ambulatory Care Provider Survey, an annual survey sponsored by the Fund and New York University's Robert F. Wagner Graduate School of Public Service. Prior to coming to the Fund, she received her master's degree in health policy and management from the Harvard School of Public Health.

*Kathleen Finneran* is a senior staff associate at the United Hospital Fund, where she works on Medicaid managed care and home care initiatives.





# The Urban Institute

2100 M Street, N.W.  
Washington, D.C. 20037

Phone: 202.833.7200

Fax: 202.429.0687

E-Mail: [paffairs@ui.urban.org](mailto:paffairs@ui.urban.org)

<http://www.urban.org>

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