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From Regulation to Competition:
How Some Providers in New York Responded

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– Mary Dillon, New York State Department of Health.

The New York Health Care Reform Act (HCRA) of 1996 sent a shock wave through New York's hospital and provider community by terminating the hospital reimbursement rate system put in place 14 years earlier by the New York Prospective Hospital Reimbursement Methodology. By eliminating the relatively non-competitive marketplace experienced by the states' providers, HCRA's passage heralded a growing wave of managed care market penetration. It challenged providers to work within the context of new market forces to decrease costs and increase efficiency and quality. With the help of demonstration grants from the New York State Department of Health (DOH), regional providers acquired the skills and resources needed to re-organize themselves into integrated delivery systems (IDS) that would potentially enable a smoother entry into the era of competitive markets. Over time, this project became known as the ProNets (prospectively paid health networks) project.

"Providers feel more empowered to deliver care in a competitive environment, which benefits consumers tremendously," says Mary Dillon, project director at the DOH. "The ProNets experience motivated providers to develop collaborative relationships within their community that may not have otherwise evolved, to the detriment of consumers." Although New York's hospitals and individual providers knew they were not immune to the encroachment of managed care, they were also not prepared for what it meant to operate in a deregulated environment where negotiations for managed care contracts at competitive rates would determine their success or failure.

To assist providers, the state made grants to six sites to develop provider network demonstrations with the ultimate goal of assessing the feasibility of implementing an integrated network of providers operating under a prospective payment system within a region. Three sites had to withdraw from the demonstration. Bronx-Lebanon Hospital Center, Hudson Valley Medical Care Services, and North General Hospital participated in the demonstration. Under its *Changes in Health Care Financing and Organization* (HCFO) initiative, The Robert Wood Johnson Foundation provided additional funding to support technical assistance that helped the provider community in a number of specific areas, the most crucial of which was providing hospitals with guidance about how to negotiate managed care contracts. Educational seminars also addressed electronic information systems, quality assurance and patient satisfaction, confidentiality and privacy, actuarial analysis and risk sharing, and legal issues faced by integrated networks. While market pressures may have resulted in similar changes among the providers over time, staff on the projects feel strongly that the technical assistance and other resources provided by the state enabled them to develop a broader level of expertise in areas critical to operating in a competitive managed care environment.

Getting Ahead of the Managed Care Curve

The DOH and the Foundation originally viewed their support as assisting hospitals financially. Theoretically, a prospectively paid IDS (particularly the physician-hospital organization model) has the bargaining power to create new efficiencies of scale between providers and managed care organizations. Providers in an IDS make resource allocation decisions prior to service delivery, resulting in more cost-effective, high-quality, and accessible care. The communities served have made great strides toward the provision and integration of health care services. For example, Bronx-Lebanon Hospital Center expended considerable effort in developing free-standing ambulatory (primary care) centers. They conducted analyses of available providers, inpatient data, and street surveys of outpatient utilization to get a better sense of patient needs. They also worked with the U.S. Department of Housing and Urban Development to ensure that

Changes In Health Care Financing and Organization (HCFO) is a national initiative of The Robert Wood Johnson Foundation. Technical assistance and direction are provided by the Academy for Health Services Research and Health Policy.

the ambulatory centers would be located near the populations they hoped to serve. "The principles underlying integrated delivery systems are very important when creating a seamless community health care system," says Howard Yager, chief administrative officer at the United Cerebral Palsy Association, which worked in conjunction with Hudson Valley Medical Care Services. "Creating an IDS requires providers to balance fiduciary responsibilities and fiscal realities while never forgetting that the patient is the center of their universe."

According to Dillon, the elimination of rate regulation meant that providers had to approach care delivery with an eye toward how to make the best business decisions. "Providers had to ask themselves whether they should join an independent physician association, become a salaried health maintenance organization employee, or try other organizational options," says Dillon. "The grants allowed providers to become educated and access technical assistance that wasn't available to the general physician population."

Lessons Learned from the Demonstrations

Integrating providers so they could work more effectively in a competitive market took serious effort on the part of the participating systems, health plan representatives, information systems specialists, and actuarial and antitrust experts. Though the ultimate objective of creating state-licensed IDSs was not achieved during the course of the grant, many smaller-scale victories may bring the licensing of IDSs in New York closer to a reality. The Bronx-Lebanon Hospital Center took steps in its IDS development to improve service delivery, and the Hudson Valley site is also close to completing an application for an IDS license.

Providers also learned a great deal from each other as well as the experts. "Each of the participating systems was at a different stage in each process," says Patricia Norman, chief financial officer of Manhattan's North General Hospital. For example, North General had begun outsourcing information services contracts for certain administrative and clinical activities, and could share that experience with other sites. "The technical assistance forums opened a window into understanding firsthand the successes and failures experienced by the other sites," Norman adds. The cooperation among providers proved particularly timely in building information systems capacity. "Building information systems was the most crucial piece for building our network," says Yager. "An effective communications infrastructure allows providers to examine critical pathways to care and work together to create real efficiencies. It was remarkable to hear people talking candidly about what worked and did not work," without fear of condemnation.

Opportunities and Obstacles

Unlike the providers, who had the benefit of learning how to deal with this major paradigm shift, consumers were feeling the same anxiety, without the same support. Between the early 1990s and 1997, approximately 50 percent of the privately insured population shifted into managed care from commercial fee-for-service coverage, a trend that led to much "bafflement and confusion," according to Dillon. Furthermore, in 1996 Medicaid beneficiaries began enrolling in managed care plans in addition to the traditional Medicaid fee-for-service financing model. This had significant implications for the ProNets providers since the majority of their consumer base was made up of Medicaid and/or Medicare enrollees.

The Future of Prospective Payment in New York State

A recent analysis of New York's health care providers and their response to the 1996 HCRA states that "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 approach is having its desired effect will be the response of providers."[1] Several current studies looking at the effects of prospective payment on health outcomes within the context of the Balanced Budget Act's Medicare mandates may shed some light on the effects of this type of financing system on providers. Recently, the literature has argued that integrated delivery systems may not be introducing cost-based efficiencies into the health care system, despite what appears to be a direct relationship between level of managed care penetration in a market and the number of hospital-provider integrated networks.[2] If global capitation and managed care are motivating providers and hospitals to join together under some sort of contractual arrangement, why aren't those arrangements effecting changes in financing such that costs decrease? While much is yet to be learned of the effects of service integration on health care outcomes, the ProNets model will be an interesting one to watch in the coming years. ■

[1] Joel Cantor, et al., "Health Care in New York City: Service Providers' Response to an Emerging Market," the Urban Institute's Assessing the New Federalism program, Occasional Paper No. 3, March 1998.
[2] Peter Kongstvedt, et al., The Managed Health Care Handbook, Fourth Edition, pp. 42-71.

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