The Healthcare Revolution Impacting Social Service Agencies

By Robert Creighton

While the fight in Washington has been focused on the future of Obamacare, here in New York a healthcare revolution is well underway. Over the past several years, major changes in New York healthcare laws and regulations have transformed how healthcare providers approach patient care. Providers of mental health services, services for individuals with developmental or physical disabilities, and substance use disorder services for those battling addictions, and a variety of other nonprofits and social services agencies are similarly impacted. Health and human services providers are now under pressure to focus on value-based purchasing – that is, to be more efficient in how they deliver their services, and to focus more on overall patient outcomes rather than just the delivery of the specific services they provide. Hospitals and provider organizations across the State are undergoing functional reorganizations, and though growing pains should be expected as inter-agency relationships and service teams are restructured, this should ultimately prove to be a period of increased efficiency in the delivery of clinical and social services.

Since long before the passing of the Affordable Care Act, New York State has taken active measures designed to ensure better outcomes for patients and to minimize unnecessary and costly acute care visits. This has allowed the downsizing of inpatient capacity, and its replacement with new and expanded primary care and other community-based services. Before these reforms, New York's healthcare system was designed as a fee for service model - - healthcare providers were paid each time a service was delivered. Arguably, this model created an incentive to provide as many services as possible rather than focus on patient outcomes. This system unintentionally resulted in barriers among service providers, either leading to redundancy in care or missed opportunities to treat patients holistically.

Governor Cuomo's Medicaid Redesign Team, and more recently the Delivery System Reform Incentive Payment ("DSRIP") program, are fundamentally restructuring the Medicaid system, with the

goal of reducing hospital visits - particularly readmissions - and providing patients with increased preventative care and more community-based alternatives. By requiring providers (including, e.g., hospitals, physician practices, long term care providers, behavioral health providers and other community-based organizations) to join together into Performing Provider Systems ("PPS's") and eventually assume risk, the State is moving beyond traditional managed care to ensure that the full range of providers share incentives for achieving positive patient outcomes and improving population health. Now, rather than just measuring whether and to what extent services were delivered, providers will theoretically be judged on the overall wellness of the patient regardless of how many services are provided. This incentivizes healthcare providers to spend more time collaborating to find the best and most efficient treatments for each patient.

These regulatory transformations are driving many practical changes in the healthcare industry. There has been increased consolidation of payors and providers. Community hospitals continue to be absorbed by increasingly large systems. Payors continue to merge, and providers and other entities continue to enter the payor market (with varying degrees of success). Here, on Long Island, the entry of new mega-systems into the market has resulted in new competition to established systems.

We can expect that consolidation will continue and will move into new and different areas. Hospital systems under pressure to work more closely with other providers and better manage discharges are likely to focus on acquiring new long term care, behavior health and social services capacity. And we can expect more consolidation among providers within each of those industries, as well as providers of primary care services, developmental disabilities services, pharmacy services, medical transportation, and others. In regard to physician practices, expect to see even more employment of physicians by healthcare systems. These regulatory reforms should encourage more collaboration between physicians and other licensed professionals, including not only physician assistants and nurse practitioners, but also pharmacists, chiropractors, physical therapists, acupuncturists and others. In addition, efforts are

ongoing to increase opportunities for primary and long term care providers to collaborate, creating a variety of possibilities in that area.

These new relationships can take a variety of forms, including mergers, affiliations, joint ventures, or other contractual arrangements. Notwithstanding new regulatory flexibility, a variety of legal barriers remain in place that likely make it difficult to implement these new arrangements, including limitations on corporate practice of medicine, fee-splitting, self-referral, and assignment of Medicare/Medicaid payments. Providers will need to be creative in developing new structures and reorganizing funds flow. And far-thinking leadership will be required at all levels.

These changes are impacting the entire spectrum of providers. Larger systems and providers are responding by forging new relationships, and reconsidering everything about their business models. The new regime is especially challenging for smaller nonprofit providers to navigate. Many simply do not have the internal resources to formulate strategies to address these changes or to evaluate new proposed relationships. Consolidation in this segment of the market appears to be a desired outcome of the regulatory changes and it is an inevitable consequence of this new regime. Without strong external advisors, small not-for-profits risk being forced into arrangements that seem attractive in the short term, but which in the long term will prove problematic. Nonetheless, the services of these not-for-profit health and social service providers will be essential to achieve the consumer-centered goals of the new paradigm. It is therefore in our collective best interest that such providers have a place at the table as discussions regarding regulatory reform proceed.