HISTalk
HEALTHCARE IT NEWS & OPINION

December 12, 2016

Readers Write:
The Six Bedrocks in a Post-Trump Healthcare Landscape

By Steve Levin

With a Trump administration and Republican-led Congress on the horizon, a shift in the direction of national healthcare policy is a near certainty. But the exact nature and timing of that change might be, unfortunately, less clear. Based on the principles outlined by Trump's team themselves, the history of appointees, and conversations with clients and industry pundits, it feels as if there are some bedrock themes to orient efforts while Washington turns over and argues its way forward.

Expect more creativity from payers. Multiple factors are at play here. Moving the locus of health insurance requirements from federal levels to the individual state organizations will promote flexibility. The pullback on the individual mandate means that the days of Bronze, Silver, Gold, and Platinum plans will go the way of the floppy disk drive. Couple this with increased incentives for consumers to set up HSAs and take control of their health insurance purchase means that payers can let loose their product design teams for new solutions to meet the range of consumer challenges.

Consumers will end up paying for a larger share of their healthcare. There is simply no money left in the checking accounts of government—federal, state, or city – or employers to fund the growth in healthcare costs. Add on more plan innovations, the disappearance of the individual mandate, and Medicaid expansion being reined in and the future for the consumer is pretty clear. If we have insurance, we are going to be paying more in the form of co-payments, co-insurance, and deductibles. More procedures will go from covered to un-covered. Many consumers will end up on the far end of the insured continuum —namely, uninsured.

Bundles and risk-based reimbursement will march forward. Over the past several years there have been pilots, tests, and more pilots and tests comparing and contrasting fee-for-service to something along the lines of pay-for-value. CMS has led the charge. While the incoming leadership has historically been less bullish on all the pilots and innovations, the results to date do suggest bundles can create positive care integration and control total costs. Readmission penalties, while still rough, are raising an issue that organizations know they need to tackle. Certainly the current risk programs are not polished and perfect, but they are driving integration around the patient and toward higher value at an overall lower cost. So build out those teams of contract modeling talents; continue the march toward building your own insurance solution; and figure out how you can process those contracts amid clinical workflows and revenue cycle in volume.

Time to become patient relationship experts. Combine items 1, 2, and 3 and a fourth bedrock principle emerges—specifically, figuring out how providers manage the patient relationship both clinically and financially before, during, and after treatment. This relationship will become of paramount importance. Moving forward, the patient is going to control a great deal of our cost structure and cash flow. Providers need to be proactive to shape patient decisions.

Extracting more value from every budget dollar will be table stakes. Every scenario comes back to the same operational mandate— lower operating costs and improve the impact of every activity. Eliminate the 20 to 30 percent of processing work that is predictably of no value or impact. The double whammy in my reading of the future is that every activity is more expensive when the counter party is the patient themselves and not a commercial or government payer. It is simply more expensive to manage patients than a large business partner. So regardless of how Washington reshuffles ACA, healthcare processes need to be more efficient at every turn.

Time to get more ROI from those EHR investments. Organizations spent millions on big-iron electronic health records and went through the agony of stabilizing processes. Now it is time to actually optimize those platforms using the higher quality information at hand. Using predictive analytics to reduce low and no-value efforts (see point five), optimizing insourcing and outsourcing logic, and targeting high-cost patient engagement processes are just examples of how these bedrock systems can begin to finally drive financial improvement.

Only time will tell what Washington actually decides and when those decisions truly have bearing on the thousands of hospitals and millions of patients. However, while the exact policies and processes are TBD, the six bedrock items listed here are most likely enabling and contributing regardless of the final rules and regulations.

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