

Value-Based Care Drives Smart Modernization

Risk and Reward at the Edge of the Enterprise

Introduction:

Executive Summary

Sweeping changes, many driven by government mandates, are rocking the healthcare industry. At the epicenter is the decision by the Centers for Medicare and Medicaid Services (CMS) to implement value-based purchasing. That fundamental shift affected more than half of U.S. healthcare expenditures and created a new context for a cascading set of changes involving Meaningful Use, Operating Rules, electronic medical record (EMR) incentive payments, accountable care organizations (ACO) and patient-centered medical homes (PCMH). Early results are encouraging: According to CMS, preliminary data shows savings of more than \$380 million in 2012.¹ As a result, expectations are high for raising care quality and reducing costs. Meeting these expectations requires unprecedented levels of collaboration and risk-sharing among payers, providers and other entities to deliver quantifiable value at an agreed-upon cost.

Once aspiration turns into action, the magnitude of the work required becomes daunting. Organizations responsible for administering health benefit plans and care delivery contracts have many factors to consider: What are my risks? What are the risks borne by my providers and other partners and vendors? How will I assess the care provided? What objective measures will we agree to use? How will agreements be enforced? What if there is a disagreement or challenge to a value assessment? Can we first try new arrangements on a small scale, and make

adjustments later? These questions represent just the tip of the iceberg.

What lies just below the surface is data: Who has it and who needs it? How can it be exchanged and combined? Perhaps most importantly, how can the data be quickly acted upon? It's immediately clear that participating in ACOs and PCMHs or complying with Shared Savings Administration requirements will not be sustainable with care management and reimbursement processes supported by unstructured data. What's more, taking action to improve care or reduce costs is too little too late if accomplished after the patient has left the clinical setting. Paper files, text notes within data repositories, nonstandard data exchange formats and email or fax transport methods are slow. They won't scale relative to the demand for information.

The volume, structure, range and timeliness of available data flowing both into and out of every healthcare organization is not manageable with existing infrastructure. Critical data will continue to be confined within disparate source systems and constrained by infrastructure unable to orchestrate and correlate inbound and outbound messages exchanged among trading partners. This white paper outlines how data partnerships — and the infrastructure required to support them — enable value-based care.

Organizations often take a reactive rather than strategic approach to mandates.

When it comes to data exchange, standards matter

The exchange of data among trading partners, whether mature (electronic claims) or emerging (adding clinical data, such as continuity of care documentation), is the foundation for value-based care agreements. Although the concept of trading partners is prevalent in health care, there is no common understanding of what trading partners trade and how. Rather like the stock market, the exchange of information is accomplished by the trading of transactions. For an industry still digging its way out of paper-based processes, the ability to exchange electronic transactions lags far behind other industries. According to a recent Black Book survey of payers concerning their experiences with health information exchanges (HIE), nearly all respondents indicated that public HIEs are struggling to exchange data between payers and providers.

In order to jump-start progress, mandates have emerged to rapidly drive standardization of transactions. Familiar to all are HIPAA X12, NCPDP SCRIPT, Operating Rules, and Meaningful Use certification for EMRs. Less familiar may be ongoing work by the Office of the National Coordinator for Health Information Technology (ONC), the multitude of HL7 workgroups and the Office of eHealth Standards and Services within CMS.

For health plans and providers alike, responding to mandates and the drive toward value-based care are often viewed separately, but they actually go hand in hand.

Unfortunately, a reactive approach to each individual mandate is common. Almost half of healthcare executives surveyed feel their company's response to healthcare reforms have tended to be reactive rather than part of broader, considered strategic change.

The drive to standardize via new mandates will only accelerate. The challenge for many health plans and the providers that serve their members is that the systems put in place over the past decade will fail to support newly mandated transactions and the data requirements for value-based contracts. Given that current systems require programming changes for each new information type and transaction, it is reasonable to assume that the costs associated with the customary incremental approach will accelerate so fast they will negatively impact medical loss ratios (MLR).

Once clinical data exists, it will become required

As providers respond to Meaningful Use, they are now documenting more clinical data in structured formats than ever before. New sources of data, such as consumer-oriented technology to track personal metrics (products like Fitbit log activity levels, weight and more) are emerging as well. The existence of this data will make its use a de facto

business requirement for payers. Thus, rapidly emerging value-based care initiatives require correlation of existing administrative and financial transactions with the structured clinical information now quickly becoming available. This correlated data, medical utilization reports or care gap analyses, presents additional challenges because standards have yet to be defined.

Moreover, the transition to value-based care is not a straight line. Given the many forms value-based care arrangements can take, health plans and their trading partners are challenged to put agreements in place with measurable metrics. Health plans and care providers also need flexibility to ask, “What if?” They need to experiment on a small scale, analyze results, and gain insight to inform new arrangements.

Following are a just few examples of initiatives underway:

- Reduce readmissions. Requires coordinated and collaborative discharge and follow-up care planning or hospitals risk penalties for avoidable readmissions.
- CMS’s Bundled Payments for Care. Requires a highly coordinated set of clinical activities arranged and delivered across a single episode of care, e.g., a hip replacement.
- Reduce medical costs: Requires that payers aggregate and correlate clinical data with claims data and use advanced analytics in order to intervene quickly when cost reduction or avoidance opportunities are identified.

- Medical management. Requires that payers combine and aggregate clinical and administrative data to efficiently oversee both cost and quality for chronic conditions, such as diabetes and asthma.
- Population management. Requires that payers and providers share patient rosters and combine and aggregate clinical and administrative data to identify gaps in care and analyze medical utilization.
- Operational transparency. Requires cost and outcome data to be aggregated and made available in near real time to all parties.
- Network steerage. Requires orders for services, e.g., lab and/or imaging information, along with eligibility, benefits and provider network information be available at the time of service in order to direct patients to preferred, in-network providers.

To support initiatives like these effectively, organizations need to take advantage of existing channels and existing data where possible. As Figure 1 outlines, existing data can be brought together to support certain value-based initiatives. However, if that results in current data being submitted multiple times or via multiple means, providers will never adopt it. Thus, the scale, complexity and importance of information exchanged through transactions will only continue to grow.

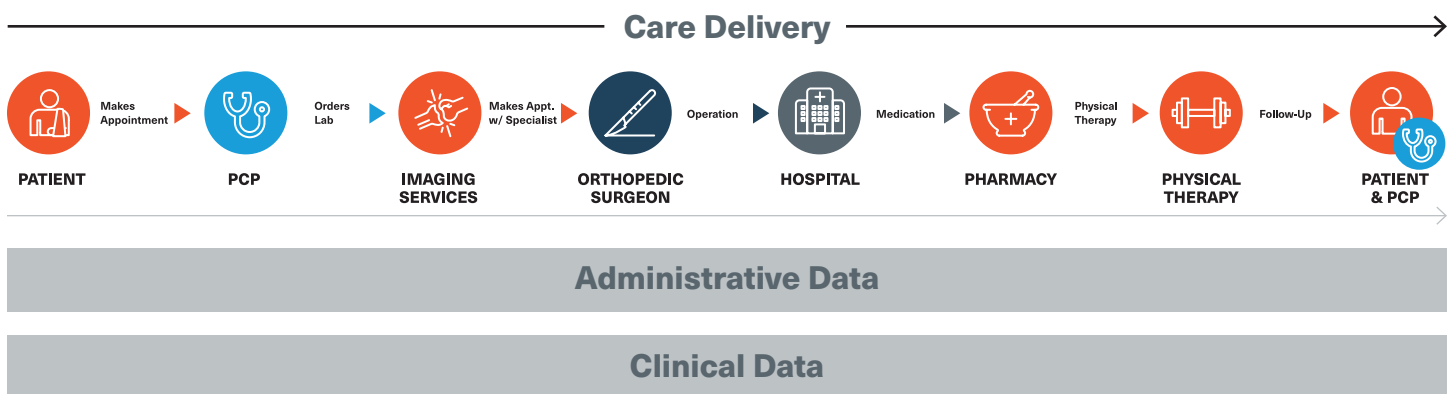
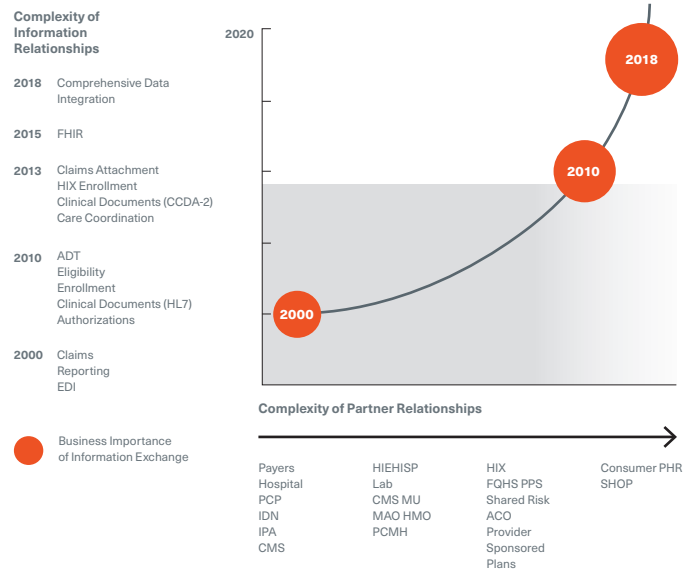


Figure 1- illustrates a common episode of care with silos of administrative and clinical data that provide few opportunities to intervene to affect clinical and financial outcomes.

Speed and intersection points will only increase

As Figure 2 illustrates, in order to support value-based care, organizations exchange information with a growing number of trading partners: providers, CMS, ACOs. At the same time the complexity of the information is also increasing – claims, referrals, CCDs, ADTs. This growth is accelerating geometrically and it’s reasonable to assume the growth curve will be steep. Eventually, information exchange relationships will extend from first responders in the field to hospitals and delivery sites to home care organizations to public health agencies and even medical devices.



If the infrastructure is wrong, no amount of time and money will fix it

Value-based care holds great promise to improve care and reduce costs. As organizations take incremental steps to implement strategic initiatives for emerging, highly collaborative approaches, such as ACOs and PCMHs, the infrastructure that will enable the exchange of information moves into the spotlight.

Generally, the infrastructure currently used by organizations to handle HIPAA X12, HL7, NCPDP transactions and the like is based on dedicated and siloed business applications. These applications are coded specifically to the business processes that govern the various exchanges of information between specific business units and their trading partners. Add to that the need to integrate with a growing number of external data introduced by EMR and practice management system (PMS) vendors, healthcare information service providers (HISP), and internal master data management systems (MDMS). Each has its own API requirements and each requires a separate interface to legacy business process applications. The sheer number of data silos plus inadequacies of current standards presents unprecedented challenge.

More than a decade ago, standards organizations recognized a critical weakness. The existing message format standards intended to achieve interoperability between different information systems had a high degree of variability and were often not implemented in a standard manner. Well-intended options were incorporated to accommodate the variability of workflow and the availability of information in different healthcare settings. The result: costly and time-consuming custom programming.

Unfortunately, the environment today is even more complicated than when the shortcomings in the standards were first noted. Old-school electronic data interchange, or EDI, was modeled on supply chain interactions, which were basically linear processes. Patient care today is quite different with its complex matrix of circular processes, divergent pathways, redundant processing and constant hand-offs. In short, healthcare is not a process flow but a process community: Integration of systems and processes needs to span business enterprises as well as treatment networks and facilities. The flow of information has to occur in both real time and batch for both clinical and

financial data. On top of that is the need to simultaneously support both longitudinal, historical analysis and real-time alerts and notifications.

While the ability to connect via business-to-business (B2B), machine-to-machine interfaces is growing more critical, the supporting infrastructure is specialized, customized, proprietary and inflexible. Therefore, the goal of continuous compliance with formal regulations and contract terms may soon be out of reach for many organizations. Worse, organizations lack the agility and flexibility within their infrastructure to move forward from a fee-for-service to a value-based payment model.

What's needed is a smart approach

The right infrastructure will enable organizations to embrace partnerships and succeed both with mandates and value-based care. A flexible, edge-of-the-enterprise trading platform that can interpret, parse, check compliance and correlate messages across multiple standards domains will dramatically reduce the effort and cost associated with each new transaction type.

An edge-of-the-enterprise approach enables organizations to actively manage the information flow into and out of the enterprise while delivering low-cost integration, a high level of automated throughput, highly adaptable trading relationships, and low-risk experimentation. The flow of information at the edge becomes a centralized conversation among an unlimited number of partners, including hospitals, provider groups, payers, government agencies, and so on.

Visibility into the centralized data conversation makes using the data for multiple purposes in both real time and retrospective ways possible, as Figure 3 illustrates. Proactive intervention while the patient is in the facility to improve care outcomes or avoid unnecessary costs becomes standard practice. A health plan responsible to an ACO for a patient population can proactively identify

An edge-to-edge enterprise approach enables organizations to actively manage the information flow into and out of the enterprise.

gaps in care and then fill them through collaboration with providers. Access to such data takes analytics for service and product development, contract management, and performance improvement to a new level.

Further, the ability to fully integrate an edge-of-the-enterprise infrastructure with a robust trading partner management capability will make new partner onboarding, format updating, transaction routing and end-to-end testing significantly more efficient.

Lastly, with an increasing need for transparency, it's critical that the infrastructure can preserve the semantic context of parsed data throughout the lifecycle of any given process (i.e., details about the type of transaction, from where and from whom it came, with which member or patient it was associated, and more). Otherwise, it will quickly lose its meaning and value as the various transactions make their way through multiple downstream systems. The consequences of a lack of this level of transparency can already be seen in health insurance exchange enrollment where payer systems receive incomplete, incorrect or duplicate information and have no capability to access details, such as a time stamp, for validation purposes.

Care Delivery

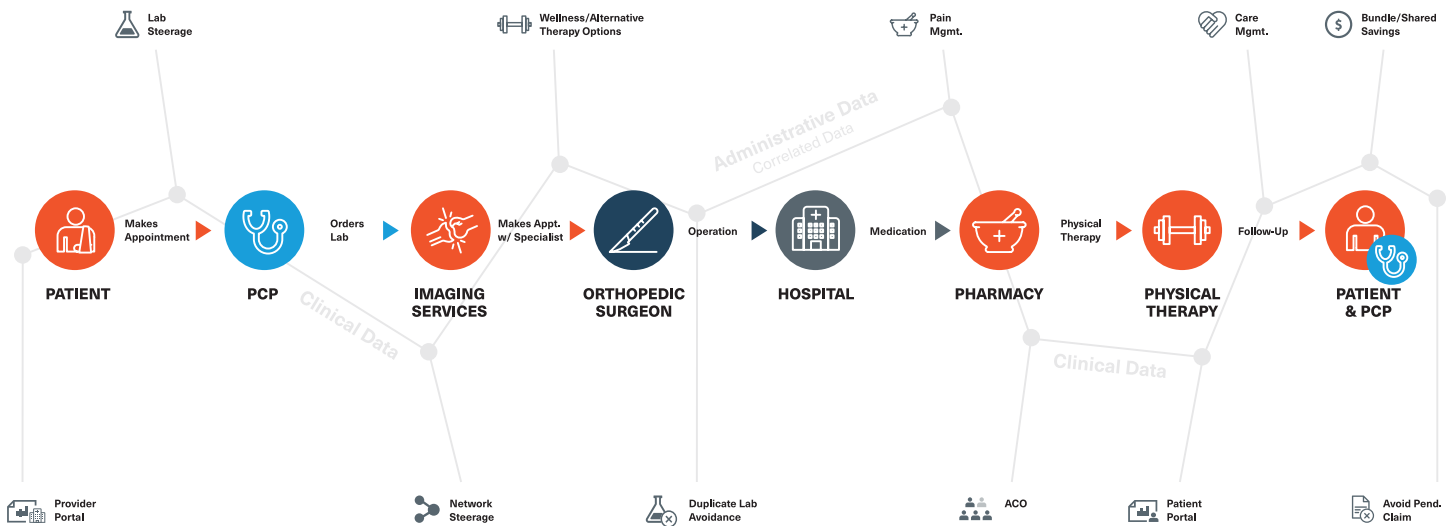


Figure 3- illustrates how the same patient scenario might be different when administrative and clinical data are correlated and aggregated to enable insight and real-time intervention.

Conclusion

Collaboration is essential for value-based purchasing in healthcare. As all parties involved in delivering patient care share accountability for quality, value and outcomes, the demand for an infrastructure that serves as the trusted, transparent, adaptable engine for trading information will only continue to grow.

At the same time, the return on investment delivered by this new infrastructure is significant from more than just an economic perspective. Merely stopping bad data from claims at the edge of the enterprise will increase auto-adjudication rates and translate quickly into millions of dollars in savings. More importantly however, investment in an edge-based trading platform is a quid pro quo for competing in the emerging healthcare marketplace in order to deliver the requisite value to all the stakeholders and customers—those who will ultimately decide the winners and losers under healthcare reform.

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