White Paper

Healthcare Reform

Successful Strategies for IT-Enabled Transformation in an Era of Accountable, Coordinated Care

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Introduction:
The Healthcare Transformation

In the United States, healthcare is undergoing a dramatic transformation. In recent years, the U.S. healthcare system has failed to deliver quality care at costs commensurate to other first-world countries. In fact, U.S. healthcare typically costs eight to ten times more without demonstrably better outcomes.

While the Patient Protection and Affordable Care Act was initially designed to provide coverage to millions of uninsured Americans, the industry was forced to reconsider the effectiveness of its delivery system.

By combining the provisions of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, and the Patient Protection and Affordable Act (PPACA) of 2010, healthcare reform aims to provide higher levels of care at rates that eventually close the gap with world market values.

Reforms strive to align incentives for care delivery and financing toward a more collaborative, coordinated, and preventive model that rewards high quality and appropriate stewardship of healthcare resources.

The Patient Protection and Affordable Care Act strives to change healthcare delivery through a "Three Part Aim":

- Improve the healthcare experience for patients
- Improve population health
- Lower per capita costs

New Models of Care

The Affordable Care Act provides significant latitude for providers to create innovative ways to achieve these objectives through the development of Accountable Care Organizations (ACOs).

The ACO concept represents a much-needed departure from the insurer-driven status quo to a provider-driven model of quality improvement and lower costs by leveraging technology and communications to improve efficiencies.

Generally, an ACO can be defined as a set of healthcare providers—driven by primary care physicians, to collaboratively accept collective "accountability" for the cost and quality of care delivered to a patient population. If successful, ACOs will create innovative ways to measurably improve quality, cost, and patient outcomes, while creating a more "value-driven" healthcare system.

Medicare Pioneer ACOs

The Affordable Care Act includes a provision that allows Medicare to reward healthcare organizations with a share of resulting documented savings. To participate in this shared savings program, healthcare organizations must first become ACOs. In the past 12 months, there has been significant ACO development activity.

In December 2011, CMS named 32 medical groups, health systems, and hospitals as ACO "pioneers" due in part to their readiness and financial resources to absorb and manage ACO shared risk. These ACOs will strive to integrate clinical information and coordinate care, thereby easing the burden of today's fragmented system in which medical records are often lost or inaccessible, and treating providers are unable to collaborate as quickly and efficiently as professionals in other industries.

For example, while it typically takes 9 milliseconds to process a credit card transaction around the world with 24 points of contact with different banks, most treating physicians can't get copies of a patient's recent medical record, lab results, pharmacy records, or imaging studies from other providers when needed. As a result, physicians frequently have to reorder expensive tests. In addition, physicians often have to wait days to obtain telephonic utilization review approval for vital procedures, or wait weeks or even months to get paid for a medically appropriate visit or procedure.

In the initial pioneer ACOs, a minimum of 15,000 Medicare beneficiaries will be attributed to each ACO primary care physician based on the "plurality of services" historically provided to Medicare fee-for-service beneficiaries. The primary care "ACO Professionals" are then in control of selecting specialists and other service providers to improve care and "bend the cost curve" associated with what would otherwise be the expected rate of healthcare inflation for this attributed patient population.

CMS will establish a cost benchmark for each ACO based on the last three years of Medicare expenditures, adjusted for risk and other factors. The

benchmark will be trended forward using projected growth in national Medicare spending.

CMS will use patient surveys, provider reporting and claims data to rate ACO pioneers on 33 measures of patient experience and safety, care coordination, preventive health and at-risk care. In order to succeed, ACOs must have the ability to track and report these quality and performance measures and calculate shared savings and loss rates.

The Commercial Market

While the government's focus on ACOs is in the context of Medicare, the ACO concept applies to all patients and all forms of insurance. If ACOs can extend beyond Medicare patients, the advantage is tremendous, as it means providers will be able to interact with both public and private payers based on similar clinical objectives and financial incentives.

The Medicare Pioneer ACO program has given many hospitals, provider organizations, and large integrated healthcare systems the opportunity to consolidate independent physician practices into ACOs. These organizations have developed the legal and technical infrastructure to enable more accountable, coordinated care than the current fee-for-service system.

Leveraging this same infrastructure, many organizations have begun to team with health plans to launch commercial ACOs. Many of these commercial programs will initially aim to cover the healthcare organization's own employees.

For example, a large fifteen-hospital, $15 billion healthcare system may be responsible for more than $200 million worth of healthcare claims for its own employees and their dependents. This type of organization may qualify as a Medicare pioneer ACO and use the same ACO infrastructure to deliver and finance its employee health coverage.

As a next step, many ACOs can use data analytics, predictive models, and business intelligence tools to analyze their local patient populations in order to target specific employers in the region and offer them better rates and coverage than competing non-ACO-based insurance companies.

Whereas under a Medicare ACO model, organizations must adhere to a set rate structure and shared savings formula; the commercial ACO market is ripe for

innovation, negotiation, and opportunities to leverage patient and provider data to design more favorable care delivery, financing, and risk-sharing models.

Historically, providers often rely on insurance companies to provide actuarial claims data for their contract negotiations. Today, however, provider organizations can invest in their own data analytics and predictive capabilities, and connect to physician practice management and electronic medical records systems. In this way, they can gather and analyze data in order to "level the playing field," and use business analytics to secure more favorable contract terms and rates than in the past.

New Trends in the Landscape

With the introduction of the Affordable Care Act, new trends are becoming broadly accepted throughout the healthcare industry. As a result, even if provider organizations do not choose to develop or participate in ACOs, key principles will likely affect their contracting arrangements and reimbursement models. Here are some key trends to keep in mind:

- ***Accountability & Risk***. Traditionally, healthcare has not been accountable to payers or consumers for quality outcomes. The concept of accountability will strive to tie performance to financial reward. As part of being accountable, provider organizations will need to assume financial risk for quality-of-care standards and essentially act more like insurance companies.

- ***Quality & Performance Measures***. To facilitate accountability, public and private payers will increasingly rely on quality and performance measures to ensure providers are meeting minimum standards of care. Today, key measures reflect the "Three Aims" – to improve population health, improve patient experience, and lower per capita costs. Payers and provider organizations must be able to measure, track, and report on new clinical, financial, and performance standards.

- ***Coordinated Care; Clinical Integration***. Provider organizations will need to coordinate care seamlessly across all care settings. To do this, they need to be clinically integrated, bringing data together from both an inpatient and outpatient setting. Clinical integration depends on having the right IT infrastructure and connectivity tools, and receiving data in an actionable format to further enhance quality and savings.

- ***Managing Patient Populations***. To take responsibility for a patient population, provider organizations need a complete understanding of the care and services those patients used in the past and will need in the future. As a result, organizations need analytic and predictive capabilities to understand the health status and future medical needs of a designated population, so they can better coordinate care and enhance outcomes.

- ***Handling New Reimbursement Models***. Provider organizations will also need to accept and track a range of various payment arrangements, including fee-for-service, episodes-of-care, bundled payments, as well as full and partial population-based prepayment options, similar to monthly per-member-per-month capitation.

Transformative IT Tools: Data Analytics, Predictive Models, and Business Intelligence

While many payers and provider organizations intend to participate in new models, including value-based plans, pay-for-performance, and ACOs, many do not currently have the technology to realize the objectives of these initiatives.

In the era of accountable care and healthcare reform, MZI HealthCare recognizes that advanced technology solutions—including data analytics, predictive modeling, business intelligence, and connectivity tools—will play a pivotal role in supporting the rapid transformation that is needed to meet new clinical, financial, and performance requirements.

The growing need to account for performance is driving greater demand for business intelligence. Whether looking at the health of a single patient or an entire population, care management will require access to clinical information, and if healthcare is to build a more efficient, cost-effective model, we must also be able to integrate clinical and financial information for a complete 360-view of their healthcare data.

As a result, organizations are looking for new tools to aggregate, analyze, and report data in various ways. Such data management capabilities are critical to ensuring compliance with measures for CMS (Centers for Medicare & Medicaid Services), PQRS (Physician Quality Reporting System), pay-for-performance, ACO, and other reimbursement models.

One factor assisting in data management today is new tools for interoperability and data mapping. This type of connectivity facilitates efficient data exchange

and improved data mining, and has placed powerful data analytics and predictive modeling within reach.

MZI HealthCare – A Suite of Solutions

In the climate of accountable care and healthcare reform, MZI HealthCare, LLC (MZIHC) is the leading provider of advanced technology solutions that enable healthcare organizations—and accountable care organizations (ACOs) in particular—to facilitate the rapid transformation that is needed to meet the new clinical, financial, and performance requirements discussed in this white paper.

With more than 25 years of experience in providing data management solutions to the healthcare market, MZIHC has an in-depth understanding of the technical capabilities needed to minimize financial risk associated with healthcare delivery.

In October 2011, MZIHC launched two new products—EZ-ANALYTICS™ and EZ-CONNECT™—to the healthcare market.

EZ-ANALYTICS

EZ-ANALYTICS offers a full spectrum of data analytics and predictive modeling capabilities. It has the power to analyze data in multiple ways, perform flexible slice-and-dice reporting, and predict utilization and costs.

For example, EZ-ANALTYTICS enables organizations to analyze chronic conditions and co-morbidities that exist in given patient populations. Using sophisticated data models, organizations can then predict healthcare needs, utilization trends, and costs associated with those populations—and even drill down to episodes of care, as well as profile patients and providers.

The solution offers the following key capabilities to operate in today's era of accountable, coordinated care:

- ***Shared Savings***. EZ-ANALYTICS is currently the only system on the market that can calculate shared savings for physicians participating in Medicare pioneer ACOs.

- ***Performance Measures***. EZ-ANALYTICS tracks comparative benchmarks for over 250 quality measures, which include the 33 quality measures Medicare requires under current ACO rules, Health Effectiveness Data and Information (HEDIS), and PQRS.

In addition, as commercial payers create their own set of standards, EZ-ANALYTICS will enable organizations to track, report, and monitor various indicators of clinical quality, patient experience, costs, and utilization. These measures can be used for physician evaluation, benchmarking, and reimbursement, as well as to help organizations achieve cost effectiveness and continuous quality improvement.

- ***Episodes of Care***. EZ-ANALYTICS gives organizations the ability to combine and group claims according to episodes of care. The system has a standard set of episodes, but organizations can also modify them and control how episodes are correlated. Besides analyzing episodes of care, EZ-ANALYTICS allows organizations to analyze patient care needs in a variety of other ways.

- ***Patient Populations***. EZ-ANALYTICS enables organizations to analyze patient populations to understand current health status as well as future healthcare needs. The system can stratify populations based on health risk, and identify population segments in which care management will have the greatest value and impact.

  EZ-ANALYTICS is able to breakdown patient populations according to resource utilization and disease categories, and combines these factors to classify patients by risk-adjusted case mix. EZ-ANALYTICS gives a historical view of patients and uses predictive modeling to identify prospective patient needs over a set time period.

  For example, a 75 year-old man may have experienced $10,000 in claims in the last three years. He may seem like a well-managed patient. However, using EZ-ANALYTICS, an organization would be able to quantify this man's healthcare risk to the ACO, as well as his needs over the next two to three years. In fact, he has a 50% probability of being hospitalized, a 22% probability of requiring ICU services, and an 8% probability of experiencing a slip and fall. As a result, the patient would likely cost the program $50,000 to $75,000.

  As you can see without EZ-ANALYTICS, an organization might rely solely on historical data to estimate future costs. And, thereby, risk losing millions of dollars—especially when such incorrect estimates are generated across an entire patient population.

- ***Profiling Physicians***. In an accountable, coordinated care model, organizations will want to identify and partner with the most cost-effective physicians. EZ-ANALYTICS enables organizations to analyze each participating physician's practice patterns, using a hybrid approach versus just an episode of care methodology. In this way, organizations can better understand which physicians contribute to cost savings and which providers must improve practice patterns.

  EZ-ANALYTICS also gives organizations the ability to use severity-adjusted benchmarks of their providers and engage in a cooperative peer-to-peer comparison that enables the organization as a whole to work toward the common goals of bending the cost curve, improving quality of care, and decreasing costs. In essence, EZ-ANALYTICS helps to identify physicians who are performing well from both a clinical and financial perspective, as well as identify those who need improvement.

- ***Contracting Module***. MZI HealthCare understands the risk associated with healthcare delivery. This expertise is reflected in the contracting module of EZ-ANALYTICS. It helps organizations better negotiate contracts, minimize the financial risk associated with a given patient population. With this module, organizations also have the business intelligence to build better models of care delivery to meet the "Triple Aims."

EZ-CONNECT

Today, provider organizations utilize disparate, disconnected systems, including various Electronic Medical Record (EMR) systems. Moving forward as organizations partner with one another, they must be able to easily connect with one another to share clinical information.

To meet this need, MZI HealthCare introduced EZ-CONNECT, an out-of-the-box connectivity solution that facilitates the interoperability and information sharing necessary for care coordination, analytics, and performance measures.

EZ-CONNECT offers more than 160 plug-and-play connectors—a number that is continually growing. With this tool, organizations can easily aggregate data from multiple sources and seamlessly exchange information between payers, providers, and partners.

With drag-and-drop mapping capabilities, EZ-CONNECT also gives organizations the power to transform data to and from various formats—such as Health Level 7 (HL7), EDI X12 (the current standard in electronic data interchange), UB-04 (a CMS required form), and many other formats.

This accelerates an organization's ability to comply with regulatory and reporting requirements. EZ-CONNECT not only streamlines information flow, but also facilitates the creation of complete and sophisticated process flows—from initial data receipt to end output in various applications, such as electronic medical records (EMRs), practice management systems (PMS), and others.

Using EZ-CONNECT, organizations can compile and integrate claims, EMR, pharmacy, and lab data into EZ-ANALYTICS in order to create a more comprehensive healthcare picture of patient needs, utilization, and costs. In turn, this information can help to focus care management and case management resources to achieve optimal quality, savings, and value.

Other MZIHC Solutions

With the addition of EZ-ANALTYICS and EZ-CONNECT, MZI HealthCare has built a suite of solutions to help organizations thrive in today's environment of coordinated, accountable care. These systems are highly flexible and can meet any organization's specific business needs.

In addition, these two systems work seamlessly with the other EZ solutions. Together, the entire suite empowers organizations to deliver unique models of quality, affordable care.

The other solutions in the MZIHC suite include:

EZ-CAP®

EZ-CAP v6, the flagship product of MZI HealthCare, is a powerful .NET platform that provides a browser-based environment to help organizations manage complex health insurance benefits, automate claims and other transactions, and oversee financial and medical management. The system is competitively priced, easy-to-use, as well as easy-to-adapt and configure. For more than 25 years, EZ-CAP has enabled a host of users to efficiently and cost effectively automate their healthcare administration to meet evolving requirements and stay in control of data.

EZ-CARE™

EZ-CARE is a comprehensive care management solution. Designed by case managers for case managers, it drives an integrated approach to complex case management, utilization management, and disease management. Ensuring that a holistic view of patient care and evidence-based medicine is considered in

treatment plans, EZ-CARE helps contain the costs of high-risk patient cases, while enabling organizations to improve quality of care. In addition, with its browser-based platform, EZ-CARE is now fully integrated with the EZ-CAP® v6 solution—more closely aligning care management with benefit administration to better ensure proper patient eligibility, authorization of services, and other complementary capabilities.

EZ-EDI™

EZ-EDI is a groundbreaking data-mapping tool. EZ-EDI is designed to reduce the time and effort it takes to implement and maintain an EDI solution. With a simple "drag and drop" feature, clients can easily do-it-themselves—creating custom maps for both inbound and outbound HIPAA-standard files to EZ-CAP data sets.

EZ-NET™

EZ-NET is a real-time provider portal that facilitates timely, cost-effective sharing of clinical and administrative information between a healthcare organization, network providers, and health plans. By communicating and performing administrative tasks via EZ-NET, informational flow is expedited and data accuracy is enhanced—all while maintaining secure, controlled access.

EZ-ANALYTICS Pilot Program

Access Health in Muskegon, Michigan is recognized as a progressive community-based not-for-profit that provides affordable healthcare coverage to moderate-income, working uninsured employees in several Michigan counties.

Access Health has evolved over the years and is committed to continual improvement. The organization realized it couldn't use a traditional model. Instead, it emphasizes health improvement and empowerment, while fostering fiduciary responsibility.

"Traditionally, physicians have focused on providing care to the sick," said Jeff Fortenbacher, president and CEO of Access Health. "Within a fee-for-service reimbursement model, physicians who failed to practice to a certain standard of care actually generate more hospital admissions and higher revenue. However, this paradigm is costly and unsustainable, and is currently undergoing a dramatic shift. Moving forward, we realized that data analytics could help us set appropriate quality measures that ensured optimal outcomes.

"Regardless of where reform is headed, our vision is to create a proactive and economically feasible model over the long-term. As such, we support strategies for early intervention, preventive medicine, and management of chronic conditions.

"Recently, we ran a pilot program using EZ-ANALYTICS. We found the system's data analysis and predictive modeling capabilities were well aligned with our vision for care. In Muskegon, we operate as one health system. Within this context, EZ-ANALYTICS can serve as a powerful business intelligence tool."

Continued Fortenbacher, "We want to truly assess our community's healthcare needs. EZ-ANLYTICS would enable us to analyze our patient population from both a broad 50,000-foot level—all the way down to the individual level, where physicians need to build relationships in order to affect the behavioral changes necessary for care management."

"EZ-ANALYTICS will also identify where healthcare spending is high," said Milt Kruger, director of finance at Access Health. "We can then use that information to focus care management and case management resources on appropriate segments of our patient population.

"The system can also help us to evaluate the performance of physician practices," he continued. "We'll be able to benchmark provider performance against normative data, establishing a standard level of performance for treating diabetic patients. In their defense, physicians may claim their patients are sicker, but using the case mix capabilities in EZ-ANALYTICS, we'll be able to risk adjust, enabling a fair peer-to-peer comparison.

"We applied to become a health insurance co-op, which is governed by members to solve healthcare challenges for members. As part of this proposal, we used EZ-ANALYTICS to provide our actuary with historical and predictive information," Kruger summed up.

Adds Fortenbacher, "Eventually, our aim is to have every claim in Muskegon submitted into EZ-CAP, and all claims data could then feed into EZ-ANALYTICS, where we could integrate EMR, lab, and pharmacy data to create a comprehensive picture of healthcare in our community.

"As our patient population expands, EZ-ANALYTICS will play a more expansive role in our management strategies. We'd like to take our delivery model, which we provide to approximately 300 to 350 small businesses, and expand it throughout our healthcare community," he concluded.

An IT-Enabled Vision for Care

The Affordable Care Act strives to curb rampant healthcare inflation. To achieve this objective, care delivery must shift from a fee-for-service model that drives volume to an accountable model that supports the provision of medically appropriate, cost-effective care.

In this environment, physicians and hospitals will be rewarded for bending the cost curve, and performance measures will form the basis of reimbursement. Every member of the provider team will be held responsible and accountable for achieving a good patient experience and better outcomes, including lower hospital readmissions and lower use of expensive medical services.

To be successful in these aims, healthcare organizations need advanced technology solutions, including data analytics, predictive modeling, business intelligence, and connectivity tools. These new solutions must work hand-in-hand with claims administration processing and comprehensive care management systems in order to integrate clinical and financial data and effectively manage patient populations in the future.

MZI HealthCare, LLC (MZIHC), with offices in Longwood, Florida and Valencia, California, is a leading provider of transformative healthcare solutions to meet new clinical and performance requirements for accountable care and healthcare reform. With more than 25 years of experience in delivering advanced data management solutions to the healthcare market, MZIHC has a comprehensive understanding of the IT capabilities organizations need to design delivery models that optimize the efficiency, quality and cost of care, while minimizing the financial risk associated with a patient population.

To learn more about its transformative solutions, contact:

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