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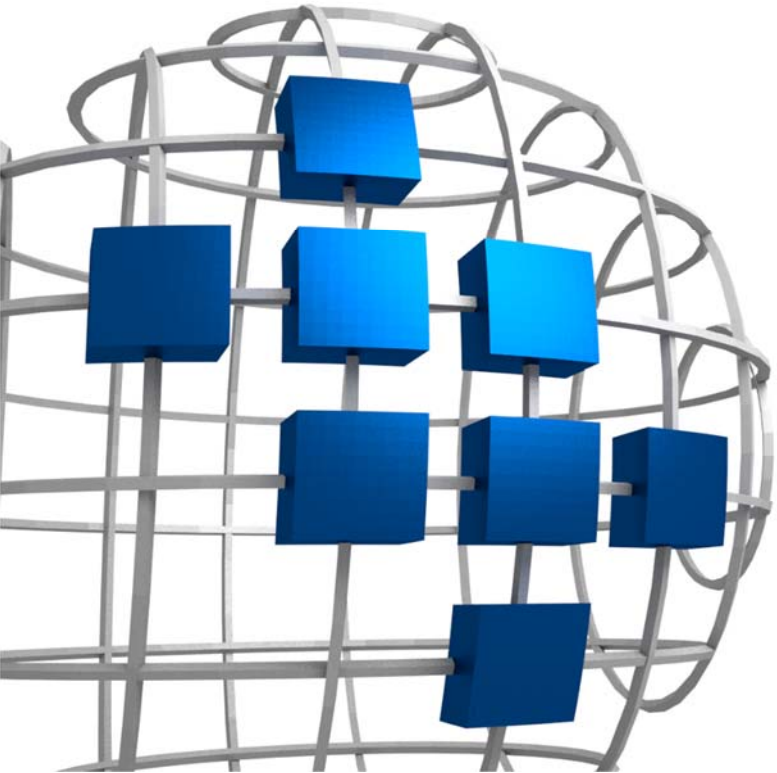
| Healthcare Executive Report |

ICD-10 Transition
2016 and Beyond



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INTRODUCTION

The transition to ICD-10 and the resulting increases in historical claim and clinical information promise to add fuel to the healthcare community's drive to empower consumerism. The ICD-10 transition provides opportunities that add value to healthcare organizations within the following value streams: business analytics, operational efficiencies, payer-provider contracting, and consumer-centric quality improvements. Health plans can start to capitalize on each of these value streams to drive new business opportunities and payment models and to ultimately support and increase patient/member satisfaction.

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Prior to the ICD-10 transition, the healthcare community had been constrained with the limitations of the code sets available for rationalizing pre-authorizations and with the minimal detailed information available through claims processing. Once the transition to ICD-10 is complete, the wealth of new and more exact details of patient/member information will enable health plans to realize their transformation strategies. Health plans will be able to maintain key performance indicators (KPIs) at numerous levels for both monitoring and trending operational and financial performance as well as enabling modeling to gain insights for improvements.

The following content provides a foundation for working through each of the value streams and enables health plans to be better informed and positioned to achieve higher levels of patient/member satisfaction and performance ratings.

BACKGROUND AND TECHNOLOGY

Federal heath IT policy has undergone significant changes in recent years through administrative and legislative efforts addressing broad concerns over the US healthcare system. The first Federal Health IT Strategic Plan was published in June 2008. The Health Information Technology for Economic and Clinical Health (HITECH) Act, passed as part of the American Recovery and Reinvestment Act of 2009, allocated billions of dollars for the healthcare system to adopt and meaningfully use health IT to improve health. As a part of HITECH, Section 3001(c)(3) of the Public Health Service Act established the Office of the National Coordinator for Health Information Technology (ONC). The ONC is responsible for developing the framework to accommodate the changing landscape of health IT and to help establish policy.

Passed in 2010, the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (referred to collectively as the Affordable Care Act), builds on HITECH and recognizes health IT as a critical enabler to broad transformations in healthcare. The ONC was given responsibility for the development of the Federal Health IT Strategic Plan in close collaboration with other federal partners for working with the private and public sectors to realize Congress and the Administration's health IT agenda.[1]

The illustration in Figure 1 presents the goals of the strategic plan over the continuum of time.

Federal Health IT Vision

A health system that uses information to empower individuals and to improve the health of the population.

Federal Health IT Mission

To improve health and healthcare for all Americans through the use of information and technology.

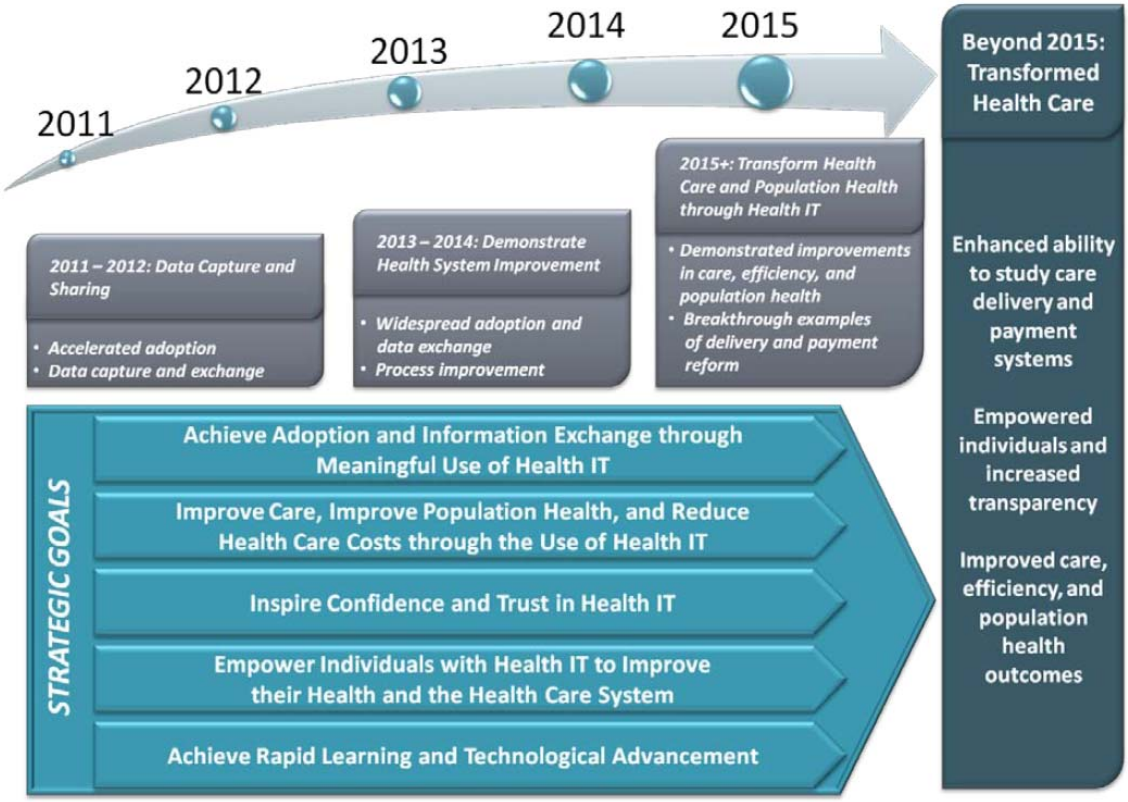

Figure 1. ONC's Federal Health IT Strategy Map

While the Federal Health IT Strategic Plan establishes the framework for achieving health IT policy goals, initiatives such as Meaningful Use phases and the implementation of ICD-10 code sets are the vehicles to leverage interoperability, data transformation and sharing, and technology to power the healthcare of the future. These initiatives provide a catapult to empower individuals and increase transparency, enhance the ability to study care delivery and payment systems, and, ultimately, achieve improvements in care, efficiency, and population health.

Technology has made significant steps towards empowering individuals to monitor and track individual health and performance. Aside from federally regulated medical technology, available technology has enabled the promotion of personalized products from smartphone applications to wearable devices for immediate monitoring feedback along with upload capability for personalized historical health information and trending. Additionally, consumers can take advantage of web-based technologies in the marketplace for booking medical appointments, making payments, reviewing claims history, and buying health insurance and other health plan products.

The advancement in many of these technologies has been rapid. However, not all of the healthcare community has been able to sustain and take advantage of the technology advances. The healthcare community has encountered delays with the implementation of the ICD-10 code sets as well as Meaningful Use. Interestingly, these two implementations found impediments within the small- to mid-sized provider community. Working alongside various agencies, the Centers for Medicare and Medicaid Services (CMS) supported the delay of ICD-10 and phases of Meaningful Use to allow time for the provider community to catch up with the implementations achieved by health plans, clearinghouses, vendors, and hospitals. The intent is to further adoption in an orchestrated manner to enable current technology to help drive consumerism along with healthcare delivery services and modernization of health plans' consumer benefit programs. Together, this allows consumers to be more in control of personalized health.

Four cornerstones for empowering consumers and improving competitiveness:

- *Business analytics*
- *Operational efficiencies*
- *Payer-provider contracting*
- *Consumer-centric quality improvements*

For health plans, there are four cornerstones to empower consumers and be more competitive in the marketplace. These are business analytics, operational efficiencies, payer-provider contracting, and consumer-centric quality improvements.

BUSINESS ANALYTICS

Health plans have for a long time been in the business of managing financial risks and have developed numerous safeguards to lower risk opportunities and financial challenges. However, to capitalize on the state of the transitioned claims data among various code sets (e.g., ICD-9, ICD-10, DSM, DRG, and CPT-4), more effort has to be exercised to better manage those risks. Moving forward, the use of KPIs will evolve along with the expanded use of dashboards.

Health plans will continue to be challenged with the volume of healthcare data. Guiding the focus of strategic data, asking the right questions, and knowing how to bring the information into a meaningful form will be paramount for reporting trends and developing predictive models to empower sales and marketing teams. Take, for example, representing demographics for consumer portal touches, especially for claims history and payment information. Currently, the demographic and financial analysis typically reflects claim billed amounts, physician paid amounts, and consumer payments owed to providers. Additional analytics may also reflect demographics of providers using or not using EFT/ERAs, as this relates to the mutual desire for an overall reduction of administrative costs to consumers.

Health plans will find continued business opportunities and an increased competitive advantage.

The ONC envisions driving an array of interoperable health IT products and services that allow the healthcare system to continuously learn and advance the goal of improved healthcare. The technology will lower healthcare costs, improve population health, truly empower consumers, and drive innovation in the delivery of healthcare. The health IT ecosystem should support critical public health functions, such as real-time disease surveillance and disaster response, data aggregation for research, and value-based payments that reward higher quality care.[2]

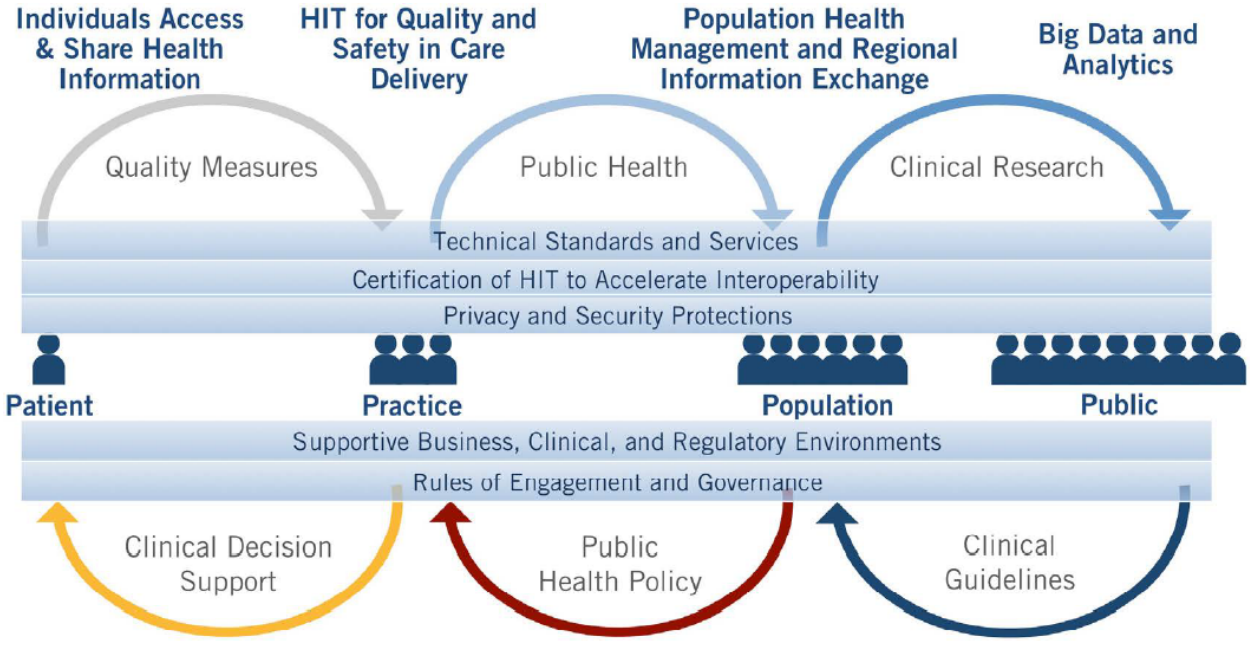

Figure 2. ONC's Health IT Ecosystem

The focused use of new business analytics, best practices, and predictive analytic models will enable health plans to gain better insight of current patient outcomes, clinical protocols for conditions, treatment plans of providers and provider organizations, and consumer educational practices to advance improved outcomes. The continued advancement towards better outcomes is critical for lowering healthcare costs and increasing consumer satisfaction. Health plans achieving greater consumer satisfaction levels through the use

of better business analytics and innovative methods will find continued business opportunities and an increased competitive advantage.

OPERATIONAL EFFICIENCIES

Health plans continually update and upgrade their information technology and infrastructure to support changes and meet competitive demands. In a future state, health plans will be driven to leverage the best of the best practices to aid with reductions in operational costs. The overhead required for administrative functions of claims processing, actuarial and risk analysis, medical policy updates, provider networks, customer call centers, care management, and sales and marketing programs continue to climb with each new fiscal year.

Productivity and workflow challenges will significantly influence the 2016 KPIs.

Challenges to workflow within and among health plan business units will increase as data volumes continue to grow along with disparities in the data content and quality. A key area of focus is claims processing. This business function is strategic and core to the entire health plan. Workflow touch points should be given attention for manually touched claims, a continual administrative expense. However, other claims processing touch points include provider chart reviews or audits, Medicare risk adjustment reviews, claims denials, pends, and rejects that each require manual intervention for resolution. These activities are compounded by the potential claim coding reviewer training constraints due to the transition to the newer code sets of ICD-10 and DSM. Productivity and workflow challenges will significantly influence the 2016 KPIs in comparison to those of 2014 and early 2015.

Health plans will need to monitor the workflow and staff performance levels for care management particularly with the issuance of pre-authorizations and chronic conditions of consumers. Automation and manual review processes for medical necessity will need continued monitoring and review to aid with downstream claims auto-adjudication rules to avoid the potential for denials or pended claims. Either of these two can trigger an immediate increase in call center questions from providers and consumers.

The sales and marketing of commercial and government programs are closely associated with employer groups. The ability of health plans to quickly react to prospective and existing customer demands directly impacts the product development business unit in terms of new and expanded benefit programs which in turn directly affects the maintenance activities of the provider and employer adjudication rules for automated processing. As this cycle continues to expand so does the overall complexity of the technology to support the consumer demands which thereby provides health plans with an opportunity to be highly competitive and maintain strong levels of consumer satisfaction. Assessing claims processing, adjudication, and workflow, including vendor product release schedules, and the development of guiding roadmaps enable improvements to the health plan's claims operational efficiencies. Planning and preparation for this opportunity is valuable to a health plan's strategic growth.

PAYER-PROVIDER CONTRACTING

Health plans will gain valuable insight from the lens of the 2016 claims history data at the provider level. By the first half of 2016, health plans will have gathered nine months of ICD-10 claims data that will be reviewed in conjunction with the prior year's ICD-9 data. The billing and service habits of the participating providers will reveal trends and more specificity to enable provider network business units to re-evaluate provider contracts in greater detail. Prior to this point in time, only ICD-9 history will have been exercised for forecasting; however, with aggregated billing history data, health plans will be able to review and restructure their provider contracts.

Many provider contracts have carve-outs and other special considerations given to providers based on provider performance and employer group demands. With the newly aggregated information, health plans can better assess provider habits, yielding numerous changes to provider contracts.

The Star Ratings[3] measures span five broad categories:

- *Outcomes*
- *Intermediate Outcomes*
- *Patient Experience*
- *Access*
- *Process*

The provider network team will be better positioned to engage the provider performance assessment process and develop contract guidance through an improved provider contracting roadmap. Further analysis can be given to medical necessity, which has a direct influence on reimbursements, administrative costs particularly relative to EFT/ERA use, payment methods leveraged, population health, and overall consumer satisfaction.

Technology will be leveraged to enhance provider relations and provider administration. The continued promotion and increased use of electronic transactions will further deliver value to the provider. This, combined with an expanded use of secured messaging services and secured health plan-to-provider portals, can further reduce provider and health plan administrative burdens and improve provider administrative efficiency and productivity.

Health plans will be able to measure the triple-aim equation to drive cost containment, improve quality, and improve the consumer experience through provider relations. Provider surveys and education will aid as measures to secure higher levels of consumer satisfaction and drive long-term growth.

CONSUMER-CENTRIC QUALITY IMPROVEMENTS

In today's technology climate, it is typical to encounter consumers using smartphone devices to book haircuts and stylists, make banking deposits and funds transfers, read a book, submit business travel expense reports, review apps for low carb food items on a restaurant menu, confirm airline travel and select preferred seats, transmit blood pressure measures to physicians, and make refill prescription requests to their local pharmacy. Additionally, consumers can automatically record, track, and trend the number of steps taken each day. Plus, consumers can check their coffee account balance, reload the balance if needed, and buy coffee using a smartphone app scanner code with the near real-time app while standing in line at the coffee store. Consumers do this conveniently on their

smartphone all in the same day. Consumers are in control. Convenience is the valuable concept and lesson.

Health plans have already had plenty of competition, and with the growth of the health insurance marketplace via the web, the competition has increased. Consumers are looking to health plans to deliver solutions to entice innovative encounters and support new payment models. Consumers want to take a more active role in their personal health and engage their health plans. Health plans will need to assess current payment models and explore new options to enable mobile health and redefine telehealth services. Consumers desire to book their own appointments with their providers and, in some cases, can do this today. To consumers, the convenience enables more time for themselves without the constraints of phone calls and being placed on hold for a period of time.

Consumers look to control their healthcare costs and will act to take advantage of healthier habits especially if there is a monetary value perceived. Health plans can lead healthier habits by way of benefit plans and consumer health surveys that directly empower consumers and allows participants to lower the overall plan deductible by completing activities that lead to better health. By completing eligible activities in a timely manner, participants can earn deductible credits that lower their out of pocket cost of healthcare.

Payment models will be expanded to allow for the collaborative experience to:

- *Drive improved patient care*
- *Lower administrative costs*
- *Increase consumer satisfaction*

By developing quality improvement guidance with a roadmap for the future, the care management team will be better positioned to engage the assessment process to review the quality impacts of the changes made to the health plan's medical management services, operations, and quality care and reporting.

The ability for the health plan to measure quality improvements and habits will empower the health plan. Wearable devices offer a future where consumers will be able to upload health activity habits, such as walking activity per day/week, swimming, sports, and other activities, that demonstrate healthy lifestyles directly to the health plan. The technology will be used to drive consumers to healthier activities and continue to support the concept of earning deductible credits.

Remote medical device monitoring for care management with an emphasis on chronic conditions will be leveraged to support consumer trends, enabling health plans to work collaboratively with providers. Payment models will be expanded to allow for the collaborative experience to drive improved patient care, lower administrative costs, and increase consumer satisfaction.

Overall population health management improvements aimed at patient safety and quality of life will support increased consumer satisfaction ratings and levels as measurable services and will deliver future health plan growth opportunities.

CONCLUSION

Consumers will continue to make the shift to become healthcare delivery decision makers based on healthcare costs and experiences. Health plans must focus on value gained by the ability to streamline processes to ultimately reduce costs. Health plans will evolve business processes, health guidance policies, and benefit programs to leverage the opportunity that the consumer healthcare shift presents.

Health plans will take advantage of the new knowledge gained from their claims history and medical management information. Health plans will assess the claims adjudication process and claims workflow with an emphasis on stronger claims adjudication rules, fewer claims pended and denied, and reductions in manually reviewed claims and clinical records. From this effort, activities will be initiated to develop new strategic goals based on the valuable new knowledge gained.

Analytics will be used to knock down barriers by defining issues that can drive better outcomes and improve consumer satisfaction. Health plans KPIs will have spikes; however, health plans that know their KPI trends and who can make accurate KPI projections have greater chance to experience performance improvements across all business units. Developing the most effective analytics guidance and roadmap will be paramount to success.

The illustration in Figure 3 presents the value streams for gaining the greatest level of consumer satisfaction.

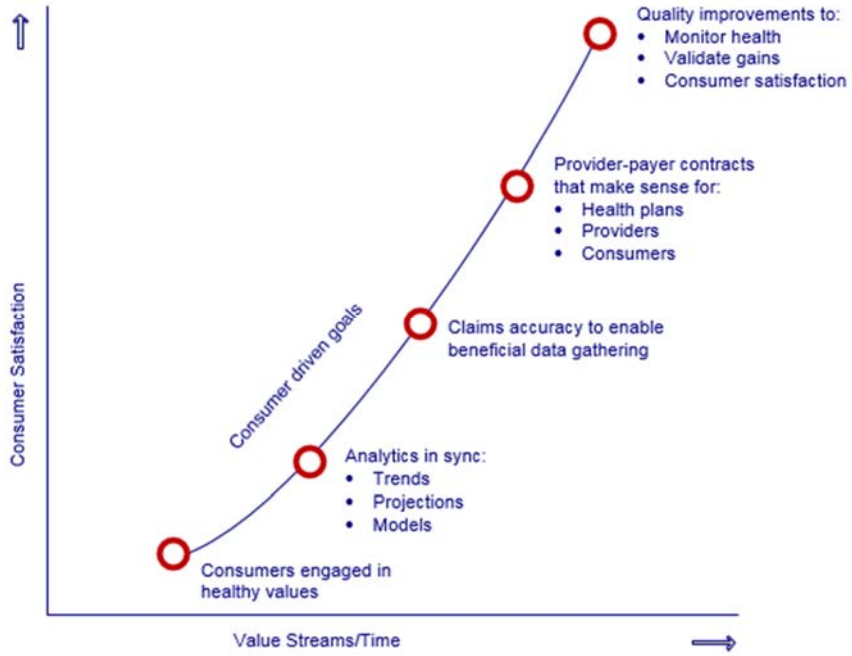

Figure 2. Consumer-Driven Value Streams

Consistent, steady-state resources will be needed to develop guidance for operational efficiencies, provider network contracting, and quality improvements aimed at improving overall consumer experiences. Health plans that respond will gain value and market share through the implementation of technology advances along with the appropriate level of security. Increased specificity and the knowledge derived from that specificity will drive improved financial, actuarial, and risk positions and will enable improvements in care management to induce cost containment and healthier populations, which yields improved consumer satisfaction.

Consumers desire convenience, better health, and lower cost and will continue to be in the driver seat, empowered by innovative solutions created by resourceful health plans in a highly competitive marketplace.

REFERENCES

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[2] "Connecting Health and Care for the Nation: A 10-Year Vision to Achieve an Interoperable Health IT Infrastructure", Office of the National Coordinator for Health Information Technology, published June 9, 2014. http://www.healthit.gov/sites/default/files/ONC10yearInteroperabilityConceptPaper.pdf.

[3] "Medicare 2015 Part C & D Star Rating Technical Notes", Centers for Medicare and Medicaid Services, published October 3, 2014. http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html.

ABOUT TM FLOYD & COMPANY

TM Floyd & Company is an information technology consulting group dedicated to being its clients' preferred strategic partner for IT initiatives. TMF has developed a high level of industry-specific subject matter expertise that it couples with its service offerings to distinguish it from the competition and to deliver exceptional value to clients. With more than 38 years of experience and working relationships with industry leading firms, TMF has the know-how to provide clients with the strong IT foundation needed to drive business success.

ICD-10 SERVICES

TMF offers ICD-10 services for health plans and providers needing to restart ICD-10 remediation efforts, leverage the benefits expected from the specificity and analytics afforded by ICD-10, or needing subject matter expertise to drive specific areas to compliance. TMF has a flexible pricing and delivery model that was designed with varying levels of preparedness in mind.

ICD-10 Re-Engagement Services

- Readiness Snapshot
- Re-Engagement Services
- Driver Services
- Project Management Services
- Remediation and Testing

ICD-10 Post-Compliance Services

- Post-Compliance Assessment
- Business Analytics
- Claims Operational Efficiencies
- Provider Contracting
- Quality Improvement

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