Statement of Sid Hebert
Humana
On Behalf of America's Health Insurance Plans
to the
National Committee on Vital and Health Statistics'
Subcommittee on Standards
Regarding the Implementation of ICD-10
February 19, 2014

Overview and Introduction

My name is Sidney Hebert. I am the ICD-10 Program Director for Humana Inc. with the primary responsibility of assisting my company with implementing the revised HIPAA electronic transaction standards, ICD-10 code sets and Administrative Simplification mandated by the Patient Protection and Affordable Care Act (ACA).

Humana Inc., headquartered in Louisville, KY., is a leading health care company that offers a wide range of insurance products and health and wellness services that incorporate an integrated approach to life long well-being. By leveraging the strengths of its core businesses, Humana believes it can better explore opportunities for existing and emerging adjacencies in health care that can further enhance wellness opportunities for the millions of people across the nation with whom the company has relationships.

Today, I am testifying on behalf of America's Health Insurance Plans whose members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market and public programs such as Medicare and Medicaid. Our industry processes millions of claims, eligibility requests, payments and other administrative and clinical transactions on a daily basis. The migration to the upgraded HIPAA electronic transaction standards and ICD-10 code sets will have a major impact on the business and administrative operations of health plans and will require significant financial and human resources for successful implementation.

In my testimony, I was asked to address:

- Findings from our recent provider surveys regarding transition planning and ICD-10 implementation
- The current status of industry testing and key test results
- Recommendations for the industry's focus over the next nine months

Humana began planning and executing ICD-10 remediation in 2009, recognizing that this complex coding system requires careful and systematic management for successful implementation. To date, Humana has completed remediation of its core processing platforms and is well into the internal and external end-to-end testing phase. Humana began its external end-to-end testing program, which is based on a select group of 70 large facilities, in July 2012. Currently, 30 facilities have entered our program and are progressing through our three stage process. Humana expects to complete testing with approximately 66 facility providers. Humana began the planning and design phases for external professional and outpatient practices in January and anticipates to begin provider engagement in Q2 of 2014.

On behalf of AHIP, I want to let the Subcommittee know that the health insurance industry is committed to the implementation of ICD-10, which will allow practitioners to identify and report conditions and condition management in more specific ways that will lead to more effective measurements of quality and outcomes.

We recommend that the Department and the Standards Subcommittee continue to stress that the October 1, 2014 implementation date will not change. We appreciate both NCVHS and the Department's steadfastness about not moving the implementation date beyond October 1, 2014. From our perspective, future delays will add additional costs and require a longer timeframe in which we are operating dual systems. Beginning in October we have to maintain dual ICD-9 and ICD-10 capable systems to account for the run out period of claims from services rendered prior to October 1. Currently, we anticipate maintaining our ICD-9 compatible system for an additional 18 months, only fixing any system bugs identified while we plan for a reduced claims volume submitted using ICD-9. Operating these dual systems come at a great administrative cost and any shifts to the implementation date will only magnify these costs.

The education and testing focus should transition from larger facilities (which are largely ready in our view) to smaller hospitals and physician organizations. We are now deep into our implementing testing with larger facilities in our network across the country. We have developed a three stage methodology to help us and our providers understand the financial implications of the migration.

- Stage 1: Coding Test: Large facilities demonstrated that they could accurately code 10 common scenarios. We reached a strong agreement on the coding of ICD-10 claims and gained confidence that large facilities were familiar with how to code in ICD-10.

- Stage 2: Coding Mapping between ICD-9 and ICD-10. We selected 150-300 historical claims to identify participating facilities top 10 claims scenarios. We asked them to recode in ICD-10 previous actual claims coded in ICD-9. Based on detailed meetings with facility staff to review the findings of our analysis, we understood where we had alignment.

- Stage 3: Electronic Claims Submission. We then asked around 70 facilities to re-code approximately 300-500 claims in ICD-10 and send to us electronically.

Going through these three stages with large facilities will complete end-to-end testing in our view. However, it will not be possible to do this type of testing with all providers and we are not able to tell providers exactly how to code due to legal issues. **This is why it is so important that CMS greatly increase its focus on provider training and outreach.** While our testing focus is now shifting beyond large facilities to targeted providers, it is much more challenging for individual health plans to train smaller and mid-size provider organizations, and thus, is why we believe centralized outreach will be more advantageous.

As the Subcommittee is aware, the key to a successful rollout will be providers understanding how to correctly code claims using ICD-10. This effort must focus on small and rural hospitals and small provider practices and should reinforce the importance of October 1 readiness. Humana has conducted provider readiness surveys both in November 2012 and again in November 2013. In November 2012, we forecasted that around 25% of our providers were prepared and ready for implementation. When we went back and re-surveyed again last fall, we saw similar results (around 25%) and are concerned that the numbers did not budge. While we will continue to focus on provider readiness an organized message needs to come from CMS about the importance of ICD-10 readiness.

We understand that the small practice provider community will need a place to go to get answers to questions concerning the clinical documentation needed to determine the correct or most appropriate diagnoses code. While large institutions and provider practices may not need such assistance, the small practice provider community will need assistance to determine if their current documentation practices will enable the selection of an appropriate ICD-10 code. The work done by WEDI and MGMA to provide coding training for specific specialties was extremely informative and useful.

Finally, we recommend the Subcommittee focus on the impact of the migration to ICD-10 on quality reporting and rating. ICD diagnosis codes are used by physicians, hospitals and other health care providers to capture diagnoses for all patient encounters, as well as for health plan and provider quality measurement and reporting. Significant differences exist between ICD-9 and ICD-10 and organizations such as the National Committee for Quality Assurance (NCQA) have taken steps to support the transition. For example, NCQA has identified a set of ICD-10 codes for their HEDIS® measures, which are used to assess commercial, Medicaid and Medicare Advantage health plan quality.

Based on AHIP's experience with quality reporting, one of the issues likely to arise with the transition to ICD-10 is the time required for providers to adjust to the new coding system and submit claims with the appropriate diagnosis codes that will capture denominator populations comparable to those defined under ICD-9. For example, ICD-10 requires a detailed code indicating a member is either a Type 1 or Type 2 diabetic in order to be included in a diabetes measure. Historically, members were included in the denominator if a diabetes-related code was submitted, but a Type 1 or Type 2 specification was not required. This coding change under ICD-10 presents the possibility of failing to capture a member if providers fail to include the appropriate specification, thus resulting in a different denominator population. Similarly, an imperfect crosswalk between ICD-9 and ICD-10 codes can cause populations to be inaccurately identified for measurement and reporting.

While organizations such as NCQA are working to identify valid and appropriate sets of ICD-10 codes for quality measurement and reporting efforts, it will be critical to monitor for any provider the coding trends or issues with data capture so that appropriate action can be taken to ensure valid and reliable measurement.

Closing

I want to reiterate the health insurance industry's support for the implementation of ICD-10, which has numerous benefits including greater precision in the identification of diagnoses and procedures, improved reporting for public health and bio surveillance and support for quality improvement programs. Health plans have expended significant resources to date in implementation and it critical that this momentum is sustained and that October 1, 2014 is the last deadline for implementation of ICD-10. We recommend that CMS focus its effort on reaching all providers and focus on educating providers on proper coding using ICD-10. Finally, it will be important for the Subcommittee to closely monitor steps being taken to update quality measures and monitor the impact of ICD-10 on quality reporting rating and recommend any necessary adjustments.

I thank you for the opportunity to provide input to the Subcommittee's deliberations.