

Looking at ICD-10 through a financial lens — what do you see?

Expert presenters

John Lloyd, Senior Vice President, Payer Consulting, Optum

Kecia Rockoff, FSA, MAAA, Director of Actuarial Consulting, Resource Optimization Group

Health plans' full transition to the ICD-10 code sets — slated to take place October 1 of this year — may be fraught with challenges, but it also could lead to both financial savings and revenue generation if analytics, modeling and projections are used to mitigate risk, improve pricing and enhance financial management practices.

First and foremost, plans essentially need to start learning “a new language” and make educated guesses about which coding and claims scenarios are most likely to happen, according to John Lloyd, senior vice president, Payer Consulting, Optum, who spoke March 6 at an Optum webinar, “Looking at ICD-10 Through a Financial Lens — What Do You See?”

“ICD-9 is the language providers currently use to talk to payers,” Lloyd said. “That language will change on October 1, so providers and payers will need to re-establish communication in the new, somewhat challenging, ICD-10 environment. There is potential for code creep any time there is a change, as well as risk adjustment revenue decrease and financial analytics instability if the transition is not handled properly.”

In comparing ICD-10 to ICD-9, Lloyd explained that there is no one-to-one mapping. “The easiest way to think about it is you have a large number of codes that are alphanumeric, so the code structure goes from about 18,000 codes under ICD-9 to the potential for more than 140,000 codes under ICD-10,” he said. “One way we describe it is the language is changing from English to Mandarin — where even the alphabet has changed.”

ICD-10 transition is more than an IT priority

Although resources are tight and there are many competing priorities, plans should be aware that ICD-10 is a major business

imperative, and not just an IT event. Lloyd explained that payers need to assess their individual environments and update and remediate their benefit plans, medical policies, medical management programs, provider contracts, and operational and financial reporting and systems, with remediation complete before October 2014.

He pointed out that although plans and providers may initially struggle with the switch to a much larger code set, there is value in greater specificity of coding. “A lot of what was intended had logic behind it,” he said, “which allows expansion in the data transmitted between payers and providers and other data users.” However, Lloyd contends that because of the greater specificity and complexity of the new codes, “we are going to see code ‘clumping’ for a predominance of code structures. Plans need to recognize now that the ‘many to one’ mapping might get clumped and try to understand the financial impact of this clumping.”

A plan’s focus “should be on minimizing risks to an acceptable variance with testing early and often to validate outcomes,” he told webinar attendees. “A comprehensive testing program includes internal end-to-end testing of systems, business processes and financial payments, as well as testing with external trading partners and providers.”

Lloyd also explained that from an actuarial point of view, changes from ICD-9 to ICD-10 data sets will have an interconnecting impact on provider reimbursement, risk adjustment, claims liability estimation, forecasts and budgets, underwriting, pricing and rate adjustment and trend analytics. “The immediate reaction is likely to be that changes in codes increase claims liability on the balance sheet,” Lloyd said. “Disruptions in processes and disruptions in data will have an effect on liability.” (See Figure 1.)

ICD-10 switch has substantial impact on DRGs, HCCs

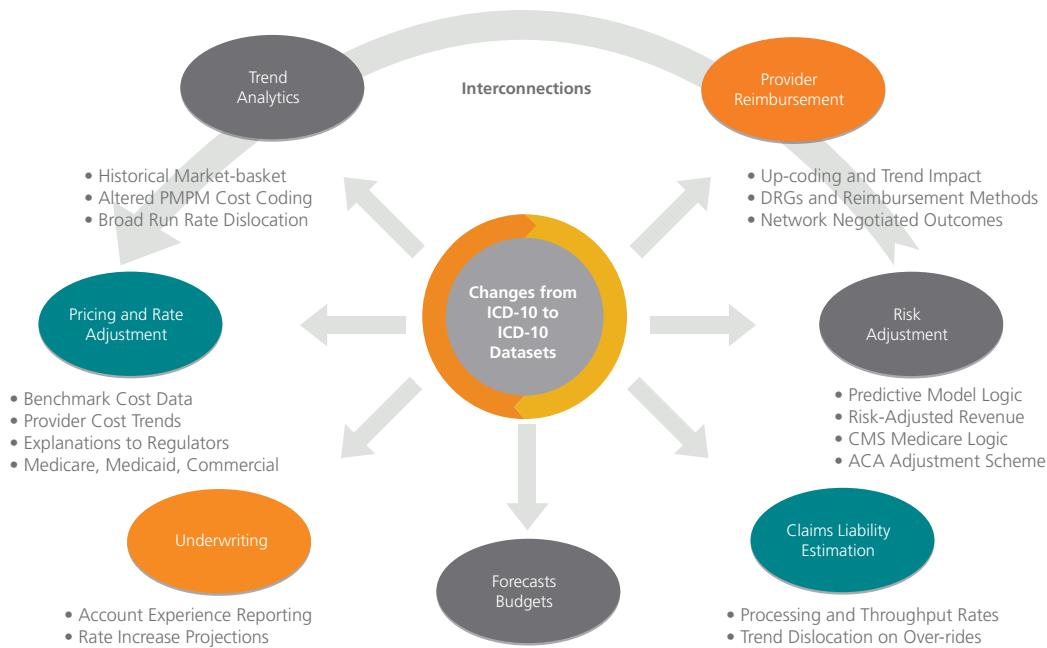
He continued by highlighting why the ICD-10 transformation matters to cost-of-care trend and hierarchical condition categories (HCC) risk scores. Regarding cost-of-care trend, Lloyd said that the

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Figure 1

Actuarial view of ICD-10 code change impacts



increased specificity of ICD-10 coding is likely to change diagnosis-related group (DRG) assignments and therefore have a significant impact on DRG risk scores. Using the ICD-10 remediated DRG version can help project potential impacts, he noted, but plans also will have to determine how to measure projected savings for cost-of-care initiatives under ICD-10 and identify which members to target for care management initiatives.

He added that ICD-10 may have a big impact on HCC risk scores, due to the vastly greater number of codes in the new code set and the potential for new HCCs, all of which will affect the payment years 2015 and 2016. “We are going to need to spend some time now to get our arms around potential areas of impact,” he said.

Although most plans currently have jumped the first hurdle of the ICD-10 transformation — being able to process claims — many have not completely figured out how whether those claims are being accurately processed “and exactly how many dollars are going to be expended on claims processing,” Lloyd said. Plans should think again about general equivalence mappings (GEMs), which the Centers for Medicare & Medicaid Services have said are only guidance; other modeling has shown that the GEMs alone will not create a clinically equivalent, budget-neutral crosswalk, he remarked.

He suggested that plans using groupers do modeling around risk scores and other topics to get a sense of the range of scenarios that

might occur under ICD-10, and that they review provider contracts, which may reference ICD-9-based definitions for reimbursement and/or include an option to open up negotiations if the impact of ICD-10 remediation is more than a target percent. “Phase 2 of this transformation is going to require a lot of analytics and forward thinking,” Lloyd said.

Estimation of risk exposure is key to successful transition

Kecia Rockoff, director, Actuarial Services, Optum, described several approaches for minimizing risk exposure during plans’ ICD-10 transition. For example, she suggested taking a five-step DRG shift analysis approach that Optum has used to help many plans capture the range of shifts that are likely to occur in this area (see Figure 2).

“Because we don’t know exactly how claims will be coded, we can take claims data and look at the minimum and maximum impact on DRGs and put a range around it,” Rockoff explained. “Then we can ask clinical experts to determine how likely the estimates are and refine our estimates.”

Minimum and maximum “substitution” codes also can be run through the HCC model to identify areas of potential impact on risk scoring. Plans also should consider pricing and underwriting issues that could affect revenue (premium determination, risk-adjusted capitation rates, Medicare star ratings); costs (both medical

costs and operating costs); and margin, she said. Additionally, she suggested that plans should consider how:

- Cost-of-care trend — the main driver of premium increases — may be altered
- Benefits defined with ICD-9 codes can be translated for ICD-10 codes
- Underwriting reports may change (and how to handle reporting with mixed codes)
- Risk adjustment can optimize revenue
- Stop-loss modeling can help determine which members to cede
- Other Affordable Care Act requirements for medical loss ratios, reinsurance and risk adjustment are impacted

In the valuation/reserving sector, plans are likely to see a “one-time hit” to historical payment patterns, according to Rockoff. “It will take longer to code claims in ICD-10 because documentation is different and there are more specialty codes,” she said, adding that there will be operational challenges (such as more claims being pending or denied or in need of manual adjudication), a major impact on inpatient claims (as well as some impact on outpatient

and professional claims), and changes in inpatient reimbursement due to DRG changes and case rate changes. Further, she noted that all modeling and reporting will need to be remediated for ICD-10.

Careful ICD-10 planning can identify financial opportunities

“Today, plans need to understand and quantify risks, define key performance indicators (KPIs), establish baselines and an ‘almost real-time’ monitoring structure and understand opportunities for performance and financial improvement,” Lloyd said, adding that “we have to get to a reasonable dialogue based on what we think might be the opportunities and outcomes.”

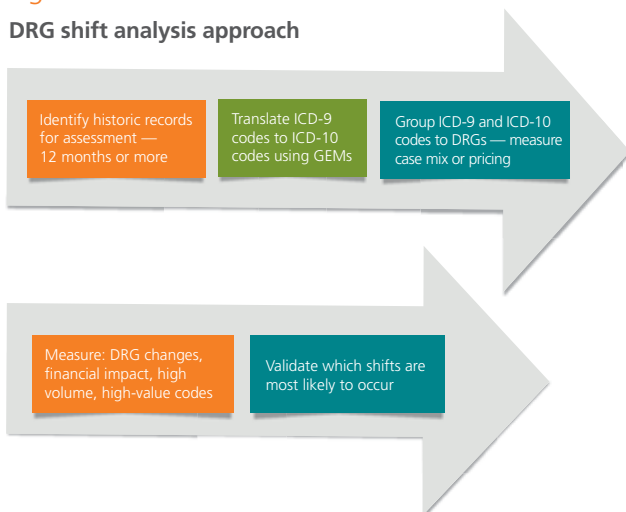
In this phase, “plans should use their claims data and conduct a reasonableness test and a structured analysis to figure out what the possible outcomes might be,” he said. “It might not be a definitive answer, but they will get an idea of where the pressure points are and where the local issues are. We think that most plans will find that certain conditions and providers represent the easiest starting point for navigating their way toward where they will need to be.”

During the transition — a two- to three-year process — plans should monitor and track KPIs, investigate significant deviations from baseline and address possible reasons for those deviations. After the transition occurs, plans should continue to track KPIs and respond as appropriate and implement plans for performance and financial improvement.

Lloyd said that when he is asked how much the ICD-10 transformation will cost, he gives this answer: “It depends on who you are working with, what your concentration of coding is by one provider versus another, which facilities you’re running most of your claims through and what your medical management structure was in ICD-9. There are a lot of variables, but one thing is clear — we should be starting now.”

Figure 2

DRG shift analysis approach



How Optum can help

Optum helps health plans make the transition to ICD-10 by:

- Providing insights on how to mitigate risk, improve pricing and enhance financial management practices
- Identifying opportunities to leverage ICD-10 changes for both financial and operational implications
- Applying operational expertise pre- and post-ICD-10 to optimize configurations, systems, and reporting while minimizing payment integrity impact

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