

**Centers for Medicare & Medicaid Services (CMS)  
CMS ICD-10 Vendor Conference  
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**Morning Plenary Session**

**Speakers:**

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Tony Trenkle: Thank you, and welcome to our first ICD-10 Vendor Conference. I appreciate everyone who did come here today, and we're looking forward to a day that we can do a number of things. I think we have a lot of work ahead of us. We think that with your help and assistance, we can get there over the next several years. I want to really focus on four themes this morning, and I'm going to turn it over to Doug Fridsma. Doug works with the Office of the National Coordinator.

And one of the themes I want to focus on this morning and today is to begin to build the pathway between the work we're doing with ICD-10 and the work that the Office of the National Coordinator and CMS are doing with the HITECH meaningful use regulations and the certification and standards programs. I think it's critical that we all recognize that these are all part of the overall agenda for promoting health IT. They're not siloed efforts; they're not efforts that are done at different times and at different venues, but they're actually part of an overall theme that over the next five to six years promises to greatly transform the health care landscape in this country.

The second thing I wanted to mention was the dates. We are focused, we are committed to meeting the dates for both 5010 and ICD-10. We'll talk more about progress this morning, but we'll keep it in our view, the October 1, 2013, date for ICD-10 and the January 1 date of 2012 for 5010. And we want to make sure that everyone here recognizes our commitment.

So that's from the CMS ONC and HHS side. From your side, we'd like to ask several things today. One is we'd like to see your commitment. We need your help to make this work. We need your help both as vendors, as clearinghouses and others who are here to work with us to ensure that this is done right, not just that it's implemented, not that it's implemented in a certain way, but it's implemented in such a way that we maximize the benefits of ICD-10 when we do implement it.

Secondly, we need to understand from your point of view what are the challenges you're facing and what are the challenges in the state of the community you serve or the state of the state for the provider community and others who you're working with. We need to continue to look ahead over the next several years to see where the gaps are, to see where we can continue to improve, to see where we can make changes as necessary for implementation to make sure that this is done correctly.

We all recognize we have a lot on our plates. We have health care reform, we have HITECH, we have ICD-10 and 5010, and we have other activities as well. So we recognize also that by working together and by ensuring that we develop consistency of message, and that we work together as a community, we can get this done and end up realizing the goal that we'd all like to achieve, which is better health care for all this country.

I'd like to especially thank Ketchum for helping organize this, Kyle Miller and Denise Buening from my staff at CMS and also HBMA (Healthcare Billing and Management Association), MGMA (Medical Group Management Association), and HIMSS (Healthcare Information and Management Systems Society), among others, who've contributed to helping us pull this together.

And now I'd like to introduce Doug Fridsma. Doug is with the Office of the National Coordinator, and Doug is going to spend a few moments just kind of talking about HITECH and how this ties in with the efforts that we're doing here. So I'd like to thank you all once again for coming and look forward to a very exciting and very successful day. Doug?

Doug Fridsma: Tony, thank you very much. I'm delighted to be here and to speak with you a little bit about some of the work that's going on in the Office of the National Coordinator around the HITECH agenda, and then to actually illustrate, or at least show you where the tech points are between the work that we're doing and where ICD-9 fits into the larger agenda that we have.

I think everybody knows by now about the HITECH back in February 2009, and it established this notion of meaningful use, which was that providers would receive incentive payments if they could use – if they could satisfy two criteria. The first was is to use a certified EHR technology that meets certain criteria for the standards and the functionality, and second, demonstrate that they've taken that technology and they've used it in a meaningful way.

And what's different about that is that the incentive payments isn't about buying and installing, but it's about using, and the kinds of ways we demonstrate use is through quality metrics and through improvement in health outcomes. And so I think that's been sort of a really interesting and nice way we focus the work that we do.

Part of what the HITECH Act did is it tried to address some of the barriers to adoption of electronic health records and so that includes some of the money and market problems, technical assistance and support, standards related to health information exchange, as well as privacy and security issues.

And so I think the thing that's important to recognize, and I'm going to talk a little bit more about this, is that as things become part of meaningful use, and certainly things like ICD-9 now and ICD-10 as we move forward, that opens up a suite of tools that we can use to help make the adoption of those standards, and the use of those standards, to make the exchange of information more successful.

So for example, we are working very, very hard to establish the standards, technology services and sort of trust relationships to support interoperability, and a lot of this falls underneath my office. And so, we are developing national standards and trying to figure out how to integrate those standards together including those to support administrative simplification. That includes the 4010 and 5010 standards, as well as ICD-9 and ICD-10.

We've got work to support research and development of new technologies to sort of advance that work and then provide guidance across the health IT standards and agreements. So for example, we've worked with an ICD-9 to come up with a list of common SNOMED (Systemized Nomenclature of Medicine) terms. We may need to do some of the same sorts of things when we talk about other standards like ICD-9 or ICD-10, and so we have a whole host of different things that we can apply to this problem that we hope will make it easier for adoption to occur.

As you all know, there's a lot of work going on to stimulate the adoption and that includes the financial incentives that physicians will get for both adopting EHR technology, as well as using it in a meaningful way. And we are right now standing up a lot of the certification criteria and the infrastructure that will help support getting electronic health records certified for use.

In addition, we have a lot of other things that we can apply to the problem as well including the Regional Extension Centers that are helping providers to adopt the technology and use it. We've got Health Information Exchanges with the States that are receiving funds and resources for that, and then we've got things like the Beacon communities that are out there that are supposed to be sort of forward-looking with the activities.

And I think it's important, as you think about taking ICD-10 and getting it out there and getting it used, identifying where the challenges might be and how we might solve that. You need to also take a look at the work that's going on with the ONC in collaboration

with CMS and see how we can leverage some of those activities to help support your goals.

Just to sort of give you a sense for the meaningful use framework, our goals, of course, are to have population health outcomes, transparency, and efficiency that is improved and the ability to study and improve health care delivery. We want to turn this into a system that learns by being able to collect information and seeing what works and what doesn't. To do that, we've got meaningful use incentive pay. So for Medicare and Medicaid-eligible providers, there's somewhere in the order between \$40,000 and \$60,000, depending on kind of when you come in and what you're eligible for, to help defray the cost of the EHR and to incentivize people to use the technology.

But there are two parts to meaningful use. It is the adoption of an electronic health record and then the exchange of that information in a meaningful way. And so the adoption of that technology is supported by the Regional Extension Centers. We've got workforce training opportunities where we are training people to help provide support to providers, and then we've also got a lot of work going on on the technology side, which includes the State grants for HIEs, standards and certification framework, and then the privacy and security framework as well. So we've got a lot of different tools in our toolbox that will help us move forward as we think about the standards and ICD-10 and things like that.

So I wanted to talk a little bit about certification just so that people can understand the framework, as well as how we think about that with regard to the standards and the IFR (Interim Final Rule) that's out there. So the certification criteria is there to assure that the electronic health records has the capacity to support meaningful use, okay? And so we have key capabilities that can be tested objectively.

We're working very closely with [inaudible] to help us develop the testing suites, but it's important to recognize that the IFR and the standards that are represented there are a minimum set, or a minimal set, of criteria. It doesn't represent everything that the technology should be out there; it doesn't include everything that an electronic health record should have. But it's just focused on those things that will help us support meaningful use. So it's a smaller subset that we can test objectively, rather than a huge checklist of all the things that we might like to see.

The standards are going to be built incrementally, and I think you need to realize that the IFR that came out in December and January earlier this year starts that escalator. And we're going to start at one point, and then we're going to gradually, over the course of the next – every two years, increase the kind of standards that we expect and the kind of functionality we'd like to see.

We've really tried to adopt common methods where it is across the industry, so security and privacy. We don't want to come up with new health care-specific criteria. What we'd like to do is leverage what's out there in the industry so that we can incorporate that, but where things are very specific to health care. So SNOMED, ICD-9, ICD-10, those sort of things, we want to push the industry so that we adopt clear standards that are specific to

health care today. Throughout this, security is a really important functionality, and we're going to try to set up a floor for what that security is and allow people to innovate above that if they want to provide innovative and new ways of providing security.

Just to give you a sense about how we've been working with CMS in terms of establishing the standards that come out of my office: So the meaningful use objectives come out of the HIT Policy Committee, and those things are incorporated into the NPRM (Notice of Proposed Rulemaking) or the regulation that CMS is working on, okay? And so for example, the Policy Committee may say, "We need to have something that allows us to do e-prescribing." That then motivates us in our office to come up with the certification criteria around electronic prescribing or it says, "We need to have an electronic health record that can use electronic prescribing. That must be a function that we can test within the EHR." And as a result, then we identify the standards that would support that. And in this case, if the NCPDP (National Council for Prescription Drug Programs) script 8.1 or 10.6 that must be used. And we've done that across all the meaningful use criteria that we get from the HIT Policy Committee.

And so across the board, we map electronic submission of data to immunization registries. So we need to have that capacity that can be tested in the EHR, and then we identify the standards that would support that as well. Now, as it stands now, the standard that is in the IFR is ICD-9, but we've made a very, very clear message when we look at going to stage two that we anticipate that that will move to ICD-10. So we've been trying to message to the industry where we think things are going. We take our guidance from the work that comes out of the HIT Policy Committee and the Standards Committee, but it seems that we're – it seems to us that that's sort of the natural migration. And the work that we're doing with CMS is trying to keep our work within meaningful use aligned with the work that's going on within CMS.

This is sort of a last slide. You've probably got all this stuff memorized already because you know what the dates are and things like that, but things are coming up pretty quickly. The first incentive payments for meaningful use actually for eligible providers within Medicaid are January 2011 and January 2011 is – well, there's some external testing that's going to begin for the 5010 compliance. The big one there is that January 2012, we move from 4010 to 5010 in terms of compliance. And then I think the other one that's really important is the October 2013, which is where the full ICD-10 compliance is required.

And so we're working very closely with CMS to make sure that as we go through and determine the certification criteria for the various administrative standards, as well as for ICD-10, that we track those things pretty carefully, and we make sure that we are sort of in step with what CMS is doing with regard to all of those things as well.

So with that, I'm going to just sort of stop so that I guess we can get onto the panel with some other questions. I'll turn it over, I guess, to Tony, and we'll go from there.

Tony Trenkle: I think the – there's a couple of critical points that Doug made, just one – a slight correction in that last side there. We haven't come out with the final regulation on meaningful use, so the start of the payment dates have not been established yet. But I think Doug's point is important, the fact that we have a lot of points of intersection over the next several years between what we're doing on the administrative side and what's being done in the meaningful use and some of the work with ONC.

I think the other point that Doug alluded to, but didn't actually make, was the fact that we're really beginning to see the coming together of administrative data and clinical data, and ICD-10 is actually a code set that really covers both worlds. It has great benefits potentially in both areas. There's certainly benefits for disease management, program integrity, and a number of other areas that the greater granularity of ICD-10 allows more accurate payments as well.

So I think as we continue to move along this road over the next several years toward meaningful use, health reform, ICD-10, and other areas, the linkages between the work that we're doing here and the work that ONC is doing need to be closely aligned. I think Doug spoke about the toolkit that ONC is putting together. Certainly, the work that the Regional Extension Centers are doing, the work that the HIT Policy Committee and Standards Committees are doing, as well as the NCVHS (National Committee on Vital and Health Statistics), these are all Federal advisory committees. And one of the things we want to make sure of is that you outside the Government can see where we're beginning to converge together and that we're not creating disincentives, but we're actually developing the synergy to make sure all these programs work in sync.

So let's continue with the program. And I'll now turn it over to Chris. Are you going to be up or – okay. Todd will be taking over now. Thank you.

Todd Coutts: Good morning. I thought it kind of ominous, isn't it? I'm taking over, but I assure you I'm not going to take over. I'm just going to talk to you for a few minutes about the work that CMS has been doing with ICD-10. And I have two intents of my talk, and the first is just to give you some context for what our covered entity has done in terms of impact analysis and PMO (Project Management Office). While Medicare is a bit bigger than most programs and most organizations, I think the steps that CMS has gone through are instructive for what your customers hopefully are doing within their organizations. And the second thing is, I do want to show you a little bit of the content of what we learned with the impact on CMS since most players in the health care industry interact with Medicare or Medicaid in some form or another.

So to do that, here are the two things I'm going to do. First is to give you some perspective on how CMS is organized for both 5010 and ICD-10, and secondly, going to show you a little bit of what we learned through the impact analysis of some of the other PMO work that we have done with the agency.

And so the first thing is how is the agency organized for 5010 and ICD-10? And essentially, CMS has two inter-related programs that work together, but they are managed

a little bit differently. The 5010 program is run out of the Office of Information Services and that is the agency's IT organization. And I think this really reflects the nature of 5010 which is it's largely an IT effort. So of course, it impacts the business, but really, there's lots of heavy lifting in terms of dealing with each of the 5010 transactions.

And the ICD-10 program is managed out of the Office of E-Health Standards and Services. That's Tony Trenkle's area. And this really reflects that ICD-10 really is IT, but it's more than IT. It also includes policies, your products, if you're in the private sector, business processes and IT, and so this ICD-10 program is not managed out of IT. It's managed out of a business component, so that it can really take into account that larger perspective that's needed for ICD-10.

Now, here are two high-level timelines that really reflect what CMS has done and where it's been for 5010 and ICD-10. The agency started both programs in 2007, and on the 5010 side, the agency actually started when the rule was still draft and went ahead and assumed 5010 and D.0 that's the direction where the industry is going to go and started very early. And the first step was doing a GAP analysis, lined up 4010, lined up 5010, produced a stack of spreadsheets this high to identify what the differences were between the two transaction sets, then identified the new data elements to change data elements and then created requirements around those with the business owners. So, hey, here are the new data elements; do we need this? Can this benefit us? Do we need to do something?

Then after those requirements were built, the agency then went into the third step, which was to kind of organize the project. Both the 5010 and ICD-10, they're so big, you have to really come up with an organizing construct to make sense of it. So the agency divided the project into the front-end projects, the ingest of claims and claims status transactions from providers, core systems, that's the actual adjudication engines that make the claims payment determinations, and then the downstream. Those are all the research systems and downstream systems that depend on claims data.

And so with that, the agency is making very good progress on 5010. It started development in 2008, and actually in 2011 is on track to begin accepting 5010 transactions from providers. So what this means is the agency is on track to be ready a year early and have a year-long transition period. So if providers are ready, they can start to send in 5010. And then of course, in 2012, 4010 becomes history, and it'll be a clean switchover to 5010.

ICD-10: The agency has gone through two phases of impact assessment. The first one, starting in 2007, really was from the perspective of awareness. Even though CMS is who it is, you know, these ICD codes are so embedded inside of operations, it actually took some awareness building to know what ICD-10 was and to make everybody realize just how important they were to the agency's operations and policies and systems. And so the first impact assessment was education awareness and really identifying those touch points of where ICD codes are in the agency.

The second phase of impact analysis went a level deeper. It really did some pretty structured business process models, systems models, and a risk and an opportunity assessment to really get to that actionable impact assessment so that the agency can move forward with its implementation program. And at this point, the agency is in the early phases of its implementation.

So this is a view of the governance structure for ICD-10, and there are a couple of things I want to point out here. First of all is the Steering Committee. There's a Steering Committee that's a cross-functional Steering Committee that's approved of mid- and high-level management within the agency. And it really has a good representation of all the business lines and all the major system owners that are affected by ICD-10.

The second thing I want to point out is that the dotted-line relationship to 5010, and I can't see that myself, but that's a dotted line, I assure you. But that's the relationship between the two programs to make sure that they stay in sync.

The other thing I want to point out in this is the distinct functions of the program office for ICD-10, and first of all, is the program management reporting. That's the area that I work in. This is focused on CMS as a covered entity and all the things it has to do internally to be ready for ICD-10 and to act as that coordinating function amongst all the projects that are required for the program.

The second piece is external outreach. CMS has the will to implement ICD-10, but also has a responsibility to all of you and all the other covered entities in the industry. And so my Ketchum colleagues are here and will talk to you a little bit more about external outreach. But CMS is going through a very disciplined and a very extensive process to understand what the communication needs are for different portions of the industry and to go through an outreach campaign for awareness, education, and to help people get what they need to be able to implement ICD-10.

And the third piece is industry compliance, and Denise will talk to you about that. This is – it might sound similar to the outreach, but this is a look at every segment of the industry, whether it's vendors, different types of providers, etc., other health plans, to really measure, at a pretty detailed level, what their progress is toward being ICD-10 compliant.

So those are the three major functions within CMS' ICD-10 program. Now, on the bottom, there are a whole lot of projects that we have to coordinate and make sure stay in sync.

So I want to turn a corner now and talk to you a little bit about what CMS has done in a little bit more detail, both the impact analysis project, the PMO, in an effort to measure the State Medicaid agencies' readiness for ICD-10. So the impact analysis, this is something that I hope every one of your customers does before they come to you. Of course, I can't guarantee that, but ideally, this is something that every organization will do that's impacted by ICD-10. And this is really the essential first step in an ICD-10

program. And the intent of an impact analysis or impact assessment, first of all, is to find what I call all the nooks and crannies – need to have an inventory of everywhere where ICD-9 codes are used now.

That might sound simple, but it can be really, really hard. And so our intent with this impact assessment was to understand, to get that comprehensive inventory of where ICD-9 codes were used and also the end-to-end process for how they flowed throughout the organization. Our scope was Medicare, Medicaid and CHIP (Children’s Health Insurance Program), and so we didn’t really go outside of CMS’ four walls, and we also didn’t really get into the State Medicaid agencies or how it impacted other business partners.

So here are the steps that we took. The first thing we did was a set of models. We did business process models. What are the activities that you do to carry out your functions? And then we did system interaction models. What are the IT systems, and how do they talk to one another? And if you have really, really good eyes, you can see those little purple blobs on there – that say “ICD.” And so after we understood the essential business processes, as well as the systems, we put that little purple ICD label on there to give that inventory of where ICD codes were used.

So after we had that foundation, we then transitioned into an assessment. We did both a risk assessment and an opportunity assessment. The risk assessment basically asked if the agency is not ready for ICD-10, what are all the really bad things that are going to happen? We put a score to that, so we could have a quantitative idea of what the risks were and where the resources should go and what the priority should be.

And then we also did an opportunity assessment. This is in one sense a compliance effort. Everybody’s got to be ready by 2013. But with better information comes opportunities, and so each place where we found the use by CD codes, we said, “Well, hey, after we go through the pain of getting ready, what are some of the benefits that the agency can experience by using this better information?”

So that resulted in these findings, and there are a couple of things I want to point out here. You’ll see that the terms business area and functional area. If you look at a CMS organization chart, you won’t see the terms business area and functional area there. We did that intentionally because what we found is that these codes, the end-to-end flow of ICD-9 codes, really went straight through the organization. And so we had to come up with another useful way to understand what the impact was and to organize the projects.

The second thing that I have to point out is if any of you have worked with Medicaid, your eyebrows might raise and say, “Moderate? What is that all about?” That’s simply because of the scope of our project. We were focused on CMS and how it interacted with States. If we went all the way to the States, we’d need something higher than red to illustrate that impact.

So if you are familiar with CMS, you pretty much will see almost every program that the agency does. The first two are the payments. The top, of course, are the fee-for-service

claims payment. The impact starts with the policy and the implementation of payment policy all the way down to claims processing, as well as the after-payment activities. Risk adjustment deals with Medicare Part C, and you can see that if you go to Medicare program integrity. I'm sure some of you know about ZPICS (zone program integrity contractors) and RACs (recovery audit contractors) and all those good things. Pretty much every major program within the agency has some sort of an impact by ICD-10.

Now, I think your customers will have to do the same thing. If they'll have to come up with some organizing construct, hopefully, so they can really understand what the impact is and manage their programs. And as they do that, they'll probably get to the point where we did which was – we've done a really good job of breaking this down into manageable chunks, but we don't want to lose all the linkages. And so we came up with views like the one you see on the screen where we really wanted to make sure that we understood in one business area, when it communicates with another business area, how are ICD codes used in that communication?

And so in this view, we use this to illustrate those links and also really to emphasize what those essential risks are. And of course, you'll notice the one right in the middle. I think any health plan can say this, that if it's not ready for ICD-10, the payments could be incorrect.

So at this point, we had our impact assessment, and it was ready to move into the strategy and the recommendations. And across the top, we had done a pretty good job of understanding what the project groupings were. We have some really high-level requirements, some schedules, but that wasn't sufficient. Even if we had everything at the top of the screen there, there were still other things that were important, and I think these same things would be important for your customers to decide.

And there they are on the left, things like what is the planning and oversight going to be with things like HITECH and the multiple things going on in the industry. What is the planning and oversight going to be, and how can it take advantage of what an organization already has? So if you go down this list, I think those things on the left are things that every organization will have to deal with. And when you marry these two things up is when you can really get the integrated strategy and plan. So for your benefit, I'm really hoping that your customers are doing this, as they're talking to you, because I think the things on the left are not specific to Medicare. They're pretty applicable to anybody impacted by ICD-10.

This slide, I'm not going to read. I just wanted to put this up and it's in your packets to give you an idea of the kind of questions that we ask in order to get to some of these overriding themes. And I think most of these questions will be very relevant for your customers as well.

Now, this next topic I do with some degree of fear and trepidation, because it's about mapping and crosswalks. And when I saw Doug put up a crosswalk in his slide, I kind of had a little shiver, because it gets everybody all worked up about this. What I want to do

is lay out some definitions for the day to use, because part of the difficulty discussing this is that people use different terms, and it gets really hard to have a productive conversation. So at least for the day, I want to propose these terms. When you go away from here, do whatever works for you.

So I'm going to talk about processes, tools, and strategies, okay? And first, with processes – there's a coding process and the mapping process, and they're different. Coding, I think, is what we all know and love. This is actually in the context of a real patient encounter. We're going to look at that patient's medical documentation after we serve them, and either a human medical coder or a computer-assistant coding is going to put the proper code to that patient case. So that's ICD codes, HCPC (healthcare common procedure coding system), CPT (current procedural terminology), SNOMED, and the whole laundry list of codes.

Mapping is different, at least as we're going to use it today. Mapping happens during, you know, implementation time in ICD-10. This is what people should be doing now. It's not specific to a patient case or a patient's medical record. If you're a health plan, this might be...here are the list of covered services we have. We currently represent those by a list of ICD-9 codes. What ICD-10 codes should we use to now represent those covered services? Okay? If you're a provider, this might be our instructions to our coders or the rules in our computer-assisted coding says when the clinician says pneumonia, we now represent that by certain ICD-9 codes. Now we're going to represent that by certain ICD-10 codes. So this is something you would do in mapping to prepare for implementation.

The second thing are tools, what we're going to today call tools. Now, there's GEMs and if you – I'm sure everybody here has heard of GEMs and has an opinion on GEMs. That's the General Equivalence Mappings. It's a free product or service that is on the CMS website, and this is a reference mapping. The best explanation I've gotten on this is that it's like a Spanish-to-English dictionary. You can look up an ICD-9 code, and it gives you all the possible ICD-10s. You can look up the ICD-10 codes and it gives you all the possible ICD-9s that are equivalent. This is a reference to help an organization make decisions about how to implement ICD-10. That's the GEMs, and this is for use by everybody. The audience are health plans, providers, clearinghouses, anybody that's got to do something to get ready for ICD-10.

Now, there are also Reimbursement Mappings, a separate tool that's really geared toward health plans. That was the original intent. And so this would allow a health plan to implement what some people call that crosswalk strategy. So if a health plan says, "You know what? We're going to leave our internal operations systems ICD-9. We're going to accept ICD-10 codes from a provider. We're going to be HIPAA compliant, but we don't want to do a lot of work to our internal systems." They could use the Reimbursement Mappings to take the inbound ICD-10 and flip it to an ICD-9 and keep their systems the same. So the audience for that are the health plans. So these tools, some people call them maps, and some people call them crosswalks as a noun. So you'll hear people call these maps or crosswalks, okay?

Now, the third things are strategies. I talked about processes and tools, but the strategies are a set of decisions that every organization needs to make. And the first one when it comes to systems that are impacted by ICD-10 is do we convert or upgrade our system to actually use ICD-10 directly or natively; or do we leave our systems working with ICD-9 and have what some people call a crosswalk strategy, a neutralized strategy, to let that system stay as is, and put something in front of it to do this flipping, okay? So those are two essential decisions for every system that's impacted by ICD-10. And so you'll see the crosswalk here again as a verb. So we can also use the word crosswalk as a strategy that allows us to keep our systems as is, and kind of shield them from some of those changes.

So let me be very clear. Pat Brooks would knock me on the head if I didn't say this. She is the CMS person who's responsible for the GEMs and a lot of the things that you all use. CMS is using the GEMs to convert its systems, convert or upgrade its systems. CMS' intent is not to implement this crosswalk strategy, okay? So as we get into the breakouts this afternoon, I hope we can use these definitions for today to facilitate those discussions.

So those recommendations are in draft right now. It's being reviewed by the steering committee and eventually, will go to the CMS administrator. And as those recommendations are getting toward final, the agency has been getting together its PMO (Project Management Office) function. And this is a view of what that function looks like. And really the takeaway here is that the agency has really established a comprehensive program management approach. And I think all of your customers will need to do the same thing. When you start to add up the number of projects that are going to have to get executed, it really needs a coordinating function sitting on top of that to make sure that it stays on track, that those linkages make sense and that there's reporting up, whether that's to your executive management, whether it's to OMB (Office of Management and Budget), if you happen to be a Federal agency.

And the second thing I want to point out is at the bottom, you'll see those projects – really, what we're trying to do as much as possible, is take advantage of the good things that the agency does now to manage projects. And so I think your customers will be making much of the same decisions.

One of the things that we did as we started up the PMO is we said, "You know, this is so big, we've got to put out some sort of a notion or a draft schedule to have something to plan around." And so I want to put this up to let you take a look at it. What's happening now is really a more detailed level of implementation planning. The impact assessment showed us where the impacts were or where the systems were. Now we're going a level deeper and so we had a JAD (joint application design/development) session with all the fee-for-service contractors, all the MACs (Medicare administrative contractors) and FIs (fiscal intermediaries) and carriers, to do a level of detailed planning. And now there's what CMS calls an Analysis Change Request, which literally gives time and money to contractors to figure out, really, at a really low level of detail, what the impacts are. So we're going through that process right now.

And the second thing I want to point out is end-to-end testing. If you look at the NCHCA (North Carolina Healthcare Information & Communications Alliance) and WEDI (Workgroup for Electronic Data Interchange) timelines for the industry, they recommend end-to-end testing in 2012 and 2013. And this end-to-end testing extends outside of four walls and includes business partners. So this means that your customers, if you're a software vendor, they should be expecting to have testable ready versions of your software so that they can go through end-to-end testing with their payers, with their health plans, with their clearinghouses. So I really want to point out the end-to-end testing date because this might be, at least in my lifetime, an unprecedented amount of testing that's required between organizations in the health care industry.

The last thing I want to touch on is State readiness, State Medicaid agencies, and this an effort that we're working with CMSO (Center for Medicaid and State Operations) – that's the organization of CMS that oversees State Medicaid agencies, and they've been very, very proactive with this implementation of making sure that they have a good understanding of each State Medicaid agency and where they are with ICD-10 and 5010 awareness, organization, and progress. And so what we've done is designed an online self-assessment tool that's pretty extensive. We have well over 100 questions there, and it's really designed to take a State through all the stuff that they should be doing to get ready for 5010 and ICD-10, and then to measure that so that CMS can decide where to focus its resources to make sure that the States are ready for ICD-10.

So with that, I'll stop talking, and I'll turn it over to Chris from Ketchum to talk to you more about external outreach and education.

Chris Handler: Thanks, Todd. I've heard Todd give that talk or a version of that talk a number of times, and I'm always impressed with the great work Noblis and CMS have done to assess the impact that this transition potentially will have on CMS, and it's I think applicable to the entire industry.

I'm going to talk to you a little bit now about communications, and as Todd said, external outreach. I work with – I'm a senior vice president at Ketchum. We have been working with CMS for about nine months now, really trying to assess the level of awareness amongst a whole variety of audiences, vendors included, about the ICD-10 and Version 5010 transitions, and really to see how we can best communicate everything that's going to need to be done to make sure that the transitions are made successfully. So that is the first goal really to make sure that all sets of entities, and I'll define that in a moment, transition successfully to both Version 5010 and ICD-10.

And really three main objectives being creating this national awareness and then making sure that we're engaging various partners and stakeholders. And those really are the associations that I'm sure many of you are members of that can work with CMS to help get the word out about the transition, and then to provide really the tools to help people and organizations make the transition successfully.

And what we do whenever we want to start any sort of communications outreach is we try to take a look at who our audiences are and then do a segmentation so we understand who we need to reach, how we need to reach them, and sort of what their levels of awareness are. And looking at the entire audience for ICD-10 and Version 5010, we really break this down to three major audiences – those being vendors, people and organizations such as yourselves, providers, and payers. Certainly, within those groups, which represent many, many different types of individuals and organizations, there are many sub-segmentations, and that's going to be one of the challenges in communication.

We're going to take a look at what the initial level of awareness is about the transitions, but then as the process goes on and we get closer to the final deadlines, we're going to really basically have to take a look at who is coming up to speed, who's lagging behind, how do we alter the messages to make sure that everyone is aware of what they need to know to make the transition successfully.

This just very simply illustrates what the various elements are of the campaign that we're putting together. Certainly, as the central focus of anything that we're going to be doing are each of the three audiences, and we try to reach the audiences with a number of tools. First among those is the development of materials and that really is providing the tools that people and organizations are going to need to make the transition. Earned media is really outreach through the press, and it's really getting the word out in a very cost-effective way so that people are aware of what they need to know.

Another element of that is what we call paid media or advertising. That's a small portion of this campaign, but it usually has – we find it has an effective role in any campaign. So I will show you some of what we're planning for for advertising that hopefully, you will then see. Stakeholder engagement is a very important part. That is working with the organizations that reach the same target audiences that we want to reach, and we like to engage these partners because they are a resource that you will naturally tap and it just helps to amplify the efforts that CMS is making on its own.

And then finally, conferences such as this. This is one of the smaller conferences that we have planned, but we think that throughout this process, this is going to be a continuing discussion and as you'll see in this afternoon's breakout sessions, we hope that these will be a combination of sort of a large-scale informational session such as the morning plenaries, as well as interactive discussions. And that both helps us to convey information as well as get information back from you.

This is a brief timeline of our first year, and really the two important takeaways from this are that we have – we've segmented this into four phases that we have mapped roughly to the various seasonal portions of the calendar. And we did start the program last fall. And it really starts with an assessment phase in which we're taking a look at what people's awareness is, what information is out there, what information is not out there. And then doing some further research to get more insights into what people are thinking and what they know. And then use that information to develop materials and begin to engage partners and actually roll out the campaign.

And then at that point, which we'll be entering in the summer, that's more of an iterative process, and then we continue to do outreach, as I said, assess, see what various groups are lagging behind in their awareness and then how we improve the materials, change the materials, and our outreach techniques so that we can get that information out.

So I'm going to talk to you very briefly about some of the formative research that we've done, and this, you'll see, dovetails and reinforces some of what Todd spoke about and what Denise will be speaking about in terms of assessing where people understand – what people understand about the transition. And really, we want to take a look at what this familiarity with ICD-10 and Version 5010, get some response from various audiences about what they knew and what they felt about the transition. And then since this is about communication, how people want to hear about the campaign.

And the formative really took two different segments. One was focus groups, which focused mostly on smaller providers and provider groups, and then what are called in-depth interviews which are basically one-on-one interviews, that we conducted with larger organizations, vendor organizations and companies, payers, larger providers. And we segment it that way for a variety of reasons, research reasons, but we feel that we get the best feedback when we use both of those methods, both group methods and individual interviews.

Jumping to the conclusion, there are a couple of very key conclusions – first of all, the knowledge of ICD-10 was very low in small organizations, what one might think was shockingly low. Some providers had no idea what we were talking about, and when it came to understanding what Version 5010 was and how that fit into the transition, that was – the recognition there was almost non-existent.

When we spoke to the larger organizations, the knowledge was much higher, to the point where many of the organizations were at the stage that CMS is at, where they had already begun assessing what the risk was there would be to their organization, and had started planning how they were going to make the transition successfully.

From there, we took a look at attitudes toward the transition, and this is really one of my key points. If you take nothing away from what I have to say during the day today, I'd like you to remember this. Small providers were really taking a wait-and-see attitude, and this is a paraphrase of what we heard in one of the focus groups, which basically was, "We haven't been told about this, and we'll react when we hear about it," which was very troubling to us because while 2012, 2013, seem like a long way away, there's a lot to do, as I'm sure many of you are aware, to successfully make that transition. So to hear from docs that, "We're not worrying about this, and we're not going to worry about this until somebody says something to us," that was concerning to us.

From there, they also told us that they were looking to trusted organizations, CMS, as part of the Federal Government, their vendors, larger providers, and payers to inform them about what to do. And since we had heard that the larger groups had already begun

to do their assessments, you know, that was comforting, but so many providers are not part of a larger organization and are part of smaller practices, which for this purpose, we defined as five providers or fewer. And to hear that they were basically waiting and looking to larger organizations to help them make the transition really told us that's going to be a key reason we're going to have to work with larger groups to make sure that we get the word out.

What they said they wanted to hear were about key dates – almost no understanding about what the transition dates were or what had to be done to meet those dates, what they need to do – they really had an interest in how do we do this – “Tell us how we do this” – where they can find information, what resources were available. It was important they heard that the information was coming from a trusted source. They knew they were going to get bombarded by information from many different sources, from their associations, from various groups, and they wanted to make sure that they could trust the information they were receiving. And they also interestingly said that despite the fact that this was really a HITECH initiative, they wanted to hear about information in various ways. Websites were great; e-mails were great, but some requested letters by plain old snail mail.

And the last point to take away was that we always like to start with a positive message, so we always try to test that first. And almost universally, we heard that the message that if there were benefits to making the transition – they were unbelievable, or they didn't want to hear about that. They were most concerned about what the costs were, what kind of negative impact it was going to have on them.

In December, we had a session similar to this that was less a conference and more of a listening session, so it was more representatives from larger organizations. We did invite organizations that cut across all of the various target audiences – payers, providers, and vendors. I list just a few on here. And what we found in this discussion, it was a day-long discussion where there was lot of give-and take, and we asked questions, and we listened to what the groups had to say. We found, as we had seen in our research, that the large groups understood and were aware of the transitions and had heard from their smaller members that there was lesser recognition amongst the smaller groups.

Certainly, the payers and the vendors were much more focused on Version 5010 than on the ICD-10 transition, and I think, in part that was due to the closer timeline and milestone that had to be hit – in January 2012. But even within this more, this well educated group, there was a lot of skepticism about the utility of the transition, what benefits there were going to be from the transition or even that the deadlines were firm. There, many of the groups said, “You know, we don't, we figure you guys are probably going to move this again.” And I can probably be – I think it's safe to say that's not going to happen.

I just want to very briefly go over what our communications work is. We always like to start campaigns with some branding and identity so that people, when they see a mark or a brand, they realize that this is a trusted source. So I'll go over our logo and tagline – go

over some of the resources that we have been putting together, the paid advertising, as I've mentioned, and then also I'll talk a little bit about our association and stakeholder outreach.

So that's our logo. You've seen it on the packets and materials that you've received, and this really came out of the focus group testing that we had done. It emphasized, as I'd said, the fact that groups wanted to see this was an official resource from CMS, and we actually have that in the tagline, "Official CMS industry resources for the ICD-10 transition." And then we want to make sure that there was the website on that, so the CMS website on ICD-10 is [www.CMS.gov/ICD-10](http://www.CMS.gov/ICD-10).

And here I just have a quick screen grab. You can go to that URL and take a look. We're in the process right now of continually updating the site. But right now, we have launched this with some new materials. It does have an overview on the site, as well as materials for each of the specific audiences. So you'll see if you go on the site that there's a section for vendors, there's sections for providers and payers, a listing of some of the calls and information that CMS has put out previous to this current work. So there are a lot of resources on there, and this is going to be a living site that we are going to be continuing to update as we have new information and new resources for everyone who's going to have to transition.

One of those resources are fact sheets. We always like to start out with a brief one or two pager that we can go out to various groups and say, "This is some of the key information you need right now." Some of that information should be available for you in your packets. The fact sheet to the left, the blue one, is actually about talking to your customers. And here are some guidelines that we have discussed, but certainly, as you discuss these in your breakout sessions this afternoon, if you have feedback, we'd love to hear that. But we also have fact sheets on other topics for providers and payers, and we are going to be, as I said, continuing to update that as we hear requests for more information on various portions of the transition.

The next part is media outreach. This is going to be a combination of earned and paid media. So many of these trades, which is what we're focusing on right now, we will both be targeting with advertising, as well as earned media stories and that we'll basically be working on pieces that we will then speak to reporters at these various outlets and try to impress upon them the importance of the transition and why they should write a story about it. We'll have spokespeople who we will offer to them. Undoubtedly, Tony will be speaking to many of these organizations. And really, hopefully, these are some of the publications that you see and read and that you'll be seeing some of the ads that we'll be placing and some of the stories that we're going to be working on in each of these outlets.

So to turn to advertising, I just want to show you some of the – two of the ads that we're currently working on for trade print. And really, the three things that we want to emphasize in these ads are the deadlines, both interim and final deadlines, the fact that there are resources available, and for the ads...we really want to emphasize the fact that you have an important role in communicating with your customers. And you can do a lot

to help them successfully transition. There will also be an online component. This is an example of banner ads, a rotating banner ad, which also hits the same interim deadlines, the importance of helping your customers and the resources that are available through CMS.

And finally, I just wanted to close with the next steps that we're currently planning. As we move into the summer and the fall of this year, we are going to be doing much more stakeholder engagement. We've already started working with some provider and vendor groups, talking to them about how we can work with them to get the message out. We're going to be planning additional resources including various planning and timeline tools. We heard from a lot of the providers that that was very important to them to help them transition their offices, as well as other audience-specific materials, toolkits, really suites of materials that people can use to communicate about the transition, as well as, as I've mentioned, updates to the website.

Additional earned media outreach – we really haven't gotten out to the press very much, yet. We expect that that's going to be picking up and will really take off as we get into the summer and fall. And then paid advertising currently is planned through December, so keep your eye on your local trade publications.

And that concludes my talk. Certainly, as you go into your sessions this afternoon, your breakout sessions, as you have feedback on any of the communication tools, we'd love to hear about it.

And with that, I'm going to turn it over to Denise, who will be talking a little bit about some of the research that's been done.

Denise Buenning: Good morning. I'm Denise Buenning, and I am the senior advisor and ICD-10 team lead at the Office of E-Health Standards and Services. When we talk about our Program Management Office, we have an ICD-10 team, most of whom are sitting in the back of the room today – who are, have been working diligently on this project since it was just a twinkle in someone's eye that we could actually start working on a proposed rule, took it through to a final rule, and now have the responsibility of implementing this, not only throughout our agency, but also within the industry as well.

When Noblis talks about our paths, we have an internal path. We have to make sure that as a HIPAA-covered entity, CMS and our State Medicaid agencies are ready and able to kick off with ICD-10 on October 1, 2013.

But we also have a responsibility to make sure that the rest of the industry comes along with us. And sometimes it's difficult to gauge exactly what's going on out there in the industry. That's why we have conferences like this and that's why we have industry-listening sessions. But when we've talked about implementations in the past, we've always relied on the kindness of our friends, associations, and different industry groups that have tried to tap into the pulse of their particular industry segment and let us know how they're doing with regard to going down the implementation path. Well, sometimes

that information is reliable – sometimes it's not. For the most part, it can be very subjective.

When I raise my hand and say, "I'm ready for ICD-10," what does that mean? Just because I'm ready doesn't mean that necessarily you're ready. And if there's anything that we've learned, it's that each of the industry segments has to work in tandem with each other and work together as a team so that we're all on the same path at the same time. And that if we're not on that path together, that we're alerted early so that we can act as a resource to help whatever industry segment might be having some difficulty to overcome those challenges and work toward the implementation.

This past year, we undertook a contract with Gartner. I think you're all familiar with Gartner – they're a widely known and respected health care consulting firm. And we asked them to take a look, or start to take a look, at what the industry scoop was on Version 5010 and ICD-10. And to not only give us a baseline among different industry segments, but also to have something that we could replicate at certain key milestones along the implementation path – so that we could do a baseline study and then go back perhaps six months later and say, "Okay, fine. Did you meet your goals, or are you lagging behind? What kind of challenges are you meeting?" etc., and continue on this, so that again, we have a better and clearer understanding of where the certain key industry segments are in the implementation process.

One of the things that Gartner did for us was to establish some levels. When we talk about the different phases of implementation, exactly what does that mean? And they came through with six different levels of progress that they used as a measurement. So if someone said that they had completed level one, what did that mean? It meant basically that they had completed perhaps an orientation and organized something – did some kind of project organization around this particular task. Level two, they did a GAP analysis. Level three, they did some analysis and planning for implementation. Number four, they got into, I'm sorry, number three was, two was installation applications development. Level five, regulatory compliance and testing and then obviously, system rollout and production. As you get farther down that path, we'll see that most of them have not reached those later stages, but made some good progress in the earlier stages.

One of the things that we asked Gartner to do was to get us a mix of different industry segments, as well as different sizes, different types of settings and different geographic dispersions. So we asked them to look at the health care environment from a segment perspective – from different types of providers, physicians both large and small; hospitals both large, medium, and small; laboratories; pharmacies; dentists. We asked them to look at both private payers, national, BlueCross BlueShield, regional plans. We asked them to look at pharmacy benefit managers. We asked them to look at different care delivery organizations and networks, and of course, then clearinghouses and vendors.

And they used certain criteria to qualify them for participation in this. One of the things we really wanted to look at was the differences between small and large organizations, just as we have here today. We have a very wide mix of small vendors and very large

corporations, and obviously, there are different resources, different challenges, and we want to hear about that. And it was the same thing with our environmental scan. We wanted to get a fuller picture.

So again, we used some specific criteria: the segment, the geography, the organization side. Participation was voluntary, but we asked them to make sure they had some specific HIPAA background. We didn't want somebody who was just vaguely familiar. We wanted someone who actually had an active role in getting HIPAA compliant within their organization, who had an understanding of how the code sets and the Version 5010 transactions worked, and had a perspective for the challenges and barriers that we face when we undertake an implementation project of this type.

Some of the key findings that we heard from the Gartner work was that there are lots of competing messages and lots of competing priorities. As Dr. Fridsma said this morning, this is not a stand-alone project, but this goes within the context of health care reform and meaningful use and ARRA (American Recovery and Reinvestment Act of 2009), and all the other health care issues that are...I say the whack-a-moles. They're kind of jumping up and down for our attention, and every once in a while, we hit one and another one pops up.

Well, it's the same thing here. We have to pay attention to make sure that the Version 5010 and ICD-10 messages don't get lost within all the different messages that we're hearing out there, both in the media, within our companies, and other methods of communication, whether it be the Internet blogs, radio, television, trade association journals, whatever. They also, obviously, as Chris had mentioned earlier, they're concerned about the costs; they're concerned about Medicare reform; they're concerned about some of the changes that are going on within the State Medicaid agencies that might affect them as well.

Another finding is that, again, not only are we competing for attention and for focus among all those different messages, but within their own organizations, they're having to compete for resources. They say, for example, some of the comments that we heard that people are very focused on 5010. They're making some progress toward ICD-10, but again, they're going to have to prioritize as they get more and more workload and have to do more and more projects within a very limited amount of time.

They often talk about the fact that management, management support is key. In some of the larger groups, yes, they definitely have management support; in some of the smaller organizations, maybe not so much. They're concerned that there might be delays in 5010 compliance that would subsequently delay ICD-10 compliance. So again, this all works – it has kind of a domino effect in terms of one being reliant on the other.

The participant organizations appear to be making significant progress on the 5010 transactions, and when we talk about that, I think we have to put this in context. Number one, this was a small survey or actually not a survey, an environmental scan. This was a really just a baseline effort. We'd like to expand it as we move forward, but we can't take

a look at this particular work in a vacuum. We really have to look at it in a context of, “What else are we hearing out there?” I know that there are a number of association groups, WEDI, for example. They consistently monitor their memberships and ask for information and share that. So we have to look at it within, “What are we seeing here, what will we see in the next round of this environmental scan, and then what else are we hearing from the industry?”

It appears that from this particular environmental scan that compliance with 5010 D.0 and 3.0 is good. And when we talk about the other two standards, D.0 and 3.0, it’s not that we’re ignoring them quite frankly, but our emphasis is really on 5010 and ICD-10. D.0 is the upgraded NCPDP standard, the telecom standard, and 3.0 is Medicaid subrogation. So those two particular standards are really specific to certain key industry segments and as they are replacing existing standards, or upgrading existing standards, there doesn’t seem to be as much concern. I’m not going to say that there isn’t concern, but there’s not as much concern as there would be, for example, with ICD-10.

5010, again, you’re transitioning from a known entity, 4010, 4010A, and I don’t want to say it’s easier, but it’s more familiar. ICD-10 is something totally different, because we’ve never adopted a new medical code diagnosis and procedure code set before. Because when we did adopt ICD-9, it was in widespread use. This is the first time we’re going to have to make a transition to a new transaction and code set, and it’s significantly different than the previous version. So I think that’s why you’ll see, number one, some low compliance on ICD-10; number two, you have to have 5010 in place first in order for ICD-10 to work. So you would imagine that, again, folks are moving toward 5010, ICD-10 will follow.

The caveat here is not to wait too long. Don’t wait until 5010 is absolutely, totally in place to start your testing or your planning for ICD-10. You can do it concurrently. Again, this is another example of the types of progress that we’re showing for each one of these different transactions. And, as you can see, on some of the levels for 5010, they’re almost either fully compliant or well on their way. For ICD-10, again, not so much.

So basically, what we’re hearing is that the industry sees a path for 5010, but not...doesn’t have the same level of confidence for ICD-10. Again, they’re familiar with 5010 because of 4010 experience. They’re familiar with the X12 standard. They feel in some instances that 5010 is an impact of IT only. That really isn’t the case, but that’s the impression that folks have, and then again, they have familiarity with HIPAA implementations. On the ICD-10 side, it is a high-business impact, as you saw from our Noblis colleagues. It really affects a large number of systems, a large number of policies and procedures that our agency has to be concerned with, which will in turn impact the industry at large.

There will be a learning curve for usage of ICD-10 codes. We’ll need training. We’ll need to work out some of the bugs as we go along in terms of again, the crosswalks, the GEMs, some of the policies, how we’re going to transition toward the end of September

of 2013 as we cross over that hump to October 1 of 2013. What will be the impact on laboratories, for example? And it's not just a matter of health care, direct health care organizations. We also have to be concerned with workers compensation programs. We also have to be concerned about the types of other insurance and liability carriers. So some of these are not HIPAA-covered entities, but yet they do use the codes in their business. So how do we get them on board, and how do we learn how to work with them as we go through this transition? So as I say, we're still kind of working our way through this.

The health plan community we know is ahead of the provider community. Health plans have more resources. They've got the IT groups that can help them. They have the organizational skills and the resources that can pretty much get them on the path. The provider community, and this is a message that we heard loud and clear both in this particular scan, as well as the work that Ketchum did with some of the billing personnel and provider offices, time and time again, we're looking to our vendor, our software supplier, our person who's going to come in, and they're going to just, you know, take care of us and everything is going to be fine.

And I won't tell this story again to embarrass him, but we did have some, we did do some focus groups, and we had one instance in particular where time and time again, our providers said, "Oh, this person, you know, we all use him, and he's great, and he provides terrific customer service. And when he shows up, it's going to be okay." I certainly hope that your customers feel the same way about you, but you know again, they're just looking for someone to tell them what to do and you know you guys are it.

The small and medium providers aren't as concerned with 5010 because, again, it's transparent to them. It's included in their practice management software or their other types of office software that they're using. So when you mention 5010 to providers, their eyes glaze over. We were in these groups, and we kept saying "837s, 835s, you know, eligibility, 270, 271" and the glaze was just incredible. We were wracking our brains trying to figure out how do we get this across? I finally said, "Did you ever make an eligibility inquiry?" "Oh, yes, we do that." Because, again, the software is so user-friendly that, you know, they're just pushing a button and hitting "send." They don't necessarily see the platform that it's running off of. So you may have to do a little bit more walkthrough with some of your smaller customers to understand that, yes, there are going to have to be changes in what we're calling 5010.

Rural and small providers – a big concern. When you have a group, a large provider network like a Kaiser or something like that, you know, they're getting all this information handed down to them, quite frankly, from their corporate office, so they're not as directly involved. When you have small providers out in Beloit, Kansas, you've got a two-person shop out there, and they're going, "Why do I have to do this?" It's a hard sell. You have to explain if you don't do it, quite frankly, you're not going to get your claims paid. It's a very powerful message.

We had one provider up in a group in Baltimore that we did. She goes, “Oh, I’ll just keep using the 9 codes.” And it was like, “It’s not a choice. This is mandatory. You have to make the change. If you use ICD-9 codes after October 1, 2013, your claims are going to get rejected.” And boy, did that light bulb go off. So it’s a very powerful message. Don’t be afraid to use it.

The other thing is that we’re constantly looking at: Do physicians need to be trained on coding? And we’ve heard both sides of the story on this. Training is obviously a very big part of this transition because the codes are really different. So when we have some instances where we have physicians who do their own coding, we have others where they have someone else in the office do it for them. So we’re constantly looking for feedback on do providers need training and to what extent do they need training?

So we’re working with AHIMA (American Health Information Management Association); we’re working with AAPC (American Academy of Professional Coders) and some other groups to determine how can we best get this information out and have it trickle down to the right people, because just because you don’t have the word code, or you don’t have a certification, it doesn’t mean that you don’t do the function – have a lot of office staff out there who code, but don’t consider themselves coders. So how do we reach those people as well?

So as part of all of this, you know, is groups like this, our outreach and our education, our website – can’t say enough about our new website. It may not be flashy, because we’re the Government, but it contains some really good information, some more user-friendly language, hopefully, better organization so that you’re not searching around. And so that if you’re looking for vendor resources, you click on “Vendor Resources,” and your information is there, and it will cross-pollinate to other things that we think you might want to see.

As Chris also said, we have an ICD-10 logo. When you see that logo, that means that this information is for the general industry. We have another logo that’s called the Medicare Learning Network, and I think probably a lot of you are familiar with it. That means that that information is specific to Medicare fee-for-service providers. However, it doesn’t mean that you can’t look at it and you might learn something that you didn’t know. So look at both sides of the spectrum and just gather as much information as you can.

The other thing that we’re going to be doing, and I had hoped to have it up and ready for today, but it gives you a good excuse to go back and check our website, is we are going to have an opt-in listserv so that every time something new comes on the website, if you opt in, you’ll get an automatic blast-out that will say, “Hey, something new here, you may want to take a look.” So we will have that up here in the next couple of weeks, so check back soon, and hopefully, you’ll see that there.

So let’s see. What else have we got? Okay, I kind of got off on a tangent there, but I’m going to reel us back in. Okay. Testing – this is a really big issue. We’ve seen this with NPI (National Provider Identifier); we’ve seen this with other HIPAA implementations.

I'm ready – I'm compliant, but my clearinghouse isn't, my vendor software isn't ready, so I can't test, or my plan's not ready to test when I'm ready. That's something that we really need to work with the industry on. What are going to be key testing dates? How are we going to get this information out to providers about when plans are ready to test and what they're ready to test? So we're going to try and make this information available as best we can, but we're also looking for suggestions from the industry as to how we get the word out on this when it becomes applicable.

As Chris also said, there's no return on investment right now for physicians on ICD-10. They're questioning whether or not this is a deal – well, it's not a question of ROI (return on investment) or not ROI. It's a mandatory requirement. So no matter what, they have to do it. But we really feel that with the more robust nature of the codes and the efficiencies that we hope will result from this, eventually, we will see some key benefits, and we'll be able to share that information. Again, they're concerned about how they're going to make this transition. Your job, our job, is to find the easiest, most efficient ways for them to do this.

Based on feedback in the order of priority, the barriers that they're seeing, again, the readiness of the business partners to accept your sent transactions. But I think that's interesting because you would think it would be number two, the cost. They're more concerned about, "I'm going to be ready to test. Is everybody else going to be ready to test at the same time?"

They're concerned about the current deadlines. There's nothing we can do about that. It's October 1, 2013, and when you communicate that date, make sure you say, "October 1," because if you just say October, you know what they're thinking? October 31. So they're thinking they've got a whole other month to do this. Nope, afraid not.

Current state of the economy. When we did this scan, it was back probably in late summer, early fall of last year, so while we were seeing some economic upturns at that time, the economy was pretty down and that was a major concern for them. Vendor preparedness, and again, see your management support, especially in large organizations.

And that's it. So I don't know, do we have any time? I'm not sure. I don't have a clock. I don't have my BlackBerry. I know you find that hard to believe, Tony, I don't have my BlackBerry attached to my hip. We have 10 minutes? Okay. Do you want to open up for any questions, comments? We have two microphones before we break, and if you would just say your name and your organization.

Audience Member: Yes, hi. My name is Paresh Shah, and I'm...

Denise Buening: A little closer to the microphone, please?

Audience Member: Yes, hi. Good morning. My name is Paresh Shah, and I'm with MindLeaf Technologies, and we are a HIPAA compliance and ICD-10 provider to the commercial market. Is it possible to explain in detail the program management approach

you have for...ICD-10? The slide you had on program management, is it possible to explain it a little bit in more detail?

Denise Buenning: I'm going to let Todd handle that one since it's his slide.

Todd Coutts: Sure, I can give it a shot. Well, first of all, we tried to stay true to standards as much as we could. If you look at that slide, and you compare it to PMI and the Program Management Institute, we tried as much as possible to really stick to that framework. And we started two ways: One, we had an activity, we call it PMO setup, where independent of the content, we asked how are we going to work and how are we going to interact with all the projects, the project-level activities? We identified over 200 projects and about 70 systems that are impacted. So we had a setup activity, and we literally defined how we're going to track and manage costs, how we're going track and manage scope and schedule, and all those really core project management things. So that was one activity was the PMO setup.

And the second thing was the implementation planning. This is where we have developed a set of draft schedules. So the first thing we did is the graphic I showed you where we said, "What's our notional schedule? Let's put some soft lines in the ground to know the milestones that we want to hit." Then we went back, used the impact analysis, which identified systems and proxies that were impacted, and we literally created milestones to reach those major milestones. We created sort of smaller milestones to get us there and then for each milestone, we identified what projects were necessary to accomplish those.

And we set up a set of seven Microsoft project schedules that were for what we called our business areas, and then we consolidate those into a master schedule. And so right now, we are going back out to the project owners to get their feedback on those schedules to try to get to a baseline in the next month or two.

Audience Member: Okay. Thank you.

Audience Member: Hi, I'm Anne Boucher with 3M. I wonder if you could speak a little bit about Medicaid outreach? I know, Todd, you said in your, you know, project management, it was more Medicaid as it relates directly into CMS. But one of the things we hear frequently from our customers is in the individual States, you know, they're not going to be ready. And so I'm just wondering if you could...and maybe it's the gentlemen from Ketchum could speak a little bit specifically to what's going to go out right to the State Medicaid.

Chris Handler: Sure. We're actually doing some work right now with putting together some information that's going to be directed directly to State legislatures to help inform them about the transition. You know, we certainly know that when we communicate to politicians that they have, they have a lot of various issues on their plates. But basically, we want to, we make them understand what the basic information is, what they have to know, and what they have to start to look at that potentially will impact their budgets. That's one of the big concerns right now is that budgets which we know are planned

years in advance. If they're not thinking about ICD-10 and Version 5010 now, there won't be budget for it next year.

So we're trying, we're putting together a series of FAQ documents, some legislative briefs, and then we're working with a group that basically has touch points in all the State legislatures to then do some outreach to the various States and talk to them about this information. So that begins to get out there and they can start thinking about those issues.

Denise Buening: In addition to that effort, we also have a Medicaid resources page on our ICD-10 website and that has a bunch of Medicaid resources including some training modules for the States, and also I can see in the back, Denise Bazemore and Bob Guenther from CMSO – welcome. If you just raise your hands...if anybody has any question specific to Medicaid, Denise and Bob are here, and they can be a great resource to you, so...

Audience Member: Good morning. I'm Juliet Santos from HIMSS. In the process of the presentations, I didn't see anybody refer to the middle providers, the mid-level providers, nurse practitioners and physicians' assistants. Is there anyone that is already reaching out to those groups? There's about 120,000-plus nurse practitioners in the country. I just wondered where we're at in reaching those provider groups.

Denise Buening: Do you want to take that?

Chris Handler: Certainly, when it comes to those mid-level providers, we consider them in our provider segment. When I spoke in one of my initial slides about the various audience areas, I was speaking very loosely, but we're very aware of that. We are going to need to segment within there. What we've been finding in general in speaking to all provider audiences is that the level of awareness is very, very low. So we're really starting at a baseline, and we're just trying to get all providers aware this is coming – these are the deadlines. What we found in our research is there wasn't even awareness of that. I think probably everyone in this audience is very aware of what ICD-10 is about, but completely foreign.

And so we're really just trying to bring everyone to the level of that awareness. Once we are moving along in the campaign, we're going to be doing interim assessments and certainly, we'll look at the mid-level providers, as well as, you know, other provider groups and other segments to make sure that we're aware of what their level of awareness is and how we're going to need to tailor information for them.

Juliet Santos: Okay. And I'd like to just invite CMS and any other groups out there – we're in the process of reaching out to those organizations. Being a nurse practitioner myself, I find them very important in the whole setting, and key to championing this cause. So if anybody wants to work with HIMSS, please contact us.

Todd Coutts: Great, thank you.

Denise Buenning: Thank you. And again, to Chris' point, this is a phased-in communication approach. The first thing is just to make people aware that this is happening. As we move forward, we'll get into more detailed messages, more call-to-action. Here's where your resources are, here's what you need to do. In terms of the physician assistants and nurse clinicians, yes, those are included also in our stakeholder outreach as well. There are lots of groups that we need to reach out to.

Chris Handler: Yes, I think in our research, we had found that there was a great level of awareness, that people were already at the stage where they had done their assessments, they were analyzing their risks and were starting to put together their plans for the transition and had specific questions. Well, you know, this is an area that if we think there's going to be difficulty, we would have structured the outreach completely differently. We would have gone right more to very more detailed materials and information resources. Because there was such a low level of awareness, we really had to start at a very, very high level. We call it the 30,000-foot view, because we just need to bring everyone to that level of awareness at this point.

Denise Buenning: We have time for one more question – actually, we don't. We just hit 10:00, and I know everybody's – oh, I'm sorry.

Audience Member: I'm sorry. I had one question. [inaudible]

Denise Buenning: Okay. There was some discussion about the code freeze at the last Coordination and Maintenance Committee meeting, which was back in March, and I know that they have asked for comments on that, and that will be another topic of discussion in the September meeting. There are two meetings of the ICD-9 Coordination and Maintenance Committee that are held every year. The next one is scheduled for September, so I imagine that will be a big topic of discussion then.