HIERARCHICAL CONDITION CATEGORIES (HCC'S)

RISK MANAGEMENT, CODING AND YOUR PRACTICE

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OBJECTIVES

- HCC Overview
- Fee For Service or Risk Adjustment Reimbursement?
- RAF Scores
- How HCC's affect Reimbursement
- Documentation Strategies
- CMS vs. Commercial HCCs
- Next Steps

HCC OVERVIEW

- What . . .
  - CMS reimbursement methodology to Medicare Advantage Organizations
  - Method used to adjust payment based on the health status and demographic characteristics of an enrollee
- How . . .
  - CMS calculates a risk factor for a member based on:
    - Demographics (age, sex)
    - Chronic conditions (diagnoses)
- Why . . .
  - Reduces CMS financial exposure by paying based on the risk of healthcare required for the conditions of the enrollees
  - Prospective – uses diagnosis as a measure of health status

HCC DATA SOURCES

- HCCs are assigned using hospital and physician diagnoses from any of five sources:
  - Hospital inpatient–principal diagnoses
  - Hospital inpatient–secondary diagnoses
  - Hospital outpatient
  - Physician
  - Clinically-trained non-physician (e.g., psychologist, podiatrist)

The CMS-HCC model does not distinguish among sources; in particular, it places no premium on diagnoses from inpatient care.

FEE FOR SERVICE OR RISK ADJUSTMENT REIMBURSEMENT?

- HCC is based on MEDICAL RISK
  - Certain chronic diseases and some acute conditions make up the HCCs
  - Each condition is given a "weight" which equates to a monetary value
    - **THE MORE HCCs A PATIENT HAS = THE MORE FINANCIAL RISK TO THE HEALTH PLAN**
  - Sicker patients cost more to care for, so the more HCCs a patient has means ***more money is made available to care for the patient***
- Fee for Service is based on PROCEDURES
  - Payment is based upon CPT procedure codes
  - Diagnosis codes minimally used only to match procedures; no comprehensive or highest level of accuracy
- CMS will only pay for health conditions being **currently** managed

RISK ADJUSTMENT FACTOR (RAF)

Total score of all relative factors related to one patient for a total year
Derived from a combination of factors:

- Demographics
  - Age and either community-based or institution-based
  - Medicaid disability and interaction with age and gender
- Disease
  - Diagnoses reported determines HCC category
  - Interaction between certain disease categories
  - Interaction between certain disease categories and disability status

CHRONIC CONDITIONS AND RISK ADJUSTMENT

Female Patient, age 75-79	NO HCC diagnoses	Patient with 1 HCC diagnosis	Patient with 2 HCC diagnoses	Patient with all applicable diagnoses
	Age gives a *RAF of: 0.457*	ICD10- E11.9 (Type 2 diabetes w/o complications)- *RAF: 0.118*	ICD10- E11.21 (Type 2 diabetes with diabetic neuropathy)- *RAF: 0.368*	ICD10- E11.21 (Type 2 diabetes with diabetic neuropathy)- *RAF: 0.368*
			ICD10- 110 (Essential primary HTN)- *RAF: 0.000*	ICD10- 112.0 (Hypertensive Chronic Kidney Disease)- *RAF: 0.224*
				ICD10- Z89.4 (Lower Extremity Amputation)-RAF: *0.779*
				ICD10-K73.9 (Chronic Hepatitis- *RAF: 0.251*

**Be sure to add diabetic complications and apply diagnoses to the highest level of specificity*
***Remember to add chronic conditions that are contributing to the patient's overall wellness*

CHRONIC CONDITIONS AND RISK ADJUSTMENT

Male Patient, Age 80-84	NO HCC diagnoses	Patient with 1 HCC diagnosis	Patient with 2 HCC diagnoses	Patient with all applicable diagnoses
	Age gives a *RAF of: .683*	ICD10- 1209 Angina *RAF: .0141*	ICD10- 1209Angina RAF: .0141	ICD10- I25119 (CAD with Angina)- RAF: .258
			ICD10- I2510(CAD)- *RAF: 0.000*	ICD10- Z6841(Body mass index (BMI) 40.0-44.9, adult)- *RAF: .365*
				ICD10-I739 (PVD) *RAF: .299*
				ICD10-I503(Diastolic HF) *RAF: .368*

**CAD in itself is not a medical HCC. Because CAD is a general term, it is imperative that if the patient has angina or an old MI, the chronic problem list should include angina or old MI as they are HCC Diagnoses.*

CHRONIC CONDITIONS AND RISK ADJUSTMENT

Female Patient, age 75-79	NO HCC diagnoses	Patient with 1 HCC diagnosis	Patient with 2 HCC diagnoses	Patient with all applicable diagnoses
	Age gives a *RAF of: 0.457*	ICD10- Z853 (Hx of Breast CA) – *RAF: 0.000*	ICD10- C838 (Lymphoma and Other Cancers)- *RAF: 0.672*	ICD10-C838(Lymphoma and Other Cancers)- *RAF: 0.672*
			ICD10- C9500 (Metastatic Cancer and Acute Leukemia) – *RAF: 2.484*	ICD10- C9500 (Metastatic Cancer and Acute Leukemia) – *RAF: 2.484*
				ICD10- Z894 (Lower Extremity Amputation)-RAF: *0.779*
				ICD10-E46 (Protein Calorie Malnutrition) - *RAF: .713*

** History of Cancers are purely informational and do not have a HCC RAF score*

***Patients with a BMI less than 20 should always have consideration for Protein Calorie Malnutrition, if warranted*

CHRONIC CONDITIONS AND RISK ADJUSTMENT

Male Patient, Age 80-84	NO HCC diagnoses	Patient with 1 HCC diagnosis	Patient with 2 HCC diagnoses	Patient with all applicable diagnoses
	Age gives a *RAF of: .683*	ICD10- F32.9 (Major depressive disorder, single episode, unspecified) *RAF: 0.00*	ICD10- F320 (Major depressive disorder, single episode, mild) *RAF: .359*	ICD10- F320 (Major depressive disorder, single episode, mild) *RAF: .359*
			ICD10- G819 (Hemiplegia, Unspec,) *RAF: .581*	ICD10- G82.50 (Quadriplegia) *RAF: 1.234*
				ICD10- M069 (Rheumatoid Arthritis)-RAF: *.346*
				ICD10-F1021(Alcohol Dependence, In Remission) *RAF: 0.251*

**Watch for how the patient's conditions are coded to ensure proper capture of their chronic conditions*

***When patients present with behavioral health problems, it is common to forget their other chronic conditions, (such as Unstable Angina or Alcohol Dependence, in Remission in this example)*

WHAT A DIFFERENCE A YEAR MAKES

66 y/o Male with Diabetes, Multiple Sclerosis, a BMI over 40 and Acute Renal Failure

HCC Diagnosis	RAF Score
HCC 19: Diabetes	0.118
HCC 77: Multiple Sclerosis	0.556
HCC 22: BMI Over 40	0.365
HCC135: Acute Renal Failure	0.476
Demographic Score	0.288
Total Coding Adjusted Score	1.803

The next year, only Diabetes and an above knee amputation are documented.

*No MS was documented; Also, clinically what diagnoses caused the patient to have AKA since the Diabetes was uncomplicated.

HCC Diagnosis	RAF Score
HCC 19: Diabetes	0.118
HCC 189: Status Above Knee Amputation	0.779
Demographic	0.288
Total Coding Adjusted Score	1.185

Using $800 PMPM financial calculation on this case, the loss would be $1442-$948 =$494/mo. Comparing the two scores for this patient

DIAGNOSES, HCCS AND RAF SCORES

- Each patient is assigned a risk score based on diagnoses and demographic criteria
- CMS calculates costs/payments in a given year
  - All diagnoses disappear on December 31
- Conditions submitted annually, particularly chronic conditions
  - ICD-10-CM codes grouped into 79 HCCs
  - Model includes factors for age/sex, special status and HCC scores
  - HCCs are generally additive with hierarchies and disease interactions
- Patients must be seen by a Primary Care Physician at least annually or they will not have any HCC diagnoses documented.

The work you are doing now affects the amount of money CMS funds next year

CMS HCC AND THE ACO BENCHMARK

- Benchmark for the ACO is determined by CMS based on per capita Part A and Part B fee for service expenditures for beneficiaries who would have been assigned to the ACO in any of 3 recent years prior to the agreement period.
- CMS uses actuarial data to determine the appropriate growth rate to trend each year's expenditures
- The historical benchmark is then updated each performance year using National Medicare expenditure data.
- Benchmarks are calculated and trended forward separately for the following cost categories:
  - ESRD
  - Disabled
  - Aged/dual eligible Medicare/Medicaid
  - Aged/ non-dual eligible

DOCUMENTATION STANDARDS

- Diagnoses must be captured in a face-to-face setting
- Complications or manifestations of a disease process must be clearly linked to that condition
- Documentation includes:
  - Identify the diagnosis as a current or ongoing problem, as opposed to a past medical history or previous condition
  - Choose the most specific diagnosis code while ensuring it is supported in documentation

DOCUMENTATION STANDARDS

- Chronic conditions affect the management of the patient, even when the patient is presenting with a straightforward illness that would appear unrelated to the chronic condition
- "History of" conditions are informational unless it's documented how the patient's care was impacted by that history
- Conditions can only be coded/reported if there is documentation that the condition has affected the patient's treatment and management on that particular encounter

EXAMPLES OF SPECIFIC REPORTING RULES

- Chronic diseases can continue to be reported on an on-going bases as long as receiving treatment and care for the condition
- Diagnoses that receive care and management during the encounter can be reported
- Diagnoses that have resolved or are no longer treated should not be listed
- Malignancy can be reported as long as receiving active treatment
- Be careful using problem list diagnoses that have been resolved

BEST PRACTICES FOR DOCUMENTATION

- Document all cause and effect relationships
- Include all current diagnoses as part of the current medical decision making and make note of them in the note on every visit
- Document history of heart attack, status codes, etc.
- Only document diagnoses as "history of" or "PMH" when they no longer exist or are not a current condition
- Use specific ICD-10 diagnosis codes to convey the true seriousness of the conditions being addressed for all types outpatient visits

COMMON HEALTH ISSUES THAT MAY BE OVERLOOKED

- Major depression (rather than depression)
- Old Myocardial Infarction
- Renal Failure
- Diabetes WITH complications
- Angina pectoris
- Breast, prostate, colorectal cancers coded as "history of" rather than active
- Protein calorie malnutrition
- Amputation status
- Drug or alcohol dependency
- Tracheostomy status or respirator dependence

CMS/MEDICARE ADVANTAGE AND COMMERCIAL HCCS

	CMS and Medicare Advantage	Commercial	Implications
Attributes	Age, gender, medical conditions	Age, gender, medical conditions and financial status for those who qualify for cost-sharing reductions. Also includes demographic attributes.	Commercial risk adjustment requires additional data capture for demographics
Dx Code Capture	Medical conditions have to be treated/addressed and documented annually or need to specify that the member no longer has the condition		Chronic conditions not documented annually are not captured in risk scores Acceptable
Acceptable Codes	Conditions documented during face-to-face encounter with accepted provider types		
Acceptable Encounters	Professional, Inpatient, Outpatient		
Historical Conditions	Coded and reported conditions transfer with member	No member-level data transferred between plans	Commercial: all conditions documented annually and when plan changes

NEXT STEPS

- The focus of HCC is on early diagnosis, treatment, documentation and coding of diseases . . .
  - AND Keeping patients well and out of the hospital

This keeps medical costs down and leads to better patient care

- Use the Risk Scores to identify "outlier" or "at risk" patients
- Organize Care Managers work around high acuity patients
- Allow physicians to document and then follow up with education quarterly for accuracy of documentation

QUESTIONS?

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