Understanding Hierarchical Condition Categories (HCC)

How hierarchical condition category coding will impact your practice and how you can use these codes to increase quality, improve the patient experience, and receive appropriate reimbursements.
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Executive Summary

For many years, insurers, physician groups, government agencies, and others in the health care industry have attempted to replace the pay-for-service model of reimbursement with a model based on quality and outcomes. Since the early 2000s, many plans and programs have been put in place to create a value-based system, one that moves risk from payers to patients and physicians. Under this new system, health care providers are not paid for the volume of work they do. Instead, the system pays providers for the quality and value of the services they deliver.

As part of this effort, the Centers for Medicare and Medicaid Services (CMS) introduced the Hierarchical Condition Category (HCC) in 2003. HCC is a set of codes that CMS uses to determine reimbursements to Medicare Advantage plans. The HCC codes are designed to accurately reflect patient “acuity” – or the severity of illnesses facing a plan’s members. A Medicare member’s health status in a given year is used to predict costs in the following year. The correct use of HCC codes can result in increased payments. Using them incorrectly can result in penalties.

Because the health care industry has turned sharply toward value-based, risk-adjustment models for payment, practices must understand HCC and use this coding system to their best advantage. To help, this white paper provides an overview of HCC coding and discusses how MIPS scores impact physicians and groups. In addition, the paper offers tips and best practices to enable your organization to comply with the law and get the most out of the system.
Introduction

Medicare, along with many commercial payers, administrators, and physicians, have long sought to produce a healthcare system that offers better care at a lower cost, while also improving the experience for patients. Such a system, most agree, requires the shifting of risk from payers to patients and physicians and implementing a payment model based on quality of services rather than volume of services.

Healthcare professionals know that there are serious challenges involved in creating such a system, and most believe that the key to addressing these challenges is risk adjustment. Medicare has introduced risk adjustment programs that reward payers who take on high risk patients, including those with chronic conditions. These efforts have been shown to bring better care to those with complex care needs and produce cost decreases across the system.

To make this process work, Medicare has introduced initiatives like HCC coding. HCC coding helps Medicare to better understand the actual conditions and projected needs of patients and determine reimbursements. Overall, risk adjustment models like HCC bring more clarity to the healthcare system and helps bring reimbursements in line with quality and value rather than volume.

What is HCC?

Created by CMS in 1997 and implemented in 2003, HCC or “Hierarchical Condition Category” is a risk adjustment model that calculates risk scores for aged and disabled Medicare beneficiaries. These scores represent the expected medical costs of a Medicare member in the coming year. CMS uses these risk scores to calculate its per-member/per-month fees to payers.

HCC coding seeks to identify Medicare members who have severe or chronic health issues. Individual diagnoses are classified using the International Classification of Diseases-10 or “ICD-10.” Some 9,000 ICD-10 codes are matched with the 79 HCC codes contained in the CMS Risk Adjustment model. Based on this information, along with other factors such as age and gender, Medicare members are given a risk factor score, and this score is used to help determine Medicare reimbursements.

Recent legislation

A large boost to Medicare’s risk adjustment initiative came in 2011 with the passage of the Affordable Care Act (ACA). This groundbreaking bill contained many provisions and incentives to boost quality and curb costs, and models tying quality to patient expenditures have been implemented.
More provisions to tie quality to cost came with 2015’s Medicare Access and CHIP Reauthorization Act (MACRA). Under MACRA, Medicare began to deny claims that lacked diagnosis specificity. MACRA also created the Merit-Based Incentive Payment System (MIPS), which determines Medicare payment adjustments to practices based on scores in several key categories, including how well they report patient acuity using HCC codes. MIPS scores can result in a practice receiving a bonus payment or paying a penalty.

Risk factors and MIPS scoring

In 2017, CMA began scoring physicians and practices on their performance in four key areas, including:

- Quality – Representing 60% of the score, this performance area concerns quality of care, the patient experience, safety, efficiency, and care coordination. HCC coding is part of this measure.

- Cost – CMS will look at claims data, but performance in this category does not affect 2019 payments.

- Improvement activities – This area involves effort to improve clinical practices, such as expanding hours and access, population management, and integrating behavioral health. It accounts for 15% of the score.

- Advancing care information – Practices care measured on promoting patient engagement and their use of certified electronic health records (EHR) technology. This measure accounts for 25% of the score.

Annual performance in these categories is used to determine a composite MIPS score, which can range from 0 to 100. MIPS scores are presented relative to other physicians and groups, setting a performance threshold. Those that score above the threshold receive a payment bonus, and those below pay a penalty. Bonuses are paid for out of the penalty payments. Also, these scores will impact a provider’s Medicare reimbursement in each payment year from -9% to +27% by 2022.

As stated above, CMS uses HCC coding and other information from physicians to determine risk adjustment factor scores. A patient’s diagnosis or diagnoses is central to the scoring, but CMS looks at other factors as well. For example, a patient’s age will influence the score because older individuals have higher expected health care costs. CMS also considers eligibility status. The organization looks whether a person aged into the Medicare program or became a member because of a disability. In addition, CMS will look at whether a person is enrolled in both Medicare (because of age) and Medicaid (because a disability).
Here’s a breakdown of the CMS risk-adjustment process:

Demographics + Diagnosis/Diagnoses = Risk Adjustment Factor (RAF) Score

**Demographics include:**
- Age
- Gender
- Whether the individual lives in the community or in a skilled nursing facility
- Whether the individual is enrolled in Medicare, Medicaid, or dually eligible for both programs

**Diagnosis/Diagnoses**
- Diagnosis/diagnoses are recorded using HCC codes.
- The codes are based on specific ICD-10 codes
- Medical conditions are hierarchically weighted within the HCC categories

**Determining Risk Adjustment Factors**
- RAF values are assigned to HCCs
- RAF score for HCC is higher if the patient is sicker
- RAF values are additive
- RAF score of baseline demographics is < 1

(Source: American Academy of Family Physicians)

**HCC coding categories and scoring**

As mentioned above, MIPS scores are based on demographic factors like age and gender, as well as diagnoses for chronic or life-changing illness. The CMS Risk Adjustment Model includes 79 HCC categories of diagnoses for chronic illnesses, matched to thousands of ICD-10 diagnosis codes. Among the most commonly reported diagnoses are:

- Chronic obstructive pulmonary disease
- Congestive heart failure
- Vascular disease
- Cancer
- Ischemic heart disease
- Specified heart arrhythmia
- Diabetes
- Ischemic or unspecified stroke
- Angina
- Rheumatoid arthritis
- Inflammatory connective tissue disease
It is important to remember that one of the key goals of HCC coding is to predict use of medical services for Medicare members in the year to come. For this reason, HCC diagnosis coding looks at all conditions a patient has been diagnosed with over the past year, which places great importance on recording comorbidities.

The coding assigns a weight to each condition. These weights, combined with demographic factors, determine the HCC score. High scores mean that a patient has more complex and serious conditions and will use more health services, resulting in higher costs in the future.

Below is an example of how complete and accurate HCC coding RAF scores and reimbursement amounts.

**HCC reporting for an 82-year-old female:**

**Scenario 1:** RAF base score 0.7 – Based on demographics for an 82-year-old female - age, sex, community vs. SNF, Medicare/Medicaid eligibility

<table>
<thead>
<tr>
<th>Diagnoses per chart documentation</th>
<th>HCC</th>
<th>RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base</td>
<td>N/A</td>
<td>RAF 0.7</td>
</tr>
<tr>
<td>Total RAF</td>
<td></td>
<td>Total RAF = 0.7</td>
</tr>
</tbody>
</table>

Based on an average per patient-per month payout of $1,000, baseline annual payout with comorbidity conditions:

$$0.7 \times $1,000 \times 12 \text{ mos.} = $8,400 \text{ per year}$$
**Scenario 2:** RAF base score 0.7 with more specific documentation of conditions and treatments

<table>
<thead>
<tr>
<th>Diagnoses per chart documentation</th>
<th>HCC</th>
<th>RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base</td>
<td>N/A</td>
<td>RAF 0.7</td>
</tr>
<tr>
<td>DM</td>
<td>HCC 19 Type II DM w/o Complications</td>
<td>RAF 0.121</td>
</tr>
<tr>
<td>Obesity</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>BME 36 (STARS)</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>HTN</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Insomnia</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Major Depression, single episode</td>
<td>None (severity not documented)</td>
<td></td>
</tr>
<tr>
<td>Smoker</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>PMH Breast C</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

**Total RAF = 0.821**

Based on an average per patient-per month payout of $1,000, baseline annual payout with comorbidity conditions:

\[
0.821 \times 1,000 \times 12 \text{ mos.} = 9,852
\]
Scenario 3: RAF base score 0.7 with even more specific documentation of conditions and treatments

<table>
<thead>
<tr>
<th>Diagnoses per chart documentation</th>
<th>HCC</th>
<th>RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Base</strong></td>
<td>N/A</td>
<td>RAF 0.7</td>
</tr>
<tr>
<td>Type II DM with diabetic CKD</td>
<td>HCC 18 - Diabetes w/ complication</td>
<td>RAF 0.374</td>
</tr>
<tr>
<td>+ CDK Stage 4</td>
<td>HC 137</td>
<td>RAF 0.153</td>
</tr>
<tr>
<td>Diabetic peripheral angiopathy</td>
<td>HC 108 (HC18 DM w/comp already assigned)</td>
<td>RAF 0.319</td>
</tr>
<tr>
<td>Diabetic non-pressure foot ulcer, R heel</td>
<td>HC 161</td>
<td>RAF 0.628</td>
</tr>
<tr>
<td>Amputation lower extremity L 2nd toe</td>
<td>HCC 189</td>
<td>RAF 0.721</td>
</tr>
<tr>
<td>Morbid Obesity (BMI 36 + DM, HTN due to obesity)</td>
<td>HCC 22</td>
<td>RAF 0.295</td>
</tr>
<tr>
<td>Hypertensive HF, chronic systolic HF</td>
<td>HCC 85</td>
<td>RAF 0.365</td>
</tr>
<tr>
<td>Major Depression, single episode, mild</td>
<td>HCC 58</td>
<td>RAF 0.300</td>
</tr>
<tr>
<td>Sedative-hypnotic Dependence, uncomplicated</td>
<td>HCC 55</td>
<td>RAF 0.336</td>
</tr>
<tr>
<td>COPD</td>
<td>HCC 111</td>
<td>RAF 2.6</td>
</tr>
<tr>
<td>Metastatic CA to spine</td>
<td>HCC 8</td>
<td></td>
</tr>
<tr>
<td><strong>Total RAF</strong></td>
<td></td>
<td><strong>7.16</strong></td>
</tr>
</tbody>
</table>

Based on an average per patient-per month payout of $1,000, baseline annual payout with comorbidity conditions:

\[ 7.16 \times 1,000 \times 12 \text{ mos.} = 85,920 \]

(Source: American Academy of Family Physicians)
HCC best practices

To comply with CMS regulations, provide the best and most efficient service to your patients, and receive the reimbursements you deserve, physicians and practices must master HCC coding. Here are some steps you can take:

**Focus on accuracy** – CMS can and will deny claims for a lack of “diagnosis specificity,” so it is in your best interest to provide the most complete and accurate information. Take a long, hard look at your practice. Make sure you have systems in place to capture the necessary information about your patients’ conditions and the services you provide. Reflect that information in your reporting and billing.

**Understand your patient population** – If you serve Medicare patients, it’s more than likely that many of them have been diagnosed with diabetes, vascular disease, or one or more of the other most common HCC diagnoses. Take a look at your patients and determine who belongs in what diagnosis category. Also, work with your administrative and clinical staff to place the right patients with the right diagnosis, and keep up-to-date, accurate records.

**Capture comorbidities** – To make sure you are providing all necessary services to a patient and to avoid claims denial for a lack of “diagnosis specificity,” be sure to capture every diagnosis. For example, if one of your patients has diabetes, but also hypertension and depression, make sure all conditions are captured. Remember: CMS requires that clinicians provide proof of the risks associated with each patient, and the HCC payment structure is based on accurate reporting. A record can have more than one HCC code.

**Report every year** – The CMS risk management model is built on reviewing a previous year’s health status to predict the following year’s health expenses. That means physicians and practices must report their information to CMS every year. Get in the habit of using HCC codes and submitting accurate information in a timely fashion.
Conclusion

Although HCC has been around for nearly 20 years, many health care professionals are not fully aware of the importance and implications of the risk adjustment model. This needs to change.

The move from fee-for-service to pay-for-performance began a long time ago, and the health care industry is not going back. CMS reimbursements and potential bonuses and penalties are tied to HCC, meaning that clinicians and practices must take steps to ensure compliance and accuracy.

All health care professionals must take steps to understand HCC and incorporate best practices in claims and coding. Ultimately, HCC and other risk adjustment efforts will help the entire industry bring higher quality care to more people at a lower cost.
About Formativ Health

We are redefining the ambulatory patient and provider experience throughout the health care ecosystem

Our purpose

To transform the patient and provider experience and make health care better for both.

Our approach

We partner with physician practices, hospitals, and health systems to improve financial health, enhance the patient experience, and free up physicians to focus on what they do best – taking care of patients.
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