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the role of HCCs in a value-based payment system

Appropriate documentation and coding of hierarchical condition categories (HCCs) can have a significant impact on payment in a value-based system.

Steadily declining profit margins constitute one of the most difficult challenges facing senior healthcare finance executives today. This challenge is especially perplexing when census volumes are steady, patient satisfaction is high, and clinical outcomes are favorable. Although such a decline can occur for various reasons, including missed charges or coding-related denials, one reason often overlooked by finance executives is inaccurate reporting of hierarchical condition categories (HCCs). In an era when payment is increasingly focused on value, inattention to HCCs can have a significant impact.

HCCs in Brief

The Centers for Medicare & Medicaid Services (CMS) originally developed HCCs in 2004 to adjust capitated payments for its Medicare Advantage (Part C) plans based on risk. However, with the growth of population health payment models in the past decade, HCCs have become more popular. HCCs are the risk-adjustment methodology for Medicare and are used by all commercial Medicare Advantage plans. They determine the payment rates for all Medicare beneficiaries based on the illness burden of each patient. HCCs are therefore essential for any health plan providing coverage or any health system providing care for a Medicare beneficiary.

With an increasing movement to value-based payment, non-Medicare plans (both commercial and Medicaid) are using other kinds of risk-adjustment methodologies to determine payment as well as to adjust quality indicators, so the work of recognizing, documenting, treating, and coding the full illness burden is increasingly important across all payment types. Some commercial plans are using HCCs, as discussed later in this article.

AT A GLANCE

- > Hierarchical condition categories (HCCs) are becoming a focus for hospitals and hospital-owned physician practices as value-based payment models grow in popularity.
- > Under-reporting HCCs could create an impression that a hospital is not providing high-quality care, as patients seem on paper to be healthier than they actually are.
- > Over-reporting HCCs can attract increased scrutiny by CMS and lead to potential recoupment of overpayments.

Top 10 Most Under-Documented HCCs

- > Amputations
- > Artificial openings
- > Asthma and pulmonary disease
- > Chronic skin ulcer
- > Congestive heart failure
- > Drug dependence
- > Metastatic cancers
- > Morbid obesity
- > Rheumatoid arthritis
- > Specific type of major depressive disorder

Source: 3M aggregated claims data

CMS currently uses HCCs when calculating Medicare spending per beneficiary as part of the total performance score under its Hospital Value-Based Purchasing program. HCCs will continue to play a role in CMS alternative payment models (APMs), such as shared-savings contracts and accountable care organizations (ACOs).

Again, commercial health plans also have begun to apply risk-adjustment approaches to patient populations using HCCs and other methodologies to more accurately predict and control the cost of care. And hospitals can benefit from making such risk adjustments because doing so ensures that payments reflect clinical complexity.

At their most basic level, HCCs stratify patient risk, allowing health plans to predict the costs on which capitated payments are based. In capitated payment arrangements, insurers render one risk-adjusted sum to a health system for providing all the care and services that a patient requires for an entire year. When a hospital inadvertently omits HCCs, it essentially deprives itself of payment because it fails to provide insurers with

an accurate picture of the severity of conditions of patients across its patient population.

Medicare Advantage (MA) plans receive a per-member-per-month (PMPM) payment from CMS to cover the cost of their enrollees. In some cases, this payment is passed on to the providers if there is a shared-savings program between the provider and the MA plan. As part of the Medicare Access and CHIP Reauthorization Act of 2015, CMS will begin to adjust fee-for-service payments using HCCs and other factors as a basis for the adjustment. If an ACO or health plan is involved, then the payment is set up to cover the cost of the enrollees, similar to a budget for care. Depending on the arrangement, most participants share in savings generated within the health plan or ACO. To accurately control costs, both types of programs need an accurate evaluation of the status of the health of their enrollees.

As the healthcare industry continues to make the monumental shift from volume- to value-based payment, HCCs will play an increasingly essential role in a hospital's financial viability.

HCC Calculations: What Finance Executives Need to Know

It's easy to get bogged down in the complexity of HCC calculations and how they translate to payment. The most important thing to understand is that each HCC is weighted using a risk-adjustment factor (RAF) that's similar in theory to a DRG relative weight. The total RAF is based on a patient's disease complexity and on demographic factors such as age, gender, and domicile (i.e., whether the patient lives in the community or in a skilled nursing facility). RAF scores also take into consideration the simultaneous presence of several conditions (e.g., congestive heart failure [CHF] and chronic obstructive pulmonary disease [COPD]). The higher the patient's RAF score, the

higher the assumed risk, and ultimately, the higher the payment.

HCCs are assigned based on diagnoses reported and coded in inpatient hospitals (both primary and secondary facilities), outpatient hospitals, and physician practices. HCC data are *not* drawn from claims submitted by skilled nursing facilities, hospices, home health agencies, labs, radiology centers, or durable medical equipment providers.

HCCs ultimately provide a snapshot into patient severity, giving insurers valuable information that they can use to assess outcomes, predict costs, and gauge overall hospital performance. It behooves executives to examine hospital data from the insurer's point of view. For example, when claims data reveal relatively *low* RAF scores, it may be difficult to explain consistently *high* costs associated with patient care. (See the sidebar on page 2 for the top 10 most under-reported HCC diagnoses.)

To illustrate, consider the case of Doris, a 76-year-old patient who lives at home with her daughter and manages multiple chronic conditions. In 2015, Doris saw her primary care physician twice and her cardiologist once. The physicians documented a total of six diagnoses:

- > Diabetes w/retinopathy (HCC 18, relative factor of 0.368)
- > Morbid obesity (HCC 22, relative factor of 0.365)
- > Rheumatoid arthritis (HCC 40, relative factor of 0.374)
- > CHF (HCC 85, relative factor of 0.368)
- > Abdominal aortic aneurysm without rupture (HCC 107, relative factor of 0.299)
- > COPD (HCC 111, relative factor of 0.346)

When added together with a demographic score of 0.437 and two HCC interaction scores (i.e.,

0.259 for the interaction between CHF and COPD and 0.182 for the interaction between diabetes and CHF), Doris's 2015 risk adjustment factor (RAF) is 2.998. When multiplied by a baseline PMPM payment of \$800 (a common amount used by many plans), the individual monthly payment for this patient comes to \$2,398.

By contrast, in 2016, Doris saw her primary care physician only once and did not see her cardiologist. The primary care physician documented three diagnoses:

- > Diabetes without complications (HCC 19, relative factor of 0.118)
- > Obesity (unlike morbid obesity, not an HCC under the CMS model)
- > COPD (HCC 111, relative factor of 0.346)

High-cost care and poor outcomes for patients who seem healthy will not reflect well on the hospital and its ability to deliver high-quality care.

When the total disease score is added together with a demographic score of 0.437, Doris's 2016 RAF is 0.901. When the total RAF is multiplied by a PMPM payment of \$800, the monthly individual patient payment for Doris comes to \$720.80.

In short, the MA plan would be paid \$1,678 less per month for Doris in 2016 than in 2015, amounting to a difference in annual payment of more than \$20,000. For providers participating in the Medicare Shared Savings Program (MSSP), this difference in annual payment would mean less shared funds. Although the physician will be paid the contracted rate, this rate will likely decrease over time when the MA plan begins to

Top 10 Most Over-Documented HCCs

- > Conditions that have been surgically corrected (e.g., abdominal aortic aneurism)
- > Diabetes with complications
- > Malnutrition
- > Nephritis
- > Pathological fractures (e.g., old pathological fractures reported as current)
- > Pneumococcal pneumonia (e.g., unspecified pneumonia reported as pneumococcal)
- > Polyneuropathy (e.g., reported as current when no treatment, evaluation, or monitoring is documented)
- > Primary site cancers (e.g., indicating historical conditions as current)
- > Strokes (e.g., indicating acute stroke instead of late effect of stroke)
- > Vascular disease (e.g., reported as current when no treatment, evaluation or monitoring is documented)

Source: 3M aggregated claims data

assume it costs less to deliver patient care for this individual.

It is important to remember that, for insurers, perception is reality. In bundled payment or shared-savings contracts, hospitals are rewarded for their ability to achieve positive patient outcomes while reducing costs. High-cost care and poor outcomes for patients who, on paper, seem healthy will not reflect well on the hospital and its ability to deliver high-quality care in a value-based system.

RAF scores also are important in negotiating value-based payment contracts. If scores are low, insurers will assume that patients are healthier and thus cost less to treat. But if RAF scores are artificially low due to HCC omissions, hospitals will pay the price through lower capitated payments, shelling out more on the front end for patient care and being unable to recoup it on the back end.

The Dangers of Over-Reporting

Over-reporting HCC diagnoses also presents risk. Inflated RAF scores lead to higher capitated payments that aren't justified. (See the sidebar at left for the top 10 most over-reported HCC diagnoses.) CMS is well aware of this vulnerability and has begun to perform risk-adjustment data validation (RADV) audits of its MA plans. The goal is to recoup overpayments resulting from provider HCC over-coding. To date, the agency has determined that it made \$16.2 billion in improper payments to its Part C supplemental plans, representing a 9.99 percent improper payment rate.^a

In addition to RADV audits, the federal government has joined a whistleblower lawsuit against United Healthcare Medicare & Retirement, the nation's largest provider of MA plans. The lawsuit accuses the carrier of implementing an organizationwide upcoding scheme to increase its operating income by \$100 million. This case comes in the wake of more than a half-dozen whistleblower lawsuits filed against MA plans in the past five years, each of which essentially alleges that these plans encouraged providers to inflate patient risk scores so the plans would receive higher payment from CMS.

Hospitals also are vulnerable in this new world of HCC scrutiny. HCC over-coding creates an inflated prediction of the costs required to care for patients, thus skewing the data on which capitated payments are based. As CMS continues to scrutinize its MA plans through RADV audits, these plans, in turn, have begun to scrutinize providers. Many providers report that MA plans are particularly aggressive in denying payment. It may only be a matter of time before MA plans start to audit providers themselves—and to recoup payments where necessary.

a. PaymentAccuracy.gov, "High Priority Programs," accessed Sept. 13, 2017.

Understanding the Role of Hospital-Owned Physician Practices

Focusing on HCC compliance ensures accurate payments based on clinical complexity and prevents denials and potential recoupments in the future. However, HCC compliance also should be a focus for physician practices and other ambulatory settings. Approximately 80 percent of patient encounters that take place within an integrated delivery system occur in physician offices and clinics, according to a 3M claims analysis. Thus, the opportunity to capture HCCs—and affect hospital payment—often falls directly on office-based physicians.

Because physicians tend to focus only on the patient's presenting diagnosis, they often omit other relevant conditions, including chronic conditions that directly affect RAF scores. Even when physicians document these conditions, they may not code them, which means the conditions aren't included in risk-adjustment methodologies. Another challenge is that HCCs must be documented—and coded—at least once per calendar year. When patients don't schedule appointments within a year, these diagnoses aren't documented, treated, or coded.

To ensure they are paid correctly, hospitals must capture patients' disease burden accurately and completely—even when those patients are never treated in an inpatient setting. Engaging office-based physicians is critical. Hospital-owned practices can start by auditing a random sample that includes the practice's highest RAF scores, its average RAF scores, and its lowest RAF scores. Such an analysis can help identify the barriers to capturing HCC diagnoses, including documentation problems, coding omissions, problems with template diagnoses, gaps in clinical care, and others. Hospitals also may be able to gather HCC data about physicians directly from the MA plans with which they contract or the ACO in which they

participate. Hospitals should request transparency around the data, including population-specific RAF scores, that insurers and ACOs use to judge performance.

Another way to identify HCC gaps is to follow patient claims throughout the continuum of care. A hospital can aggregate two years' worth of claims data from all care settings—inpatient, outpatient, and physician practice—to establish each patient's HCC baseline and annual RAF score. The next step is to monitor claims going forward to determine what HCC diagnoses might be missing in a given year. These missing diagnoses can be used to drive physician workflow changes and process improvements. This type of large-scale analysis can be enlightening because it includes various touch points for clinical care and may identify other opportunities for HCC capture, such as a hospital's outpatient or referring facilities.

Strategies to Engage Physicians in HCC Capture

Once a baseline audit is completed, hospitals can begin to engage physicians in HCC capture and measure progress along the way. Physician buy-in is critical and dependent on a process that allows physicians to maintain workflow and ability to deliver patient care. To this end, hospitals should consider the following strategies.

Address clinical care gaps. Physicians can capture HCCs for patients effectively only if the physicians see the patients at least once every year. The key is for the physician practices to identify patients without scheduled visits and encourage them to make appointments so the physicians can evaluate and document all conditions, including the HCC diagnoses, for appropriate billing.

Focus on physician documentation. Physicians should be kept apprised of electronic health

record (EHR) best practices. For example, physicians should be encouraged to review all options in a templated drop-down menu and cautioned against the temptation of choosing the first—and often unspecified—option.

Physicians also should be asked to review the option list to ensure that it doesn't include conditions that have resolved over time. In case physicians plan to use the copy-and-paste function, they should be reminded that, if they do so, they must validate the accuracy and relevance of the information to the current patient encounter. Copying and pasting irrelevant or inaccurate information can lead to HCC over-coding.

Hospitals can help physicians by providing pertinent and reliable real-time documentation alerts. An alert might notify a physician that he or she should assess and document the specific type of diabetes, for example, thereby sparing the physician from the guesswork of trying to understand what documentation affects HCC reporting.

Office-based care coordinators may be able to assist with these types of documentation reminders. Practices that perform chronic care management (CCM) may have a process in place to capture HCCs. If a practice doesn't perform CCM, it may be able to create an HCC-capture workflow for the annual wellness visit.

Another option is to train nurses to perform previsit documentation reviews. During these reviews, nurses can be on the lookout for HCC diagnoses and remind physicians to assess and document these conditions.

The following are some useful tips for physicians:

- > Assess each chronic condition at least once a year.

- > Document specificity for diabetes, angina, pneumonia, renal failure, chronic kidney disease, and pressure ulcers. Additional specificity yields a higher-weighted RAF score. For example, diabetes maps to three HCCs: with acute complications (HCC 17, relative factor of 0.312), with chronic complications (HCC 18, relative factor of 0.312), and without complications (HCC 19, relative factor of 0.102).
- > Clarify the historical status of all diagnoses (i.e., active versus a history of a condition).
- > Report all diagnoses that affect the patient's evaluation, care, and treatment, including the presenting diagnosis, coexisting acute conditions, and any chronic conditions. Note that electronic claim forms allow providers to capture as many as 12 diagnoses.

Ensure coding accuracy. When physicians assign their own codes in the EHR, there is room for error. Hospitals can help physicians by hiring certified professional coders who can review physician-assigned codes and serve as resources to answer questions about coding rules and guidelines.

Another option is to consider computer-assisted coding (CAC) technologies. An effective CAC solution can analyze a provider's visit notes and codes to determine whether coding and billing are complete and accurate.

Physician engagement can make or break a hospital's HCC-capture strategy. Hospitals should collaborate with physician practices to determine what works best and identify what physicians need to feel supported in this process. The goal is to ensure that true clinical complexity—and the value of care provided—are what ultimately drive payment for hospitals and physicians alike.

A Look Ahead

CMS has said that it aims to be tying 50 percent of all fee-for-service payments to value-based payment models such as ACOs, medical homes, bundled payments, or population-based payments by 2018.^b HCCs and other types of risk adjustment likely will play a role in each of these models going forward, reinforcing the need for hospitals to focus on HCC documentation and coding. ■

b. "Better Care, Smarter Spending, Healthier People: Paying Providers for Value, Not Volume," Centers for Medicare & Medicaid Services, Jan. 26, 2015.

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