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Hierarchical condition categories

Measuring the impact of HCCs

Evolving reimbursement methodologies and regulations can make it difficult for an organization to prepare for the future. Some may choose to stick to current processes but savvy organizations should be looking ahead. Risk-adjusted and value-based models are the future of reimbursement, for both commercial and government payers. Organizations must keep the doors open today while building a solid foundation for the years to come.

These changes and challenges require organizations pay attention to a sometimes neglected coding topic: hierarchical condition categories (HCC). HCCs are the basis for risk adjustments for reimbursement models like Medicare Advantage, accountable care organizations (ACO), and other value-based purchasing measures such as Medicare Spending Per Beneficiary. Poor understanding and application of HCCs mean that a hospital's patients may be much sicker in reality than they appear to be on paper. And that will hit reimbursement hard.

Getting HCCs right requires support from clinical staff, CDI specialists, and coders, but nearly everyone at an organization will be impacted in some way. HIM professionals must dive into the data and find out what HCCs are telling payers.

Because HCCs generally apply to only certain patient populations, identifying those patients from the start can help coders, CDI specialists, and clinicians focus their efforts. HIM professionals should consider working with their information systems, EHR vendor, and front desk staff to ensure an understanding of the financial classes or insurance plans for Medicare Advantage patients. However, complete, accurate, and timely documentation of all conditions for all patients will ensure accurate coding and data submission regardless of payers.

Reimbursement models

If a provider organization traditionally had a relatively small Medicare Advantage population or chose not to focus on data from that

population, it may not be fully aware of what factors influence HCCs and eventually Medicare Advantage payment. Many payer organizations, however, are well-versed in applying risk adjustments based on HCCs or other similar models. It can sometimes be difficult for a provider organization to pin down the impact of HCCs because it's less straightforward than other models, says **Monica Pappas, RHIA,** president of MPA Consulting, Inc., in Long Beach, California. Medicare Advantage payments are calculated once a year and the rate is set by CMS, communicated to the payer, and then to the provider via contract. It can be difficult for a provider organization to wrap its arms around a process that happens at such a remove, particularly when it must keep up with changes that happen throughout the year, she says.

HIM, particularly in hospitals, has largely escaped having to know about HCCs, but as hospitals purchase more physician practices and hospital reimbursement models evolve, it's time to take a closer look. "I think it's partly because it's fairly new in terms of the reimbursement models that HIM professionals have worked with," Pappas says. "I think the complexity comes from the fact that it's the data, all of the hospital's inpatient and outpatient data, plus the professional data that is merged at the health plan and then scrubbed and ultimately submitted to CMS."

CMS analyses the data. The agency then determines what the yearly payment will be for a patient based on that patient's particular set of aggregated data.

Some provider organizations may not even be aware of how HCCs impact their Medicare Advantage payments, says **James P. Fee, MD, CCS, CCDS,** vice president of Enjoin, Collierville, Tennessee and a hospitalist at Our Lady of the Lake Regional Medical Center in Baton Rouge, Louisiana. If a provider did not have a risk-bearing contract with its Medicare Advantage payer, it didn't need to know about HCCs. The onus would be on the payer to drive risk scores to determine capitated rates and prospective payments with CMS for the fiscal year. But new reimbursement models are changing the game for providers. Health Care Options (HCO), ACOs, and the Merit-based Incentive Payment System (MIPS) all use HCC risk adjustments. Providers taking part in these programs are suddenly getting interested in HCCs, Fee says, but they may have more to learn than they realize.

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"HCCs are going to be the next greatest impact for CDI, whether that be determining a capitated rate and prospective payment models such as Medicare Advantage, to some of the next gen ACOs and ACOs in general," Fee says. "HCCs run the gamut if you look at the industry in general. It's a changing world for organizations because if you haven't been in this space then you're not quite aware."

However, organizations should be careful to separate rumor from fact, he adds. Some may mistakenly believe that HCCs are currently being applied to all models or may not understand the nuances of how risk adjustments are calculated for certain claims-based outcomes such as mortality or readmissions. Be wary of claims that HCCs are used to risk-adjust everything, he advises. Organizations need to begin understanding HCCs and what their risk-adjustment factor (RAF) is, but these codes do not currently impact all reimbursement models across the board. For example, HCCs primarily impact the cost category of MIPS. The relative category weighting for cost is 0% for 2017 but will be 30% for 2019 and will not begin to affect payment until 2020. Evaluate what metrics and reimbursement are impacted by HCCs and target resources.

Finding the code

HIM professionals should study the models that affect their organization, or may affect it in the future, and familiarize themselves with HCCs. "All of these risk-adjustment methodologies and HCCs in particular are being used in compensation in ACOs and in the value-based purchasing models that we're looking at for future reimbursement," Pappas says. "So we really have to learn more about the system and be more informed about the impact of some of these codes that we typically don't pay attention to."

Organizations already specify if codes are complications or comorbidities or major complications or comorbidities and make calculations based on Medicare Severity-Diagnosis Related Groups. The same general principle can be applied to HCCs, Pappas says. Although the sheer number of codes can seem overwhelming, hospitals can work with vendors to create systems to track and flag the codes, and many HCCs fall in the same category, she says. Coders can use that as a shortcut to help them remember. As demand rises, vendors will likely develop more sophisticated tools to assist in identifying these codes, flagging documentation for physicians and CDI specialists, and analyzing data. "I don't think any human being is capable of knowing all this," she says. "The amount of information is massive and if we don't look to some technology solutions, we'll never win."

Systemwide approach

Hospitals and physician practices are seeing the effects of HCCs. That effect may be doubled as hospitals buy physician practices and form health systems made up of a spectrum of different types of providers. Physician reimbursement has become increasingly complex and some physicians find it easier to operate with the support of a larger organization. There are clear benefits on both sides but also challenges. Organizations that were once solely hospital-based now have to grapple with the complexities of a different set of billing and reimbursement regulations. And while independent physician practices probably don't have HCCs on their radar, practices that operate as part of a larger health system are more aware, Fee says.

In current models affected by HCCs, much of the responsibility still falls at the level of the health plan or, in ACOs, at the health system level, Fee says. Physician leaders at these practices are now aware that their RAF scores should accurately reflect the severity of illness of the patient population. Fee says he's seen a lot of interest in HCCs from large multi-practice groups affiliated with a larger organization. Some smaller physician practices have also started to pay attention to HCCs, particularly if they work with a larger organization for EHR assistance to support meaningful use. "I think we're at a tip of the interest. I think providers have a lot more to learn about HCCs," he says. "I think it's a brand new concept to a lot of physicians and physician extenders."

When hospitals purchase physician practices, they should take a closer look at the practice's documentation and claims submission processes, Pappas says.

Some hospitals may feel it's easier to allow the practice to continue following the same processes it did before the purchase rather than engage in what may be a lengthy education and transition period. And while some physician practices maintain excellent documentation and coding standards, as with any type of facility, some may not. Some practices may not realize they're falling short—or may not understand why—simply due to a lack of resources. Taking a closer look will benefit both the practice and the parent organization.

Pappas recalls encountering a sophisticated health system that had acquired physician practices several years ago. The hospital and the practices used the same EHR but did not used the shared system to produce merged data. Data from each of an organization's entities, hospitals, physician practices, and other ambulatory clinics, are merged by CMS and commercial payers for Medicare Advantage and risk calculations. As provider organizations grow, they should create a program to collect and merge patient data for analysis just as payers do. This will give the provider insight into what reimbursement they can expect for certain patient populations and it can help pinpoint what departments need more help.

Education and resources

Coders, CDI specialists, and clinicians are key players in HCCs, Pappas says. Organizations must ensure these professionals have the tools and knowledge to successfully navigate the documentation complexities of HCC-based models.

One of the common documentation pitfalls is annual documentation of chronic conditions, Fee says. Clinicians are generally trained that, to maximize the medical necessity of a service, they should document four diagnoses. But in HCC models, clinicians must document beyond the patient's immediate diagnosis. For HCCs, all chronic conditions, including past surgeries, must be documented annually during a face-to-face encounter. For example, if a patient has an amputation and the physician documents it the year it happens, but does not document it during subsequent visits, HCC data will not reflect the amputation. HCC data is calculated once a year based on information reported on claims. Data and risk adjustments for that patient will be created as if the patient never had an amputation, leading to a negative payment impact.

Remember that HCCs are grouped into related "families," Fee says. Disease groupings with progressively higher severities establish a hierarchy that gives the highest severity the highest weight. HCC12 (breast, prostate, and other cancers and tumors) progresses to HCC11 (colorectal, bladder, and other cancers), HCC10 (lymphoma and other cancers), HCC09 (lung and other severe cancers), to HCC08 (metastatic cancer and acute leukemia). The coefficiencies for these HCCs range from 0.146 (HCC12) to 2.625 (HCC08). CMS pays for the most severe form of disease reported in a given year. For example, in February 2016 a patient is diagnosed with prostate cancer (HCC12 = 0.146). In July 2016, the patient is diagnosed with metastatic prostate cancer to vertebra (HCC08 = 2.625). HCC08 is higher in the hierarchy than HCC12. All disease groups lower in the hierarchy than HCC08 are dropped. More resources are allocated to sicker patients; therefore, it's vital that documentation and coding accurately express the patient's condition.

Physician practices generally don't have access to the resources hospitals do; staffing shortages and tighter budgets mean fewer people typically do more work. Yet as hospitals expand into health systems, they can't afford to neglect the practices they purchase. "They need to standardize things and then HCCs become an overarching program," Pappas says. "Again, the feds are putting all that data together."

Looking at the data can be an eye-opening experience, especially for physicians, Fee says. The data will make the connection between accurate documentation that includes chronic conditions and supports a patient's actual level of severity and risk score, and poor documentation that makes a sick patient appear relatively healthy. The medical record should document the patient's actual condition, the services that are medically necessary for the patient, and should reflect the hard work clinical staff put into caring for him or her.