HCC’s and Providers: Get Paid For What You Do!

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Speaker’s Disclaimer

• **D. Scott Jones, CHC** has no financial conflicts to disclose.
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Objectives

- Help Providers capture HCC (Hierarchical Condition Categories) complexity for all patients seen
- Understand how the RAF (Risk Adjustment Factor) and HCCs are used to calculate CMS risk scores
- Identify the connections between risk adjustment, care management, quality reporting, and financial impact
- Give providers key messages for capturing patient complexity accurately

This presentation was developed and presented to providers by Barbara Fenton, MD, and accredited by AAFP/ACCME for Augusta Health as a CME program for Physicians and APPs.

The Why…

Benefits of HCC’s and Risk Adjustment

- Improved insight and stratification: Direct Care Management and Target Interventions for patients
- Improved performance on quality metrics: Adjust for patient acuity, or ensure accurate diagnoses
- Reduced administrative burden: Avoid chart audits
- Get paid for what you do: Capture appropriate reimbursement!
### The Who of Risk Adjustment…

<table>
<thead>
<tr>
<th>Who uses it?</th>
<th>Who actually does it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Advantage</td>
<td>Providers - ICD10 codes on claims</td>
</tr>
<tr>
<td>Medicaid Plans</td>
<td></td>
</tr>
<tr>
<td>Commercial Carriers</td>
<td>CMS - runs HCC risk model 3 times a year to calculate beneficiary risk scores</td>
</tr>
<tr>
<td>ACOs</td>
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<td>Value Based Purchasing Programs</td>
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<td>MIPS</td>
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</tbody>
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### The What: HCC’s Explained

- **Disease Category Hierarchy in CMS HCC V23 (2019)**
  - Infection  Blood  Cerebrovascular Disease  Complications
  - Neoplasm   Substance Abuse  Vascular  Transplant
  - Diabetes   Psychiatric    Lung    Openings
  - Metabolic   Spinal        Eye    Amputation
  - Liver       Neurological  Kidney  Disease Interactions
  - Gastrointestinal  Arrest  Skin  Disability Status
  - Musculoskeletal  Heart  Injury
And there are two types of HCCs.....!

Hierarchical Condition Categories (HCCs)
There are two types of HCC's

CMS HCC
- Developed by CMS for risk adjustment of the Medicare Advantage Program (Medicare Part C)
- CMS also developed a CMS RX HCC model for risk adjustment of Medicare Part D population
- Based on aged population (over 65)

HHS HCC (Commercial HCC)
- Developed by the Department of Health and Human Services (HHS)
- Designed for the commercial payer population
- HHS-HCCs predict the sum of medical and drug spending
- Includes all ages

ICD-10 Codes vs. HCCs (CMS V23, 2019)
- CMS utilizes HCC grouping logic:
- HCCs are groups of related diagnosis codes based on disease groups
- Not all diagnosis codes map to an HCC - most are chronic conditions
- Only diagnosis codes that map to an HCC are used to calculate risk (RAF’s)
- HCCs have an associated weight, based on anticipated beneficiary expenditures
- HCCs in the current model (V23, 2019) are subject to revision, regrouping, and deletion by CMS
Risk Adjustment Factors (RAF’s) and HCC’s

Risk Adjustment CMS - HCC: Hierarchical Condition Category (HCC)

- The RAF score is calculated for each member by adding Hierarchical Condition Categories (HCCs)
- There are approximately ~9500 ICD-10-CM diagnoses that map to 79 Hierarchical Condition Categories (HCC)
- A coefficient or "weight" is assigned to each category of chronic complex diagnoses as well as severe acute diagnoses

RAF example based on CMS HCC V22 (2018)

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CMS Risk Adjustment (RA)

So, What is CMS Risk Adjustment?

As defined by CMS:
- Risk adjustment predicts (or explains) the future healthcare expenditures of individuals based on diagnoses and demographics.

Demographic Factors + Health Status = Adjusts Future Payment to Plan
Risk Adjustment (RA) Components

Demographic Factors and Health Statuses

Demographic Factors
- Age & Gender
- Disabled Status
- Original Reason for Entitlement (OREC)
- Medicaid Status (for Part C)
- Long Term Institutionalized (LTI) and Low Income Subsidy (LIS) Statuses (for Part D)

Health Statuses
- Conditions and Diseases
- Interactions

How to Calculate the RAF

A Member’s RAF (Risk Adjustment Factor) is the Sum of their Demographic Factor + the Coefficient of Any HCCs

Established Enrollee

\[ \text{RAF} = \text{Demographic Factor} + \text{HCC}_a + \text{HCC}_b + \text{HCC}_c + \ldots \]

New Enrollee

\[ \text{RAF} = \text{Demographic Factor only} \]
HCC’s to RAF’s – Severity Adjustment

Risk Adjustment: Payments Based on Highest Degree of Severity

Hierarchy Example:
- January 2016 Sally Smith is diagnosed with: LUQ Breast Cancer = HCC 12
- June 2016 Sally Smith is diagnosed with: LUQ breast cancer = HCC 12 (0.146) with mets to ribs = HCC 8 (2.625)

<table>
<thead>
<tr>
<th>Hierarchical Condition Category (HCC)</th>
<th>If the Disease Group is Listed in this column...</th>
<th>...Then drop the Disease Group(s) listed in this column</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hierarchical Condition Category (HCC) LABEL</td>
<td>9,10,11,12</td>
</tr>
<tr>
<td>8</td>
<td>Metastatic Cancer and Acute Leukemia</td>
<td>9,10,11,12</td>
</tr>
<tr>
<td>9</td>
<td>Lung and Other Severe Cancers</td>
<td>10,11,12</td>
</tr>
<tr>
<td>10</td>
<td>Lymphoma and Other Cancers</td>
<td>11,12</td>
</tr>
<tr>
<td>11</td>
<td>Colorectal, Bladder, and Other Cancers</td>
<td>12</td>
</tr>
</tbody>
</table>

HCC’s to RAF’s – Disease Interactions

Risk Adjustment: Disease Interactions

- CMS recognizes the increased burden and cost of managing members with multiple complex conditions, not accounted for in the mere adding of the disease coefficients
- Disease interactions provide additional coefficients or “weight” to help with offsetting the additional cost burden caring for these members based on Medicare eligibility

Example:
Disease interactions for Community based, Non-Dual, Aged

<table>
<thead>
<tr>
<th>Description Label</th>
<th>Community, NonDual, Aged</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immune Disorders* Cancer Group</td>
<td>0.893</td>
</tr>
<tr>
<td>Congestive Heart Failure*Diabetes Group</td>
<td>0.154</td>
</tr>
<tr>
<td>Congestive Heart Failure*COPD Disease Group</td>
<td>0.190</td>
</tr>
<tr>
<td>Congestive Heart Failure*Renal Group</td>
<td>0.270</td>
</tr>
<tr>
<td>Cardiorespiratory Failure Group*COPD Disease Group</td>
<td>0.336</td>
</tr>
<tr>
<td>Congestive Heart Failure*Specified Heart Arrhythmias</td>
<td>0.105</td>
</tr>
</tbody>
</table>

Note: Coefficients shown are based on CMS HCC Model V22 – community, non-dual, aged

CMS applies these coefficients annually based on diagnosis data captured within the collection year
RAF’s: The Financial Benefit of Capturing Complexity

Risk Adjustment Factor (RAF) Financial Comparison

<table>
<thead>
<tr>
<th>Sam Brown DOR 1/10/1931 Clinical picture: Diabetic CKD Stage 5, Chronic Diastolic CHF, AFB &amp; RA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No Conditions Documented</strong></td>
</tr>
<tr>
<td>84 yr old Male – Non-dual aged</td>
</tr>
<tr>
<td>No RA documented</td>
</tr>
<tr>
<td>No Diabetes documented</td>
</tr>
<tr>
<td>No CHF stage 5 documented</td>
</tr>
<tr>
<td>No Chronic Diastolic CHF documented</td>
</tr>
<tr>
<td>No Chronic Atrial Fibrillation</td>
</tr>
<tr>
<td>No Disease Interaction</td>
</tr>
<tr>
<td>No Disease Interaction</td>
</tr>
<tr>
<td>Total RAF (Demographics and MCC)</td>
</tr>
<tr>
<td>Total RAF (Demographics and MCC)</td>
</tr>
<tr>
<td>PMPM Payment</td>
</tr>
<tr>
<td>Annual Payment</td>
</tr>
</tbody>
</table>

Why Patient Complexity Isn’t Captured...

- Diagnoses are **not coded** to the highest level of specificity
- **Comorbidities** of the primary disease are **not documented**
- **Risk scores reset yearly**, and chronic conditions are not consistently **recaptured** on claims
Recapturing chronic disease...

How soon we forget

Physicians do not provide a complete and accurate listing of ICD-9 codes for members, particularly those with chronic diseases. All of the conditions listed are chronic, yet only 17 percent of members with, for instance, coronary artery disease are coded with this condition in the second year and only 11 percent are coded in the third year.

Status matters

Status Conditions

Document status conditions when applicable (e.g., ostomy status, dialysis status, amputation status, major organ transplant, etc.)

Note: CMS HCC risk adjustment requires recapturing chronic conditions/statuses each year even when stable
Recapture is key

Financial Impact: Non-Recapture Documentation

Population under risk contract = 100,000
30% carried the diagnosis of PVD in 2015
5% not recaptured in 2016
Financial HCC Impact:
$2,861 x 1,500 = 4,291,500

The How:
Tools for Accurate HCC Capture
Remember: On 1/1, Every HCC Resets

The CMS Annual “Miracle Cure”

Member on December 31st

Same Member on January 1st

CMS requires all HCC diagnoses to be submitted each and every year the condition is present. It is of critical importance that plans ensure that members with HCC diagnoses be seen by a qualified provider and all current HCC diagnoses be evaluated and reported each year.

Remember: Face to Face is a Key CMS Guideline


“All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit.”
Remember: Take the Time…

Document All Co-Existing Conditions

• Per CMS Participant Guide:
  - Physicians should document and code all conditions that co-exist at the time of the encounter/visit that require or affect patient care treatment or management.

• Co-existing conditions include:
  - Chronic, ongoing conditions
  - Status conditions

Guideline Specifics
CMS Guidance: Co-Existing Conditions

Coexisting conditions include chronic, ongoing conditions such as:

• Diabetes
• Atrial Fibrillation
• Congestive Heart Failure
• Chronic Obstructive Pulmonary Disease

These diseases are generally managed by ongoing medication and have potential for acute exacerbations if not treated properly, particularly if the patient is experiencing other acute conditions. It is likely that these diagnoses would be part of a general overview of the patient’s health when treating co-existing conditions for all but the most minor of medical encounters.

2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide 6.4.1 Co-existing and Related Conditions
Guideline Specifics
Language is Important: History vs Active

“History of” is different for clinicians and coders
• ICD10 coding guidelines: condition has resolved and is now history
• For providers: condition may be in the past, or may be ongoing

Use these phrases to reflect a current condition:
• HPI: “Patient here for management of...”
• A/P: “Compensated CHF” vs “h/o CHF”
  “Leukemia in remission” vs “h/o leukemia”

Example: Recent Provider Notes

Assessment #3: Paroxysmal atrial fibrillation (I48.0)
• “Has a past history of paroxysmal atrial fibrillation and sick sinus syndrome. Currently paced rhythm. He is on chronic warfarin anticoagulation and denies bleeding concerns except for a past history of mild epistaxis. INR is monitored through Dr. – office.
Plan: EKG, complete

As compared to......

Assessment #4: Pacemaker (Z95.0)
• “He is pacemaker dependent. Device appears to be functioning normally.”
Different Languages...

**CMS Interpretation of Documentation**

<table>
<thead>
<tr>
<th>Medical Note States...</th>
<th>CMS Interpretation...</th>
</tr>
</thead>
<tbody>
<tr>
<td>H/O CHF</td>
<td>CHF has resolved</td>
</tr>
<tr>
<td>CHF Compensated, continue Lasix</td>
<td>CHF active and stable</td>
</tr>
<tr>
<td>History of Angina</td>
<td>Angina has resolved</td>
</tr>
<tr>
<td>Stable Angina, continue atenolol</td>
<td>Angina is stable on active treatment</td>
</tr>
<tr>
<td>H/O Afib</td>
<td>Afib has resolved</td>
</tr>
<tr>
<td>Afib controlled on digoxin</td>
<td>Afib is stable on active treatment</td>
</tr>
<tr>
<td>Prostate Cancer s/p Chemotherapy</td>
<td>History of prostate cancer. Documentation does not indicate when patient completed chemotherapy (e.g. Jan ’09-Dec ’15)</td>
</tr>
<tr>
<td>Prostate Cancer, adjuvant Lupron® Injections Q4mo</td>
<td>Prostate cancer is active with active treatment</td>
</tr>
</tbody>
</table>

If your patient has an active condition documentation must reflect the correct story.
If active, “History of” language should not be used.

Remember the Documentation Basics...

**Needed documentation: MEAT**

- **Monitored**
  - Disease progression/regression
  - Ordering labs/x-rays
  - Diagnostic tests (echo, EKG)
  - Review of logs (blood sugar, B/P)

- **Evaluated**
  - Reviewing lab/test results
  - Review of diagnostic tests
  - Relevant physical examination
  - Medication/treatment effectiveness

- **Assessed**
  - Stable, improving, worsening etc.
  - Exacerbation of condition
  - Discussion/counseling
  - Relevant record review

- **Treated**
  - Referral to specialists
  - Adjusting, refilling, prescribing medication
  - Surgical procedures

https://www.aapc.com/blog/41212-include-meat-in-your-risk-adjustment-documentation/
Assess Chronic Conditions

**ALL chronic conditions—even if stable—should be assessed and captured at least every year as well as each time a chronic condition has an impact on the diagnosis or treatment of an acute or other chronic condition.**

**Commonly Missed Chronic Conditions**
- Amputations
- Parkinson’s Disease
- Rheumatoid Arthritis
- Atherosclerosis of Aorta
- Ectasia
- Aneurysm
- Morbid Obesity (BMI ≥ 40)
- Malnutrition
- Organ Transplants
- Multiple Sclerosis
- Compensated CHF
- Chronic Psychiatric diagnoses
- Alcohol +/or Drug dependency
- COPD
- Ostomies (open)
- Congenital diagnoses

Take the Opportunity: Annual Visits

**AWVs or Comprehensive visit**
- Capture diagnoses that would otherwise go uncaptured
- Close gaps in care
- Comprehensive review of problem and med list
- Personalized preventive care plan

**Visits must be completed by a CMS approved provider to risk adjust**
- MD
- DO
- NP
- PA
- Clinical Nurse specialist
Tips for Closing Billing Gaps

Be aware of the limitations of your EMR & practice management system. How many dx codes does the system allow?

Make sure the data is captured on the claim.

Verify Clearinghouse or Submission Vendor can send and receive all recorded codes and that payer Health Plans can do the same.

Conclusion:
Provider’s Favorite Takeaways
Takeaways

• The slate is wiped clean every January 1st. All ongoing conditions must be addressed again each calendar year.

• An AWV and/or comprehensive visit at least once a year is important!

• Diagnoses must be documented during a face-to-face visit, according to ICD-10-CM Guidelines.

• Remember the impact of interactions, status codes on Risk Scores

• Avoid “h/o” - means “resolved” to CMS.

Takeaways

• Symptoms vs. disease: Once a definitive diagnosis is made, code the disease instead of symptoms, and to the highest specificity.

• Code ALL active diagnoses or conditions you are managing: Use language like controlled, compensated, in remission, currently managed on...

• Remember MEAT documentation to support your code.

• Remember those commonly missed diagnosis codes for all patients with chronic diseases!
Takeaways

• The goal is to create a total picture of the patient, across the continuum of care.

• Not just a primary care issue – specialists have a role and are impacted too, help connect to primary care.

• Specific, accurate documentation is the only way to ensure reimbursement for more complex care, and sicker patients.

• HCC Coding is a team sport!

Risk Based Reimbursement

The Future of Healthcare Reimbursement

- Will pay for the treatment of diseases, not for office visits and procedures
- Will promote quality care through value based reimbursement
- Will put primary care physicians back in the driver seat

• 50% risk adjustment by 2015
• 75% value based payments by 2020
• 85% of codes that drive the RAF score are generated by primary care providers

Health Care Transformation Task Force is an industry consortium that brings together patients, payers, providers and purchasers to align private and public sector efforts to clear the way for a sweeping transformation of the U.S. healthcare system. We are committed to rapid, measurable change, both for ourselves and our country. http://www.hctt.org/
CMS: HCC Capture Aligns with Good Healthcare

Align Initiatives with the Practice of Medicine

Goal 1: Make care safer by reducing harm caused in the delivery of care.

Goal 2: Strengthen person and family engagement as partners in their care.

Goal 3: Promote effective communication and coordination of care.

Goal 4: Promote effective prevention and treatment of chronic disease.

Goal 5: Work with communities to promote best practices of healthy living.

Goal 6: Make care affordable.

Better Care

Healthier People, Healthier Communities

Smarter Spending

Questions?

Answers!
Resources

AHA Coding Clinic
http://www.ahacentraloffice.org/

AAPC
https://www.aapc.com/

AHIMA
http://www.ahima.org/

Resources

Quality Payment Program: Delivery system reform, Medicare Payment Reform and MACRA. The Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)

Centers for Medicare & Medicaid Services (CMS) Health Insurance Marketplace Quality Initiatives website:

CMS Qualified Health Plan (QHP) Enrollee Experience Survey (QHP Enrollee Survey) website:
http://qhpcahps.cms.gov

National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)1 Compliance AuditTM website:
Resources

2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide


ICD-10-CM The Official Guidelines for Coding and Reporting

* www.cdc.gov/nchs/icd/icd10cm.htm

CMS News and Resources:


ICD-10 CME modules developed by CMS and Medscape:


CMS MLN Matters


• Reden & Anders (Optum 360 LLC), Chronic Disease Coding Drops After First Year in Medical Record,


• CMS, Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide


• CMS, Risk Adjustment 101 Participant Guide – CSSC Operations


• American Association of Procedural Coders (AAPC) Blog, Include MEAT In Your Risk Adjustment Documentation

https://www.aapc.com/blog/41212-include-meat-in-your-risk-adjustment-documentation/
Thank you!

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