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3M Health Information Systems

Executive briefing:

HCCs: A frequent factor in the value equation

Hierarchical condition categories (HCCs) determine patient financial risk in many value-based payment models. The Centers for Medicare & Medicaid Services (CMS) use them in several programs, including:

- Medicare Advantage
- Medicare Shared Savings Program
- Accountable Care Organizations (ACO)
- Comprehensive Primary Care Plus Program (CPC+)

Some state Medicaid agencies and commercial payers also use HCCs to determine hospital and health system population risk.

Unlike DRG-based risk adjustment, HCCs are calculated over a period of time, typically a year, across all inpatient, outpatient and physician office settings. CMS calculates HCCs using claims data. Pertinent conditions are those that are treated, evaluated and/or monitored and billed each calendar year in at least one of these care settings.

However, it's often difficult for providers to monitor and capture HCCs when patients don't have annual or more frequent doctor visits. HCC capture is also challenging when providers are unaware of the care that patients receive from other specialists (e.g., an endocrinologist is unaware of a patient's recent ER visit for chest pains). It's challenging in a physician office where most coding supports professional fee billing. A physician may document an HCC diagnosis but neglect to code or report it (i.e., obesity). This often happens when the HCC isn't related to the primary complaint.

When negotiating contracts with providers, payers often use the HCC/ Risk Adjustment Factor (RAF) to determine actuarial financial risk. CMS uses HCCs to calculate the total performance score (TPS) under the Hospital Value-Based Purchasing (VBP) Program to risk adjust efficiency and spending.

HCCs directly affect reimbursement for hospitals that:

- Administer a Medicare Advantage plan (i.e., RAF scores are payment multipliers for certain payment plans)
- Participate in a Medicare shared savings ACO or commercial ACO (i.e., HCCs risk adjust financial benchmarks and savings/risk targets), or
- Own medical groups or employ physicians participating in CMS Alternative Payment Models (APMs)

As with VBP, CMS uses HCCs in the Medicare Access and CHIP Reauthorization Act (MACRA) and Merit-based Incentive Payment System (MIPS) to risk adjust APM performance metrics. The agency also uses RAF scores to determine care management fees in its CPC+ program.

How are HCCs and RAF scores calculated?

Each HCC group, which includes various clinical conditions, has an associated weight that determines a patient's disease risk score. Patient risk is also determined by interactions among the disease categories as well as the patient's disability status.

The total RAF score combines the disease risk score and a demographic risk score. Demographic factors include age, whether the individual resides in an institution, and disability status. HCC diagnoses determine each patient's disease factors.

A healthcare provider can't change the demographic factors that contribute to the RAF score. However, providers can improve the accuracy of the disease risk score by capturing and reporting all appropriate HCC diagnoses. Doing so ensures the accuracy of payment, financial targets, and performance measures under VBP models.

Total score of all relative factors related to one patient for a total year

Demographic Risk Score	+	Disease Risk Score	=	Patient RAF
• Age • Residence (in community versus Skilled Nursing Facility or institution) • Medicaid disability and interaction with age/gender		• Reported HCC diagnoses • Interaction factors (for interactions between disease categories) • Disability status		• Key factor is capturing all HCC diagnoses

What does a low RAF score mean?

In the HCC model, the sickest patients receive the highest RAF scores. Lower RAF scores suggest healthier patients. Though this may be true, these scores could also indicate an absence of information in the patient's records, such as no documentation of a chronic condition from one year to the next. Low RAF scores could also indicate a care gap, in which case conditions are also not monitored and documented. Either way, a provider's performance profile suffers when RAF scores don't accurately reflect the financial risk of its patient population. Patients with artificially low RAF scores may experience poorer outcomes and higher costs than expected. This is not the profile that hospitals want to portray in a VBP model that rewards low-cost, high-quality care.

Unfortunately, traditional DRG-focused documentation improvement programs may not emphasize the entire disease burden. The HCC methodology requires providers to document and code diagnoses in a particular way. All HCC health conditions must be represented in claims data during the calendar year. This may be problematic for specialists who don't fully document multiple conditions or who only document what is relevant during a single encounter.

4 common challenges when managing HCCs in physician practices:

1. **Undetected year-to-year care gaps that lead to HCC omissions**
2. **Lack of electronic medical record interoperability that prevents information sharing among providers**
3. **Lack of provider education about HCC documentation and coding specificity**
4. **Absence of professional coders to help providers maintain compliance**

What are best practices for effective HCC management?

To perform successfully in CMS or other payer programs that use HCC risk adjustment, health systems must implement the following:

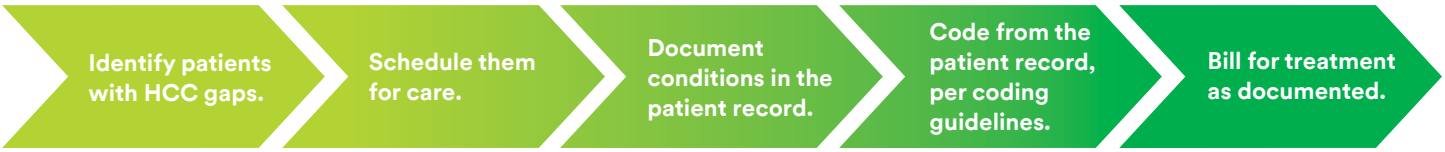
- Internal process for HCC coding review
- Population-level analysis of HCCs and RAFs
- Care coordination and scheduling based on HCC prioritization
- Outpatient and physician practice patient reviews for clinical documentation improvement (CDI)
- Physician education regarding HCC documentation and coding
- Complete and accurate coding for inpatient, outpatient, and office visits

These best practices are likely familiar to organizations with DRG-based CDI programs. However, hospitals and health systems must expand these best practices beyond the inpatient setting to include outpatient settings as well. As with DRGs, capturing more accurate diagnoses for HCC assignment improves risk-adjusted data that's used to measure clinical and financial outcomes. It should improve performance and quality scores as well.

How do providers remain compliant?

An emphasis on proactive HCC management, rather than retrospective analysis alone, helps organizations remain compliant. Consider the following four objectives of a compliant HCC management program:

1. Code and bill accurately in accordance with physician documentation and in compliance with regulations and coding guidelines.
2. Proactively identify chronic patients with HCC gaps.
3. Schedule these patients for care.
4. Alert physicians within their workflows to ensure documentation is complete.



About 3M

3M provides software and services to help organizations capture complete HCC diagnoses across all care settings. The solutions include claims analysis, medical record review, benchmarking, role-specific training, care team notifications, and computer-assisted coding—all designed to comply with clinical guidelines and regulations.

3M can help with the following:

- Assess HCC documentation, coding and reporting
- Implement an HCC management program
- Identify patients with missing HCCs
- Bridge EMRs to create a comprehensive patient profile across all care settings
- Alert primary care providers (PCP) at the point of care about undocumented diagnoses
- Prioritize high-risk patients for scheduling
- Coordinate care using case tracking tools
- Calculate the potential increase in RAF score for capturing complete HCCs

Call today

For more information on how 3M software and services can assist your organization, contact your 3M sales representative, call us toll-free at **800-367-2447**, or visit us online at **www.3M.com/his**.

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