HCC CODING FOR RISK AS A BEHAVIORAL HEALTH PROFESSIONAL

HIERARCHICAL CONDITION CATEGORY CODING (HCC)

Helps to communicate patient complexity and paint a picture of the whole person. They also help to predict health care resource utilization. By accounting for difference in patient complexity, quality and cost performance can be more appropriately measured.

Why It Matters

Higher risk scores for a population translate into a higher benchmark for expenditures, while lower risk scores translate into a lower benchmark. Having an accurate benchmark is vital in achieving shared savings.

For Medicare Advantage (MA) plans, higher risk scores translate into higher per member per month (PMPM) payments, and lower risk scores translate into lower PMPM payments. MA programs may suffer financial losses if their HCC scores underestimate the degree of illness within their beneficiary population

Risk Adjustment Factor (RAF)

The Risk Adjustment (RA) model uses a patient's demographics and diagnoses to determine a risk score,
which is a relative measure of how costly that patient is
anticipated to be.

Calculating Risk Scores

- Demographics: age, gender, living status
- Eligibility Status
- Chronic Disease Burden (ICD-10)
- Disease hierarchies (severity, specificity)
- Disease interactions (complexity, completeness)

How It Works

A risk score of 1.000 is an average patient.

Medicare calculates a beneficiary’s risk adjustment factor (RAF) on an annual basis or cost per beneficiary per year.

For example, if the RAF for your patient is 1.000, Medicare would expect to spend $10,000 on that patient.

If your patient had an RAF of 1.100, Medicare would expect to spend $11,000 ($10,000 x 1.100).

This method of cost prediction is used by the Medicare and Medicare Advantage programs.

CMS vs HCC

CMS-HCC is the model used to pay MAs.

Health and Human Services (HHS) HCC was developed after the passage of the Affordable

Care Act to pay health insurers in the ACA marketplace. This model includes categories for infants, children, and all age adults, and includes obstetrical diagnosis codes for high risk OB care.

CMS-HCC Characteristics	HHS-HCC Characteristics
Primarily use for Medicare Advantage (Part C) reimbursement	Primary use is commercial payer managed care plans (Health Exchange plans under the Affordable Care Act)
Intended for patients over 65 and/or disabled patients	Intended for patients of all ages
Risk-adjusted attributes include age, gender, demographics, medical conditions, and institutional status	Risk-adjusted attributes include age, gender, demographics, medical conditions, and financial status
Data capture included in regular Medicare processes	Requires additional data capture for demographics
Predicts future medical spending	Predicts future medical and drug spending
Prospective: Uses diagnostic information from a base year to predict costs for the following year	Concurrent: Uses data from the current benefit year to predict costs for that same year
Includes a special needs plan for individuals with severe or disabling chronic conditions	Includes an adult model (age 21+), child model (age 2-20), and infant model (age 0-1)
Provides frailty adjustment to predict expenditures for the community-residing frail elderly	Contributing elements vary by age (e.g., child model does not include disease severity interactions and categories in the infant model are defined by birth maturity)

PUTTING IT ALL TOGETHER

Payers with a higher population of high-cost patients get more money, right? Perhaps, but in a lot of cases, no.

The payer submitting patient risk and data to CMS, HHS, and the state is reliant on coding, claims and documentation from the patient's medical home. Unless rigorous audits are conducted of the claim data submitted the payer has no idea whether they are accurately capturing the health status of their populations. Unlike overpaying for services that are billed, risk adjustment payers aren’t losing money in the traditional sense.

What happens is that the payer doesn’t realize the true cost of the patient attributing to higher risk. In the example below, you can see the difference in attributed cost depending on the specificity of the diagnosis coding.

Variable	Demographic Info Only	Inaccurately Coded	Accurately Coded
45-year-old Male: Silver	0.164	0.164	0.164
Diabetes, with Comorbidities Inaccurately Coded: E11.9 Accurately Coded: E11.22	0	0.463	0.463
Chronic Kidney Disease, Stage 5 Inaccurately Coded: N18.9 Accurately Coded: N18.5	0	0	1.224
Amputation Status, Left Inaccurately Coded: Not Coded Accurately Coded: Z89.512	0	0	3.29
Risk Adjustment Factor	0.164	0.627	5.141
Annual Payment (assumes $800/mo)	$1,574.40	$6,0190.20	$49,353.60
Payment Difference	($47,779.20)	($43,334.40)	$0.0

Demographic info only: The provider sees the patient and simply codes a well visit. There are no conditions and the risk adjustment factor (RAF) is simply the demographic information.

Inaccurately coded : The provider codes for the patient's diabetes, but again is not specific. The RAF now increases, and assuming a baseline annual payment of $800 per month, the payment increases by approximately $4,500 — meaning, that this patient with diabetes will cost the plan approximately $6,000 a year instead of $1,500 a year.

Accurately coded: The provider accurately codes all the patient's chronic conditions, including diabetic CKD, stage 5, and the amputation status code for his prior left leg amputation. The RAF is significantly higher, and cost of this patient rises by more than 800 percent. Payers with a higher than average high-cost/high-risk population and inaccurate reporting will end up spending a disproportionate amount of funds on those patients rather than what was budgeted.

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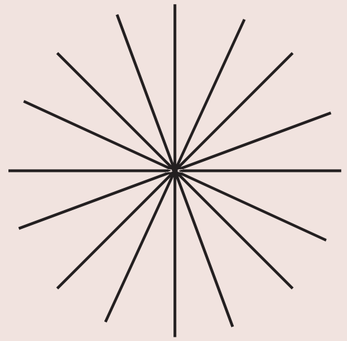
In the example, the payer budgeted between $1,000 (example 1) and $6,000 (example 2), but by the end of the year the patient's actual cost is almost $50,000.

The cost is not offset by the governmental entities (CMS, HHS, etc.) since this patient was considered low or average risk.

As a result, payers must recoup the monies in other ways, such as increasing premiums or excluding payment for specific conditions.

What is your role



- Thorough and specific documentation
- Encourage Annual Wellness Visits and Well Child Checks
- Focus on HCCs you treat
- Educate team on areas of focus
- Chart prep
- Ask for feedback on documentation
- Communicate with providers

COMMON HCC DIAGNOSIS

- Depression
- Major Depressive Disorder
- Bipolar Disorder
- Schizophrenia
- Alcohol Related Disorders
- Drug Related Disorders
- Diabetes
- COPD
- CHF
- Cancer
- Rheumatoid Arthritis
- Stroke
- Protein calorie malnutrition
- Obesity
- Smoker's cough

Resources

Documentation:

- Realize the Value of HCC Coding - AAPC Knowledge Center
- HCCA.book (optumcoding.com)
- ICD-10 — HCC Coding Reference for Family Medicine (aafp.org)

Code Lists:

- Risk Adjustment | CMS
- 2022 Benefit Year Final HHS Risk Adjustment Model Coefficients (cms.gov)

Questions?

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