Hierarchical condition categories and revenue leakage prevention

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Physician practices that treat and monitor patients with chronic illnesses can have revenue gains or losses depending on hierarchical condition categories (HCC) and prescription drug hierarchical condition categories (RxHCC) in Medicare risk-adjustment models. The risk-adjustment has an impact on physicians' reimbursement from Medicare Advantage (MA) because these plans utilize the HCC risk adjustment methodology, which is linked to individual member's risk profiles. The assigned ICD-10 clinical modifications are the primary indicator of each member's health status. With upcoming changes to regulations, compliance and coding guidelines, it is imperative for physician practices and their coding staff to have a solid understanding of the impact of HCC/RxHCC documentation and audits in order to maximize revenue potential.

HCC/RxHCC background

There are two types of HCCs. One for the Centers for Medicare & Medicaid Services (CMS) and another type for the Department of Health and Human Services (HHS). This article will focus on CMS-HCC.

In 2004, CMS developed the HCC risk adjustment model to calculate risk scores to adjust capitated payments to private MA plans for elderly and disabled beneficiaries. The CMS-HCC is a diagnosis prospective model, which uses health status in an annual base to predict the following year's cost. For those beneficiaries that carry dual eligibility in the Medicaid program, the HCC model considers the Medicaid factors of gender, age, disability and community or institution status. Included in the model's calibration are two risk segments based on the beneficiary's residential status, community or long-term acute care facility. These residential statuses are used to identify unique cost patterns.

In 2007, RxHCC diagnosis codes were added to the reimbursement for managing other illnesses in patients. These diagnoses did not increase the level of care complexity, however they did qualify for additional reimbursement due to the increased cost of medications. Some of the RxHCC diagnosis codes are not covered in the HCC.

Today, the HCC classification includes 70,000+ diagnosis codes, 805 diagnostic groups, 189 condition categories and 189 HCCs. As of 2014, CMS-HCC utilizes 9,500+ ICD-10 modifications and 79 condition categories for their payment model.

Diagnostic classification system

CMS utilized 10 principles that guided the creation of HCCs. The bolded principles below have an impact on provider's clinical documentation:

- **Principle 1** – Diagnostic categories should be clinically meaningful
- Principle 2 – Diagnostic categories should predict medical expenditures
- Principle 3 – Diagnostic categories that will affect payments should have adequate sample sizes to permit accurate and stable estimates of expenditures
- Principle 4 – Creation of an individual's clinical profile should use hierarchies to characterize level of illness within each disease process
- **Principle 5** – Diagnostic classification should encourage specific coding
- **Principle 6** – Diagnostic classification should not reward coding proliferation
- **Principle 7** – Providers should not be penalized for recoding additional diagnoses
- Principle 8 – Classification system should be internally consistent (transitive)
- Principle 9 – Diagnostic classification should assign all ICD-10 codes (exhaustive classification)
- **Principle 10** – Discretionary categories should be excluded from payment models

HCC risk adjustment methodologies

There are four prominent systems used for risk adjustment payments:

- HCC
  - CMS-HCCs (Managed Care Part C)
  - HHS-HCCs (Managed commercial in health insurance exchange)
  - RxHCC (Medicare Part D)
- Ambulatory care groups
- Chronic illness and disability payment system
- Diagnostic cost groups

Also noteworthy: the Affordable Care Act defines the risk adjustment methodology as premium stabilization.

- Premium stabilization programs were established by the Affordable Care Act and were intended to mitigate the potential impact of adverse selection and stabilize the price of health insurance in the individual and small group markets.

- The risk adjustment model uses an actuarial tool to predict health care costs based on the relative actuarial risk of enrollees in the risk adjustment covered plans.
- The individual risk scores are based on demographic and health status information.

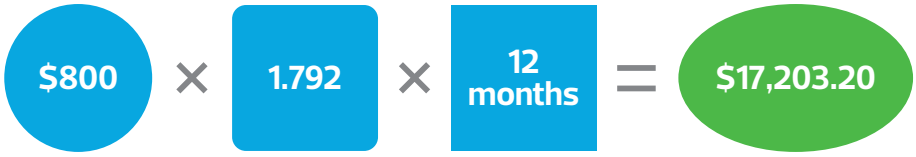
  - Each chronic condition that has not been resolved and maps to an HCC or RxHCC must be reported at least once during the calendar year, during a face-to-face visit.
  - If the chronic condition from the previous year is not documented, during the following calendar year at a face-to-face visit, the diagnosis *falls off*.
  - Lack of chronic condition reporting from year to year, as applicable, can result in revenue leakage.

Identifying revenue leakage

Note the following example illustrating revenue leakage in a two-year clinical scenario.

A 76-year old female presents with Type 2 diabetes with acute complication. Also, the patient has congestive heart failure that is being monitored by the provider. Patient is dual eligible for Medicare and Medicaid, for a per month per member (PMPM) payment of $800.

Correctly coded conditions		
Description	**HCC**	**Weight**
76-year old female	Demographic	0.437
Dual eligibility	Demographic	0.437
Type 2 diabetes mellitus (DM) with acute complication	17	0.368
Congestive heart failure (CHF)	85	0.368
Disease interaction, diabetes mellitus type 2 (DMII) + CHF	Disease interaction	0.182
Total risk adjustment factor	----------	1.792
PMPM payment	$800	----------
Annual payment	**$17,203.20**	



Second year: Follow-up (same patient)

Incorrectly coded conditions		
Description	**HCC**	**Weight**
76-year old female	Demographic	0.437
Dual eligibility	Demographic	0.437
Type 2 DM with acute complication	17	0.368
CHF	Not coded	N/A
Disease interaction, DMII + CHF	Not coded	N/A
Total risk adjustment factor	----------	1.242
PMPM payment	$800	----------
Annual payment	**$11, 923.20**	

It is imperative that providers perform retrospective HCC/RxHCC audits annually. This type of audit requires a specialized skill set and dedicated resources. Because of the difficulty in hiring the right skill set or the associated costs of outsourcing, providers fail to recoup thousands of dollars in reimbursable revenue. There are a few internal steps, however, that can mitigate revenue leakage, including:

- Proper technology planning, leveraging your current vendor software to include the capture of HCC/RxHCCs
- Annual ad-hoc reporting to identify patients with chronic illnesses that map to a HCC or RxHCC
- Annual chart audits, specifically on patients identified in reports; keep in mind audits are two-fold, including verifying documentation and verifying annual capture of chronic illness

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