# Ins and Outs of HCCs

Save to myBoK

*By Valerie Fernandez, MBA, CCS, CPC, CIC, CPMA*

A Hierarchical Condition Category (HCC) is defined as a risk adjustment model that is used to calculate risk scores to predict future healthcare costs. The Centers for Medicare and Medicaid Services' (CMS) CMS-HCC model is used to predict healthcare spending for Medicare Advantage Plan enrollees. The purpose of the scoring model is to adjust capitated payments made to beneficiaries in these plans based on the member's health. HCCs were initially implemented by CMS in 2000 and have been phased in over time. This article will focus on the CMS-HCC model.

The model is based on diagnosis codes and includes 79 HCCs. Age, sex, disability, and living circumstances—such as whether the individual is living at home, in a nursing home, or in a long-term care facility—also play a part in the calculations of an HCC.

It is difficult to assess new enrollees in the Medicare program as the predictive model can only use demographics of age, gender, and community versus institutional living to determine utilization. It is only after a full year of accumulating medical expenses that accurate predictions for future healthcare utilization can be made. These challenges make the correct assignment of HCCs even more important for Medicare Advantage plan providers.

As coding departments take on greater responsibilities across their organizations, it becomes increasingly important to be aware of HCC coding and understand its nuances. This article provides an introduction to HCCs for all types of coding professionals.

## The HCC Process

Today, there are approximately 47 million Medicare beneficiaries. According to AARP, this number is expected to reach 79 million by 2030. Approximately one-fourth, or almost 12 million, of today's Medicare beneficiaries are enrolled in Medicare Advantage plans. CMS samples approximately one million beneficiaries' claims to estimate predicted costs using HCCs. Capitation payments are reduced for low-risk beneficiaries and increased for high-risk beneficiaries, thereby eliminating the need for Medicare Advantage plans to seek enrollees who are healthier and at lower risk.

The HCC process includes a prospective review of health status in a base year to predict costs in the following year. Assessments are also made of beneficiaries eligible for both Medicare and Medicaid (dual eligibility). It is important to note that these beneficiaries have a higher cost than Medicare-only beneficiaries. Those who are not dual-eligible have fewer costs than those with partial benefits. Similar distinctions also exist between disabled and non-disabled beneficiaries.

In recent years, there has been a greater focus on these dual-eligible beneficiaries. As a result, CMS now conducts ongoing reviews to determine the accuracy of expenditures and prospective payment assessments.

**Top 10 Medicare Risk Adjustment Coding Errors**

1. Health record does not have a legible signature with credentials.
2. Electronic health record was not authenticated and electronically signed.
3. Highest degree of specificity was not assigned to diagnosis.
4. A discrepancy exists between billed diagnosis and actual description of the condition noted in documentation.
5. Documentation does not indicate a condition as being monitored, evaluated, assessed, or treated.
6. Cancer status is unclear and treatment is not documented.
7. Chronic conditions such as hepatitis are not documented as chronic.
8. Lack of specificity is an issue, such as unspecified arrhythmia versus a specific type of arrhythmia.
9. Chronic conditions and status codes are not documented on an annual basis.

10. Required linking language, causal relationship, or manifestation codes are missing.

## Accuracy, Analysis, and Updates

When it comes to accuracy, more attention is focused on predicting expenditures for beneficiaries who are dual-eligible and living in an institution. This is because community-based dual-eligible reviews were less than accurate in the past. For the beneficiaries who are lower risk and not falling into an HCC, expenditures have historically been underpredicted.

To address these concerns, there are planned updates to the predictive analysis model. One update is to change HCC coding from assessing a single segment to reviewing cases of all community beneficiaries. These reviews include an assessment of full benefit, partial benefit, and non-dual-eligible individuals who are either in the aged or disabled categories. Each of these subgroups has distinct cost profiles. The institutional model subgroup has no planned changes as it is currently predicting expenditures accurately.

Medicare Advantage Plan carriers are concerned about these planned updates for three reasons:

- Reduced payments potentially occurring for certain demographics and disease states
- Higher expenses for treating those suffering from Alzheimer's disease due to the long-term implications and access to quality healthcare
- Growing unease for those enrolled in the Programs for All-Inclusive Care for the Elderly (PACE), which provides services for the frail and elderly living in the community

As more physician practices are acquired by hospitals and physicians become employees, reduced reimbursement for services that do not demonstrate quality services based on severity of illness and risk of mortality will adversely impact the facility's bottom line. Documentation of the HCCs will maximize the revenue of hospital-based practices.

## HCCs in Value-Based and Risk Adjustment Models

The objective of HCCs is to compensate health insurance plans for the differences in enrollees' health mix. The program is an important element of value-based purchasing. It assesses actual rates and predicted rates to confirm the quality of care provided, including care planning and coordination. It is also used to set capitation payments to managed care plans, and in combination with fee-for-service to compensate accountable care organizations (ACOs) and Medicare Shared Savings Programs (MSSPs).

The difference in HCC expenditures to cover enrollees varies greatly. The 13 percent of beneficiaries who reside in long-term care facilities are three times more expensive to cover than beneficiaries living in the community. The average expenditure for a beneficiary in a long-term care facility is $8,960, compared to the $2,835 paid out for an individual living in the community. Out of pocket expenditures were $17,534 for those in long-term care facilities as compared to those living in the community with approximately $1,858 in out of pocket expenditures.

## Conditions to Know

Within the HCC model, a number of different risk adjustment models impact fee-for-value reimbursement. For example, patients with End Stage Renal Disease (ESRD), who represent one percent of the Medicare population but seven percent of the budget, average from $15,614 to $38,230 in expenditures depending on their comorbidities. For this reason, a separate model was developed for ESRD enrollees. Patients are categorized by treatment status—including dialysis, transplant, and functional graft. It is important to note that ESRD patients cannot join a Medicare Advantage plan. But if they develop ESRD after enrollment, they may stay on the plan.

PACE uses the functional status of patients to measure frailty based on activities of daily living and the ability to perform them. The Chronic Condition Special Needs Plans coordinate care for beneficiaries with special needs. There are three types: patients who are institutionalized, those who are dual-eligible, and individuals suffering from chronic disabling conditions. Chronic conditions under this plan include chronic alcohol and other drug dependence, autoimmune disorders, cancer,

cardiovascular disorders, chronic heart failure, dementia, diabetes, end stage liver disease, ESRD, severe hematological disorders, HIV/AIDS, chronic lung disorders, neurological disorders, and stroke.

Finally, there is also a risk adjustment model for Medicare Part D, the prescription drug program (Rx HCC) that involves HCCs. It is similar to the process used for Medicare Advantage Plans. The same diagnosis is used, but only the prescription drug costs are considered. Copayments and deductibles are excluded from coverage.

## HCC Reporting

There are definitely challenges to accurate HCC reporting. Hierarchies ensure an individual is coded for only the most severe manifestation among related diseases. Diagnosis codes roll up to diagnostic categories (DXG), which are included in condition categories (CC), which then become HCCs. Documentation must support each mapped diagnosis, and procedures for timely, accurate, and complete coding and billing must be followed. Status codes can also affect reimbursement—such as dialysis status, amputation status, and more.

Risk adjustment data validation audits are conducted regularly. These audits can trigger identification of improper payments with extrapolation to the total enrollment, along with False Claims Act violations that can result in triple the amount of damages.

Maximizing the use of HCC tables to capture diagnosis codes as well as complication/comorbid conditions (CCs) and major complication/comorbid conditions (MCCs) is critical. Optimizing Medicare Severity-Diagnosis Related Groups (MS-DRGs) assignments that confirm severity of illness and risk of mortality is also important. Forty-two percent of HCCs are complications and comorbidities while 16 percent of HCCs are major complications and comorbidities. Just as in ICD-10 coding, complete and accurate clinical documentation is the foundation for proper HCC assignment.

## All HCC Roads Lead to CDI

When it comes to HCCs, all roads lead to clinical documentation improvement. Reimbursement and the level of available health plan services are directly linked to the accuracy, specificity, and overall quality of a physician's clinical documentation. Quality documentation then enables more meaningful data exchange between provider and carrier.

As value-based healthcare continues to expand, HCC coding and an emphasis on its accuracy will become even more important. With the nationwide rise of chronic conditions, the benefits of the HCC risk adjustment model ensures proper allocation of resources to treat high-cost patients while also identifying opportunities for disease management intervention and improving the quality of our nation's healthcare.

## References

Cubanski, Juliette et al. "How Much Is Enough? Out-of-Pocket Spending Among Medicare Beneficiaries: A Chartbook." The Henry J. Kaiser Family Foundation. July 21, 2014.

Feder, Judith and Jeanne Lambrew. "Why Medicare Matters to People Who Need Long-Term Care." *Health Care Financing Review* 18, no. 2 (Winter 1996).

National Institute of Diabetes and Digestive and Kidney Diseases. "Kidney Disease Statistics for the United States." December 2016.

University of California, San Francisco Schools of Pharmacy and Medicine. "The Kidney Project: Creating a Bioartificial Kidney as a Permanent Solution to End Stage Renal Disease: Statistics."

Valerie Fernandez (valerie.fernandez@himoncall.com) is the manager of coding program development at H.I.M. ON CALL, Inc. and is an AHIMA-approved trainer for ICD-10-CM/PCS.

---

**Article citation**:
Fernandez, Valerie. "Ins and Outs of HCCs" *Journal of AHIMA* 88, no.6 (June 2017): 54-56.