

2020
OUTPATIENT
CDI
POCKET GUIDE
Focusing on HCCs
--Third Edition--

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We have prepared this reference guide using authoritative regulatory and industry resources — the ICD-10-CM code books, the Official Guidelines for Coding and Reporting, and CPT® coding reference (a registered trademark of the American Medical Association) — and have made every reasonable effort to ensure its accuracy. Nevertheless, any distillation of copious information into a handy, portable reference is of necessity incomplete, and unusual cases may require returning to the primary source material. The ultimate responsibility for correct coding lies with the user.

Any errata or updates for this guide will be posted on our web site,
www.pinsonandtang.com, prior to the publication of the 2021 edition.

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INTRODUCTION

Based on our considerable experience with outpatient diagnosis clinical validation and the success of our original *CDI Pocket Guide* for inpatients, we decided to create this pocket guide for healthcare organizations to appropriately capture and audit HCCs and to extend their hospital's clinical documentation improvement (CDI) efforts to the outpatient setting.

The biggest challenges in this setting are understanding the differences between outpatient and inpatient payment methodologies, understanding how Hierarchical Condition Categories (HCCs) are used, and focusing your outpatient CDI efforts. This is covered in the Outpatient CDI section of this guide and should be studied first.

WHO WILL BENEFIT FROM THIS GUIDE?

This guide is for CDI specialists, coding specialists, CDI and HIM managers, risk adjustment auditors, and physicians who want to:

- Expand their CDI program to include HCCs and the outpatient setting and who wish to focus on areas of greatest impact;
- Improve capture of HCC diagnoses to increase hospital and physician risk adjustment for value-based payments;
- Increase risk scores for a Medicare Advantage organization; or
- Ensure their organization's outpatient coding is compliant and meets clinical validation and documentation requirements.

HOW TO USE THIS GUIDE

The **Outpatient CDI** section provides an HCC overview, background and methodology; the differences between outpatient and inpatient payment methodologies; how HCCs affect health plans, physicians and hospitals; the CMS pay-for-performance programs; and where and how to expand your CDI program.

The **Guidelines** section provides the most important outpatient diagnostic guidelines for compliant coding and reporting purposes in the physician practice; outpatient physician queries; E/M guidelines and requirements; and regulatory compliance.

The **Key Diagnoses** section provides a description of the clinical definitions, diagnostic criteria, and relevance criteria based on coding and documentation guidelines and accepted industry standards for the most common chronic HCC conditions.

The **HCC** section provides the CMS-HCCs with description and weights and a listing of the most common HCC conditions with the associated ICD-10 code, HCC category and weight — sorted by diagnosis code and by HCC.

This guide references the CMS-HCC version 24.0 HCC listing and data tables. This is the current risk adjustment model for Medicare Advantage plans and the primary HCC classification used for risk adjustment for the CMS pay-for-performance programs.

GLOSSARY OF TERMS AND ABBREVIATIONS

| | |
|---------|-------------------------------------------------------------------------------------------------------------------|
| ACO | Accountable care organization |
| APC | Ambulatory Payment Classification |
| APM | Alternative Payment Model |
| CC | Complication or comorbidity (cf. MCC) |
| CDI | Clinical documentation improvement |
| CDPS | Chronic Illness and Disability Payment System |
| CMS | Centers for Medicare & Medicaid Services |
| CMS-HCC | Centers for Medicare & Medicaid Services Hierarchical Condition Categories |
| CPT | Current Procedural Terminology (codes devised by the American Medical Association) |
| DRG | Diagnosis-Related Group |
| DxCG | Diagnostic Cost Groups |
| E/M | Evaluation and Management codes |
| EHR | Electronic health record |
| FFS | Fee for service |
| GPCI | Geographic Practice Cost Indexes |
| HAC | Hospital-acquired condition |
| HACRP | Hospital-Acquired Condition Reduction Program |
| HCC | Hierarchical Condition Categories |
| HCPCS | Healthcare Common Procedure Coding System |
| HHS-HCC | Health and Human Services Hierarchical Condition Categories. Developed under the aegis of the Affordable Care Act |
| HRRP | Hospital Readmission Reduction Program |
| ICD-10 | International Classification of Diseases, 10th Edition |
| IPPS | Inpatient Prospective Payment System |
| LCD | Local Coverage Determination |
| MA | Medicare Advantage |

GLOSSARY OF TERMS AND ABBREVIATIONS, cont'd

| | |
|--------|-----------------------------------------------------------------------------|
| MCC | Major complication or comorbidity (cf. CC) |
| MIPS | Merit-based Incentive Payment System |
| MPFS | Medicare Physician Fee Schedule |
| MSSP | Medicare Shared Savings Plan |
| MS-DRG | Medicare Severity-Diagnosis Related Group |
| NCD | National Coverage Determination |
| OPPS | Outpatient Prospective Payment System |
| P4P | Pay for performance |
| PLI | Professional liability (malpractice) insurance |
| PSI | Patient safety indicators |
| PSI-90 | Patient safety indicator composite of 10 specific patient safety indicators |
| RAF | Risk adjustment factor |
| RBRVS | Resource-Based Relative Value Scale |
| RVU | Relative value unit |
| SOI | Severity of illness |
| VBP | Value-Based Purchasing Program |

OUTPATIENT VS. INPATIENT PAYMENT METHODOLOGIES

The scope and volume of outpatient services is vast compared to inpatient services. Outpatient encounters include emergency services, ambulatory surgery, observation, diagnostic (colonoscopy, etc.), infusion, wound care, and physician office visits, among others. Understanding the differences between inpatient and outpatient payment methodologies is crucial when expanding into the outpatient area.

Payment for an outpatient encounter is determined primarily by HCPCS (Healthcare Common Procedure Coding System) codes reported on the claim. HCPCS is a standardized code set for Medicare and other health insurance providers; HCPCS Level I codes include the AMA CPT® codes, whereas HCPCS Level II codes mainly represent medical supplies, durable medical goods, prosthetics, orthotics, non-physician services, ambulance, and other services not represented in the Level I code set.

Although the ICD-10 diagnosis codes must correspond with the service provided to avoid denial of payment, the reimbursement for these services is based on *the level of service and procedures performed*.

HOSPITAL OUTPATIENT PAYMENT

For Medicare, outpatient encounters are paid under the Outpatient Prospective Payment System (OPPS), as part of Medicare Part B.

OPPS claims include the HCPCS codes which determine an Ambulatory Payment Classification (APC) that has a fixed payment rate. APCs are applicable only to hospitals and have no effect on physician payments.

Unlike the Inpatient Prospective Payment System (IPPS), in which reimbursement is based on an MS-DRG determined by ICD-10-CM diagnosis and ICD-10-PCS procedure codes, the APC rate is determined by the services using HCPCS codes. Multiple APCs can be paid for an encounter.

APC payments apply to outpatient surgery, outpatient clinics, emergency department services, and observation services. APC payments also apply to outpatient testing (such as radiology and nuclear medicine imaging) and therapies (such as certain drugs, intravenous infusion therapies, and blood products).

Examples of APC code payments for hospitals:

| Procedural Service | APC | Weight | APC Payment |
|------------------------------------------------|------|---------|-------------|
| Laparoscopic appendectomy | 5361 | 57.0818 | \$4,117 |
| ED visit level 3 | 5023 | 2.7863 | \$201 |
| Cataract extraction with IOL | 5491 | 24.2937 | \$1,752 |
| Hospital observation service > 8 hours (G0378) | 8011 | 28.8820 | \$2,155 |

Note: these examples are not meant to reflect actual final payments, which may differ according to geographical location and other variables.

PHYSICIAN PAYMENT

Physician payment is determined primarily by AMA CPT® codes, which in turn are based on the annual Medicare Physician Fee Schedule (MPFS), state Medicaid rates, or contractual payment rates. The fee schedule is updated annually by CMS with new rates going into effect January 1 of each year.

The MPFS includes payment for more than 10,000 physician services based on CPT code and covers both outpatient and inpatient physician visits, as well as other sites of services. Medicaid and most commercial payers use a similar fee schedule payment system.

CMS bases MPFS payments on national uniform relative value units (RVU) that account for the different levels of resources — physician work, practice expense, and malpractice expense — used in furnishing a service. CMS also establishes each year's reimbursement amounts for all physician services paid under the MPFS, including adjustments for variations in the costs of furnishing services in different geographic areas.

In short, the influence of MPFS on a physician’s Medicare payments is largely a function of three key factors:

- The Resource-based Relative Value Scale (RBRVS)
- The Geographic Practice Cost Indexes (GPCI)
- The monetary conversion factor

The formula for calculating payment schedule amounts entails adjusting RVUs, which correspond to intensity of services, and by the GPCIs, which correspond to payment localities. Malpractice insurance (professional liability insurance or PLI) is also a factor. The result is then multiplied by an annually adjusted dollar amount conversion factor (\$36.04 for 2019):

$$\begin{aligned}
 & [(\text{Practice expense RVU} \\
 & \times \text{Practice expense GPCI}) \\
 & + (\text{PLI RVU} \\
 & \times \text{PLI GPCI}) \\
 & + \text{Total RVU}] \\
 & \times \$36.04
 \end{aligned}$$

The table below provides MPFS payments for physicians for the corresponding services shown in the previous table of APC code payments for hospitals:

| Procedural Description | RVUs | National Payment Rate |
|-------------------------------|-------|-----------------------|
| Laparoscopy appendectomy | 17.42 | \$627.80 |
| ED visit—moderate severity | 1.75 | \$63.07 |
| Cataract surgery IOL 1 stage | 18.16 | \$654.47 |
| Observ/inpt hosp care 50 mins | 4.77 | \$171.91 |

Source: www.cms.gov/apps/physician-fee-schedule

HCCS AND RISK ADJUSTMENT

MEDICARE VS. MEDICARE ADVANTAGE

To understand HCCs and their impact, it is important to first understand the differences between traditional fee-for-service Medicare and Medicare Advantage. **Traditional Medicare** benefits are paid directly from the federal government and include Part A (inpatient care) and Part B (outpatient services). The benefits are exactly the same for every person who enrolls and offers more flexibility than a Medicare Advantage plan; for example, you can use any healthcare provider who accepts Medicare and prior authorization for services is not required.

Through **Medicare Advantage** (Part C), CMS allows Medicare beneficiaries to receive Part A and Part B benefits from private insurers, otherwise known as Medicare Advantage Organizations (MAOs). Medicare Advantage (MA) plans now account for 1 in 3 people on Medicare. Medicare pays the MAO a monthly per-person amount for each beneficiary enrolled as a member in their MA plan. MAOs must then use that money to pay hospitals, physicians and other health care providers for the services the plan members receive. While all MAOs must cover the same services as Parts A and B, different MA plans may offer additional covered services that traditional Medicare does not; however, many MAOs have different provider networks, co-pays, and drug formularies, and require members to choose a primary care provider within their network, referrals to see specialists, and prior authorization for procedures and services.

WHO USES HCCS, AND HOW?

HCCs were originally developed by CMS as a risk adjustment payment model to pay MAOs. This risk adjustment model enables Medicare to forecast costs for MA plan members for the coming year by calculating anticipated risk from ICD diagnosis codes. In a nutshell, HCCs provide a mechanism for adjusting capitated payments to these payers (not providers) according to differences in the total expected healthcare costs for their plan members each year: higher payments for sicker populations, lower payments for healthier populations.

Diagnostic information submitted on claims directly affects the capitated payments an MAO receives for each of its members by influencing a patient's risk score, or risk adjustment factor. As with any risk-adjustment model, it is intended to be accurate at the group level; different individual patients will likely have healthcare costs for a given year that are higher or lower than predicted, but below-average costs will balance out above-average costs at the level of the whole population of plan members.

Now here's the part lots of hospitals and providers miss: HCCs are also used to risk-adjust cost and quality measures for pay-for-performance programs and value-based contracts, which have been developed as an incentive to improve healthcare quality and lower costs. Although hospitals and providers continue to bill and be paid using the same fee-for-service model currently in place (inpatient DRG, CPT code, etc.), overall fee-for-service payments are adjusted to reward outcomes believed to indicate higher-quality care and penalize outcomes thought to indicate lower-quality care. A higher risk adjustment (severity of illness) for the patient population can result in a higher incentive payment (or lower penalty) to hospitals and physicians. This is why HCCs have become crucial for hospitals and physician practices.

Therefore, Medicare payments to MAOs (private insurers) are *directly* affected by HCCs. Individual Medicare payments to providers (hospital or physician) are not directly affected by HCCs, unless the provider participates in a capitated contract (which currently only a few do).

Medicare and commercial insurer payments to providers and Affordable Care Organizations (ACOs) based on quality and cost-saving measures are risk-adjusted based on HCCs, and in these cases, the payment to the hospital or physician will be *indirectly* affected by HCCs.

Improving coding and documentation in the physician practice is particularly important, since the majority of HCC diagnoses are documented within the primary care setting. Fortunately, many of the same diagnoses that documentation specialists concurrently query for clarification in the inpatient setting are the

same ones that affect risk adjustment, which makes learning how to improve your documentation relatively straightforward.

HCC METHODOLOGY

Hierarchical Condition Categories (HCCs) were originally developed in 2000 as a risk adjustment model that would enable Medicare to forecast costs for Medicare Advantage members.

The two primary HCC methodologies are (1) CMS-HCCs for Medicare Advantage (Part C) plans and (2) Health and Human Services (HHS-HCC) for managed commercial health plans as part of the Affordable Care Act. Medicare Advantage plans have been paid by CMS based on CMS-HCCs since 2004, and managed commercial health plans based on HHS-HCCs since 2014.

There are a number of other risk adjustment payment methodologies that have been developed since the HCC models including CDPS (Chronic Illness and Disability Payment System) primarily used for Medicaid managed care plans and DxCG (Diagnostic Cost Groups) used by other commercial managed care plans.

The HCC model places patients into different categories based on ICD-10 diagnosis codes (similar to inpatient DRGs). HCC categories are designed to group patients that are clinically similar and follow similar cost patterns to predict future healthcare costs. HCCs are therefore used as both a payment methodology for payers and a diagnostic classification for risk adjustment. The HCC model is cumulative (added up), meaning a patient can have multiple HCC categories assigned.

There are a total of 189 Condition Categories, of which 83 HCCs are used in CMS-HCCs and 127 for HHS-HCCs. Each HCC carries a risk adjustment value or weight, similar to the DRG relative weight or relative value unit (RVU) for CPT codes.

Each HCC contains from one to several hundred diagnostic codes. For example, HCC 1 in the table below has three diagnosis codes: B20 (HIV disease), Z21 (HIV status), and B9735 (HIV Type 2 as the cause of diseases classified elsewhere).

EXAMPLE: HCCS AND WEIGHTS (CMS-HCC)

| HCC | HCC Description | # of Codes | Weight |
|-----|--------------------------------------|------------|--------|
| 1 | HIV/AIDS | 3 | 0.335 |
| 2 | Septicemia, Sepsis, SIRS/Shock | 51 | 0.352 |
| 6 | Opportunistic Infections | 37 | 0.424 |
| 8 | Metastatic Cancer and Acute Leukemia | 81 | 2.659 |

An HCC's value reflects the cost, complexity and severity of the codes it contains. HCC conditions and weights are thus primarily driven by chronic diseases, which tend to have greater annual costs than episodes of acute conditions.

HCC disease classifications are also used for risk adjustment of quality and outcome measures for the CMS pay-for-performance programs and ACOs. Hospitals and providers are not paid solely according to HCCs in these situations but overall payments can be affected by penalties and rewards.

CMS-HCC PAYMENT METHODOLOGY FOR MA PLANS

The CMS-HCC risk adjustment payment model, which determines payment for Medicare Advantage plans, uses an individual's demographic data and diagnostic HCCs from the prior year to determine a risk score — a relative measure of how costly that individual's care is anticipated to be — for the subsequent year.

Demographic data used by CMS includes age, gender, eligibility for Medicare ("aged" vs "disabled"), Medicaid beneficiary or dually eligible for both, and community residence vs. SNF.

Risk scores are reset to 0 in January each year—and the HCC slate is wiped clean. All chronic non-resolving HCC diagnoses and any new diagnoses need to be reported at least once during the calendar year on claims with face-to-face encounters from an acceptable type of provider in an eligible setting.

A total weight of 1.0 represents an individual with average annual costs. A higher weight represents a sicker patient with higher costs and a higher payment. Conversely, a lower weight indicates a healthier, less costly patient and a lower payment.

For diseases that are not closely related, HCCs are cumulative (added up); for example, a patient with CKD, heart failure, and cancer, will have those three respective HCCs added together. More than one HCC diagnosis can be assigned per encounter, but each single HCC can be used *only once during the calendar year* for the calculation of the risk score.

Hierarchies. Hierarchy means “a ranking of one thing above another.” For CMS-HCCs and HHS-HCCs, hierarchies are imposed on some HCC categories that are closely related, like the diabetes HCCs. Only the HCC with the highest weight (most costly) in these situations is allowed for the risk score calculation.

For example, in February 2019, a patient is diagnosed with prostate cancer, which is classified as HCC 12 (0.150) as shown in the table below. In June 2019, the patient is diagnosed with prostatic bone metastases, which is HCC 8 (2.659). The risk score will be calculated only with HCC 8, which has the highest weight, and HCC 12 will be excluded.

| HCC | HCC Description | Weight |
|-----------|------------------------------------------------|--------|
| 8 | Metastatic Cancer and Acute Leukemia | 2.659 |
| 9 | Lung and Other Severe Cancers | 1.024 |
| 10 | Lymphoma and Other Cancers | 0.675 |
| 11 | Colorectal, Bladder, and Other Cancers | 0.307 |
| 12 | Breast, Prostate, and Other Cancers and Tumors | 0.150 |

Another example is the diabetes hierarchy:

| HCC | HCC Description | Weight |
|-----|-------------------------------------|--------|
| 17 | Diabetes with Acute Complications | 0.302 |
| 18 | Diabetes with Chronic Complications | 0.302 |
| 19 | Diabetes without Complication | 0.105 |

If a patient with uncomplicated diabetes is subsequently diagnosed with a chronic diabetic complication, HCC 19 would be dropped from the risk score and HCC 18 used instead.

Disease Interactions. The CMS-HCC model recognizes the additional cost of managing multiple complex conditions. Certain combinations of coexisting diagnoses called “disease interactions” will add weight to the risk score over and above the HCC weights for the two conditions individually. Disease interactions include:

| | |
|----------------------------------|-------|
| CHF + Diabetes | 0.121 |
| CHF + COPD | 0.155 |
| CHF + Renal Disease | 0.156 |
| CHF + Heart Arrhythmia | 0.085 |
| Cardiorespiratory Failure + COPD | 0.363 |
| Immune Disorders + Cancer | 0.838 |

Weights are for community, non-dual, aged.

As an example, for a patient with CHF and diabetic retinopathy, the “CHF + Diabetes” disease interaction would add 0.121 to the weights for CHF (0.331) and diabetes (0.302), a total of 0.754.

DIAGNOSIS SOURCES

Diagnoses on claims from the following eligible practice settings and providers can be used for gathering HCCs and computing the risk score for MA plans:

- Hospital inpatient
- Hospital outpatient
- Physician office visits
- Physicians and clinically trained non-physicians (nurse practitioners, PAs, therapists, psychologists, etc.)

The settings and services not used for HCC diagnosis capture include: freestanding ambulatory surgery centers, SNFs, hospice, home health, ambulance, lab, radiology, DME, prosthetics, orthotics, and supplies.

The table below illustrates the HCC risk adjustment factor (RAF) scoring for a hypothetical patient in an MA plan, using both the patient's demographics and the information in the medical record:

| Status/Condition | HCC | Weight |
|------------------------------------------|---------------------|--------------|
| 80-year-old male, community, aged | Demographics | 0.528 |
| Angina I20.9 | 88 | 0.135 |
| Diabetes E11.9 | 19 | 0.105 |
| Heart failure I50.9 | 85 | 0.331 |
| CHF + Diabetes | Disease interaction | 0.121 |
| Total Score | | 1.220 |

HCC IMPACT ON MEDICARE ADVANTAGE PLANS

HCCs first and foremost affect Medicare Advantage (MA) plans and ACA plans that are administered by large health insurers, e.g., UnitedHealthcare, Humana, Cigna. HCCs determine the reimbursement from CMS for plan members of these insurers.

For *traditional Medicare* patients, CMS pays a "fee for service" directly to hospital and physician providers through a fiscal intermediary called Medicare administrative contractors (MAC). Hospitals are paid a DRG for inpatient services and APC for outpatient services. Physicians are paid based on CPT codes for inpatient and outpatient physician services and procedures.

For *Medicare Advantage* patients, CMS pays a monthly capitated ("risk") payment to MA plans for each member to cover that individual's annual healthcare costs. The MA plan in turn pays providers, both hospitals and physicians, for services provided to its MA members.

Each MA member's risk score (RAF) is based on demographic criteria and the member's HCC diagnoses for the prior year to calculate a per-member, per-month fixed payment to the MA plan in the subsequent year. The average capitated payment rate is around \$10,000 per year for the average beneficiary. The health plan is "at risk" if the healthcare costs for the individual exceeds the "risk" payment.

The example below illustrates how HCC diagnoses determine the per-member, per-month capitation payment.

| Status/Condition | HCC | Weight |
|------------------------------------------|--------------|--------------|
| 75-year-old male, community, aged | Demographics | 0.473 |
| Diabetes E11.9 | 19 | 0.105 |
| COPD J44.9 | 111 | 0.335 |
| H/O CVA Z86.73 | N/A | 0.0 |
| | Total RAF | 0.913 |

The risk adjustment based on this patient's total RAF (weight) with a plan-specific base payment rate of \$10,000 is as follows:

$$\begin{aligned}
 & 0.913 \text{ (total weight)} \\
 & \times \$10,000 \text{ (base payment rate)} \\
 & = \$9,130
 \end{aligned}$$

The diagnostic information submitted on claims for all eligible inpatient and outpatient encounters directly affects the *health plan's* annual reimbursement for each of its MA members. Hospitals and physicians who are better at capturing the relevant HCC diagnosis codes in either the inpatient or outpatient setting thereby directly increase the amount that CMS reimburses *the health plan* — this is why many insurance companies were pushing hospitals and practices to document those HCCs.

Because CMS holds MA plans accountable for the accuracy of the HCC diagnoses submitted by providers, MA plans are reluctant to engage in contracts that directly pay providers based on RAF scores. Such arrangements can create a “perverse” incentive that might improperly lead to “upcoding” or “over-diagnosis” of HCCs. However, ACOs and value-based provider agreements that include payment bonuses and penalties for improving quality of care and cost reduction require proper documentation of HCCs since many of these measures are influenced by risk adjustment.

In the long run, better documentation and improved RAF scores may allow MA plans to increase benefits to patients and providers, such as lower patient co-payments. Lower co-payments mean greater affordability for patients and better access to providers, thereby improving quality of care and outcomes.

HCC IMPACT ON PROVIDERS

While most providers (hospitals and physicians) continue to be paid by health plans in the traditional manner (DRG or CPT code), payment is increasingly being tied to quality and risk adjustment.

For traditional Medicare (Part A & B), hospital inpatient DRG payments are affected by payment adjustments from three CMS pay for performance programs. Certain measures within these programs are risk-adjusted based on certain HCC conditions. A higher risk adjustment that reflects higher costs and severity of illness may reduce any penalty and increase any incentive payment.

CMS pay for performance program scores can reduce a hospital's inpatient Medicare DRG payment revenue by as much as 6%. Physician fee schedule payments can also be affected (positively or negatively) by as much as 5% in 2020 reaching 9% in 2022 through MIPS. See next section *CMS Pay for Performance Programs*.

Physician revenue is also affected by payment adjustments from the CMS pay-for-performance program Merit-based Incentive Payment System (MIPS) although few of the measures are currently risk-adjusted.

In addition to physician office claims, the hospital's inpatient and outpatient data are used for risk adjustment. Because chronic conditions drive HCCs, they deserve as much attention as acute conditions to ensure they are properly documented and coded in both the inpatient and outpatient setting.

It is helpful to clarify that the HCC diagnoses used for risk-adjusting the measures included in these CMS pay for performance programs are based on the original "condition category" (CC) classification (precursor to HCCs). The hierarchical component (the "H" in HCC) used for MAO risk score calculations is not used for provider risk adjustment; however, we still refer to HCCs to not confuse with the CC (comorbidity/complication) conditions for DRGs. In addition, the risk adjustment coefficients (weights) for these HCC diagnoses all vary by measure as well as the scoring methodologies and performance periods. For example:

The risk adjustment coefficient (weight) for a diagnosis of **metastatic cancer** condition category varies significantly among the different measures:

| Measure | Coefficient (Weight) |
|------------------------------------------|----------------------|
| Medicare Spending Per Beneficiary | 2.6549 |
| Mortality—Pneumonia | 1.1039 |
| Mortality—Acute MI | 0.6518 |
| Mortality—Heart Failure | 0.5408 |
| Readmission—COPD | 0.2304 |

| Measure | Coefficient (Weight) |
|----------------------------------|----------------------|
| Readmission—Acute MI | 0.1739 |
| Readmission—Heart Failure | 0.1341 |
| Readmission—Pneumonia | 0.2029 |
| Readmission—CABG | 0.0389 |
| THA/TKA Complications | -0.0570 |

Only the measure for Medicare Spending Per Beneficiary (MSPB) is risk-adjusted according to the actual CMS-HCC weight with the mortality and readmission measures having very different weights for a metastatic cancer diagnosis, and a negative factor for THA/TKA complications.

Regardless of the different weights assigned across the different measures for HCC diagnoses, to "keep it simple" the CMS-HCC diagnoses should be the focus of any inpatient or outpatient CDI program.

CMS-HCC VS. HHS-HCC

CMS developed the CMS-HCCs as a risk adjustment payment methodology for the Medicare Advantage program (Medicare Part C), based on the *over-65* population, and the RxHCC model for Medicare Part D to predict drug spending.

The Department of Health and Human Services developed HHS-HCCs as a risk adjustment payment methodology for the commercial (*non-elderly*) payer population for the ACA plans. HHS-HCCs predict both medical and drug spending.

Although the HHS model has more HCC categories than the CMS model, the CMS-HCCs have more diagnosis codes.

| | CMS-HCCs (Medicare) | HHS-HCCs (Non-Medicare, Adult) |
|---------------------------------|---------------------|--------------------------------|
| Number of HCC categories | 86 | 115 |
| HCC categories | 1–189 | 1–254 |
| ICD-10-CM codes | 9,700 | 8,200 |

Although CMS-HCCs and HHS-HCCs share many of the same diagnoses, the primary difference in the HHS-HCC model is conditions found in the non-Medicare population, such as pregnancy and labor/delivery complications, congenital disorders, and chronic conditions such as asthma, anorexia, bulimia, and developmental disorders. The HHS-HCC excludes conditions found predominantly in the adult population (but included in CMS-HCCs) such as angina, morbid obesity, alcohol/drug dependence, and aortic aneurysms.

CMS PAY FOR PERFORMANCE PROGRAMS

The Affordable Care Act of 2010 mandated the development of quality reporting and pay for performance programs in all practice settings including hospitals, outpatient facilities, physician practices and post-acute care. CMS's goal was to have 90% of traditional Medicare fee-for-service payments tied to quality and 50% linked to alternative payment models by 2018.

The CMS hospital and physician pay for performance programs are a major component of Medicare's effort to shift healthcare away from the current payment system in which providers are paid for services regardless of outcome.

HOSPITAL PAY-FOR-PERFORMANCE PROGRAMS

There are three hospital P4P programs in which all hospitals (who serve Medicare patients) participate:

1. Hospital Value-Based Purchasing Program
2. Hospital Readmissions Reduction Program
3. Hospital-Acquired Condition Reduction Program

All three P4P programs include measures that are risk-adjusted based on certain HCC diagnoses, but not all. The following measures are risk adjusted:

- Medicare Spending Per Beneficiary (MSPB)
- Mortality rates for acute MI, heart failure, and pneumonia
- THA/TKA complication rates
- Readmission rates
- Patient Safety Indicators (PSI-90)

The three hospital CMS P4P programs are described below

HOSPITAL VALUE-BASED PURCHASING PROGRAM (VBP)

The Hospital Value-Based Purchasing (VBP) Program is the main P4P program that provides incentive payments to hospitals based on indicators of patient care, quality, cost efficiency, and patient satisfaction.

For VBP, Medicare *withholds 2% of hospitals' annual base operating DRG payments* for an incentive pool that pays back money to hospitals *based on the quality of care provided*. The amount each hospital receives depends on its ranking compared with all other hospitals.

A hospital with average performance gets back the 2% withheld (a net change of zero). Those below average get back less than the 2% withheld (0% back for the very worst performance — a net loss of 2%). The best performers get back an additional amount up to 2% above the 2% withheld. Therefore, the risk/opportunity ranges between -2% to +2% of DRG payments.

The 2020 VBP consists of four components (domains) of equal weight (25% each) that include a total of 20 measures:

1. **Clinical Outcomes:** 30-day mortality rates for acute MI, heart failure, and pneumonia; THA/TKA complication rate.
2. **Person and Community Engagement:** 8 measures of patient satisfaction from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey.
3. **Efficiency & Cost Reduction:** Medicare Spending Per Beneficiary (MSPB) = all Part A and B payments to all providers from 3 days prior to admission through 30 days post discharge.

4. **Safety:** CLABSI, CAUTI, CDI (Clostridium difficile infection), MRSA bacteremia (positive blood culture), SSI (surgical site infections) for abdominal hysterectomy and colon surgery; PC-01 Elective delivery < 39 weeks.

The Clinical Outcomes and Efficiency & Cost Reduction component measures are risk-adjusted based on certain HCCs.

HOSPITAL READMISSIONS REDUCTION PROGRAM (HRRP)

A readmission is defined as a patient who is readmitted for any reason to the same or another acute care hospital within 30 days of discharge. The 30-day readmission measure excludes planned readmissions, such as planned chemotherapy or rehabilitation.

The HRRP imposes a monetary penalty on hospitals for excess readmissions of Medicare patients 65 years of age or older originally admitted (“index admission”) with any of four diagnoses (acute MI, heart failure, pneumonia, COPD) or two procedures (CABG and elective hip or knee replacement). The excess readmission rate for each of the six index admission categories is defined as exceeding the risk-adjusted national average readmission rate. The total penalty is an aggregate of any penalties for each of the six categories. The maximum penalty is 3% each year.

As noted before, the severity of illness based on certain HCC conditions influences the risk adjustment for the readmission rates. Sicker patients are expected to have higher readmission rates, so hospitals with a patient population reflecting higher severity of illness will have their readmission rates adjusted downward and therefore are less likely to be penalized. Hospitals with lower severity of illness will have their readmission rates adjusted upward with a greater likelihood of a penalty.

HOSPITAL-ACQUIRED CONDITION REDUCTION PROGRAM (HACRP)

Under the HACRP, CMS penalizes hospitals that perform poorly for certain select hospital acquired conditions (HAC)s. Hospitals ranked in the lowest-performing

quartile (worst 25%) for these HACs are penalized 1% of their total Medicare DRG payments. The 2020 HACRP comprises:

- **CMS PSI 90 measure:** Includes a composite of ten "claims-based" Patient Safety Indicators (PSI) derived from ICD-10 codes with POA status assigned on the hospital claim, and determined by physician documentation.
- **CDC Hospital Acquired Infection (HAI) measures:** Derived from "abstracted" measures for adverse events. Measure abstraction is typically performed by a hospital's quality or infection control department using CDC case definitions based on objective information in the medical record independent of physician documentation. Physician documentation and code assignment have no influence on these abstracted measures.

PSI-90 MEASURES (CLAIMS-BASED):

- PSI-03 Pressure ulcer (13%)
- PSI-06 Iatrogenic pneumothorax (4%)
- PSI-08 In-hospital fall with hip fracture (1%)
- PSI-09 Perioperative hemorrhage and hematoma (4%)
- PSI-10 Postoperative acute kidney injury (8%)
- PSI-11 Postoperative respiratory failure (21%)
- PSI-12 Perioperative pulmonary embolism or DVT (19%)
- PSI-13 Postoperative sepsis (25%)
- PSI-14 Postoperative wound dehiscence (<1%)
- PSI-15 Unrecognized abdominopelvic accidental puncture/laceration (4%)

Note that **four measures** (pressure ulcer, postoperative respiratory failure, postoperative sepsis, perioperative PE/DVT) contribute 78% to the total PSI-90 measure score.

CDC HAI MEASURES (ABSTRACTED):

- CLABSI (central line–associated bloodstream infection)
- CAUTI (catheter-associated UTI)
- SSI (surgical site infections) for total hysterectomy and colon surgery

- MRSA bacteremia (positive blood culture)
- Clostridium difficile infections

Each measure for which a hospital has a measure score is of equal weight. For example, if a hospital only has a measure score for PSI-90, CLABSI, CAUTI, MRSA bacteremia, and C-diff infection (5 of the 6 measures), each measure would account for 20% (1/5) of the total measure score.

PHYSICIAN PAY-FOR-PERFORMANCE PROGRAMS

Like hospitals, clinicians are incentivized to improve quality of care and reduce costs through the CMS Quality Payment Program. These quality incentive programs for physicians and other eligible clinicians reward value and outcomes through Alternative Payment Models (APMs) and the Merit-based Incentive Payment System (MIPS).

An Alternative Payment Model (APM) is a payment approach that gives added incentive payments to encourage high-quality and cost-efficient care. The different models can apply to a specific clinical condition, a care episode, or a population. APM examples include joint replacement (bundled payments), comprehensive ESRD care, accountable care organizations (ACO), among others.

Accountable Care Organizations (ACOs): ACOs are groups of healthcare providers (physicians and hospitals) that agree to be accountable for the cost and quality of care for a group of beneficiaries. For this defined population of beneficiaries, Medicare ACOs are “accountable” for the total Medicare Part A and Part B spending and their quality of care.

Providers in ACOs continue to be paid their normal fee-for-service rates but can earn bonus payments if at the end of the year actual total spending is less than the expected spending (based on a predetermined benchmark) for those beneficiaries. If there is a savings (actual spending is less than expected), those savings are shared between Medicare and the ACO at a defined shared savings rate. The calculation of savings and losses are influenced by their quality measures and beneficiary

risk adjustment scores based on HCCs. The higher the quality and risk scores the greater share of the savings the ACO receives.

MERIT-BASED INCENTIVE PAYMENT SYSTEM

The vast majority of clinicians currently participate in MIPS. MIPS was designed to tie payments to quality and cost-efficient care, drive improvement in care processes and health outcomes, increase the use of healthcare information, and reduce the cost of care.

MIPS determines traditional Medicare fee schedule adjustments. Using a composite performance score, eligible clinicians may receive a payment bonus, penalty or no payment adjustment. The potential MIPS adjustment in 2020 will be $\pm 5\%$, increasing to $\pm 9\%$ by 2022. The 2018 performance period will determine the 2020 adjustment.

MIPS eligible clinicians include physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists.

The 2020 MIPS performance year final score will be based on the following measures:

1. **Quality—45%**

Clinicians must collect and submit data for at least 6 measures selected from a list of 257 measures; at least one must be an Outcome measure.

Examples of measures include: Age appropriate screening colonoscopy, 30-day all-cause hospital readmission rate, controlling high blood pressure, biopsy follow-up, breast cancer screening, zoster (shingles) vaccination.

2. **Promoting Interoperability—25%**