Hierarchical Condition Category (HCC) Coding for MIPS Cost

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Quality Payment Program of Illinois

Visit our website at http://qpp-il.org! We will help you navigate the complexities of the new CMS payment models so you can focus on what you do best – taking extraordinary care of your patients.

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Agenda

- Brief MACRA/QPP Overview
- MIPS Cost Category Refresher
- CMS Risk Adjustment
- Hierarchical Condition Categories (HCC)
- Practical Application

Brief MACRA/QPP Overview

MACRA (2015)

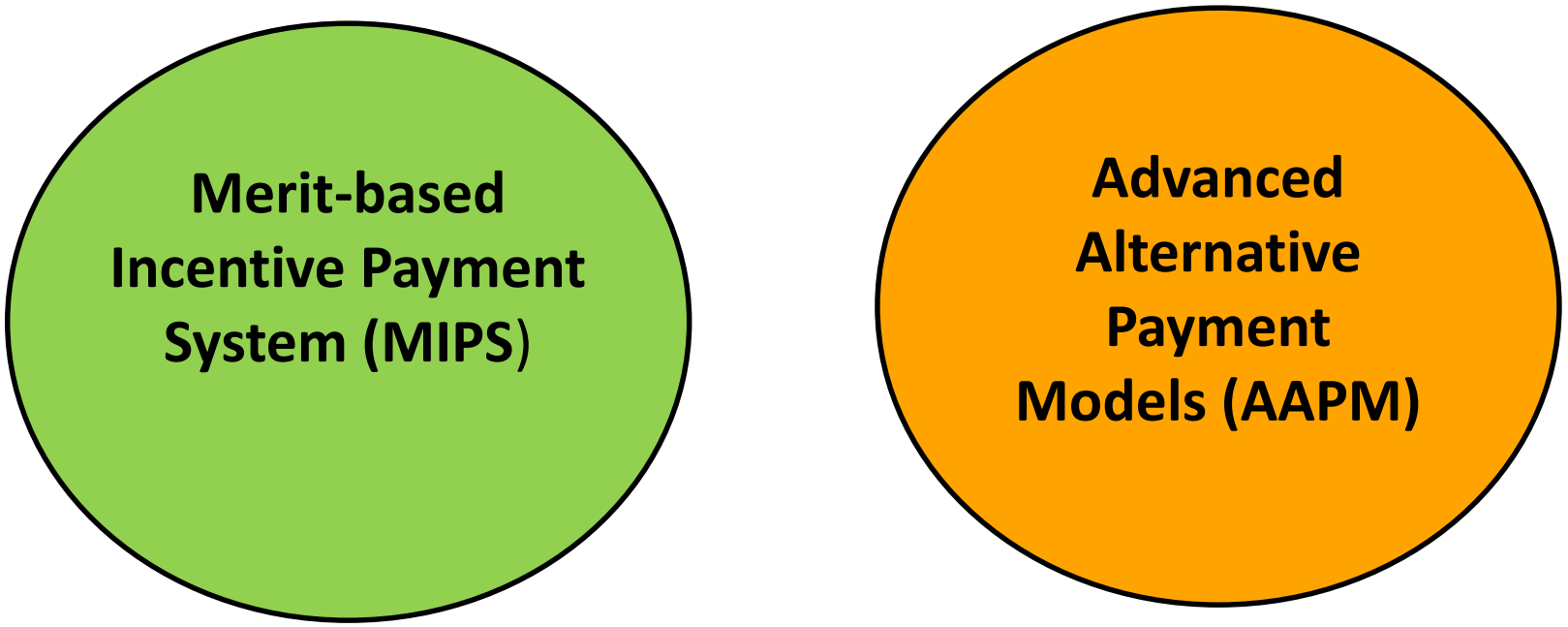
- Repeals “Sustainable Growth Rate”
- Streamlines multiple quality programs
- Expands pathways for level of risk and reward
- Supports multi-payer initiatives

2018 QPP Eligibility

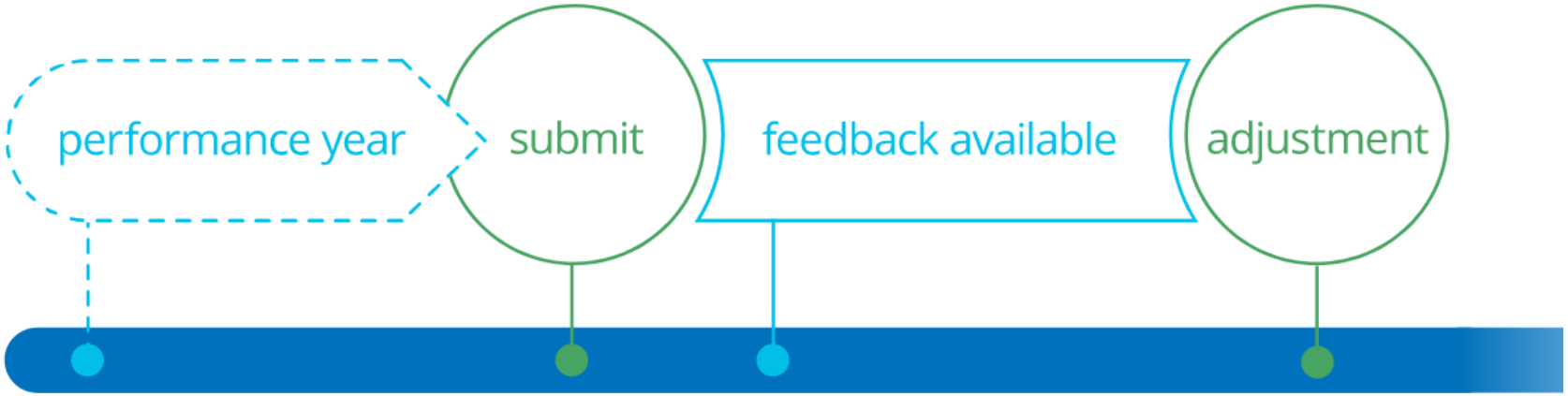
1) Billing > $90,000 and treating > 200 Medicare patients per year (MIPS)

or

2) Treating 20% patients/receiving 25% of Medicare payments through an Advanced Alternative Payment Model (AAPM)



2018 QPP Timeline



Calendar Year 2018	March 31, 2019	2019	2020
Performance period begins 1/1/18 and ends on 12/31/18. During the year, record quality data, how you used CEHRT and implemented improvement activities.	Deadline to report QPP data to qualify for positive payment adjustment under MIPS or 5% bonus under AAPM.	Medicare analyzes reported data and provides feedback on performance and MIPS payment adjustments or AAPM bonus.	MIPS payment adjustments applied to Medicare Part B reimbursements beginning 1/1/20. AAPM bonuses awarded in 2020.

MIPS Cost Category Refresher

Cost Category Basics

- Uses parts of the Value Modifier, a legacy CMS program
- Quantifies resource use and payments for beneficiaries and their hospital stays, compared against national benchmarks
- Automatically calculated based on claims data for full year performance period
- Calculations adjusted to achieve fair comparisons based on:
  - Patient factors (complexity)
  - Provider factors (specialty, geography)
- Contributes 10% weight towards MIPS score for 2018
  - Was 0% in 2017
  - Must be 30% by 2022 (can be set anywhere between 10%-30% until then)

Cost Measures

- Total Per Capita Cost (TPCC)
  - Includes all Part A and Part B costs related to all treatment
  - Each patient, and their cost, is attributed to a single TIN/NPI
  - Sum of costs divided by number of attributed beneficiaries

- Medicare Spending Per Beneficiary (MSPB)
  - Includes all Part A and Part B costs related to hospital stays
  - Each patient, and their cost, is attributed to a single TIN/NPI
  - Sum of costs divided by number of attributed admissions

- Episode-based measures in development for future
  - Inform clinicians of cost of managing care for an acute medical condition or procedure
  - Field testing conducted for subset of episodes (e.g. screening/surveillance colonoscopy, pneumonia hospitalization)

Cost Measures

- TPCC
  - Measures overall cost of care provided to beneficiaries
  - Calculated from Part A and B claims from inpatient/outpatient hospital, skilled nursing facility, home health, hospice, equipment/prosthetics/orthotics/supplies, and Part B Carrier

- MSPB
  - Measures overall cost of care related to beneficiary hospital stay
  - Calculated from Part A and B claims within “episode window” of 3 days prior to admission through 30 days after discharge

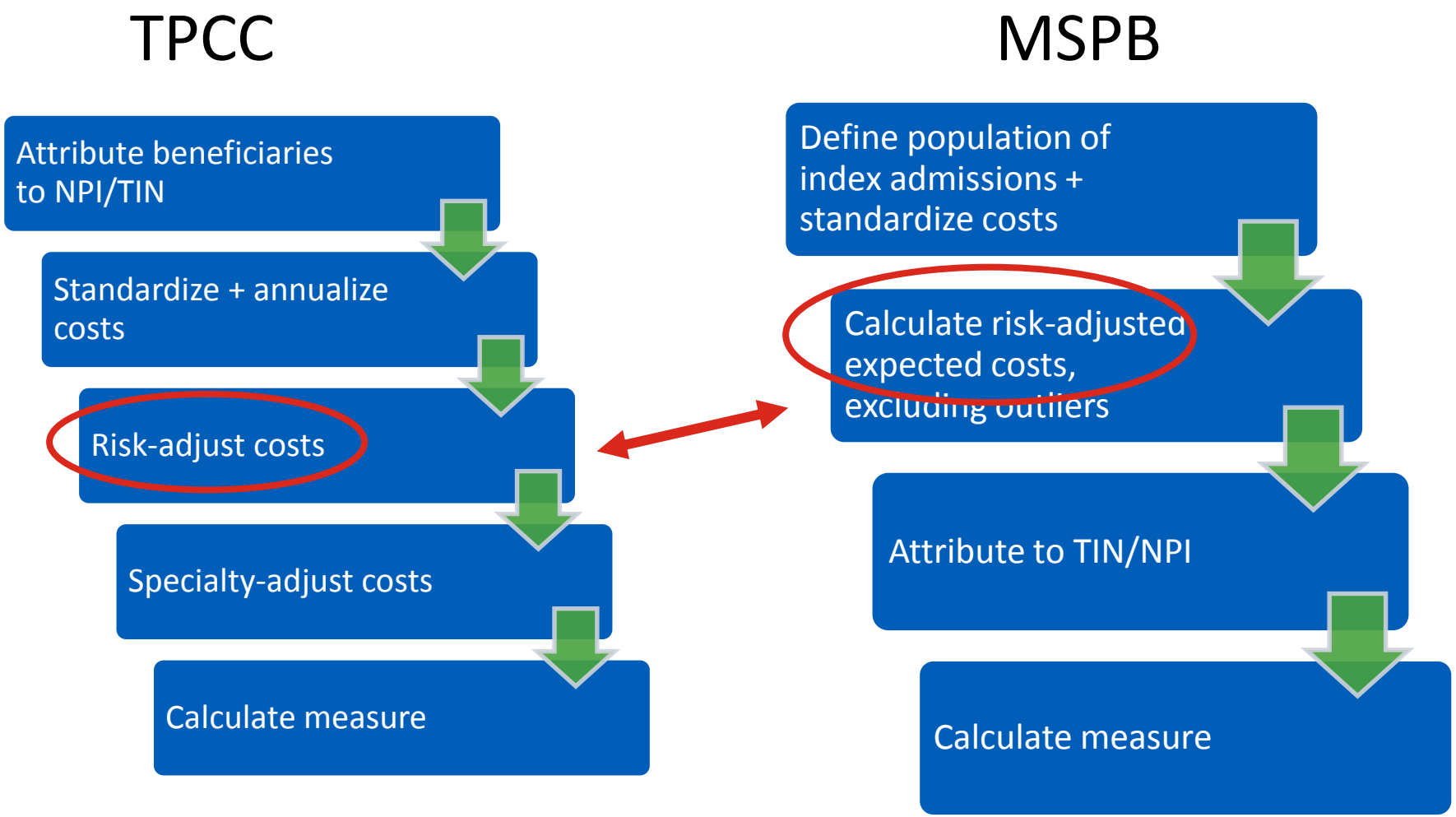
CMS Risk Adjustment

CMS Risk Adjustment Models

- Account for differences in clinical complexity of beneficiaries
- Enable more accurate comparisons of quality and cost across TINs
- Estimate expected performance based on complexity of patient population, then compare to actual performance

$$Risk\ Adjusted\ Measure\ Score = \left(\frac{Actual\ Performance}{Expected\ Performance} \right) * National\ Average$$

Risk Adjustment in MIPS Cost



Hierarchical Condition Categories (HCC)

CMS-HCC Basics

- Initiated by CMS in 2004 to adjust payments for Medicare Advantage
- Goal was to use billing data to accurately predict future expenses
- Identify a limited set of conditions that reliably reflect how an individual's disease burden contributes to healthcare costs
- CMS-HCC Model Category V22:
  - Includes 79 clinical condition categories within 31 hierarchies
  - Each category contains one or more ICD-10 code
- Approximately 9,500 ICD-10 codes (14%) map to an HCC
  - Includes most chronic conditions
  - Excludes non-diagnostic (e.g. "abdominal pain"), insignificant (e.g. "sprain"), definitively treated (e.g. "acute appendicitis")

HCC Risk Adjustment

- HCC based on retrospective claims review of ICD-10 codes
- Any ICD-10 code that appears on at least one claim will be reviewed for mapping to HCC
- Patient may have diagnoses representing more than one HCC
- Risk Adjustment Factor (RAF) = numeric value representing degree of risk of each HCC to cost performance
- Only highest RAF HCC within hierarchy will contribute (if a beneficiary has condition in both HCC 135 (Acute Renal Failure) and 136 (Chronic Kidney Disease, Stage 5), then DG 136 will be dropped)
- Demographics, Medicaid eligibility, disability also contribute to total RAF

HCC in MIPS Cost Measures

- TPCC uses CMS-HCC Model
  - New enrollee model
    - Used if beneficiary has less than 12 months of Medicare claims history
    - Risk score based on age, sex, disability status
  - Community model
    - Used if beneficiary has 12+ months of Medicare claims history
    - Includes reason for Medicare entitlement, Medicaid enrollment and clinical conditions

- MSPB is based on HCC model used for Medicare Advantage plans
  - Accounts for age
  - Assesses severity of illness based on:
    - HCC indicators + interactions
    - ESRD status
    - Diagnosis Related Group (DRG) code

Practical Application

Annual Comprehensive Diagnoses

- Providers *know* that patients are sicker than CMS *thinks* they are
- HCCs communicate patient complexity
- Comprehensive ICD-10 coding produces more accurate RAF
- RAF resets every January 1
  - Treatment within current year is evidence of diagnosis
  - Amputations grow back!
  - Diseased lungs return to normal!
  - Pancreases regenerate!

Documentation Demands

- Coding co-morbidities does not affect reimbursement under fee-for-service model, but matters with value-based care
- There is no “goal” RAF; ICD-10 coding must be justifiable based on evidence in the medical record
- Avoid discrepancy between codes on claim forms and codes used in medical record
- Clearly indicate that diagnoses are being monitored, assessed or treated as part of the medical record

For detailed guidelines, visit https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2018-ICD-10-CM-Coding-Guidelines.pdf

CMS-HCC Model RAF

- Sample from AAFP CMS-HCC value handout:

Diabetes	
HCC17 = Diabetes with Acute Complications	0.368
HCC18 = Diabetes with Chronic Complications	0.368
HCC19 = Diabetes without Complication	0.118
Heart and Circulatory Disease	
HCC84 = Cardio-Respiratory Failure and Shock	0.329
HCC85 = Congestive Heart Failure	0.368
HCC106 = Atherosclerosis of the Extremities with Ulceration or Gangrene	1.413
HCC107 = Vascular Disease with Complications	0.410
HCC108 = Vascular Disease	0.299

* Values from Table 1, page 67 of https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2014.pdf

Example A

- Diabetic, hypertensive, overweight patient
- “Basic” ICD coding communicates HCC RAF of 0.118

ICD-10	Description	RAF
E11.9	Type 2 diabetes without complications	0.118
I10	Hypertension	0
Z68.37	BMI of 37.2	0

Example A

- "Optimized" ICD coding for same patient communicates significant risk due diabetic complications, morbid obesity, leg amputation

- HCC RAF = 1.512

ICD-10	Description	RAF
E11.42	Type 2 diabetes with diabetic polyneuropathy	0.368
I10	Hypertension	0
E66.01 & Z68.37	Morbid obesity with BMI of 37.2	0.365
Z89.512	Acquired absence of left leg below knee	0.779

Example B

- Patient with CKD, alcohol abuse, depression
- “Basic” ICD coding communicates HCC RAF of 0.224

ICD-10	Description	RAF
N18.5	CKD, Stage 5	0.224
F10	Alcohol related disorders	0
F32.9	Major depressive disorder, single episode, unspecified	0

Example B

- "Optimized" ICD coding for same patient communicates dialysis, alcohol dependence, and severe depression

- HCC RAF = 1.226

ICD-10	Description	RAF
Z99.2	Dependence on dialysis	0.476
F10.182	Alcohol abuse with alcohol-induced sleep disorder	0.420
F32.2	Major depressive disorder, single episode, severe without psychotic features	0.330

References

- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-RiskAdj-FactSheet.pdf
- https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/2018MidyearFinalICD-10-CMMappings.zip
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