MATCHING FINANCIAL REWARDS TO CLINICAL COMPLEXITY
Rising practice costs, downward pressure from third-party payers and government budget problems are among the major issues that affect practice profitability. Many private practice physicians have joined larger groups or become hospital employees to minimize the impact of these issues, but larger organizations face the same pressures. Physician organizations have tried to combat reduced profitability with a variety of methods, including the Risk Adjustment Factor (RAF) program, which rewards physicians for treating more clinically complicated cases. If used appropriately, this method could result in better patient care and higher reimbursement for practice professionals who negotiate with payers.

The RAF is used by the Centers for Medicare & Medicaid Services (CMS) to adjust payments made to Medicare Advantage (MA) contractors to reflect the severity of their enrolled population. The MA program and its CMS predecessors have always attempted to adjust their payments based on severity, which has not traditionally been done by individual practices. Originally demographic factors were the lone basis for adjustment. The largest adjustment in the adjusted average per capita cost method was the county of residence. Payments to MA contractors could vary by hundreds of dollars a month depending on which side of a county line a patient lived. This original method predicted less than 1 percent of the variation in costs of care for individual patients, and CMS has continued to change the method to improve its prediction capabilities. The RAF method improves on all previous efforts by combining a demographic factor for each patient with a measure of his/her clinical condition. Hierarchical Condition Categories (HCC) provide clinical component data.

The HCC model takes all ICD-9-CM codes (more than 14,000) and classifies them into approximately 800 diagnostic groups (DXG). Each ICD-9 maps to only one DXG. Each DXG is, in turn, converted into 189 condition categories (CC) that have a numeric weight reflecting the severity of the condition. At this point, the hierarchical structure is applied. An individual who is associated with two clinically related CCs will only have the most severe counted. For example, if two separate patient encounters generate HCC 17 — diabetes with acute complications, and HCC 19 — diabetes without complications, only HCC 17 will be associated with the patient.

The sickest Medicare enrollees have dozens of HCC conditions. Fully capturing all available HCCs...
can positively affect patient treatment and Medicare payments, but the program rewards MA contractors for enrolling sicker patients. Physician groups and hospital-owned groups may not share in the rewards unless they ask specifically about this during the negotiation process, which has been done by at least one New York-based practice. Payers will generally not offer to share in the additional revenue from CMS.

Additionally, CMS does not reward groups for patients who die during a measurement year. While this might be a logical decision, it poses a challenge for groups given the mortality rates of patients who have the most complex conditions.

Every medical group, hospital-owned physician network and accountable care organization should evaluate whether additional revenue will be available through an HCC program and negotiate

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**Figure 1**

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>DXG</th>
<th>CC</th>
<th>HCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>410.91 AMI of unspecified site, initial episode of care</td>
<td>81.01 AMI, initial episode of care</td>
<td>81 AMI</td>
<td>81 AMI</td>
</tr>
<tr>
<td>413.9 Other and unspecified angina pectoris</td>
<td>83.02 Angina pectoris</td>
<td>83 Angina pectoris/old myocardial infarction</td>
<td></td>
</tr>
<tr>
<td>491.2 Obstructive chronic bronchitis</td>
<td>108.01 Emphysema/chronic bronchitis</td>
<td>108 COPD</td>
<td>108 COPD</td>
</tr>
<tr>
<td>518.1 Interstitial emphysema</td>
<td>131.06 Renal failure, unspecified</td>
<td>131 Renal failure</td>
<td></td>
</tr>
<tr>
<td>585.9 Renal failure, unspecified</td>
<td>131.05 Chronic renal failure</td>
<td>131 Renal failure</td>
<td></td>
</tr>
</tbody>
</table>

In excluded:

786.5 Chest pain → 166.18 Chest pain → 166 Major symptoms, abnormalities → 166 Major symptoms, abnormalities

845.00 Ankle sprain → 162.12 Sprains → 162 Other injuries → 162 Other injuries

contract provisions to share in the revenue. Furthermore, the contract must specify the payment formula. For example, if CMS increases its payment to a payer, the group will get a pro rata share based on its percentage of total enrollment.

HCC coding protocol compliance should also be part of value-based physician compensation plans. Plans should specifically not reward physicians for codes they select. The compensation plan should reward physicians if they comply with procedures that allow a physician to review and consider historical diagnoses, such as diabetes.

**Coding practices**

More accurate and comprehensive coding that focuses on HCC will be necessary to improve HCC scores. These tools must provide physicians with historical diagnosis data and prompts for coding requirements under the HCC program (i.e., a diagnosis of diabetes with complications must be accompanied with the diagnosis explaining the complication). Whether providers employ an automated program or develop a retrospective manual audit system, additional resources will help achieve success.

Hierarchies are only applied to clinically related CCs. In the example given, HCC 17 and HCC 19 have weights of 0.349 and 0.119, respectively. The patient is only associated with HCC 17 and receives a score of 0.349. Nonclinically related HCCs are additive, not hierarchical. If the hypothetical patient also had congestive heart failure (HCC 80 — weight 0.325), the score would be 0.674 (.0349 + .0325).

The HCC payment model includes 70 HCCs that best predict Medicare Part A and Part B medical expenditures. HCCs containing diagnoses that are vague or nonspecific (e.g., symptoms), discretionary in medical treatment or coding (e.g., osteoarthritis), not medically significant (e.g., muscle strain), or transitory or definitively treated (e.g., appendicitis) are excluded from the RAF calculation. The payment model also excludes HCCs that do not add to costs as well as HCCs that are fully defined by the presence of procedures or durable medical equipment to ensure that payments are based on medical problems that were chronic and present rather than services offered.

In Figure 1, the patient encounter resulted in eight separate diagnoses. The first diagnosis (410.91) maps to a single DXG, a single CC and HCC 81 (AMI) with a weight of 0.276. The second diagnosis (413.9) also maps to a single DXG and a single CC, but the hierarchical methodology does not count HCC 83 because it is related and clinically less complex than HCC 81. The third and fourth diagnoses (491.2 and 518.1) map to the same DXG, which maps to a single CC and HCC 108, chronic obstructive pulmonary disease. The fifth and sixth diagnoses (585.9 and 586) map to separate DXGs, but those DXGs map to a single CC and HCC 131. The seventh and eighth diagnoses (786.5 and 845.00) do not contribute to the payment model. Diagnosis 786.5, unspecified chest pain, is not specific enough to qualify. Diagnosis 845.00, ankle sprain, is not medically significant.

Notes:
2. Risk adjustment under the Affordable Care Act: A guide for federal and state regulators (Commonwealth Fund, May 2001: commonwealthfund.org/~media/Files/Publications/IssueBrief/2011/May/1501_Hall_risk_adjustment_ACA_guide_for_regulators_ib_v2.pdf)