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HCCs Address Some MD Complaints in Value Era, But Not Without MEAT Documentation

By Nina Youngstrom

As more payment is tied to quality, outcomes and cost, physicians often lament they're penalized because they see their patients as different—more complex, poorer—or their facilities as disadvantaged, with fewer staff or outdated equipment.

"You hear that often enough and probably there is a lot of legitimacy to it. Patients don't come in uniform fashion and the human condition is heterogeneous," said Ellis "Mac" Knight, M.D., senior vice president and chief medical officer for the Coker Group in Alpharetta, Georgia. "We have to take into account whether quality measures are applied evenly to different providers with different populations and practices."

Physicians' concerns are somewhat addressed through a risk-adjustment methodology using hierarchical condition categories (HCCs), but only if physicians satisfy unique documentation requirements that may be unfamiliar, Knight said. Their reimbursement depends on it, and accuracy will matter as they start to face audits in this area.

Medicare Advantage plans use HCCs for provider payments, and they will become more pervasive with CMS's Bundled Payments for Care Improvement Advanced initiative and other Medicare and commercial value-based reimbursement programs, Knight said at a webinar sponsored by the Health Care Compliance Association on Aug. 1. The mother of all pay-for-performance programs—the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs), which were created by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015—will be fully implemented on Jan. 1, and will use HCC methodology to risk adjust quality and cost metrics. Commercial plans, which follow Medicare, also are adopting value-based models, another reason for providers to become more adept at risk-adjustment coding and documentation, he said.