HealthCare
Kentucky Regional Extension Center

HCC Scores: Need to Know

The CMS Hierarchical Condition Categories (CMS-HCC) model generates a risk score for each beneficiary. CMS uses these CMS-HCC risk scores in the risk-adjustment methodology for Medicare Advantage, and can impact the Merit-Based Incentive Payment System (MIPS). This score summarizes each beneficiary's expected cost of care relative to other beneficiaries. Separate CMS-HCC models exist for new and continuing enrollees.

Basics of HCC Scores

- Larger weighted HCC Scores reflect greater patient risk & will be paid out at a higher reimbursement, allowing for better care for those who need it most.
- HCC Scores are mapped directly to the ICD-10 diagnosis codes.
- HCC Scores can have an effect on the MIPS Cost Category, which accounts for 10% of the total MIPS points for Year 2.
- Gives CMS an idea of what the course of treatment may look like for the patient.

How HCC Scores Are Used

Demographic Risk Factor	+	HCC weight per Diagnosis	+	HCC weight per Complications	=	Overall Risk Factor
92 years (0.857)	**+**	**Metastatic Cancer (2.625)**	**+**	**Diabetes without complication (0.104)**	**=**	**3.586***

*If the overall risk factor is 1.0, your patient's cost of care will be what CMS has determined as the 'average' cost of providing treatment. Low risk patients (younger, healthier, fewer complications) will be paid out less than average, whereas high risk patients (older, more complex cases) will be paid higher.

MIPS Cost Performance Category

- Year 2 Cost Category worth 10% of overall score
- Year 3 Cost Category worth 30% of overall score
- No data submission required-Claims are used to determine cost performance, including HCC Scores.

HCC Score: Impact on MIPS Final Score

- MIPS scoring in Year 2 can apply up to 5 bonus points using Complex Patient Bonus to final score.
- Highly complex (risky) patients will increase this bonus.

Helpful Hints:

1. Encounters which benefit from HCC/high risk patients must be face-to-face.
2. Encounters must be from an acceptable data source (i.e. hospital inpatient facilities, hospital outpatient facilities, and physicians)
3. Ensure diagnoses are all being captured, CMS 1500 (standard CMS paper claim form) will allow for up to 12 diagnoses per claim, and documentation must allow for capture of the highest degree of severity.
4. Must show current state of disease process
    a. Acute, chronic, compensated, decompensated, exacerbated
    b. If ruled out/resolved, indicate in the documentation
    c. If cause of condition is known, capture it
5. Show relationships to other disease processes, using verbiage such as:
    a. "With…," "Due to…," "Caused by…," and/or "Secondary to…"
6. Although many EHRs show HCC Scores for each diagnoses, providers can also find them on their QRURs.

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