HCC

Drafted March 19, 2022 by HIM and Pop Health

Q: What are HCCs?

A: HCC stands for Hierarchical Condition Category. These are diagnosis codes billed to a payor. The payor uses HCC codes to calculate a Risk Adjustment Factor, or RAF scores. RAF scores tell CMS how much each Medicare beneficiary should need to spend every year on their healthcare costs.

Q: Why should providers care about HCCs?

A: Insurance companies are moving more and more to value-based payment (VBC) structures. In order to maximize financial performance under these VBC arrangements, providers need a way to accurately portray how sick their patients are. This allows the insurance company to assign the appropriate cost to care for that individual. The way providers can communicate with the payors is through diagnosis coding. This communication should occur annually through continued opportunities to add or combine HCCs and improve the overall RAF score for the patient.

Q: What is the difference between value-based reimbursement and the reimbursement we have received in the past?

A: We have some insurance payors who offer additional incentives for meeting quality measures, known as P4Q, or Pay for Quality. The addition of value-based arrangements (VBC), means the path to receiving rate increases is tied to partnering with the insurance plan to help reduce the total cost of care, or manage lives within a budget. When we are able to keep the healthcare spend for a particular set of beneficiaries within a defined threshold, we share in the savings. The inverse is that under VBC, we also share in any deficit if the defined threshold is exceeded. The HCCs and subsequent RAF score help us ensure that the defined threshold is a realistic target for the applicable population