

What is Risk Adjustment?

A process used by the Centers for Medicare & Medicaid Services (CMS) involving diagnosis reporting to measure a beneficiary's health status. Risk adjustment heavily relies on diagnoses to provide more accurate payments to Medicare Advantage organizations.

Implementation and Goal of Risk Adjustment

In 1997 the Balance Budget Act and later legislation required CMS to adjust per-beneficiary capitation payments with a risk adjustment method. Different models were developed to represent different Medicare populations. CMS goal was to select a clinically sound risk adjustment models that improved payment accuracy.

CMS-HCC Model Functions

- Categorizes International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) codes into disease groups called Hierarchical Conditions Category (HCCs).
- Each HCC includes diagnosis codes that are related clinically and have similar cost implications.
- Model is driven by costs associated with chronic diseases.
- Captures the systematic risk associated with Medicare populations
- Combines diagnosis codes and demographic characteristics to produce a risk score. The risk score reflects the beneficiary's expected health status and the projected cost for their care for one calendar year.

The Provider's Role

- Accuracy and specificity in coding and medical documentation is critical for risk adjustment, specifically diagnosis coding.
- Physicians are the main source of ambulatory information for the risk adjustment model.
- The CMS-HCC model relies on ICD-9-CM coding to represent the beneficiary's health status, not just CPT procedure codes.

To learn more about Risk Adjustment, schedule a presentation today. Contact: Erin Simon (541) 768-5352, esimon@samhealth.org