Risk Adjustment 101

What is risk adjustment?
• Risk adjustment is a statistical methodology used to compare the health risk of populations enrolled in health plans¹ (Medicare Advantage, ACA/Marketplace, Medicaid).
• A relative risk score is calculated for each individual which is used to predict member costs.
• Generally, individuals with certain disease burdens will have higher risk scores and cost more to care for than healthier members.
• This ensures government entities reimburse health plans appropriately for members’ predicted health costs.
• Health plans can also use the data to identify the need for disease management interventions as well as closing quality care gaps.

What is hierarchical condition category (HCC)?
• HCC is a risk adjustment model originally designed to estimate future health care costs for patients².
• ICD-10-CM codes are mapped to diagnosis groups, then condition categories.
• These categories, along with other elements, are used to calculate relative risk scores, known as Risk Adjustment Factor (RAF).
• RAF scoring helps communicate patient complexity and are used to risk adjust quality and cost metrics².

How does risk adjustment impact members and providers?
• Directs resources to sicker members whose care is more costly.
• Encourages physicians to accurately document their patients’ conditions.
• Helps to identify gaps in clinical documentation.
• Creates opportunity for those high-risk individuals to be identified for care management or disease intervention programs.

¹ Medicare Advantage, ACA/Marketplace, Medicaid
² ICD-10-CM codes are mapped to diagnosis groups, then condition categories.

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Importance of documentation

Because risk adjustment relies on physicians to maintain accurate medical records to capture a comprehensive health status and complete risk profile of their patients, documentation and coding to the highest level of specificity is critical.

- To support an HCC, clinical documentation in the member’s record must support the presence and treatment of any risk-adjustable condition.
- Two recommended methods to assist in validating diseases:
  - M.E.A.T.
  - T.A.M.P.E.R.
- Documentation and diagnoses are the basis for funding and reimbursement.
- Accurate clinical documentation will allow open communication between health plans and providers and generate opportunities for education and feedback.

Record requirements and documentation

- Each note must stand alone.
- Contain a legible provider signature with credentials.
- Follow Official ICD-10-CM Guidelines for Coding and Reporting.
- Diagnoses must be documented to the highest level of specificity.
- Meet medical necessity.
- Utilize Monitor, Evaluate, Assess/Address, Treat (M.E.A.T.)/Treat, Assess, Monitor/Medicate, Plan, Evaluate, Refer (T.A.M.P.E.R.) methods to support members’ health conditions.

References