Risk Adjustment for Medicare Advantage (MA)
Risk adjustment is the methodology developed by the Centers for Medicare & Medicaid Services (CMS) to calculate the risk adjustment payment made to Medicare Advantage plans based on member health status and demographic factors. Medicare Advantage plans are required to provide all traditional Medicare covered benefits to its members. Plans use the payment from CMS to provide benefits, manage patient care and include additional benefits not covered by original Medicare.

Using this methodology, CMS assigns each patient a risk adjustment score, also known as a RAF (Risk Adjustment Factor), based on a calculation of his/her demographic and health status.

A lower RAF indicates a healthier patient with potentially low utilization of health plan benefits; a higher RAF indicates a patient with increased health risks and a potentially higher utilization benefits.

The RAF supports what it would cost a health plan to provide annual benefits and resources for each patient.

Accurately documented and reported diagnoses ensure that CMS assigns members an accurate RAF score in order to appropriately allocate funds to Blue Cross of Idaho to administer original Medicare benefits, enhanced benefits and other resources (such as disease management programs) for our members.

Risk Adjustment for the Affordable Care Act (ACA) Qualified Health Plans (QHP)
Per Section 1343 of the Affordable Care Act (ACA), permanent risk adjustment program applies to non-grandfathered individual and small group health plans purchased on and off the healthcare exchange (i.e. Your Health Idaho).

The risk adjustment methodology used for ACA populations is similar to the methodology used for Medicare Advantage: CMS determines the RAF of the health plan's members to determine accurate funding. The most significant difference between the two risk adjustment models is that the health plan does not receive funding from CMS; rather the ACA risk adjustment model requires that funds are transferred from health plans with lower risk member populations (members with a low RAF) to health plans with higher risk member populations (member with a high RAF) annually.

 Appropriately Reporting a Patient’s Health Status
As a best practice across all lines of business, it is important to remember that diagnosis codes alone do not support just the E&M or services performed; diagnosis codes included on claims also support the health status of the patient.

The provider should document all conditions considered as part of their medical decision making. To assist coders in determining if the provider considered a condition as part of their medical decision making, IonHealthcare, LLC created the acronym T.A.M.P.E.R., which the American Academy of Professional Coders currently supports.
T.A.M.P.E.R

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Assessment</th>
<th>Monitor or Medicate</th>
<th>Plan</th>
<th>Evaluate</th>
<th>Referral</th>
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</thead>
</table>
| • Medications  
• Therapies  
• Other treatment options | • Order tests  
• Condition discussion  
• Review records  
• Counsel | • Signs or symptoms  
• Disease status (progression/regression)  
• Medications (add, change, monitor) | • Medications – Therapies  
• Other treatment options | • Medication effectiveness  
• Treatment responses  
• Test Results | • Specialists  
• Disease management programs  
• Diagnostic testing |

If a presented condition within the chart seems unclear, coders/billers should ask, “Did the provider T.A.M.P.E.R. with the diagnosis in question on that date of service?”

Common Industry Terms & Acronyms used in Risk Adjustment:

- **AAPC**: American Academy of Professional Coders
- **ACA**: Affordable Care Act
- **AWV**: Annual Wellness Visit
- **CC**: Chronic Condition
- **CMS**: Centers for Medicare & Medicaid Services
- **CPT**: Current Procedural Terminology
- **CPE**: Comprehensive Physical Exam
- **CWV**: Comprehensive Wellness Visit
- **DHHS/HHS**: Department of Health and Human Services
- **EHR**: Electronic Health Record
- **E&M**: Evaluation and Management
- **EMR**: Electronic Medical Record
- **HCC**: Hierarchical Condition Category
- **HCPCS**: Healthcare Common Procedure Coding System
- **HIOS**: Health Insurance Oversight System
- **ICD-10-CM**: International Classification of Diseases, 10th Revision, Clinical Modification
- **IPPE**: Initial Preventive Physical Examination
- **IVA**: Initial Validation Audit
- **MA**: Medicare Advantage
- **MCO**: Managed Care Organization
- **MDM**: Medical Decision Making
- **MEAT**: Monitor, Evaluate, Assess, Treat
- **NCQA**: National Committee for Quality Assurance
- **PMPM**: Per Member Per Month
- **QHP**: Qualified Health Plan
- **RA**: Risk Adjustment
- **RADV**: Risk Adjustment Data Validation
- **RAF**: Risk Adjustment Factor
- **TAMPER**: Treatment, Assessment, Monitor/Medication, Plan/Evaluation and Referral
- **VBP**: Value Based Payments / Value Based Programs