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GUIDE

The Risk Adjustment Reality Check

Why most programs quietly underperform, and what high-performing organizations do differently

Inside this guide:

✓ The 5 warning signs your program has drifted from care to compliance

✓ Side-by-side scenario: same patient, two documentation approaches, radically different outcomes

✓ A 15-point self-assessment checklist with specific remediation actions

✓ A 30-day action plan to begin the shift from compliance exercise to care-delivery model

For CMOs, Compliance Leaders, VBC Directors, and Population Health Executives

salesteam@doctustech.com

www.doctustech.com

With CMS expanding to annual RADV audits for every MA contract starting in 2026, adding 2,000 new coders, and accelerating clawback timelines, risk adjustment programs that run on compliance alone are about to get exposed. This guide is your diagnostic tool.

Most risk adjustment programs don't fail because clinicians lack commitment. They underperform because organizations treat risk adjustment as a **coding exercise** rather than a **care-delivery model**. That distinction determines whether documentation improves outcomes, or simply generates compliant paperwork that collapses under audit scrutiny.

This guide is designed to help leaders see where programs quietly break down, and what high-performing organizations do differently. It is written for leaders accountable for outcomes, compliance, and long-term sustainability.

The guide is built around three core questions:

1. How does risk adjustment actually influence clinician behavior?
2. Where does documentation drift away from care and outcomes?
3. What do high-performing programs do differently and how can you start the shift in 30 days?

The financial reality: why this isn't just a quality conversation

Before examining where programs break down, leaders need to understand the financial stakes. Under the CMS HCC V28 model, the margin for error has narrowed dramatically:

- **Dozens of previously risk-adjustable HCCs have been eliminated.** Conditions that once contributed to RAF particularly high-frequency, lower-acuity diagnoses common in older populations, no longer carry payment weight.
- **Remaining high-value HCCs demand stronger clinical evidence**. Conditions like advanced heart failure, complex neurologic disease, severe COPD, and complicated diabetes now carry more strategic weight, but require diagnostic confirmation, specificity, and longitudinal MEAT support.
- **Every documentation failure is now amplified.** With fewer HCCs carrying payment weight, a single unsupported diagnosis that triggers a clawback has a proportionally larger revenue impact.

The net effect: organizations can no longer generate revenue stability through coding volume alone. Revenue protection now depends on documentation quality, diagnostic confidence, and the ability to defend every submitted diagnosis under audit.

Same patient, two programs: a side-by-side comparison

The difference between a compliance-driven and a care-driven risk adjustment program isn't theoretical. It shows up in how the same clinical presentation is handled, with dramatically different consequences for the patient, the RAF score, and the organization's audit exposure.

Meet Mrs. R: 74, Medicare Advantage, three chronic conditions
Mrs. R presents with shortness of breath, lower extremity edema, fatigue, and an A1c of 8.2%. She has a documented history of hypertension and Type 2 diabetes. Her last echocardiogram was two years ago.

	Program A: Compliance-Driven	Program B: Care-Driven
Documentation approach	Clinician copies forward prior problem list. Notes "HTN, DM2, SOB." No reassessment of symptoms against diagnostic criteria.	Clinician reviews prior diagnoses, current symptoms, and suspect conditions surfaced at point of care. Orders echo, updates A1c context, documents clinical reasoning.
Diagnoses captured	Hypertension (I10), Type 2 diabetes without complications (E11.9), Shortness of breath (R06.02)	Hypertension (I10), Type 2 diabetes with chronic kidney disease stage 3 (E11.22), Stage B heart failure (I50.1)
RAF impact	Minimal. SOB and unspecified diabetes contribute little to no RAF under V28.	Meaningful. Heart failure and diabetes with renal complications are high-value HCCs with strong V28 weighting.
Care triggered	No change. Lifestyle counseling repeated. No referrals, no follow-up labs, no care coordination.	Cardiology referral, dietitian consult, medication review, care manager assigned, follow-up labs scheduled.
Audit defensibility	Weak. Copy-forward without reassessment is a top audit flag. SOB symptom code won't withstand RADV scrutiny.	Strong. Echo results, clinical reasoning, updated treatment plan, and MEAT criteria all present in the note.
Patient trajectory	Mrs. R returns to the ED three months later with acute decompensated heart failure. Preventable admission.	Mrs. R's heart failure is managed proactively. Medications adjusted, symptoms monitored, admission prevented.

Both clinicians spent approximately the same amount of time with Mrs. R. The difference wasn't effort, it was whether the system surfaced the right information at the right moment, and whether the clinician had the confidence and tools to act on it.

5 warning signs your program has drifted from care to compliance

Most risk adjustment programs don't fail dramatically. They drift. These five patterns are the early signals, use them as a diagnostic in your next leadership meeting.

1. Perfect documentation, flat outcomes

RAF scores are stable. Notes look compliant. But preventable admissions haven't declined, screening rates haven't improved, and care plans haven't changed. This is the most dangerous failure mode because it creates the illusion of success. Leaders stop asking hard questions because the metrics they're watching suggest progress, while the metrics that matter (admissions, quality, prevention) remain flat.

Why it matters: Under annual RADV audits, documentation that looks compliant but lacks clinical substance (missing MEAT, copy-forward patterns, no treatment changes) will be flagged at scale. The illusion collapses when 2,000 new CMS auditors start reviewing your charts.

2. High suspect rejection rates

High rejection rates for clinically supported conditions usually signal a failure to build conviction in the suspect's validity, not a failure of clinical reasoning. When clinicians can see transparent evidence for a suggested condition and understand its connection to future care decisions, engagement changes. When they can't, dismissal becomes the path of least resistance.

This usually fails for one of three cultural reasons:

- The supporting evidence isn't visible or accessible at the point of care
- The intent behind the suggestion feels financial rather than clinical
- Past experiences taught clinicians that engaging wasn't worth the effort

Why it matters: Every rejected but valid suspect is a missed HCC, a missed care intervention, and, under V28, a proportionally larger revenue loss than it was under V22.

3. Education that doesn't change behavior

Your organization ran annual HCC training. Attendance was logged. But three months later, the same documentation patterns persist. Specificity is still missing. MEAT criteria are still incomplete. The same conditions are still undercaptured.

Why it matters: One-time training sessions create awareness, not behavior change. High-performing organizations deliver education in short, ongoing, personalized bursts tied to the clinician's actual patient panel, not generic slide decks delivered once a year.

4. Coding and care teams operating in silos

Coders identify documentation gaps months after the visit. Clinicians never see the feedback. Compliance reviews happen in isolation. The result is a permanent lag between what's documented and what's defensible, with no mechanism to close the gap in real time.

Why it matters: CMS's accelerated clawback timelines mean organizations can no longer afford months-long feedback cycles. By the time a retrospective review catches a problem, the submission window may have closed and the audit exposure is locked in.

5. RAF scores rising without corresponding resource allocation

If your documented acuity is increasing but care coordination, specialist referrals, and preventive interventions remain flat, the documentation isn't driving care, it's drifting toward unsupportable coding. This is precisely the pattern CMS's expanded audit program is designed to identify.

Why it matters: Rising RAF without corresponding care activity is the single strongest signal to CMS auditors that an organization may be over-reporting. It's also the signal that patients aren't getting the care their documented complexity demands.

The clinician trust equation: why culture eats policy

Risk adjustment does not succeed on policy alone. It succeeds, or fails, on trust. When risk adjustment is framed primarily as a compliance requirement, clinicians adapt defensively: documenting from the problem list without reassessment, dismissing suggested conditions reflexively, and prioritizing box-checking over clinical judgment.

The result, perfect documentation with no change in outcomes, doesn't just waste effort. **It actively erodes the trust required for the program to work.** Clinicians feel they've complied without seeing any benefit to patient care. Leaders assume the program is "mostly working." Meanwhile, admissions remain flat and opportunities for early intervention pass by.

What strong programs recognize:

This behavior is rarely a training failure. It's a signal that clinicians don't see how risk adjustment connects to real care decisions in the moment they're treating the patient.

That's why leading organizations focus less on after-the-fact queries and more on point-of-care visibility,where recapture history, clinical evidence, and documentation expectations are clear before the note is closed.

How leadership tone determines adoption

Risk adjustment adoption is shaped by both policy and culture,but culture is what determines whether policy translates into daily behavior. What leaders consistently signal about why the work matters shapes how clinicians engage with it.

Organizations that succeed make one thing clear: documentation is a clinical input that shapes future care decisions,not an administrative output that satisfies a payment requirement. When leaders consistently connect documentation to who needs closer follow-up, who is likely to deteriorate, and where prevention can still change the trajectory, clinicians begin to see risk adjustment as relevant to their work, not adjacent to it.

Tone is established through repetition and alignment, not slogans.

High-performing programs reinforce leadership intent by pairing it with:

- Lightweight, ongoing clinician education delivered in short bursts, not annual marathons
- Clear, visit-level guidance on what matters this year under V28
- Feedback loops that prevent documentation surprises months later
- Incentive models that reward engagement with tools and education, not just coding volume

What high-performing programs do differently

High-performing programs do not ask clinicians to work harder. **They redesign the system around them.**

Based on patterns across organizations that have made this shift successfully, three investments consistently separate high performers from the rest:

1. Education at scale without overwhelm
Short, personalized, and tied to the clinician's actual patient panel. Delivered through mobile platforms in weekly micro-lessons, not generic annual slide decks. Tracked for engagement and tied to incentives that reinforce adoption over time.

2. Automation that reduces burden
Documentation support and coding validation that works inside the existing EMR workflow,not alongside it. AI-powered tools that aggregate patient data, surface suspected conditions with transparent clinical evidence, and identify MEAT gaps before the note is closed.

3. Audit-ready documentation across all notes
Continuous, automated review of 100% of notes for MEAT compliance, copy-forward patterns, specificity gaps, and internal consistency,not post-hoc sampling of a fraction after the submission window has closed.

Most importantly, they treat risk adjustment as a care-delivery operating model. Education, point-of-care guidance, and documentation quality checks reinforce each other, turning risk adjustment into a supported workflow instead of an added job.

This is the operating model behind the DoctusTech ecosystem: mobile HCC education, EMR-embedded diagnosis assist, and always-on documentation review working together to make risk-aligned care easier to deliver and sustain.

Self-assessment: Is your program built for outcomes or compliance?

Use this checklist in your next leadership meeting. For every "No," the remediation action column tells you exactly where to start.

Area	Key Questions	Y/N	Remediation Action (if No)
Trust	Do clinicians see risk adjustment as relevant to care, not as an admin task?	☐	Reframe leadership messaging around patient outcomes, not RAF targets.
Trust	Are suspect conditions presented with visible clinical evidence at point of care?	☐	Implement EMR-embedded diagnosis assist with transparent evidence logic.
Trust	Is suspect rejection tracked and analyzed for cultural vs. clinical causes?	☐	Run a 90-day rejection analysis; audit top 10 rejected suspects for validity.
Education	Do clinicians receive ongoing education (not just annual training)?	☐	Deploy mobile micro-learning tied to each clinician's patient panel.
Education	Can you track whether education changes documentation behavior?	☐	Link education completion to documentation quality metrics, not just attendance.
Workflow	Are diagnoses and recapture history surfaced before or during the visit?	☐	Integrate pre-visit planning with real-time clinical decision support.
Workflow	Are diagnoses and recapture history surfaced before or during the visit?	☐	Do newly documented conditions trigger care plan changes?

Workflow	Is feedback between coders and clinicians happening in real time?	☐	Replace quarterly retrospective review with continuous automated review.
Quality	Are 100% of notes reviewed for MEAT compliance?	☐	Deploy AI-powered continuous note review across all clinicians.
Quality	Are preventable admissions declining as documented acuity rises?	☐	Cross-reference RAF trends with admissions and ER data quarterly.
Quality	Do HEDIS/Stars metrics improve alongside RAF scores?	☐	Align risk adjustment and quality teams with shared outcome targets.
Audit	Can you defend every high-risk diagnosis to CMS today?	☐	Deploy mobile micro-learning tied to each clinician's patient panel.
Audit	Do you run pre-submission reviews on a defined cadence?	☐	Link education completion to documentation quality metrics, not just attendance.
Audit	Is your compliance process proactive,not reactive to audit notices?	☐	Shift to always-on documentation governance with automated flagging.

Scoring:

- 12–15 Yes , Your program likely operates as a care-delivery model. Focus on sustaining and optimizing.
- 8–11 Yes , Foundation is solid, but gaps may be limiting outcomes and creating audit risk.
- 7 or fewer Yes , Your program is operating as a compliance exercise. Redesign is needed, not more effort.

The 30-day shift: from compliance exercise to care-delivery model

You don't need to redesign everything at once. The organizations that make this shift successfully start with focused, high-signal actions that build momentum. Here's a 30-day roadmap.

Week 1: Establish your baseline

- **Run the self-assessment above** with your medical director, compliance lead, and coding leadership together. Identify the 3 highest-priority "No" answers.
- **Pull 50 high-risk charts** from the past 90 days. Audit for MEAT criteria, copy-forward patterns, and whether documented conditions triggered care plan changes.
- **Quantify your V28 exposure:** identify which ICD-10 codes in your current portfolio are no longer risk-adjustable, and estimate the revenue gap.

Week 2: Close the visibility gap

- **Analyze suspect rejection rates by** clinician and condition category. Identify whether rejection correlates with evidence visibility or cultural resistance.
- **Map your documentation feedback loop**: how long does it take for a coding gap identified in review to reach the clinician who wrote the note? If the answer is "months" or "never," this is your highest-leverage fix.
- **Identify your top 10 undercaptured conditions** by comparing documented prevalence against expected clinical benchmarks for your population.

Week 3: Realign your teams

- **Deliver a leadership message** to all clinicians that explicitly connects documentation to patient outcomes, not to revenue targets. Be specific: name the conditions, name the care decisions, name the patients who benefit.
- **Establish a cross-functional rapid response team** (medical director + compliance lead + coding supervisor) with weekly check-ins on audit readiness and documentation quality.
- **Begin piloting point-of-care decision support** for your top 5 highest-value, most-undercaptured HCCs. Even a manual pre-visit checklist is better than nothing.

Week 4: Build the feedback loop

- **Launch ongoing micro-education** for your clinician panel. Start with the 3 conditions where your documentation gap is largest and V28 impact is highest.
- **Set a 90-day review cadence** to measure whether the self-assessment scores are improving, and whether outcomes (admissions, screening rates, care plan changes) are moving alongside RAF scores.
- **Share early wins with the team**. When a newly documented condition leads to a care plan change that prevents an admission or catches a missed diagnosis, make that story visible. Nothing builds trust faster than proof that the work matters.

Clarity determines outcomes

By this point, most organizations can see the pattern clearly. They can identify where effort is being expended without changing outcomes, where clinicians are disengaging, and whether risk adjustment is functioning as prevention enablement or documentation enforcement.

That clarity is the inflection point.

It's the moment when programs either continue optimizing around compliance,or begin redesigning risk adjustment as a care-delivery model. Most organizations don't recognize this decision because risk adjustment rarely fails in obvious ways.

It fails quietly: through disengagement, missed opportunities for prevention, and value that is never fully realized.

Organizations that make the shift don't do it by asking clinicians to work harder. They do it by making risk-aligned care **easier to see, easier to act on, and easier to sustain.**

See what this shift looks like in practice

DoctusTech helps organizations move from compliance-driven documentation to care-delivery operating models, with EMR-embedded diagnosis assist, mobile clinician education, and continuous documentation review.

One FQHC used this approach to move recapture rates from 30% to 85% and RAF scores from 0.6 to 1.1 over two years.

Book a demo to see how your documentation would perform under this framework.

salesteam@doctustech.com www.doctustech.com