| PROVIDER RESOURCE |

AN INTRODUCTION TO MEDICAL RISK ADJUSTMENT

NEBRASKA HEALTH NETWORK | METHODIST | Nebraska Medicine

Medical Risk Adjustment (MRA) is an important component of value-based care that helps estimate the cost of treating a patient in a given year. This actuarial process calculates a patient's risk score using a combination of patient demographics, health conditions and disease burden, as indicated by ICD-10 diagnosis codes.

MRA is important because it recognizes that not all patients are the same and that the cost to care for them varies based on their risk score. It assists health insurance payers, including Medicaid and Medicare, align cost targets with a population's illness burden. Payers evaluate the average risk of our entire patient population to determine our cost benchmarks. This ensures the ACO is not penalized for caring for sicker, more complex patients.

In a value-based care model, where shared savings and risk payments are linked to the perceived risk and quality of care, keeping risk scores consistent through coding practices is crucial for financial success.

How Does MRA Work?

Using Medicare's Hierarchical Condition Category (HCC) risk model as an example, it is the combination of demographic characteristics plus disease burden that determines a patient's risk score. The sicker the patient, as determined by accurate coding, the higher the score—and the higher the projected cost to treat that patient.

Here's an example:

Mrs. Jones
78
Lives at home

	Demographic-Only Risk Score	Demographic and Disease Burden Risk Score
Risk Score	**0.452**	**1.326**
	• Became eligible for Medicare at age 65	• Became eligible for Medicare at age 65
	• Overweight, E66.3	• Morbid Obesity, **E66.01**, with coding of BMI, **Z68.41** **+0.250**
	• History of chronic cough, R05.3	• Chronic Obstructive Pulmonary Disease, **J44.9** **+0.335**
	• Chronic Kidney Disease, unspecified, N18.9	• Stage 4 Chronic Kidney Disease, **N18.4** **+0.289**
Projected cost	**$5,265*** to treat Mrs. Jones $	**$15,562*** to treat Mrs. Jones $$$

*Average Financial RAF of 1.0=$1,105.10 based on aged and disabled USPCC-United States Per Capita Cost

How do I optimize risk capture?

With Medicare's Medical Risk Adjustment, patients begin each calendar year with a clean slate. In the eyes of Medicare, this means that a patient with diabetes this year is considered to no longer have diabetes in subsequent years if it is not documented and coded every calendar year.

Our recapture rate refers to how well we consistently and accurately document recurring HCC diagnoses yearly. **NHN's Medical Risk Adjustment recapture rate target is 82.5%.**

NHN MRA TARGET

82.5%

HCC Recapture Rate

HCCs are termed hierarchical because, for some disease states such as diabetes, multiple HCCs capture differing severity of illness. Within an HCC grouping, a patient is assigned the highest HCC that corresponds to the most severe manifestation of disease documented through ICD-10 coding.

Who is responsible for coding?

The short answer is everyone. There is not a single best practice when it comes to Medical Risk Adjustment. Some facilities rely on providers to incorporate coding into their assessments. Others leverage medical coding teams that either listen to annotations or review assessments to assign coding.

Regardless of whether you are personally capturing codes or working with a team that is supporting your efforts, here are a few best practices to consider:

- Document every patient encounter as if it is the only encounter of the year.
- Review and update the patient's active problem list at each visit.
- Avoid documenting and using the phrase, "past medical history" or "history of" in the progress note for a condition that is chronic, but stable.
- Be as descriptive as possible. Keep in mind that if your clinic utilizes medical coders, they can only capture what is included in your clinical note.
- Avoid using acronyms in your documentation. Spell out the complete health condition to assist with proper coding of diagnosis codes.
- All chronic and complex conditions should be reviewed and documented annually.
- Review and document conditions managed by a specialist.

M-E-A-T: A Guide to Coding

Coders use the M-E-A-T acronym to identify documentation that supports coding accuracy:

- **Monitor:** signs, symptoms, ordering or reviewing and referencing of tests/ labs, disease progression or disease regression.
- **Evaluate:** test results, medication effectiveness, physical exam findings and response to treatment.
- **Assess or Address:** by discussion, acknowledging, reviewing records, documenting status/level conditions and counseling.
- **Treat:** with prescribing/ continuation of medications, referral to specialist for treatment/ consultation, surgical/other therapeutic interventions and plan for management of condition(s).

Ensuring the inclusion of one or more M-E-A-T details during face-to-face or telehealth consultations for every condition requiring patient care treatment or management is pivotal for achieving success.

MRA514

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