A new Centers for Medicare and Medicaid Services (CMS) policy proposal likely to take effect in 2016 has implications for Medicare Advantage (MA) plans, healthcare businesses reimbursed by MA, and providers, patients, and those closely tracking trends in health payment innovation.

**Key Takeaways**

- CMS wants a return on investment on risk assessments that MA organizations do inside the patient’s home. Specifically, it wants to see evidence of improvement in the care beneficiaries receive and not just an increase in risk scores.

- The agency proposes to start tracking and analyzing the care done after in-home assessments to see if patients that the MA plans identify as having higher risk are actually receiving recommendations, following through on them, or getting the right services.

- The agency’s proposal is an important step to start pushing MA plans to better document and share the information gleaned from in-home risk assessments; it is another example of CMS’s broader efforts to tie payment to value.

- The policy could benefit organizations that can help MA plans better capture what’s done during these assessments, share the information with patients and providers, and begin to show a link between the assessment and downstream savings or outcomes’ improvement.

- CMS stopped short of a more severe payment policy. When determining an MA plan’s risk-adjusted payment, CMS had considered disregarding diagnoses obtained from in-home assessments if a follow-up physician “clinic” visit did not confirm the in-home assessment’s diagnosis. The agency instead created best practices for MA plans to implement.

- In the long term, the agency’s new policy could potentially benefit a range of businesses, including those providing patient safety-related products and services to clinic-based primary care and behavioral health providers that provide therapy for patients diagnosed with depression, according to Bryan Cote, a BRG managing director and founder of a behavioral health accountable care organization in Connecticut. Software- or IT-related businesses able to help improve the assessment process from capture to exchange should also monitor these policy developments. “Plans want to see if the assessment is bringing an ROI, that a diagnosis of depression actually leads to a care plan the patient can understand and providers can support,” says Cote.

- Olga Ziegler, a BRG senior consultant and former director of Medicare Risk Adjustment at Coventry, and Laura Bukowski, RN, a BRG managing consultant, have written this primer on the proposed changes that includes recommendations on in-home assessment program design, as well as monitoring and regulatory compliance considerations. Ziegler says that CMS has been worried that nothing is being done with the diagnosis post assessment, and that the assessments are at times being conducted merely as a way to increase payment.
Background

Health plans participating in the Medicare Advantage (MA) program have a history of pioneering new innovations to improve quality of care for their beneficiaries while reducing costs and providing value-based benefits in excess of those under traditional Medicare. As an example, starting in 2008, many MA plans began offering in-home assessments to a select group of beneficiaries. Most plans launched this as a pilot program, with the intent of providing history and physical evaluation to the beneficiaries in their homes in conjunction with coordinating follow-up care. By 2010, the number of MA plans offering these programs to their beneficiaries and the number of in-home assessments conducted had grown tremendously.

MA plans may also profit by implementing in-home assessment programs, because during in-home visits additional medical data, particularly diagnosis information, is collected by the healthcare practitioner and subsequently submitted by the plan to the Centers for Medicare and Medicaid Services (CMS). In-home assessments typically help to increase beneficiaries' risk scores, thereby translating into higher premiums for MA plans under the existing Medicare Risk Adjustment payment model.\(^1\) CMS has expressed concerns that in-home assessments are not offering patients actual medical services or tangible health benefits and are "used as a vehicle for collecting risk adjustment diagnoses without follow-up care or treatment being provided to the beneficiary."\(^2\) In its 2015 Advance Notice proposal, CMS suggested to "exclude for payment purposes diagnoses identified during at home visits that are not confirmed by a subsequent clinical encounter" and requested comments on this proposal. In correspondence with CMS, the industry argued that the program does support beneficiaries' healthcare needs and provided examples, such as beneficiaries' lives being saved because an acute episode took place during the time of the in-home visit (e.g., stroke, convulsions) and/or the in-home assessment uncovered a home safety issue that may have otherwise resulted in a fall. After receiving feedback from MA plans and vendors, CMS did not include this proposal in its Final Call Letter for calendar year 2015.\(^3\)

In its 2016 Advance Notice proposal, released on February 20, 2015, CMS reiterated its concern that in-home assessments were "merely a strategy by MA plans to find and report more diagnosis codes to CMS, generating higher levels of coding and, therefore, payment than assumed under the risk adjustment methodologies." Additionally, CMS noted its concern that providers who regularly care for MA plan enrollees may not actually receive and use the information collected in these in-home assessments to improve the care provided. Despite these concerns, CMS did not propose to exclude diagnoses identified during home visits that are not confirmed by a subsequent clinical encounter. It did, however, lay out a core set of "best practice" components for in-home assessments, announced that it will "track and analyze care provision following in-home assessments" and put forth the expectation that MA plans "promote their primary use as tools for improving care for MA enrollees and not just as a process to collect diagnoses that increase risk adjusted payments."\(^4\)

With interest in the future of in-home assessments growing, this paper examines various program designs and provides best practice recommendations for clinically focused and compliant programs.

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1. The Medicare Risk Adjustment model is a payment mechanism applied to Medicare Advantage plans through which plan premiums are based on the demographic profiles and health status of beneficiaries. Health status is measured by the diagnoses of the members as submitted by qualified health practitioners and hospitals.


3. Starting in 2014, CMS began requiring MA plans to flag diagnoses from in-home assessments in the Risk Adjustment Processing System (RAPS) data submissions. Specifically, CMS noted that it is particularly interested in studying which conditions are being reported during in-home visits, whether reported conditions are supported by subsequent providers, and the impact on the beneficiary overall risk scores to determine whether further modifications to the program are required.

Program Components

The in-home assessment is a voluntary program offered to beneficiaries in their homes. Assessments are typically performed annually by either a physician or a nurse practitioner, both of which are acceptable provider types for risk-adjustment submission purposes. The cost to the MA plan per completed assessment ranges from the mid $200s to upper $600s depending on the plan’s geographic area, the type of practitioner performing the assessment, and the assessment program components. Physicians are typically more expensive but generally have less-complete documentation than nurse practitioners; however, physicians are the best and closest substitute to the beneficiary’s physician primary care (PCP) visit.

The in-home assessment program is offered at no cost to the beneficiary. Most MA plans do not offer in-home assessments to every beneficiary and rather target beneficiaries based on factors including diagnosis drop-off, inconsistencies with member claims data, and utilization.

In-home assessment program components—including CMS’s best practice core components, noted with an asterisk (*)—should include:

- Confirmation of member contact information and PCP assignment
- Review of active and past medical history
- Review and reconciliation of current medications*
- Review of associated diagnoses
- Performance of Healthcare Effectiveness Data and Information Set (HEDIS) measure screening (e.g., fall risk assessment, colonoscopy, mammograms)\(^6\)\(^7\)
- All components of an annual wellness visit, including health risk assessment*
- Physical examination
- Assessment for self-care ability, mobility, frailty, and depression
- Assessment of the home for safety risks, need for adaptive equipment or additional support*
- Evaluation and assessment of the beneficiaries’ diagnoses
- Formulation of an individualized plan of care/treatment
- Performance of basic lab/diagnostic tests in-home, for which there may be a deductible and/or co-payment applied
- Referrals to the plan’s case management/disease management programs and enrollment as appropriate*
- Reporting of results to the MA plan and beneficiaries’ PCPs

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6 The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used to measure health plans’ performance on important aspects of care and service. HEDIS consists of 81 measures across five domains of care. HEDIS data is collected by the National Committee for Quality Assurance (NCQA) on behalf of the CMS and state agencies.
• Completing a follow-up check list to leave with beneficiaries, which includes a summary of information including
diagnoses, medications, scheduled follow-up appointments, plan for care coordination, and contact information for
appropriate community resources*

• Assisting beneficiaries in scheduling an appointment with a PCP, specialist, or other appropriate provider or community
resource*

• A process to verify that information obtained during the assessment is provided to the appropriate plan provider(s)*

• A process to verify that needed follow-up care is provided*

• Considerations for Conditions Diagnosed at an In-Home Visit

Some of the most sophisticated Medicare Advantage plans arm medical practitioners performing in-home assessments with
pre-populated member information, such as prescription medication lists, recent laboratory and diagnostic data, known
and suspected condition lists, lists of open HEDIS measures, and mock Health Outcomes Survey (HOS) questions related
to member satisfaction with the MA plan.8, 9 This enables practitioners to perform a comprehensive review and assessment
with the necessary support for decision making regarding beneficiaries’ medical diagnoses, evaluation, and development of
a meaningful care plan. In lesser-developed programs in which little or no information is provided to the practitioner on the
beneficiary’s history prior to the in-home visit, it is more likely that beneficiaries’ diagnoses and health status evaluations are
primarily based on self-reported conditions for which less support exists.

The accuracy of diagnoses generated at an in-home assessment visit depends on factors including:

• Availability of beneficiaries’ prior and current health information, including past medical, surgical, social, and family
history, current medications, and recent laboratory and diagnostic test results

• Reliability of the person(s) (beneficiary, significant other, and/or caregiver) providing the history and detailing any
current complaints, signs, and/or symptoms

• Thoroughness of the physical examination

Some conditions can be diagnosed based on a combination of reliable history elicited from the beneficiary or other informant,
reported complaints, signs and symptoms, medication review, and/or comprehensive physical examination. Examples of
such conditions and data to consider may include:

• Diabetes – history of condition and on medications prescribed to treat it, such as insulin or oral hypoglycemics

• Peripheral vascular disease (PVD) – history of condition; symptoms of leg pain on walking (intermittent claudication);
physical findings, such as decreased pulses or skin changes; and/or medications prescribed to treat PVD, such as
Cilastazol

• Paroxysmal atrial fibrillation (PAF) – history of condition and on medications prescribed to treat it, such as Pradaxa
or Warfarin

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8 The Health Outcomes Survey (HOS) program is the first patient-reported outcomes measure used in Medicare Managed Care. The goal of the
Medicare HOS program is to gather valid and reliable data from Medicare patients via survey; CMS uses the results of the survey for targeting quality
improvement activities and resources, monitoring health plan performance, and rewarding top-performing health plans.

Default.aspx; NCQA, Medicare Health Outcomes Survey [2014], accessed November 5, 2014, at:
• Hemiparesis – history of stroke and weakness on one side of body apparent on physical exam
• Chronic skin or decubitus ulcers – history of non-healing ulcers and physical exam
• Artificial openings for feeding or elimination – apparent on physical exam
• Lower limb amputation – apparent on physical exam
• Morbid obesity – physical exam and height/weight/BMI measurement

In addition, accepted screening tools correlated with history, signs and symptoms, and/or medications may be used to diagnose conditions such as major depression and alcohol or drug dependence.

Other conditions cannot be definitively diagnosed by history and physical examination alone and require various levels of laboratory and/or diagnostic testing for confirmation. One would not expect to see these conditions diagnosed at an in-home assessment unless extensive health information is made available to the practitioner before the home visit. Examples of such conditions include:

• Chronic kidney disease (CKD) or nephropathy, unless on dialysis
• New onset diabetes
• Diabetes with renal complications, unless on dialysis
• Diabetes with ophthalmologic complications
• Cardiomyopathy
• Pulmonary hypertension
• Chronic obstructive pulmonary disease (COPD), asymptomatic and not on related medications
• Atherosclerosis of the aorta
• New compression fracture
• Active cancer, unless on chemotherapy and/or radiation

Program Design Considerations

Although the in-home assessment program is simple in theory, it could present Medicare Advantage plans with challenges in practice. The majority of issues around the program seem to be related to:

1. physicians’ negative response to the fact that their beneficiaries were seen by another practitioner without their consent;
2. whether follow-up care is coordinated for conditions identified during assessments and/or lab tests drawn during assessment; and
3. the health plans’ ability to develop and maintain compliance monitoring and oversight activities around the program.

While various approaches address these challenges, some elements could positively contribute to the success of the program.
MA plans should consider:

- Developing or enhancing the ability to retrieve consistent and accurate data to determine which beneficiaries will benefit from in-home assessment
- Providing beneficiaries’ pertinent clinical information to practitioners prior to the home visit
- Employing a request for proposal (RFP) process and reference checks for prospective assessment vendors and subcontractors¹⁰
- Developing an in-home assessment form in accordance with standard provider progress note documentation requirements, which also includes capturing HEDIS elements allowing MA plans to close gaps in care¹¹
- Performing a pilot study on a small number of assessments at the outset to assess the performance of the program and address issues or gaps
- Assessing the existing PCP network to consider engaging PCPs to perform the assessments at their offices¹²
- Requiring in-home assessment vendor practitioners to assist beneficiaries with scheduling follow-up appointments and/or making direct calls to beneficiaries’ PCPs to discuss follow-up
- Providing a copy of the assessment form to beneficiaries to take to their next PCP appointment (leave-behind) and making the form available to PCPs within a few weeks from the date of the assessment
- Implementing consistent quality and coding reviews on completed assessments and immediately addressing potential issues identified
- Analyzing data collected from in-home assessments in conjunction with the health plan’s claims and encounter data to assess whether other providers have reported the same condition for the beneficiary¹³

Monitoring, Oversight, and Regulatory Compliance Considerations

CMS requires Medicare Advantage plans to sign an annual attestation certifying that the diagnoses submitted for reimbursement are accurate, complete, and truthful based on best knowledge, information, and belief, including those submitted based on in-home assessments. There are regulatory, litigation, and enforcement risks for MA plans that fail to account for the accuracy of diagnosis submissions. The penalties could include the repayment of overpayments, sanctions arising from government audits of diagnosis submission accuracy, and, perhaps more significantly, enforcement actions seeking damages and penalties under the False Claims Act.

¹⁰ Among typical RFP questions, it is beneficial to ask vendors to code several progress notes to demonstrate how they apply the ICD-9 CM coding guidelines and documentation requirements.

¹¹ The typical progress note is referred to as a SOAP note, which includes documentation on symptoms (S), observations (O), the provider’s assessment of the beneficiary’s conditions (A), and an action plan (P).

¹² To enlist participation by PCPs, the health plan may need to develop an incentive program that has reasonable goals and metrics and is effectively communicated. Additionally, the health plan may want to assess physicians’ documentation and provide training to those who may benefit from it prior to including them in the program.

¹³ For example, identifying newly diagnosed conditions and whether they were confirmed by another provider in the same year can be a useful tool in targeting providers for education and/or for developing chart sample criteria during vendor audits.
MA plans should take reasonable actions to ensure that the data submitted from in-home assessments meets these requirements. With that in mind, important compliance considerations for MA plans under the in-home assessment program include:

- Develop internal policies and procedures related to risk adjustment and diagnosis coding and submissions
- Implement proactive programs and initiatives related to provider education and training on risk adjustment, documentation and diagnosis coding, and awareness of the in-home assessment program
- Ensure that the in-home assessment program has a beneficiary focus and is clinically sound, with mechanisms in place to refer members for follow-up care and testing
- Perform routine compliance audits on internal processes or those of delegated entities administering the program
- Perform ongoing quality control (QC) review, including conducting routine coding and documentation reviews of in-home assessment forms
- Consider how a well-defined data analytics program could be leveraged to monitor diagnosis submissions for reasonableness and accuracy, such as having processes in place to identify diagnoses that may require secondary support from another provider, such as a PCP, specialist, or hospital

**Future of the Program**

In its 2015 Advance Notice proposal, CMS proposed to exclude, for payment purposes, diagnoses submitted as a result of in-home assessments that are not confirmed by a subsequent clinical encounter. Analysts’ studies suggest that diagnoses collected from in-home assessments contribute as much as 2 percent to the beneficiaries’ premiums. After evaluating MA plans’ feedback response to the 2015 Advance Notice proposal, CMS decided not to implement the proposed policy for the 2015 payment year. In the recently issued 2016 Advance Notice proposal, CMS reiterated its concern that in-home assessments were primarily a process used by MA plans to collect additional diagnoses that increase risk-adjusted payments rather than a tool to improve planning and coordination of beneficiary care. Despite these concerns, CMS did not reiterate its proposal to exclude diagnoses identified during home visits that are not confirmed by a subsequent clinical encounter. It did, however, propose a core set of “best practice” components for in-home assessments and announced its intentions to track and analyze the care provided following the in-home assessments.

While major modifications to the in-home assessment program do not appear to be likely in the short term, CMS will continue to scrutinize these programs and attempt to measure their clinical outcomes going forward. It is worth mentioning that for the past few years, CMS has required MA plans to flag diagnoses resulting from in-home assessments in their diagnosis code submissions. Having said that, CMS could perform a deep-dive analysis on submissions resulting from in-home assessments and the impact on beneficiaries’ risk scores. In light of this continued scrutiny, MA plans should take a proactive approach to ensure that in-home assessments are as clinically focused as possible, mirroring traditional visits to the PCPs and including key CMS “best practice” core components.

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Some of the more effective in-home assessment programs are structured using a two-pronged approach in which the MA plans 1) offer an incentive to physicians who are wholly owned and/or willing to perform assessments in their office, and 2) take the in-home assessment program in-house and have employed nurse practitioners visit beneficiaries whose PCPs opted not to participate in the program. The former will alleviate the effects of future changes in the acceptance of diagnoses from in-home assessments for payment purposes. Ideally, the MA plan would have access to its providers’ EMR system, allowing for a real-time data exchange. For example, some MA plans send a quarterly target list of beneficiaries that are due for assessment to their PCPs, asking them to complete the assessment by a certain date in return for an incentive. Other MA plans simply incorporate the annual assessment requirement in their PCP contracts. Advantages for running the program in-house include transparency of data, flexibility in program modification, ability to have better controls and real-time auditing, and increased member satisfaction and PCPs' acceptance of the program. The concerns include time and cost associated with the program development, monitoring, and implementation.

The in-home assessment program appears to have CMS's conditional approval, but the long-term viability of the program is unclear if CMS changes its position. In the interim, Medicare Advantage plans with in-home assessment programs should consistently ask, "Have we optimized our program design while providing clinical benefit to our members and mitigating regulatory compliance risks?" If the answer is anything other than "yes," it would be prudent for the plan to perform a comprehensive evaluation of its existing program with a focus on 1) the clinical benefits being derived by beneficiaries and 2) the plan’s compliance program (e.g., assessing the accuracy of diagnoses originating from in-home assessments).
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