In-home AHRAs: A Best Practice Model for Changing Times

**Synopsis:** Annual health risk assessments (AHRAs) are a critical component of accurate risk-adjustment coding under Medicare Advantage. This paper outlines a partner-driven approach to in-home assessments and offers evidence that this approach can result in improved outcomes for health plans and, for their members, improved quality of life and care. It can also result in more accurate, appropriate and complete identification of high-risk diagnoses for coding accuracy, while meeting or even exceeding CMS best practices.
AHRAs: a challenge for health plans

In recent years, annual health risk assessments (AHRAs) under Medicare Advantage (MA) have been conducted by vendor-partners in the home. In 2013, the Centers for Medicare and Medicaid Services (CMS) issued guidance calling for an end to in-home assessments based on its assumption that they encouraged overdiagnosing to create higher payments to health plans. As a result, some health plans have been gravitating toward having physicians conduct AHRAs in-office, believing this to be cost-effective as well as more compliant with CMS best practices.

However, in February 2015, CMS issued advance notice of its 2016 Call Letter, softening its stance on in-home assessments and instead reiterating their value:

*We believe that in-home assessments can have significant value as care planning and care coordination tools. In the home setting, the provider has access to more information than is available in a clinical setting. For example, the provider is able to evaluate the enrollee’s home for potential risks, the need for supports to enable an enrollee to continue living in the community, and other relevant aspects of the enrollee’s living situation. We expect plans to take advantage of the opportunities afforded by performance of in-home assessments to obtain and use that full spectrum of information to revise, develop, or implement comprehensive care plans for affected enrollees.*

For health plans, this has created a dilemma: how to minimize cost, maximize revenue and improve member quality of life while ensuring compliance and increasing member impact? Physician in-office assessments seem efficient and are compliant. However, physicians are not incentivized to code thoroughly; office time available for comprehensive patient visits is limited; the plan is dependent on when or even if patients actually see their doctors; and, important to note, the member’s home environment cannot be assessed, leaving a key component of the member’s health profile unaccounted for.
How should health plans now conduct AHRAs?

We propose that the optimal approach to AHRAs—a best practice for these changing times—is to utilize a partner with specific expertise in in-home assessments. This allows a more holistic approach that can include the ability to identify members who may benefit from care monitoring and coordination. This approach has many advantages that benefit the member, plan and provider, including:

- Uses a proprietary algorithm to accurately and appropriately determine a patient’s Raw Risk Score for accurate risk-adjustment coding
- Identifies problematic cases in time for preventive care
- Connects the patient back to the healthcare delivery system—can escalate back to the plan or provider
- Affords access to critical environmental information not available to physicians in their offices, e.g., evaluation of the enrollee’s home for potential risks, such as harmful drug-drug interactions (i.e., medication review and reconciliation) and fall hazards
- Takes place in the home to establish patient trust
- Is consistent with CMS best practices
- Aligns with HEDIS/Star outcome measures
- Keeps members safe at home and in their communities whenever possible
The ComplexCare Solutions approach: improved accuracy for appropriate assessment

ComplexCare Solutions (CCS) is a provider of face-to-face care management services and risk assessment for complex care needs populations. The CCS model's guiding principle is that data-driven tools such as assessments play an integral role in engagement of members and development of care plans. Key differences in the CCS assessment model versus the physician in-office assessment include:

• Face-to-face assessment in the home
• Assessment of social determinants
• More complete capture of appropriate high-risk diagnoses
• A closer look at pharmacy coordination
• Ability to seamlessly escalate to care planning and coordination
• Improved ability to reduce admissions and readmissions

Further, the CCS model aligns with CMS assessment best practices and supports assessment based care management:

<table>
<thead>
<tr>
<th>CMS Assessment “Best Practice”</th>
<th>CCS Assessment Based Care Management</th>
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<tbody>
<tr>
<td>Primary use as a tool for care management</td>
<td>✔</td>
</tr>
<tr>
<td>Tracking and analysis of care provision post-home visit</td>
<td>✔</td>
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<tr>
<td>All components of the annual wellness visit including an HRA</td>
<td>✔</td>
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<tr>
<td>Medication review and reconciliation</td>
<td>✔</td>
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<tr>
<td>Scheduling appointments and ensuring appropriate referral to community resources</td>
<td>✔</td>
</tr>
<tr>
<td>Conducting an environment scan of member home for safety along with review for need for adaptive equipment</td>
<td>✔</td>
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<tr>
<td>Verification that needed care was provided</td>
<td>✔</td>
</tr>
<tr>
<td>Verification that information provided by member was given to plan personnel</td>
<td>✔</td>
</tr>
<tr>
<td>Provision for the summary information obtained to be shared with the member (or POA)</td>
<td>✔</td>
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<tr>
<td>Enrollment of the member into the appropriate care and/or disease management programs</td>
<td>✔</td>
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<tr>
<td>Demonstrations of improved enrollee health outcomes</td>
<td>✔</td>
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Case studies: improved coding accuracy using the CCS assessment model

In 2015, CCS conducted a thorough analysis of mature data sets from two organizations, Health Plan A and Health Plan B, comparing CCS in-home assessments with those plans’ physician in-office and other out-of-home assessments. These two case studies showed that the CCS approach, in addition to aligning closely with CMS best practices, resulted in improved coding accuracy—as many as two to three times the number of appropriate diagnoses identified by physician in-office assessments.

Health Plan A: 6-month data. For Health Plan A, in the first half of the year CCS assessed 1,989 members and recorded 23,795 diagnoses during those AHRAs. This compared with 3,720 found by Health Plan A from a different source that comprised PCP assessments as well as facility, specialist, outpatient surgery and other visits. Data highlights include:

- Of those members who had both a PCP assessment and a CCS assessment, CCS found 74% of the total number of diagnoses, PCPs found 21% and 5% were found by both.
- CCS found 20,075 diagnoses uniquely (84%).
- Of the 1,989 members, only 4 (0.2%) did not have at least one unique CCS diagnosis.
- CCS found an average of 12.0 diagnoses for these 1,989 members. Health Plan A, from all other sources, found an average of 1.9 diagnoses for these members.

Health Plan A: 6-month assessment data

<table>
<thead>
<tr>
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<th>Members Assessed</th>
<th>Diagnoses</th>
<th>Avg. Diagnoses/Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCS</td>
<td>1,989</td>
<td>23,795</td>
<td>12.0</td>
</tr>
<tr>
<td>All other sources</td>
<td>1,989</td>
<td>3,720</td>
<td>1.9</td>
</tr>
<tr>
<td>Total</td>
<td>1,989</td>
<td>24,000</td>
<td>12.0</td>
</tr>
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In viewing these results, it is important to acknowledge that these data only reflect the first six months of the year. It is expected that Health Plan A’s PCP assessments would generate additional diagnoses over the rest of the year as providers submit additional codes. Nevertheless, because CCS succeeded in assessing all these members before the June 30, 2015, cutoff date for the January 2016 premium adjustment, Health Plan A will see more revenue lift sooner, in January 2016. With PCP assessments only, Health Plan A would need to wait for its providers to record these diagnoses over the entire year, meaning it would have to wait until July 2016 (with a December 31, 2015, cutoff) for the majority of codes to affect its premium adjustment.

CCS found 12.0 diagnoses per member (Health Plan A) vs All other sources found 1.9 diagnoses per member

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**Health Plan B: full-year data.** For Health Plan B, CCS assessed 11,563 members and recorded 147,039 diagnoses during those AHRAs over 12 months, compared with 72,826 diagnoses found by PCPs for the health plan during the same time period. Data highlights include:

- CCS found 72.0% of diagnoses, double that of PCPs (35.6%).
- CCS identified 12.7 diagnoses per member, double that of PCPs (6.3).
- Of those members assessed by both CCS and PCPs, CCS identified 64.4% of diagnoses, PCPs identified 28.0% and 7.6% were found by both.

**Health Plan B: 12-month assessment data**

<table>
<thead>
<tr>
<th></th>
<th>Members Assessed</th>
<th>Diagnoses</th>
<th>Unique Diagnoses</th>
<th>% Total Diagnoses</th>
<th>Avg. Diagnoses/Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCS</td>
<td>11,563</td>
<td>147,039</td>
<td>131,501</td>
<td>72%</td>
<td>12.7</td>
</tr>
<tr>
<td>PCPs</td>
<td>9,727</td>
<td>72,826</td>
<td>57,288</td>
<td>36%</td>
<td>6.3</td>
</tr>
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Because it records a full year, this data set more accurately reflects the extent to which the CCS in-home assessment model codes more accurately compared with physician in-office assessments. It also codes more completely: during the 12-month period, CCS assessed 100% of members and PCPs assessed 84.1%, emphasizing that with in-office assessments, health plans are at the mercy of patients following through on having at least an annual visit.

**CCS found 12.7 diagnoses per member (Health Plan B) vs PCPs found 6.3 diagnoses per member**
Discussion: the assessment of the future?

As CMS notes, the utility of in-home AHRAs is “to obtain and use that full spectrum of information to revise, develop or implement comprehensive care plans for affected enrollees.” One key advantage of in-home assessments over in-office assessments is, as CMS also notes, “access to more information than is available in a clinical setting.” “More information” includes the ability to identify social determinants that, when addressed, may enable the member to remain safe at home instead of being admitted to a hospital (or other facility) due to a risk factor in the home environment that was missed by an in-office assessment. This full spectrum of information enables more comprehensive care plans that can improve member health outcomes as measured by HEDIS/Star quality scores, as well as improve quality of life outcomes to a greater extent than care plans based on in-office assessments. This makes the in-home assessment appealing for clinical quality outcome as well as patient satisfaction considerations.

The in-home assessments will meet or exceed CMS best practices, further assuring the plan of full compliance. Thus, from the clinical, quality, financial and regulatory perspectives, and given the recent position by CMS, the in-home assessment may be considered best practice for these changing times and one that is forward-thinking.
Conclusion: meeting the challenge, from code to care

Health plans face a challenge in completing AHRAs for Medicare Advantage enrollees: how to minimize costs, maximize revenue and ensure compliance. Should assessments be done in-office by a physician or in-home by a vendor-partner? The two case studies presented here demonstrate that in-home assessments, when performed within a comprehensive model that aligns with CMS best practices, can identify two to three times the number of appropriate diagnoses when compared with in-office assessments by physicians. This more comprehensive information, combined with the ability to provide care monitoring and coordination or even escalation by the same partner that conducted the assessments, presents a model for AHRAs that meets the needs of member, plan and provider, with the added advantage of being not only more economically viable, but economically advantageous. This supports an ultimate result of enhanced or even improved outcomes.

The ComplexCare Solutions approach brings value to the member, the plan and the provider by reducing medical cost trend, improving quality Star measures, quickly addressing care issues that arise, escalating members to care management, and improving member satisfaction and engagement.

Connecting Code to Care is an ongoing series that explores current market conditions impacting health plans and offers possible solutions designed to improve outcomes. Your feedback is welcome and encouraged. Please contact us at Code2Care@complexcaresolutions.com with comments or suggestions for future topics.

1 Raw Risk Score = Patient Demographic Score + Health Status. The Raw Risk Score is a key factor in informing risk adjustment under the CMS Hierarchical Condition Category (HCC) payment methodology.