

DSNP Health Risk Assessment (HRA) Program

WHAT IS THE DSNP HEALTH RISK ASSESSMENT (HRA)?

An HRA is a standard list of questions to identify the current care the member is receiving as well as any medical conditions for which they are receiving care.

- ✓ Encouraged by CMS as a way to identify and close gaps in care and increase quality.
- ✓ Information contained in the HRA helps improve access to care and affordability.
- ✓ Members are more likely to receive the care they need in the right setting for both preventive and chronic medical conditions.
- ✓ The HRA is one of the tools used by CMS to calculate STAR ratings.
- ✓ Plans are required to report the number of HRAs completed to CMS.
- ✓ Affects STAR Ratings that provide a measure of quality and performance.



Sales Initiated HRA Program Details

- Agents must be certified to sell our Medicare Advantage plans.
- Eligible policies include New Medicare Advantage sales and current members where an HRA is over 12 months old.
 - *Plan switchers do not apply unless it's Non-SNP to SNP or vice versa.
- Agents receive bonus payment for their time and effort involved in collecting and submitting qualified HRAs.
- Bonus payments for qualifying agent submissions:

Sales Channel	SNP HRA	Simply DSNP HRA	Non-SNP HRA
External (Field or EMO)	\$125	\$75	\$50
- Bonus payments paid to the Agent of Record (AOR) on active policies within 60 days of the Policy Effective Date for POS submission and within 60 days of submission for current members.



Not all plans and service areas apply

Out of Scope: CareMore, Simply Non-DSNP, and any CSNP ESRD plans

HOW TO COMPLETE A DSNP HRA?

Sales agents can use several options to complete the HRA:

1. The HRA form can be completed after submitting an electronic application (mProducer)
2. Broker Portal – using the Book of Business or Customers section
3. Using fillable PDF – available in English, Spanish, Chinese, Korean, and Vietnamese (instruction included)



Electronic Collection Details

- Preferred method of submission
- Provides the most accurate and timely information (*which also means timely bonus payment*)
- Available at Point-of-Sale for both SNP and Non-SNP HRA, where applicable
- Agent can guarantee the right form with populate and submit timely



Collection Methods for all HRAs



Electronic at POS

*via mProducer or SunFire/DRX**



Electronic Post-Sale

via Producer Toolbox under Book-of-Business



Fillable PDF via secure email

SNP: EMOsalesinitiatedHRA@anthem.com
Non-SNP: NonSNPHRASubmissions@anthem.com



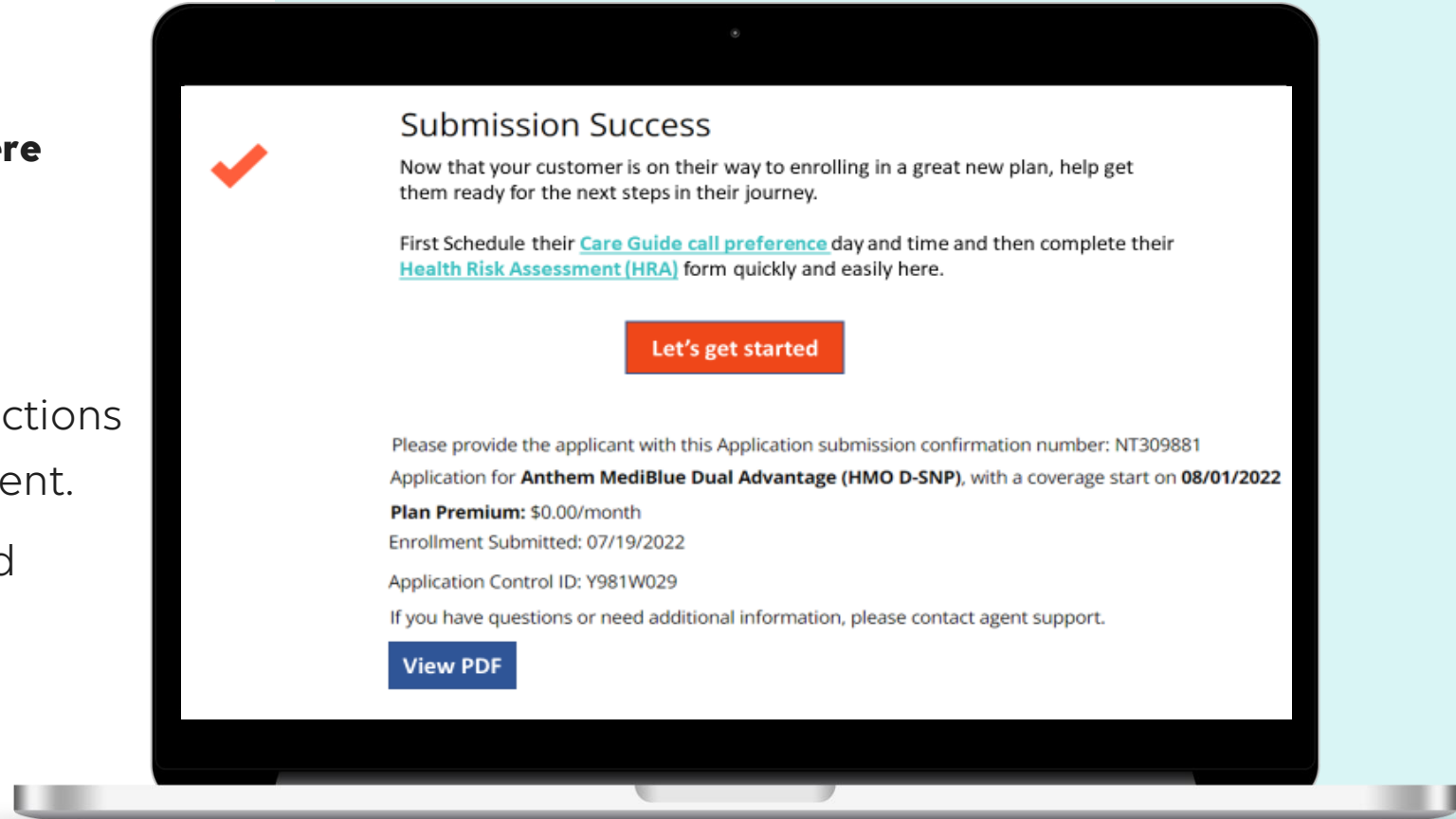
**Third party application submission platforms*

Electronic Submission

Preferred submission method

Same process for both SNP and Non-SNP (where applicable)

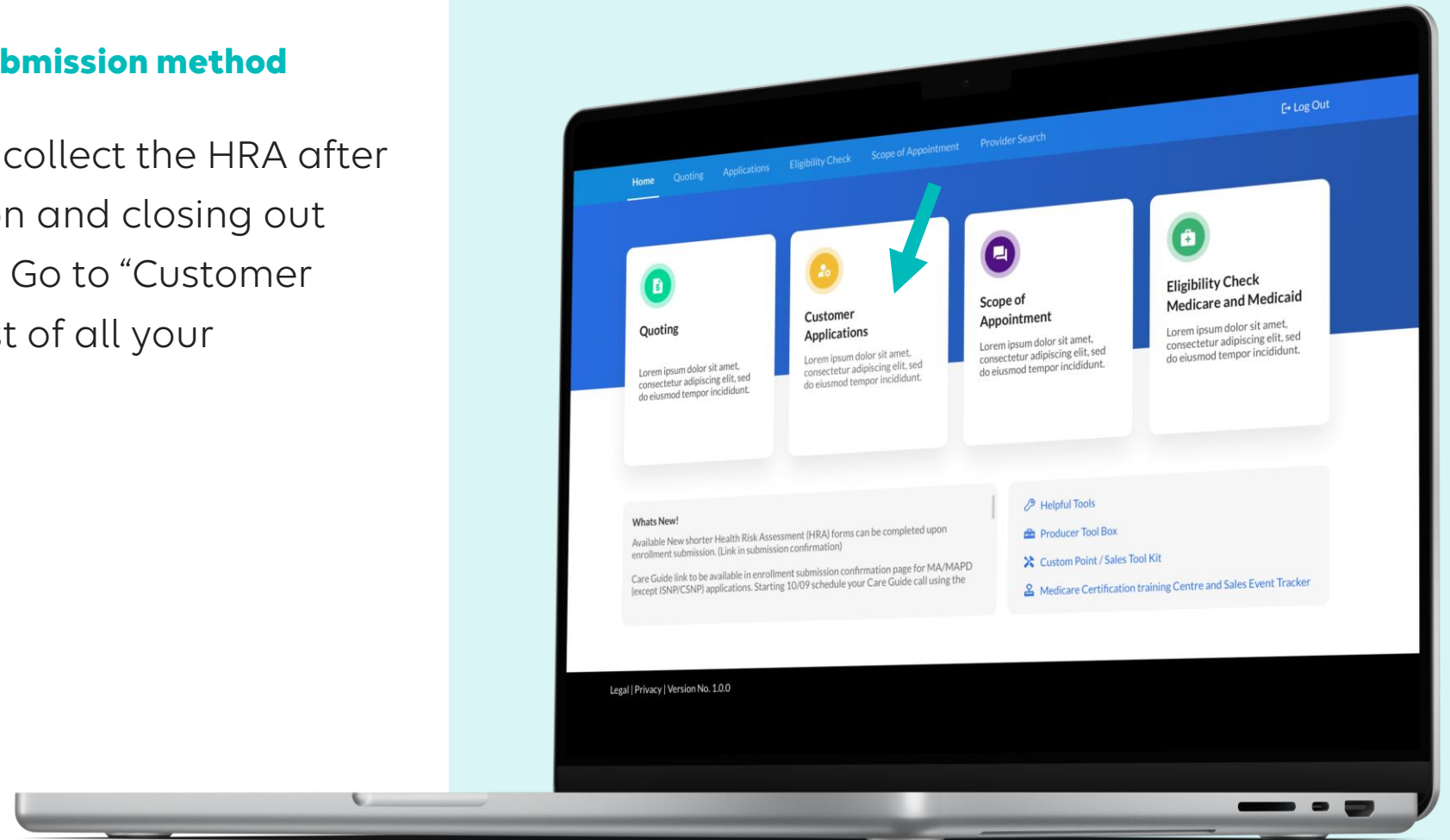
1. After the application is submitted electronically, on the submission confirmation page you will see instructions to complete the Health Risk Assessment.
2. Complete the HRA with the client and submit electronically.



Electronic Submission (Option 2)

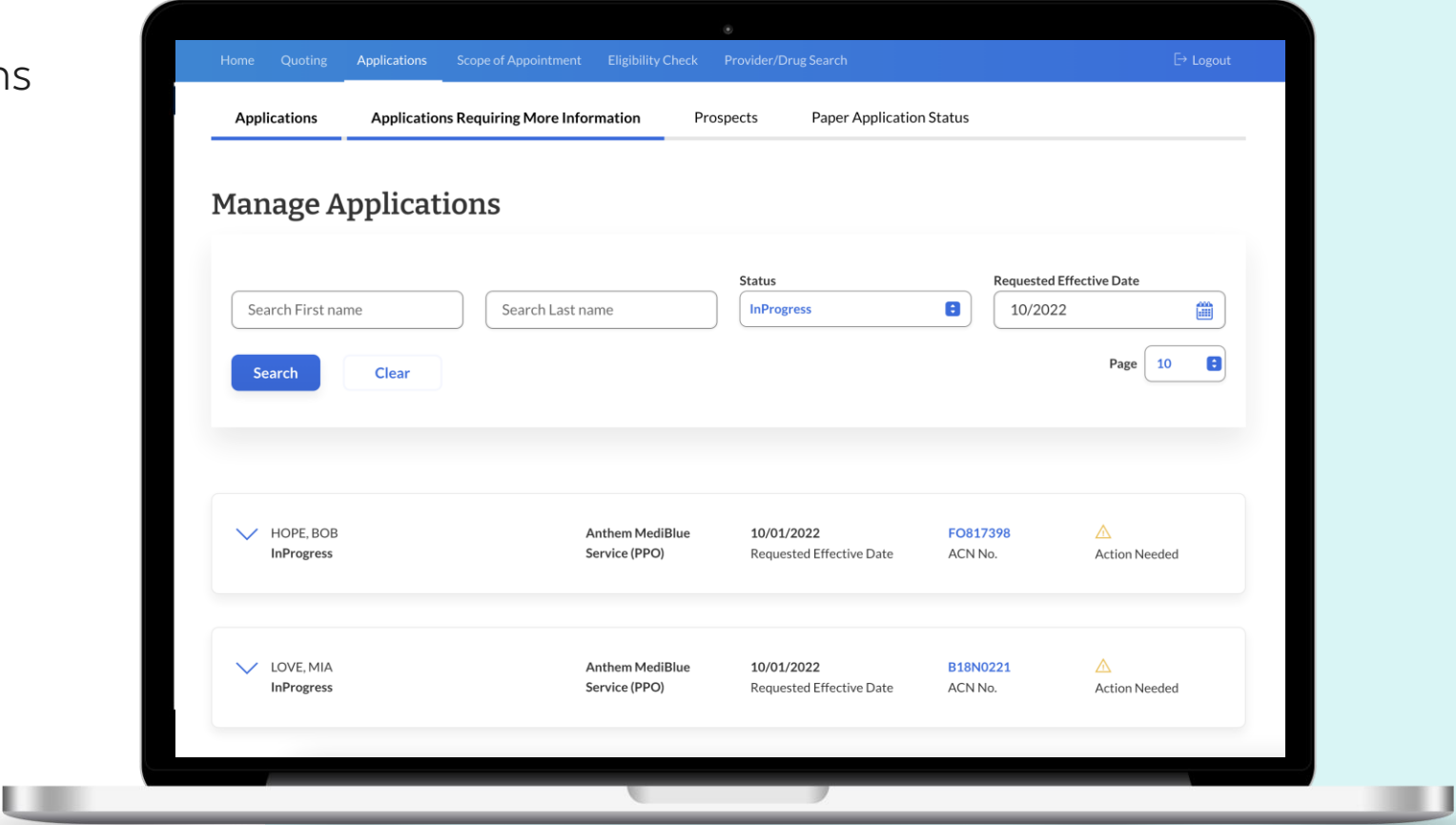
Electronically is the preferred submission method

1. If you need to go back to collect the HRA after submitting the application and closing out the confirmation screen – Go to “Customer Applications” to view a list of all your customers



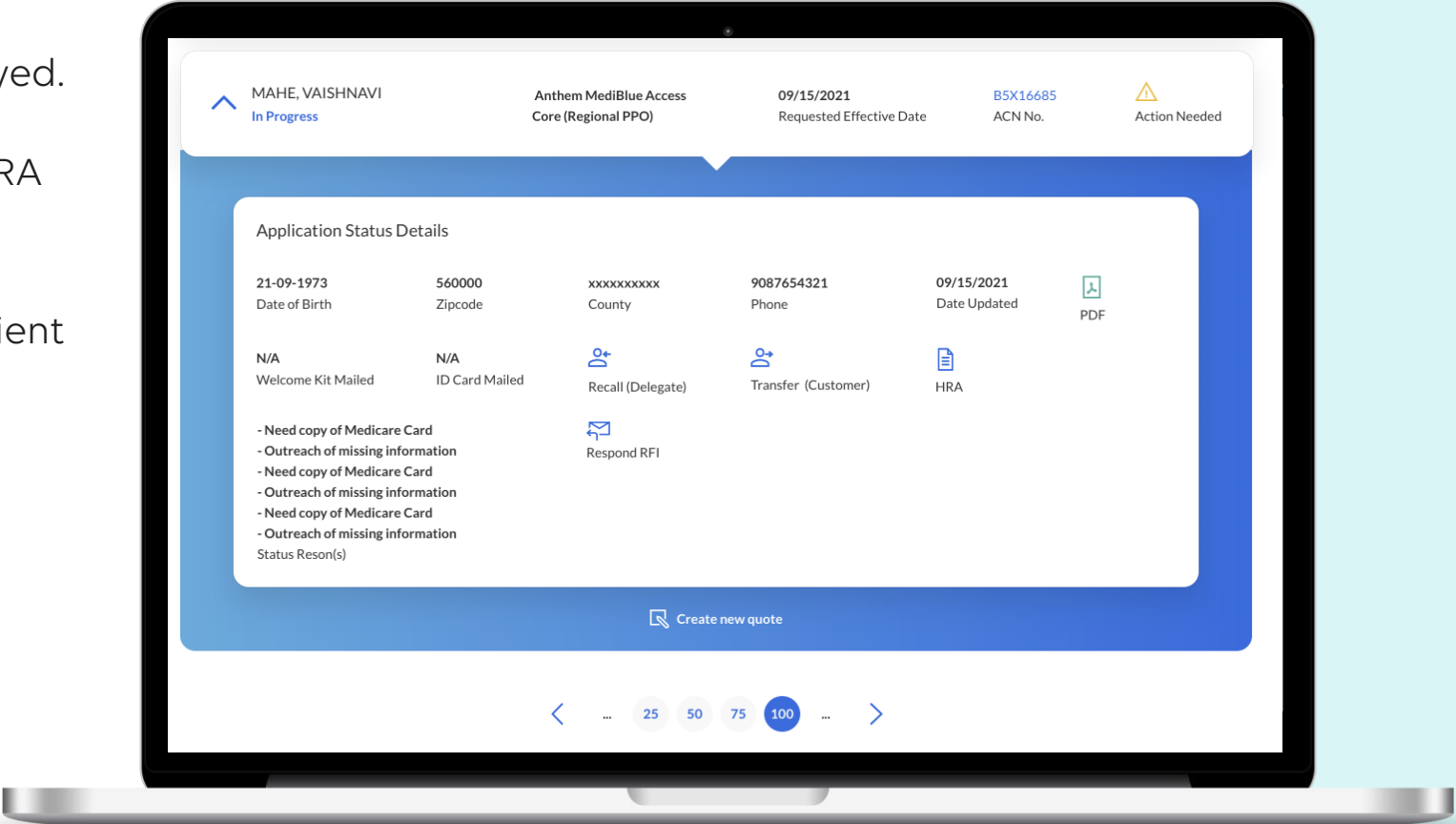
Electronic Submission (Option 2, cont.)

- 2. Locate the member in your applications list and click to view more details.



Electronic Submission (Option 2, cont.)

- 3. If an HRA is available, an HRA is displayed.
- 4. Clicking the icon will open the online HRA form specific to that application.
- 5. Collect the HRA information with the client and submit electronically.



SNP Health Risk Assessment

3 pages

More extensive questions

Fillable PDF available in:

- English
- Chinese
- Korean
- Spanish
- Vietnamese

Email to:
EMOsalesinitiatedHRA@anthem.com

All versions available on CustomPoint or through your RSM

Medicare Health Risk Assessment (HRA) for Designated Special Needs Plans*
Sales agents to complete with beneficiary and email to: EMOsalesinitiatedhra@anthem.com

Place an X in the boxes that apply to you. The information you provide will help us tailor your care plan to your needs. The sooner we get your HRA back, the sooner we can design your care plan.

Contact Info		
First Name	Last Name	Middle Initial
Medicare ID #	Date of Birth (MM/DD/YYYY)	
Street Address		
City	State	Zip
County		

How would you rate your overall health? Poor Fair Good Excellent

How are you managing your health conditions?	
Do you take any prescription medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you need help taking your medicines?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you seen your primary care physician (PCP) in the last 3 to 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you need help filling out health forms?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you need help answering questions during a doctor's visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been hospitalized in the last six months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the past three months, have you gone to an emergency room for care?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever been treated for or told you have any of the following?	
Breathing problems, like chronic obstructive pulmonary disease (COPD) or asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart failure or an enlarged heart <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes or other blood sugar problems <input type="checkbox"/> Yes <input type="checkbox"/> No	A behavioral health condition, like depression or anxiety <input type="checkbox"/> Yes <input type="checkbox"/> No
Other <input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No

Please answer the following questions	
Have you had any changes in thinking, remembering, or making decisions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have family members or others willing and able to help you when you need it?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you ever think your caregiver has a hard time giving you all the help you need?	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?	<input type="checkbox"/> Yes <input type="checkbox"/> No

*This HRA form is not applicable for all special needs plans across all counties and service areas.

YD114_23_3003345_1_C_000210/05/2022

Page 1

1044644MUSENMUB_0002

Do you need help with any of the following tasks? (Check yes or no for each)			
	Yes, but I have the help I need.	Yes, but I am not getting the help I need.	No
Taking a bath or shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brushing teeth, brushing hair, or shaving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using the toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting a ride to the doctor or to see friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going up stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making meals or cooking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking or balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doing house or yard work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keeping track of appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting out of bed or a chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washing dishes or clothes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going out to visit family or friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting dressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping and getting food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing checks or keeping track of money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using the phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Miscellaneous	
Do you need to stay in the house most or all of the time?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you exercise regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you afraid of falling?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you fallen within the last month?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Can you live safely and move easily around in your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, does the place where you live have: (If yes, put an X. If no, leave blank.)	
<input type="checkbox"/> Good lighting <input type="checkbox"/> Good heating <input type="checkbox"/> Good cooling <input type="checkbox"/> Rails for stairs or ramps <input type="checkbox"/> Hot water <input type="checkbox"/> Indoor toilet <input type="checkbox"/> Elevator <input type="checkbox"/> Door to outside that locks <input type="checkbox"/> Stairs into or inside your home <input type="checkbox"/> Space to use a wheelchair <input type="checkbox"/> Clear ways to exit your home	
Do you currently use assistive devices to move around?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, which devices do you use?	
<input type="checkbox"/> Wheelchair <input type="checkbox"/> Cane or walker <input type="checkbox"/> Scooter <input type="checkbox"/> Prosthetic (artificial limb)	
Do you think you have a problem with drinking and/or smoking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a flu shot in the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any recent vision changes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any problems with urine leaking?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Page 2

Miscellaneous continued	
Has anyone close to you ever threatened to hurt you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you afraid of anyone or is anyone hurting you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is anyone using your money without your OK?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you sometimes run out of money to pay for food, rent, bills, and medicine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Within the past 12 months, how often have you been worried that your food would run out before you got money to buy more?	
<input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never	
What is your living situation today?	
<input type="checkbox"/> I have a steady place to live. <input type="checkbox"/> I have a place to live today, but I am worried about losing it in the future. <input type="checkbox"/> I do not have a steady place to live. (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park.)	

What is your normal pain level on a scale of 0 to 10?	
0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10	No pain <input type="checkbox"/> Unbearable pain <input type="checkbox"/>

Over the past month (30 days), how many days have you:	
Had little interest or pleasure in doing things?	<input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half days <input type="checkbox"/> Nearly every day
Felt down, depressed, or hopeless?	<input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half days <input type="checkbox"/> Nearly every day
Felt lonely?	<input type="checkbox"/> None <input type="checkbox"/> Less than 5 days <input type="checkbox"/> More than half days <input type="checkbox"/> Most days, I feel lonely

If you have any questions, please call Customer Service at the number on your member ID card.

Preferred phone #	May we text you at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date (MM/DD/YYYY)	What is the best time to reach you? _____ a.m./p.m.

Sales agent to complete with beneficiary and email to: EMOsalesinitiatedhra@anthem.com

YD114_23_3003345_1_C_000210/05/2022

Page 3

1044644MUSENMUB_0002



Non-SNP Health Risk Assessment

1 page

Fillable PDF available in:

- English
- Korean
- Spanish

Email to:
NonSNPHRASubmissions@anthem.com

All versions available on CustomPoint
or through your RSM

Non-SNP ONLY *Sales agents to complete with member and email to: NonSNPHRASubmissions@anthem.com*

Medicare Health Risk Assessment (HRA)

Place a ✓ on the boxes that apply to you. The information you provide will help us tailor your care plan to your needs. The sooner we get your HRA back, the sooner we can design your care plan.

Contact Info			
First Name	Last Name	Middle Initial	
Medicare ID #	Date of Birth (MM/DD/YYYY)		
Street Address			
City	State	Zip	County

How would you rate your overall health? Poor Fair Good Excellent

In the past three months, have you gone to an emergency room for care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Were you admitted to the hospital anytime within the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been diagnosed with Diabetes or blood sugar problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you even been diagnosed with Coronary Artery Disease or other heart problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No

In the last 3 months, how many unplanned admissions to the hospital or Emergency Room for Mental Health or substance use issues have you had?	<input type="checkbox"/> None <input type="checkbox"/> 1 or 2 <input type="checkbox"/> More than 2
Do you think you have a problem with alcohol or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you fallen two or more times in the last 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you need help with daily living skills?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes: Do you have the support that you need?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Preferred phone #	May we text you at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date (MM/DD/YYYY)	What is the best time to reach you? 10:30 AM

Sales agent to complete this form with the member and submit via email to NONSNPHRASubmissions@anthem.com.



PDF Collection Details

- Both SNP and Non-SNP HRAs have fillable PDFs available
- Fillable PDFs, English and bi-lingual versions, located on:
 - CustomPoint (accessible based on sales channel, meaning internal access will only see SNP HRA for available plans and external will see both SNP and Non-SNP as applicable)
- If the agent is printing the form and **WRITING** on it, ensure all information is **LEGIBLE**
- Email to:
 - SNP: EMOsalesinitiatedHRA@anthem.com
 - Non-SNP: NonSNPHRASubmissions@anthem.com

PDF Submission Process

Steps to submit:

1. Obtain Fillable PDF through RSM (RSM Messaging Resource), eShare, or CustomPoint
2. Collect the HRA with the customer
3. Email the completed PDF to the plan using the appropriate email address:
 - SNP: EMOsalesinitiatedHRA@anthem.com
 - Non-SNP: NonSNPHRASubmissions@anthem.com
4. Ensure the Subject Line includes the word “Secure”
5. Attach the correct PDF Form
6. Allow additional time for process of PDF submissions



FREQUENTLY ASKED QUESTIONS (FAQs)

FREQUENTLY ASKED QUESTIONS (FAQs)

Will the responses from the prospect/member impact their premiums, copays, or eligibility?

The prospects or member's responses to the DSNP Assessment will have no impact on the DSNP plans eligibility or enrollment processes.

What if the prospect speaks a foreign language?

The fillable PDF documents do come in English, Spanish, Chinese, Korean, and Vietnamese

How can agents verify they are receiving their bonuses?

This information is now able to be accessed on the Broker Portal within Books of Business



Questions?

Please contact your RSM

Thank you for attending the On-Demand training session. Your time and business is greatly appreciated. We look forward to working with you in the future.

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