

Commercial Risk Adjustment (CRA) Enrollee Health Assessment Program

Provider User Guide

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1. Commercial Risk Adjustment (CRA)

Commercial Risk Adjustment is a new risk-stabilization program established by the Affordable Care Act for individual and small group plans, both inside and outside the Health Insurance Marketplace (Exchanges). It is a required component for qualified health plans participating in the Exchanges.

- The intent is to stabilize rates so that carriers can offer a variety of plans to meet the needs of a diverse population and ensure all members receive the care they need.
- It improves high-risk patient identification and the ability to engage patients in disease and care management programs and preventive care initiatives.
- It relies on complete and accurate annual documentation and coding of all conditions, including severity assessment, treatment, and care plans.

The basis for risk adjustment is complete annual coding of health conditions. Health plan risk scores are based on:

- Member demographics (age/gender)
- Member health status (based on Hierarchal Condition Category Risk Adjustment model)
- Benefit richness
- Subsidy status

Member health status (as mentioned above) is determined exclusively by diagnoses contained in current year medical claims. Other sources of information, such as pharmacy, health risk assessments, etc., aren't included. Chronic conditions must be re-established each year.

2. Enrollee Health Assessment (EHA) Program

Premera's EHA Program is intended to support members with chronic conditions by leveraging the opportunity to improve patient health status through processes that:

- Improve higher-risk patient identification
- Engage members in disease and care management programs and preventive care initiatives
- Engage providers in patient diagnosis, coding, and treatment plans

Providers who sign the Quality Improvement Comprehensive Exhibit are paid for completing comprehensive health assessments, appropriate diagnosis coding, and treatment plans for high-risk patients as identified by Premera.

3. Program Basics

The provider executes the EHA contract document (could be either an exhibit or amendment) and agrees to thoroughly document care and diagnosis coding for complex care patients. As part of the program, Premera:

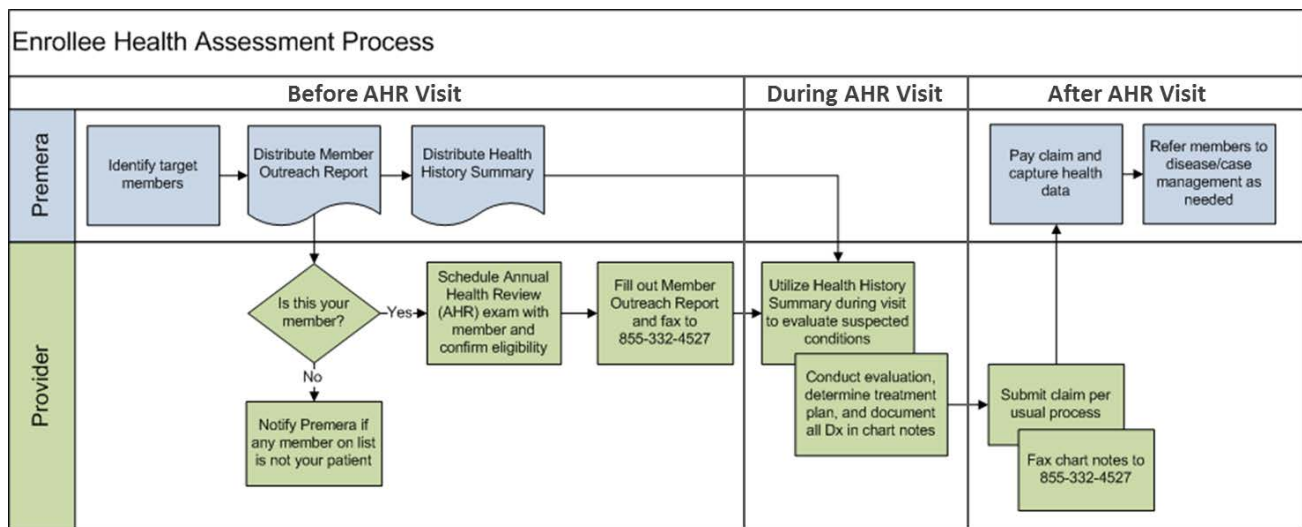
- Makes general education available to providers through Premera's Provider Engagement Team
- Supports providers' precise diagnosis coding through:
 - Providing training materials to educate and guide providers
 - Improving high-risk member identification
 - Enhancing understanding of medical record requirements and audits
- Conducts focused meetings with providers with high numbers of confirmed or anticipated members with chronic conditions to:
 - Review data on patient diagnosis coding gaps
 - Review provider diagnosis coding practices

4. Enrollee Health Assessment Process

Premera informs providers of eligible patients with chronic conditions and compensates for in-depth assessments and diagnosis coding. Here's how the process works:

- a) Premera identifies eligible members who may have complex or chronic health conditions.
- b) Premera sends the provider a list of members (Member Outreach Report) who meet the program's clinical criteria.
- c) Provider notifies Premera if any of the identified members are not their patient(s).

If the provider identifies a member on the list who is not their patient, the provider should call Physician and Provider Relations at 800-722-4714, option 4, to have the member's name removed from future mailings. If Premera doesn't hear from the provider office within five business days from the date of the cover letter, Premera assumes the members listed on the report are the provider's patients.
- d) Premera sends the provider a Health History Summary, which identifies patient-specific information, such as suspected chronic condition(s) for each member on the mailing list along with an Annual Health Review (AHR) Visit Guide, to help guide providers through documentation of the AHR visit.
- e) Provider contacts identified patients on the Member Outreach Report and schedules an AHR visit. **After patient outreach is done, the provider completes the right-hand column of the Member Outreach Report, and faxes it to Premera at 855-332-4527.**
- f) Provider conducts an AHR visit and updates the patient's medical record to capture assessment, diagnoses, and treatment plans. No copay is collected for this visit.
- g) The provider faxes patient's medical record, capturing the AHR assessment, to Premera's Provider Engagement Team at 855-332-4527. The provider should use the Health History Summary as a cover sheet.
- h) The provider bills with appropriate HCPCS code (G0438 or G0439) through normal claims submission process.
- i) Premera provides reimbursement to the provider for completing the AHR visit and submitting the patient's medical record capturing the AHR assessment.
- j) Premera mails pre-selected members an incentive upon processing of the AHR visit claim.



5. Member Identification

5.1 Premera Identification

Premera identifies members on individual and small group metallic plans (gold, silver, or bronze) who are associated with a primary care provider (PCP) and meet the program criteria. Premera includes these members on the Member Outreach Report and distributes it to providers quarterly.

a) PCP Association

Members may select their PCP or be attributed to a PCP based on claims experience.

b) Clinical Criteria

Clinical criteria include, but are not limited to, the existence of two or more conditions of chronic respiratory disorders, major depressive disorders and dementia, coronary artery disease, neurological disorders, congestive heart failure, vascular diseases, chronic kidney disease, diabetes, diabetic manifestations, and complications for which the patient has not seen a provider in the last 13 months.

c) Member Outreach Report—List Generation

- Premera generates the Member Outreach Report and distributes it to providers quarterly.

If the provider identifies a member on the list who is not their patient, the provider should call Physician and Provider Relations at 800-722-4714, option 4, to have the member's name removed from future mailings. If Premera doesn't hear from the provider office within five business days from the date of the cover letter, Premera assumes the members listed on the report are the provider's patients. Upon the completion of patient outreach, the provider should destroy the list in order to protect confidential and privileged patient information.

- Approximately two weeks after the Member Outreach Report is distributed, providers receive a Health History Summary for all the members listed on the report. Premera subsequently sends the report to providers on a quarterly basis.

5.2 Provider-Identified Members

If a provider has a patient in their office they believe qualifies for this program, but isn't on the member list, the provider can call Physician and Provider Relations at 800-722-4714, option 4, to verify their patient meets the program's eligibility and clinical criteria. Once the provider receives approval from Premera, the provider can complete an AHR visit and appropriately document and bill for the visit. **Note:** Provider-identified members are not included on the Member Outreach Report.

6. Scheduling Patient Visits

- To encourage patients to receive direct and timely care for their chronic and complex conditions, and to obtain appropriate referrals to disease and/or case management specialists, we encourage providers to see each patient with chronic conditions once per calendar year for an AHR visit.
- Chronic diseases must be addressed and documented in the patient's medical record. We encourage providers to tell patients this is a cooperative effort among their doctor, their medical plan, and themselves to address all of their chronic diseases.
- No copay is collected for this visit because there is no patient liability for participation in the EHA Program.

- It is important to verify eligibility and benefits prior to conducting the AHR visit, as eligibility and metallic plan membership can change throughout the year.
- Additional services requested during the AHR visit (such as lab, radiology, or other services) are subject to the patient's normal plan provisions.
- When providers receive Premera's Member Outreach Report, our members listed on the report also receive a letter from Premera explaining the EHA Program benefits. Premera asks them to contact their provider to schedule the AHR visit.
- Premera conducts phone outreach to select members to encourage them to contact their provider to schedule the AHR visit, and in some cases to assist them in a 3-way call with the provider to help them schedule the AHR visit. (If you prefer that Premera not contact your patients for this purpose, contact Physician and Provider Relations at 800-722-4714, option 4.)
- Select patients may be offered an incentive upon completion of the AHR visit. (Once the AHR visit is complete and Premera receives and processes a claim with the appropriate G0438 or G0439 code, Premera mails the incentive to the patient.)
- Once providers review the Member Outreach Report and attempt to schedule a visit with all the patients, providers should fill in the patient/appointment status in the right-hand column of the list and fax it to Premera at 855-332-4527.

7. Health History Summary

The Health History Summary is a statement of history and suspected conditions based on health data Premera has on file for the patient. This document is for informational purposes only and isn't the record of truth. The information on the Health History Summary may include out-of-area services, wellness program information we have on file, and non-PCP provider visits.

The Health History Summary provides the minimally necessary information to support providers when seeing a patient for an AHR visit by helping providers review all possible health conditions. **Note:** We include sensitive information related to our member's health (excluding information related to sexually transmitted diseases) on this summary.

At the bottom of the Health History Summary, Premera also provides a list of several possible HEDIS (Healthcare Effectiveness Data and Information Set) care gaps for your patient. Providers should review the information with their patient during the AHR visit to determine if services are needed. The fields for each measure should contain one of the following: date of last screening, not applicable or not on file (with Premera).

8. Submitting Annual Health Review Documentation

[Providers should completely document the AHR visit including all chronic and complex condition diagnoses in the patient's medical record.](#)

The AHR Visit Guide, a one-page document intended to guide providers through the documentation of the AHR visit in the chart, is included in the mailing with the Health History Summary. Once the documentation is complete, the chart note should be faxed to the Premera Provider Engagement Team at 855-332-4527. Use the Health History Summary as a cover sheet (noting any denied suspected conditions on the form).

9. Claims Submission

Submit claims following the provider's standard process for filing a claim. Ensure all applicable diagnosis codes are listed on the claim, in addition to the appropriate HCPCS code (G0438 or G0439) for an AHR visit.

The use of HCPCS codes G0438 and G0439 for an AHR visit are only allowed for providers participating in the EHA Program.

- G0438: Annual wellness visit, which includes a personalized prevention plan of service, initial visit
- G0439: Annual wellness visit, which includes a personalized prevention plan of service, subsequent visit

These codes are intended to be billed with medical (not preventive) diagnoses no more than once per calendar year. They are not for routine preventive visits. Continue to use the appropriate evaluation and management codes for annual preventive care visits (99381 through 99397).

10. Resources

Information related to this program is available using the following options:

10.1 Provider Website

The following information can be found on Premera's Provider Website:

- Annual Health Review Visit Guide
- User Guide
- EHA Program Implementation Guide and Best Practices
- EHA 301 Webinar
- Comparison of Annual Health Review and Other Visit Types
- Medical Records Requests page
- ACA Medical Records Audits
- Sample Medical Records Request Provider Letter
- Patient Scheduling Talking Points
- Sample Member Letter

10.2 Physician and Provider Relations

For additional information, contact Physician and Provider Relations at:

- 800-722-4714, option 4
- Fax: 425-918-6738
- Toll-free fax: 855-332-4527

Appendix

1. Health History Summary – Form Detail

The Health History Summary is a statement of history and suspected conditions based on health data Premera has on file for the patient. This document is for informational purposes only and isn't the record of truth. The information on the Health History Summary may include out-of-area services, wellness program information that we have on file, and non-PCP provider visits.

The Health History Summary provides the minimally necessary information to support providers when seeing a patient for an AHR visit by helping providers review all possible health conditions. **Note:** We include sensitive information related to our member's health (excluding information related to STDs) on this summary.

The first section of this form includes patient demographics:

- Patient's last name, first name, middle initial
- Date data was entered on the form
- Member ID number (see the member's ID card under the member's name)
- Suffix (see the member ID card to the right of the ID number)
- Group number (see the member ID card under the name and ID number)
- Patient's date of birth, age, and sex
- Provider name (PCP selected by the patient or attributed based on claims experience)
- Date of last visit

Reported Diagnoses

This section provides chronic diagnoses reported within the last 12 months. The dates next to the diagnosis are the date the diagnosis was last coded on a claim.

Due to privacy regulations, this section doesn't contain information about sensitive diagnosis codes. Those should be evaluated and documented, if applicable, in the chart note during the AHR visit.

Reported Prescriptions

This section provides prescriptions that have been reported within the last 12 months. This provides the medication, the dose, and the date of the most recent refill.

Durable Medical Equipment and Injectable/Infusions

This section provides any DME the patient may have, along with any injectables and infusions they may have received in the last 12 months. The date listed is the date the service was last coded on a claim.

Hospitalizations and Reported Emergency Room Visits

This section provides information on any inpatient admissions, other facility admissions, or ER visits, including the diagnosis and the date of admission last coded on a claim or most recent date of the ER visit for that diagnosis.

Suspected Conditions

This section provides information on suspected conditions based on information from providers and/or members. This information is extracted from patient health data and is not a confirmed diagnosis. Please note any denied conditions on this form. Use the form as a cover sheet for the AHR visit documentation and fax it to Premera after the AHR visit is complete.

Potential HEDIS Care Gaps

This section provides information on HEDIS-related quality elements. The information is based on Premera's claims records. Review any applicable HEDIS elements with your patient. If services are needed, these preventive screening services are covered in full for most Premera plans when done according to United States Preventive Service Task Force Guidelines. Remember to confirm benefits and coverage prior to scheduling these services.