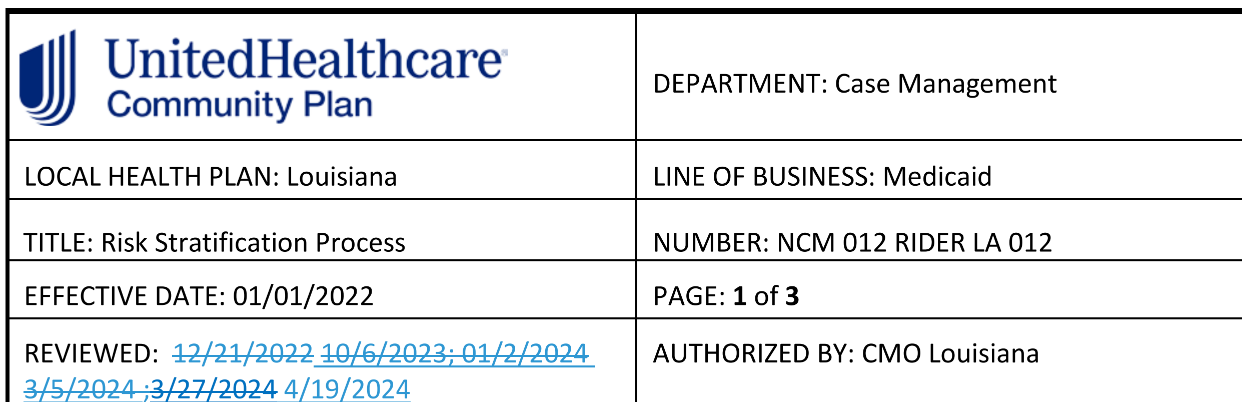


UnitedHealthcare Community Plan	DEPARTMENT: Case Management
LOCAL HEALTH PLAN: Louisiana	LINE OF BUSINESS: Medicaid
TITLE: Risk Stratification Process	NUMBER: NCM 012 RIDER LA 012
EFFECTIVE DATE: 01/01/2022	PAGE: **1** of **3**
REVIEWED: ~~12/21/2022~~ ~~10/6/2023; 01/2/2024~~ ~~3/5/2024~~ ;~~3/27/2024~~ 4/19/2024	AUTHORIZED BY: CMO Louisiana

I. PURPOSE/SCOPE

To establish guidelines and a standard process for risk stratification [KF1][AJ2][AJ3]of members upon enrollment as well as through ongoing monitoring to ensure member access to case management programs. To Identify members for Tier Level Case Management which is represented by Tier 3 (high), Tier 2 (moderate), and Tier 1 (low) by using a predictive modeling.

II. DEFINITIONS

Refer to UnitedHealthcare Community and State Louisiana (UHC C&S LA) Standard Definitions.

III. POLICY

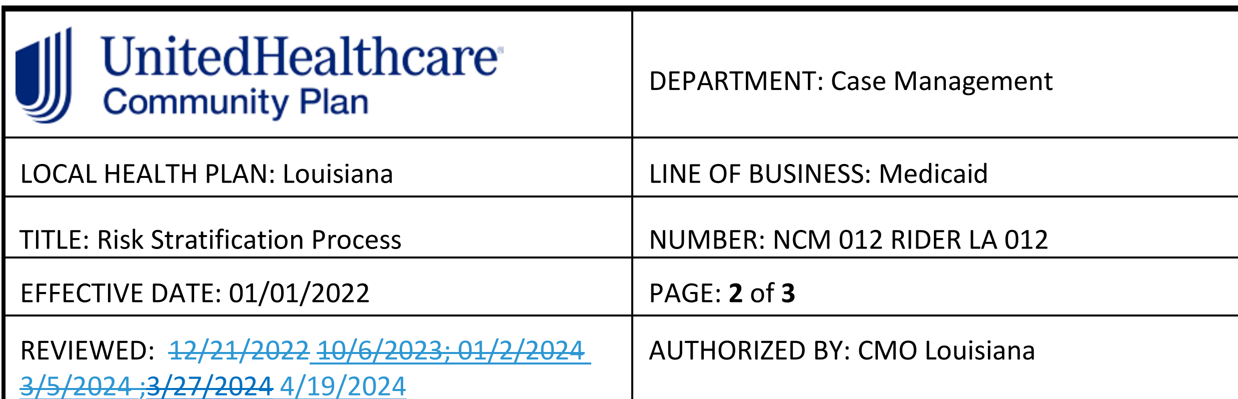
UHC C&S LA Health Plan utilizes various tools to identify a member's health risk to ensure the member has access to case management programs designed to meet their needs. Assigning risk levels at enrollment allows the plan to prioritize outreach and engagement activities to those members identified with special or immediate needs.

UHC C&S LA Health Plan utilizes the following methods to risk stratify members:

1. Health Needs Assessment (HNA) ~~(2.7.2)~~
2. Predictive modeling
   - ~~a. Impact Pro (IPRO)~~
3. Benefit enrollment flags
4. ~~Hotspotting Tool~~
5. Special Health Care Needs Reporting (SHCN) ~~– Historical Claims Data~~
6. Referrals
7. Service utilization

IV. POLICY PROVISIONS

1. A member is stratified using predictive modeling tool to identify and stratify UHC's membership. This intuitive stratification uses claims, risk scores, and eligibility data. ~~into various risk categories based on contractual and/or regulatory requirements.~~
2. UHC's tier level case management risk stratification guidelines:
   a. Tier 3 High Risk
      i. Individuals identified via predictive modeling (e.g., multiple chronic conditions, need for uninterrupted care, pattern of ED and hospital admissions)
      ii. Severe and persistent mental illness, serious emotional Disturbance, or a substance use disorder, or otherwise have significant behavioral health needs, including those Enrollees presenting to the hospital or emergency department



with a suicide attempt or non-fatal opioid, stimulants, and sedative/hypnotic drug overdose reason;

iii. SUD/OUD and presented to ED for overdose treatment;

iv. Experiencing homelessness per Section 330(h)(5)(A) of the Public Health Services Act;

v. All member, including Special Health Care Needs, as defined by the risk score.

b. Tier 2 Medium Risk

i. Identified by Emerging Risk factors with a chronic conditions but not engaging with the health care system at appropriate levels for their condition or no routine monitoring or testing.

ii. All member, including Special Health Care Needs as defined by the risk score.

iii. Experiencing housing insecurity or two or more SDOH needs that put them at risk.

~~b.~~**c.** Tier 1 Low Risk

i. Members seeking new providers

ii. Experiencing lower intensity SDOH needs

iii. Initial member self-referral or provider referral

iv. ~~All member, including Special Health Care Need as defined by the risk.~~[MS4][AJ5] Members needing care coordination support that do not fall in Tier Level 2 or Tier 3 as defined by the risk score.

~~2.~~**3.** ~~Health Needs Assessments Initial member leveling/stratification begins with a live contact welcome call with new enrollees.~~ Initial member leveling/stratification begins with the completion of the Health Needs Assessment (HNA) during new member outreach or through enrollment flags or information provided by State partners which identify members with complex or special needs. The HNA provides actionable data on Social Determinants of Health (SDOH) needs and drives one-on-one interventions and programming. Member's health and wellness status are evaluated to identify social, behavioral, medical, and functional conditions and needs.

4. Special Health Care Needs Report~~ing – Historical Claims Data uses monthly reporting designed to capture data for members meeting the definition of Enrollees with Special Health Care Needs~~. ~~Reporting is B~~based on ICD-10 codes in historical claims data, member demographics, age, eligibility file, hospital stay, and SDOH ~~and is cross referenced to IPRO data~~ to ensure qualified enrollees are identified and not excluded from case management participation which ~~.~~[KF6][AJ7]also includes the below[TB8][AJ9]:

a. have complex needs such as multiple chronic conditions, co-morbidities, and co-existing functional impairments;

b. high risk for admission/readmission to a hospital within the next six (6) months;

c. are at high risk of institutionalization;

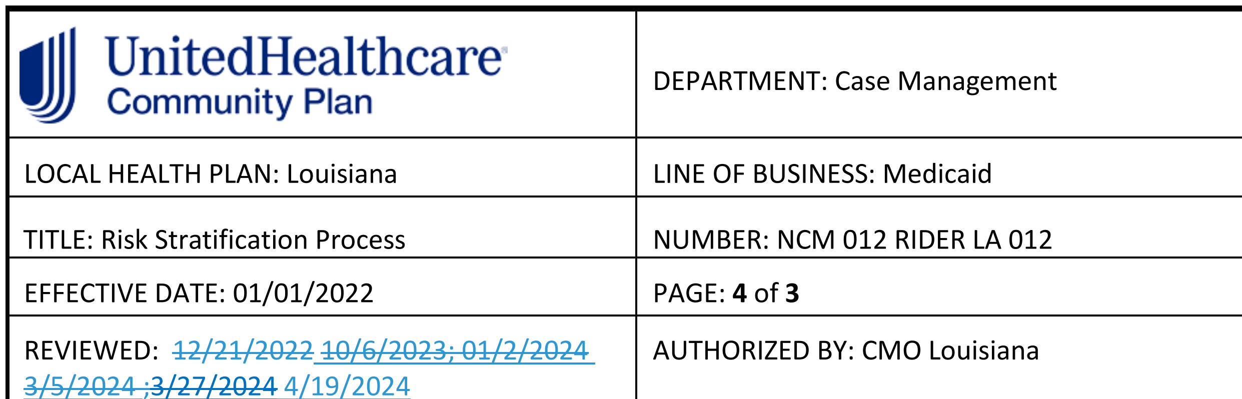
d. identified members for Pediatric Day Health Care/Private Duty Nursing/Personal Care Service;
e. Severe and persistent mental illness, serious emotional Disturbance, or a substance use disorder, or otherwise have significant behavioral health needs, including those Enrollees presenting to the hospital or emergency department with a suicide attempt or non-fatal opioid, stimulants, and sedative/hypnotic drug overdose reason;
f. are Homeless as defined in Section 330(h)(5)(A) of the Public Health Service Act and codified by the US Department of Health and Human Services in 42 U.S.C. §254(b);
g. are women with high-risk pregnancies (i.e., pregnancies that have one or more risk factors) or who have had an adverse pregnancy outcome during the pregnancy, including preterm birth of less than thirty-seven (37) weeks;
h. have been recently incarcerated and are transitioning out of custody;
i. Are at high risk of inpatient admission or emergency department visits, including certain Enrollees transitioning care across acute hospital, chronic disease and rehabilitation hospital or nursing facility setting;
j. are members of the DOJ Agreement Target Population;
k. are enrolled under the Act 421 Children's Medicaid Option; or
~~3.~~l. receive care from other State agency programs, including, but not limited to, programs through Office of Juvenile Justice (OJJ), Department of Children and Family Services (DCFS), or Office of Public Health (OPH).

[KF10][AJ11]

~~4. Hotspotting tool strategically uses data to reallocate resources to a small subset of high need, high-cost enrollees. This tool allows case managers and other team members to segment the population using over 50 filters. Filters may include risk factors, demographics, SDOH needs, diagnosis, type of utilization, mental health, and substance abuse.~~

5. Referrals are accepted from enrollees, families, providers, state agencies, community organizations, and UnitedHealthcare departments. ~~Through the Care Management Referral email address, referrals may be received from any source and will be evaluated by case management team.~~

6. Predictive modeling to identify members for Case management Programs includes:
   ~~6.~~a. a. Identification of risk level using a predictive algorithm that, at a minimum, takes into consideration inpatient hospital claims, emergency room use, co morbid conditions, social determinants of health and pharmacy claims. This includes a monthly scheduled [TB12][AJ13]data refresh to conduct an initial risk stratification of new members and an ongoing re-stratification for existing members. ~~Predictive modeling IPRO to identify members for Case management Programs includes (2.7.5)~~:



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b. Identification of care needs and rule sets which stratify all members by severity of disease and associated co-morbidities. Care needs may be gaps in care, missing targeted interventions, evidenced-based medicine guidelines, social determinants of health or missing clinical indicators. ~~Rule sets may vary by market based on State requirements~~[TB14][KF15][AJ16].

~~a. Identification of risk level using a predictive algorithm that analyzes demographics, SDOH indicators, medical, behavioral, and pharmacy claims. Members with gaps in care, high utilization, risk markers, and condition-specific triggering events.~~ [TB17][AJ18]

~~b. Identification of care needs and rule sets which stratify all members by severity of disease and associated co-morbidities. Care Needs may be gaps in care, missing targeted interventions, evidence-based medicine guidelines, or missing clinical indicators.~~

7. Through these stratification activities members are assigned to the appropriate case management programs.

8. Risk level hierarchy is established by the HNA and predictive modeling as well as the enrollment flags.

9. If a member's needs do not coincide with risk level, the Care Manager will use clinical judgement to revise, increase, or decrease member risk level.

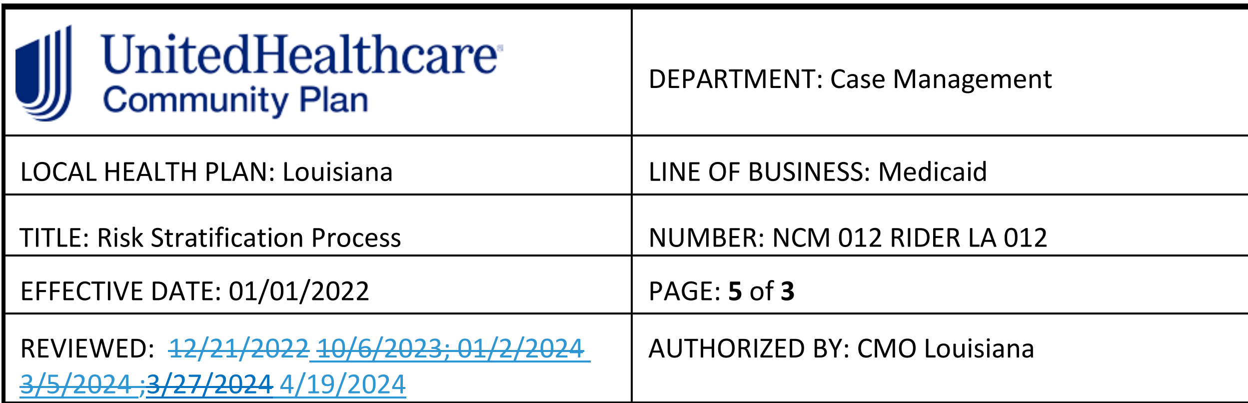
10. When predictive modeling scores identify a change from the member's current risk level, a case manager/care coordinator will review the member's record and adjust the risk level as appropriate.

V. REFERENCES:

1. 42 CFR 438.208 Coordination and Continuity of Care

2. CONTRACT BETWEEN STATE OF LOUISIANA – LOUISIANA DEPARTMENT OF HEALTH Bureau of Health Financing AND UnitedHealthcare of Louisiana, Inc. dba United Healthcare Community Plan Effective 01/01/2020

3. UHC C&S LA Health Plan CM Predictive Modeling & Stratification Methodology 2022



VI. APPROVED BY:

10/6/2023

Glenda Johnson,~~Julie Morial,~~ MD
~~Chief~~ Medical Director ~~Officer~~
Louisiana Community and State

Date

VII. REVIEW HISTORY:

Effective Date	Key update from Previous Version	Reason for Revision
02/09/2022	Adopted national policy for LA C&S	New policy for LA C&S
09/08/2022	Language added to reflect new contract	Readiness Review
12/21/2022		Readiness Review
10/06/2023	Language updated for clarity: Contract Language 2.7.5	Review
1/2/2024	Language updated for clarity per LDH request	Review
3/5/2024	Language updated for clarity per LDH request	Review
3/27/2024	Language updated for clarity per LDH request	Review
4/19/2024	Language updated for clarity per LDH review and request.	Review