SHSC's Methodologies for Member Risk Stratification

Consistent with the information provided within SHSC's February 10, 2019 response to SCDSS's Addendum, SHSC leverages a suite of analytic tools and methods to identify, classify and manage a member's risk (existing and potential risk). This multipronged approach allows SHSC to identify members in all levels of risk (low, moderate and high) and promptly link them to the most appropriate level of CM services. A description of a key set of tools used by SHSC today for risk stratification and other functions is provided below:

CareAnalyzer (CA) & the Johns Hopkins ACG® System

SHSC utilizes a variety of population health management tools. One of the primary tools leveraged on a daily basis is Care Analyzer (CA). SHSC uses CA to improve member outcomes, quality of care, and operational efficiencies. CA combines clinical and nonclinical elements of the member and provider to understand risk and opportunities for interventions and performance improvement. This tool and approach allows SHSC to proactively engage, assess and track both our general population and our most vulnerable members—those with chronic care needs, traumatic episodes, and most at risk for hospitalization, emergency room visits, and expensive medication.

The Johns Hopkins ACG® System, included in our CA solution, offers a unique approach to measuring morbidity that improves accuracy and fairness in evaluating provider performance, identifying members at high risk, and forecasting healthcare utilization. The ACG System converts member data from a variety of sources—diagnosis codes, pharmacy codes, and laboratory codes—into actionable information.

The ACG System's hallmark is its unique "person-focused" approach which was developed to capture the multidimensional nature of an individual's health at a given point in time. One of the cornerstones of CA is the Johns Hopkins ACG® (Adjusted Clinical Groups) System, a predictive model based on a multi-morbidity framework that is clinically logical, easy to use, and applicable to both clinical and financial managers.

The ACG® System is a leading risk measurement methodology that was developed and continues to be tested and improved at the Bloomberg School of Public Health. It is the only population-based methodology that is fully adaptable to a local context, impacting close to 200 million lives in nearly 30 countries. For more than 30 years, public health officials, hospital administrators and health care providers throughout the world have used the ACG System for a variety of applications ranging from care delivery, clinical case management, evaluative research, finance, and administration.

SHSC's Care Management Population by Risk & Duration of Services

Foster Care Member Population by Risk

From January to December 2018, SHSC's foster care membership grew from 3,900 members to 5,024 members. As of February 2019, the average monthly enrollment is consistent at 5,000 members. Throughout CY2018, the average monthly distribution of foster care members by risk level is shown below:

Average Percent Range			Select Health's
Low	-	*High*	ACG Risk Tiers
20%	-	35%	Very Low Risk
20%	-	35%	Low Risk
10%	-	25%	Moderate
3%	-	12%	High Risk
1%	-	2%	Very High Risk

Member Entry & Exit to/from CM Services (Monthly)

As explained in the paragraph above, the duration of CM services varies by an individual member's needs and achievement of his/her goals. Of the total number of members enrolled in CM services at any given time, approximately 8-10 percent enter and exit the program each month.

Duration CM Services

Once a member enters CM services, care managers work with members to establish clear goals and objectives for success and improvement. CM interventions are tailored to the member's needs, continuous and do not officially end until the member has achieved the desired self-management goals and/or obtained maximum improvement. Case closure does not reduce a member's benefits or result in a discontinuation of routine medical management activities or care coordination services. Furthermore, if a member's condition changes after his/her case has closed, their case can be reopened at any time in the future.

As explained in the paragraph above, the duration of CM services varies by an individual member's needs and achievement of his/her goals. Of the total number of members enrolled in CM services at any given time, approximately 8-10 percent enter and exit the program each month.

CM Resources and Capacities

Consistent with the February 11, 2019 response to SCDSS's first request for additional information beyond the original Addendum, SHSC's CM staffing model is reflected in the table below. The total number of full time equivalents (FTEs) is based on several factors and projections—those discussed with SCDSS, SCDHHS and internal SHSC analysts (see table below).

SHSC and SCDHHS believe the model proposed is reasonable and sufficient for the volume and acuity projected. In the event volume or acuity exceeds projected values, SHSC has the ability to temporarily leverage other CM resources within IHCM, for example, through the use of Pediatric Complex Care Managers. At such time, if volume or acuity significantly fluctuates or deviates from projections, Select Health will promptly address this observation with SC DHHS and DSS to determine if a change in course is required.

Additionally, SCDHHS has provided assurances that administrative expenses for human capital and costs associated with day-to-day operations, care coordination and care management will be adjusted to reflect changes in service use as a result of the SCDSS Health Plan Addendum and potential fluctuations or assumed increases in overall costs and expenses. Notably, requests for expansion of scope of responsibility outside of the agreed upon discreet functions of the health plan that may result in the need for additional staffing are subject to additional discussion and approval by Select Health and SC DHHS.

FTE	Position
6	Complex Care Manager (Clinical RN)
8	Care Connectors (Non-clinical)
0.5	Other – RN Manager
1	Other – RN Supervisor
2	Other – CM II – LCSW
0.5	Medical Director
1	Quality Improvement Specialist
19	Total

These resources will be dedicated exclusively to the foster care unit. In addition to the resources committed to the foster care unit, SHSC will draw upon its other resources/expertise within its IHCM structure to meet the commitments outlined in the care coordination model.