KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Risk Stratification and Segmentation (RSS) and Risk Tiering	**Policy #**	19.30-P
Policy Owner	Population Health Management	**Original Effective Date**	1/1/2024
Revision Effective Date	3/2025	**Approval Date**	07/01/2025
Line of Business	☒ Medi-Cal ☐ Medicare ☐ Corporate		

I. PURPOSE

To describe the population Risk Stratification and Segmentation (RSS) and Risk Tiering approach and processes to connect Members to appropriate services.

II. POLICY

The Kern Health System (KHS) Population Health Management (PHM) Service will support whole-person care by integrating and aggregating historical administrative, medical, behavioral, dental, social service, and program information from disparate sources to support risk-stratification and segmentation, tiering, assessment, and screening processes, analytics, and reporting. PHM will translate data into information that can be used to identify opportunities for continuous quality improvement, reduce bias, and error in decision-making. KHS will connect its members to the right services and supports at the right time and place depending on their needs and preferences.

III. DEFINITIONS

TERMS	DEFINITIONS
LACE Index	The LACE tool is used to assess a patient's risk of readmission to a hospital or adverse health outcomes following discharge. It is a predictive tool that helps healthcare providers identify patients who may need additional resources or interventions to avoid readmission. (L) Length of Stay, (A) Acuity of Admission, (C) Comorbidities, and recent (E) Emergency Department use.

IV. PROCEDURES

A. RSS and Risk Tiering findings from the Population Needs Assessment (PNA) and Members' needs.

1. KHS will support the unique needs of members population, including health and social needs (e.g., behavioral, developmental, physical, and oral health); Long-Term Services and Supports (LTSS) needs as well as health risks, rising risks, and health-related social needs due to social determinants of health (SDOH) in the PNA.

2. The goals for PNA:

    a. Ensure a clear understanding of the health needs, health disparities, and social needs of members.

    b. Identify available resources/gaps in resources that affect members' health and social needs. Promote strong engagement with local communities.

    c. Create a comprehensive strategy for addressing the specific disparities and gaps in care/resources aligned with the National Committee for Quality Assurance (NCQA) PHM standards.

3. The PNA will use internal and external data to identify and assess vulnerable member groups by race or ethnicity, age, sex, language, and other member characteristics.

4. KHS will use data collection on members on enrollment and thereafter at provider visits, diagnoses, and transitions of care, among other events in compliance with State and Federal Security and privacy requirements.

5. KHS provides screening, assessment, and reassessment to members.

    a. Screening (LTSS, PHQ-9, social determinants of health, ACEs, etc.) which is a brief process or questionnaire for examining the possible presence of a particular risk factor or problem, to determine whether a more in-depth assessment is needed for a specific area of concern and;

    b. Assessment and reassessment, which is a more comprehensive process than screening, involving a set of questions for defining the nature of a risk factor or problem, determining the overall needs or health goals and priorities, and developing specific treatment recommendations for addressing the risk factor or problem. KHS will work with network providers for shared decision making with the members about the services a member needs, including using real-time information. Screening, assessment, and reassessment allow KHS to:
        i. Gather timely and accurate data on preferences and needs for all members in a dynamic way to connect members to services at the individual level and family level at the time they are needed.

        ii. Safeguard the privacy and autonomy of the member, which means sharing information only within the confines of the law and in accordance with a member's preferences.

iii. Build trust by meaningfully engaging with members, such as by explaining why questions are being asked and what the information will be used for.

iv. Gather and share data in a member-centered way between physical health, behavioral health, and social services systems; this will reduce member screening fatigue by reducing duplication of questions and asking questions in a manner that is accessible to a member (e.g., electronically, during an already existing appointment with a provider).

v. Reduce bias through data standards that prevent stigma, health inequities and other negative impacts upon individuals and groups who have been economically, socially, culturally, or racially marginalized.

6. KHS will leverage information collected on the members during medical and quality management activities which is stored in the KHS data warehouse.

    a. Data from these sources is integrated with the data from assessments and screening and used for risk stratification and segmentation (RSS).
        i. Screening or Assessment Data (For instance, data supplied by members through self-reported data such as a completed Health Risk Assessments or information given by caregivers).
        ii. Claims or Encounter data.
        iii. Available social needs data.
        iv. Electronic health records.
        v. Referral data.
        vi. Behavioral Health data
        vii. Hospital, or discharge data.
        viii. Pharmacy data.
        ix. Data collected through the Utilization Management, Disease Management, Health Education, or Member Services process.
        x. Disengaged Member reports (e.g., assigned Members who have not utilized any services)
        xi. Lab results data.
        xii. Admissions, Discharged and Transfer (ADT) data.
        xiii. Race/ethnicity data.
        xiv. Sexual orientation and gender identity data.
        xv. Predictive modeling risk score.
        xvi. Members with a medical condition and a complex social situation that affects the medical management of the member's care and requires

extensive use of resources; and/or

xvii. Referrals from health plan partners and regulatory agencies (i.e., Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), etc.).

xviii. Exclusion criteria:

1) Non-members
2) Heath Homes Program (HHP) Enrolled
3) Dual Eligible (Medica/Medi-Cal) or other coverage where KHS is secondary.
4) Enrolled in Home Based Hospice Program.
5) Member or Physician opt-out.
6) Enrolled in California Children's Services (CCS) for a diagnosis for which Case Management is requested.
7) Member resides in a long-term care facility.

7. KHS will analyze service utilization patterns, disease burden, and gaps in care for our members considering their risk level, geographic location, and age groups.

    a. KHS will use these findings to evaluate the programs and services offered by KHS to determine if the benefits offered are adequate to meet member's needs.

A. Understanding Risk

1. Understanding member risk is critical to identifying opportunities for more efficient and effective interventions and ideally occurs well before a member requires more intensive treatment and care.

2. KHS will use the Adjusted Clinical Groups (ACG) Modeler that meets NCQA standards.

    a. Data sources for the ACG Modeler include member eligibility, medical claims, pharmacy claims, laboratory results, and supplemental medical data.

    b. The ACG Modeler outputs are referenced in PHM program stratification and performance measures.

3. KHS will implement a process for risk stratification, segmentation, and tiering to ensure the following:

    a. Proactively identify all members who may benefit from services or interventions, e.g., wellness and prevention programs or basic PHM services.

    b. That members who may most benefit from additional or specialized care management services or other interventions are identified and stratified and offered those services.

c. Use of data in a standardized way that reduces bias and promotes equity in RSS and risk tiering processes.

B. Data Integration

1. KHS will perform ongoing population assessment of our membership by using data from various sources (as mentioned above) to identify the needs of our members.

2. KHS's Business Intelligence department will extract data from diverse sources to assemble an integrated data source that provides detailed information on individual member needs and behavior.

3. KHS will integrate the following data sources (but not limited) to use for population health management functions:

    a. Medical and behavioral claims or encounters
        i. Claims paid by KHS are processed in the QNXT core system and referenced in PHM program stratifications to identify members via diagnosis or service codes. Additionally, these core system claims are incorporated into performance measures for PHM programs to track utilization and costs.
        ii. Vision claims paid by KHS' vision services provider are received monthly and are referenced for PHM program stratification and performance measures.
        iii. Claims paid by KHS' delegated plan partners are received weekly and are available to reference for PHM program stratification and performance measures.
        iv. Fee for service medical and behavioral claims paid directly by Department of Health Care Services (DHCS) which are not KHS financial responsibility are provided to KHS monthly in the form of encounter data and are referenced as supplemental data sources for PHM program stratification.

    b. Pharmacy claims
        i. Pharmacy claims paid by KHS' Pharmacy Benefit Manager (PBM) are received weekly and are referenced for PHM program stratification and performance measures.
        ii. Pharmacy claims paid by the DHCS Medi-Cal Rx program are received daily and are referenced for PHM program stratification and performance measures.
        iii. Pharmacy claims paid by KHS' delegated plan partners are received weekly and are available to reference for PHM program stratification and

performance measures.

iv. Fee for service pharmacy claims paid directly by DHCS which are not KHS financial responsibility are provided to KHS monthly in the form of encounter data and are referenced as supplemental data sources for PHM program stratification.

c. Laboratory results
   i. Laboratory results are received on a regular basis from the major lab providers in KHS' network and are available to utilize for PHM program stratification and performance measures.

d. Health appraisal results
   i. Select responses from the member Health Risk Assessment survey are converted into International Classification of Diseases (ICD) 10 diagnoses and referenced as a supplemental data source for PHM program stratification.

e. Electronic health records
   i. Member diagnosis history for members enrolled in Enhanced Care Management is exported from provide Electronic Health Record (her) / Electronic Medical Record (EMR) systems on a regular basis and referenced as a supplemental data source for PHM program stratification.
   ii. Comprehensive EHR data is available from our largest Federally Qualified Health Center (FQHC) providers and is available to utilize for PHM program stratification and performance measures.

f. Health services programs within the organization
   i. Existing health services program enrollments are used as part of stratification criteria to ensure proper member placement and avoid duplicative care.

g. Advanced data sources
   i. The Johns Hopkins ACG Modeler is utilized to identify member chronic conditions and risk scores. The entire KHS population is stratified monthly using this tool. Data sources for the ACG Modeler include member eligibility, medical claims, pharmacy claims, laboratory results, and supplemental medical data. The ACG Modeler outputs are referenced in PHM program stratification and performance measures.
   ii. KHS has implemented its own version of the Potentially Preventable Admission (PPA) tool which evaluates all inpatient admissions and flags whether each was potentially preventable based on diagnosis and service

codes. The PPA tool is referenced to stratify members for PHM programs as well as for performance measure tracking.

iii. KHS has implemented the LACE Index which applies a readmission risk score for every inpatient admit entered in Jiva core system by the inpatient UM team. This risk score is referenced to stratify members for PHM programs.

C. Timeframes of RSS and Risk Tiering to Risk Stratify and Segment All Members

1. No less than annually, KHS segments or stratifies its entire population into subsets for targeted intervention and during each of the following time frames:

    a. Upon each member's enrollment.

    b. Annually after each member's enrollment.

    c. Upon a significant change in the health status or level of care of the member (e.g., inpatient medical admission or emergency room visit, pregnancy, or diagnosis of depression).

    d. Upon the receipt of new information, KHS will determine as potentially changing a member's level of risk and need, including but not limited to information contained in assessments or referrals for Complex Care Management (CCM), Enhanced Care Management (ECM), Transitional of Care Services (TCS), and Community Services Supports (CSS).

2. KHS will submit its processes to DHCS upon request regarding how it identifies significant changes in Members' health status or level of care and how it is monitoring appropriate re-stratification.

D. RSS and Risk Tiering Approach

1. KHS will offer a broad range of programs and services to meet the needs of all members.

    a. Segmenting the population according to health care needs allows KHS to better target resources more efficiently and at a lower cost.

    b. Segmentation produces segments with specific diagnoses or social problems that need attention.

    c. Stratification produces different levels of risk.

2. KHS will monitor and improve the penetration rate of PHM programs and services, including, but not limited to, the percentage of Members who require additional assessments who complete them as well as the connection of Members to the programs and services they are eligible for.

    a. The number of Members, by Risk Tier, who needed further assessment and received it.

    b. The number of Members, by Risk Tier who were enrolled in programs they were eligible for.

3. KHS PHM will connect all members, including those with rising risk, to an appropriate level of service, including but not limited to:

    a. Basic Population Health Management (BPHM).

    b. Care Management Services.

    c. Transitional Care Services.

    d. Wellness and Prevention Services.

4. Risk groupings include highly complex, high-risk, rising-risk, and low-risk individuals. See Attachment A: RSS & Tiering: KHS Population Health Management Program Priority Pyramid.

    a. Unique care models and intervention strategies are then used for each group.

    b. The members move seamlessly from one risk level to another as their health situation improves or gets worse.
        i. Highly complex (ECM). This is a small group of patients with the greatest care needs. This group has multiple complex illnesses, often including psychosocial concerns, and Social Drivers of Health (SDOH) barriers. Care models for this population require intensive, pro-active care management. Members must belong to a pre-defined population of focus as set forth by the Department of Health Care Services (DHCS).
        ii. High-risk (Special Programs). This next tier includes patients with multiple risk factors that, if left unmanaged, would result in the member transitioning into the highly complex group. This cohort of patients is appropriately engaged in a structured care management program that provides one-on-one support in managing medical, social, and care

coordination needs.

iii. Rising risk (Care Management and Care Coordination). This tier includes patients who often have one or several chronic conditions or risk factors and move in and out of stability with their conditions. With rising-risk patients, successful models of care focus on managing risk factors more than disease states. Common risk factors include obesity, smoking, blood pressure, and cholesterol levels. Identifying these risks enables staff to target the root causes of multiple conditions.

iv. Low risk (BPHM and Wellness & Prevention). This group includes patients who are stable or healthy and have minor conditions that can be easily managed. The care model for this group aims to keep them healthy and engaged in the health care system, without the use of unnecessary services. This group can effectively by managed by their Primary Care Physician (PCP) with support from KHS Wellness and Prevention program.

E. Providing Services and Supports

1. KHS will interface with data to support information gathering and understanding risks of poor health and well-being outcomes, including development of standardized risk tiers in compliance with DHCS requirements requiring its use to assess member needs and determine the appropriate level and type of services for individual members.

2. KHS will connect all members to primary care, appropriate wellness, prevention, and disease management activities and to identify and connect those members who are at risk for developing complex health issues to more specialized services.

    a. These programs (e.g., Complex Care Management, Enhanced Care Management, Wellness and Prevention Programs, etc.) and services (e.g., transportation, preventative services, etc.)

3. As part of Basic Population Health Management (BPHM) Risk Stratification, KHS identifies cost drivers, at-risk individuals in patient population, prioritizes at-risk patients for clinicians, identifying and offering tailored interventions for the different segments.

    a. This helps the PCP prioritize at-risk patients, intervene to decrease both acute and long-term risks and offer appropriate patient support based on risk, provides more efficient encounter for patients/clinicians, and help the provider to implement proactive interventions to maximize outcomes and possible Pay-4-Performance (P4P) payments.

F. **Incorporation of PHM Service's RSST Methodologies**

1. Upon the release of PHM Service's RSST methodologies, KHS will:

    a. Align internal risk stratification processes with RSST guidelines and methodologies.

    b. Integrate RSST findings into existing population health management programs.

    c. Ensure risk segmentation and tiering are based on comprehensive data sources, including medical, behavioral, pharmacy, social determinants of health (SDOH), and utilization data.

    d. Conduct periodic evaluations to assess the accuracy and effectiveness of RSST methodologies in stratifying member risk levels.

    e. Ensure compliance with National Committee for Quality Assurance (NCQA) Population Health Management (PHM) standards and Department of Health Care Services (DHCS) requirements.

2. The health plan will incorporate RSST methodologies into the following processes:

    a. Member Enrollment: Risk stratification will occur at the time of enrollment to assign an initial risk tier.

    b. Annual Population Health Review: All members will be reassessed annually to update risk stratification based on new health and utilization data.

    c. Significant Health Changes: Members experiencing major health status changes (e.g., hospital admission, new diagnosis, or pregnancy) will be re-stratified in real time.

H. Assessment of High-Risk Members Identified Through PHM Service

1. Identification Process

    a. High-risk members will be identified using RSST methodologies, predictive analytics, and clinical judgment.

    b. Data sources used for identification include:
        i. Health Risk Assessments (HRA)
        ii. Claims and encounter data
        iii. Emergency department and inpatient utilization data

iv. Pharmacy records
v. Behavioral health screenings (PHQ-9, GAD-7, ACEs, etc.)
vi. SDOH screenings
vii. Care coordination referrals from providers, case managers, and community organizations
viii. Predictive modeling risk scores (e.g., ACG Modeler)

2. Assessment and Care Planning

    a. All high-risk members identified through PHM Service will be:
        i. Assigned to a care management team for comprehensive assessment within 30 days of identification.
        ii. Referred to appropriate programs such as Complex Case Management (CCM), Enhanced Care Management (ECM), or Transitional Care Services (TCS).
        iii. Evaluated for care coordination needs, including behavioral health, LTSS, and SDOH interventions.

    b. Assessments will include:
        i. Comprehensive health risk evaluation
        ii. Review of chronic conditions, medication adherence, and care gaps
        iii. Social needs assessment to identify barriers such as housing instability, food insecurity, and transportation issues
        iv. Development of an individualized care plan (ICP) in collaboration with the member, provider, and care team
        v. Connection to available resources such as community-based organizations, transportation assistance, and wellness programs

3. Monitoring and Reassessment

    a. High-risk members will receive continuous monitoring and support through:
        i. Regular check-ins by care managers
        ii. Coordination with primary care and specialists
        iii. Alerts for hospital admissions, emergency visits, and gaps in care

    b. Members will be re-stratified weekly or upon significant health status changes.

I. Method(s) for Discovering and Reducing Biases

1. KHS will meet the following requirements prior to the PHM Service's RSS functionalities becoming available:

    a. Utilize an RSS approach that:
        i. Complies with NCQA PHM standards, including using utilization data integrated with other data sources such as findings from the PNA, clinical and behavioral data, or population and social needs data.

ii. Incorporates a minimum list of data sources listed above to the greatest extent possible.

iii. Avoids and reduces biases to prevent exacerbation of health disparities.

1) The following are some examples. According to the U. S. Department of Health and Human Services (HHS) (2015) found there are examples of health inequity for people of color (POC) in the U.S., including:

a) Lower life expectancy: In 2014, Black males and females had lower average life expectancies than white males and females (HHS, 2015).

b) Higher blood pressure: Between 2013 and 2014, 42.4% of Black males had high blood pressure, compared to 30.2% in white males. During the same period, 44% of Black females also had this condition compared to 28% in white females (HHS, 2015).

c) Lower rates of influenza (flu) vaccination: Flu vaccines can save lives. However, in 2014, only 60% of Black and Latinx people aged 65 or over got a vaccination, compared to 70% of white and Asian people of the same age (HHS, 2015).

d) Black people also face higher risks during pregnancy. According to 2019 National Institutes of Health, there are 3–4 times more likely to die from pregnancy-related causes than white people in the U.S. (Howell, 2018).

e) A 2019 National Institutes of Health study found that Black people aged 51–55 were 28% more likely to already have a chronic illness compared to white people of the same age. The study also found that Latinx people of the same age accumulated chronic diseases faster than white people (Quiñones et. al., 2019).

iv. Any current RSS methodologies rely on utilization or cost data only, which may result in racial, condition, or age bias.

v. To address these biases and improve outcomes for all members, KHS will use all relevant data, keep the information updated (e.g., through care managers), continuously evaluate key performance indicators and RSS outputs, monitoring health disparities over time, use appropriate metrics to measure the accuracy and effectiveness of RSS model prediction of people who do or do not need help monitor whether RSS improves care for all populations

J. Process for segmenting population to ensure there is no racial bias in the process.

1. Evaluate eligible and enrolled program members and compare utilization and costs by ethnicity in the Program Dashboard drilldown data.
2. Use information collected through assessments and/or screenings (e.g., Health Risk Assessment) on members who share specific needs, characteristics, identifies, conditions or behaviors.
3. Evaluate data from zip codes where members reside that are historically underrepresented or underutilized. Members residing in rural areas have limited access to health care and services. These members are prioritized.

V. ATTACHMENTS

Attachment A:	RSS & Tiering: KHS Population Health Management Priority Pyramid

VI. REFERENCES

Reference Type	Specific Reference
Regulatory	U.S. Department of Health and Human Services. (2015). Health disparities and health equity: A status report.
Other	Howell, E. A. (2018). Reducing disparities in severe maternal morbidity and mortality. Health Affairs, 37(10), 1588-1595. https://doi.org/10.1377/hlthaff.2018.0729
Other	Quiñones, A. R., Eberstein, I. W., & Smith, J. M. (2019). Chronic disease in older adults: Racial and ethnic disparities. Journal of Aging and Health, 31(2), 215-239. https://doi.org/10.1177/0898264318768963

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Revised	3/1/2025	The policy was revised to align with the DHCS requirements for OR R.0110.	
Effective	1/1/2024	The policy was created to align with the DHCS 2024 contract requirements and NCQA standards.	M.C. PHM

VIII. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**

Department of Health Care Services (DHCS)	3/7/2025, Post OR D.0330.18 R.0110	04/16/2025

Chief Executive Leadership Approval *		
Title	**Signature**	**Date Approved**
Chief Executive Officer		
Chief Medical Officer		
Chief Operating Officer		
Chief Financial Officer		
Chief Compliance and Fraud Prevention Officer		
Chief Health Equity Officer		
Chief Legal and Human Resources Officer		
Deputy Chief Information Officer		
*Signatures are kept on file for reference but will not be on the published copy		

KERN HEALTH SYSTEMS

Policy and Procedure Review

KHS Policy & Procedure: 19.30-P Risk Stratification and Segmentation (RSS) and Risk Tiering

Last approved version: N/A

Reason for revision: The policy was created to align with the DHCS 2024 contract requirements and NCQA standards.

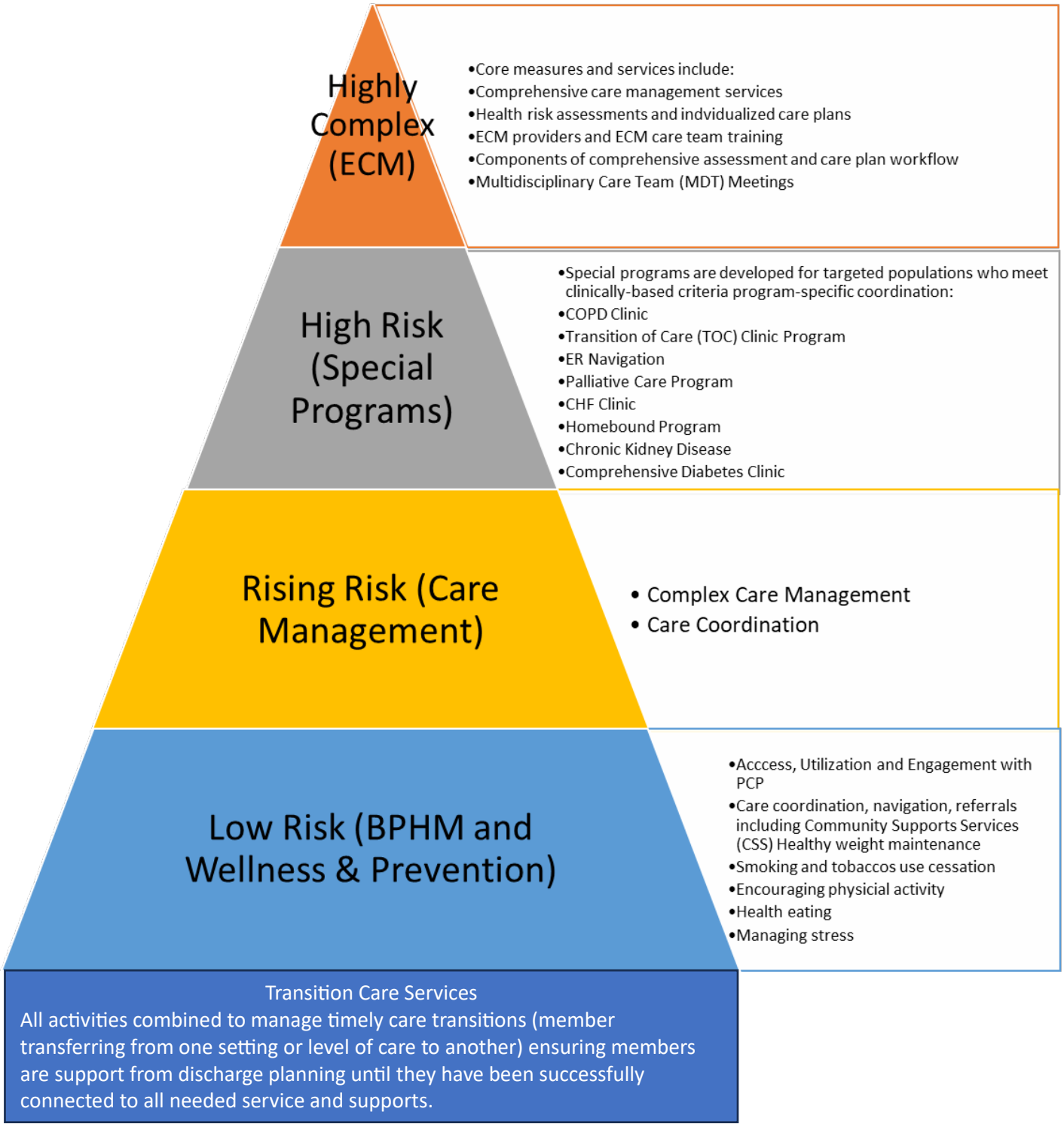
Director Approval		
Title	**Signature**	**Date Approved**
Christine Pence Senior Director of Health Services		
Dr. Sukhpreet Sidhu Medical Director of Population Health Management		
Michelle Curioso Director of Population Health Management		
Dr. John Miller Medical Director of Quality Improvement		
Magdee Hugais Director of Quality Improvement		
Isabel Silva Senior Director of Wellness & Prevention		
Melinda Santiago Director of Behavioral Health		
Adriana Salinas Director of Community and Social Services		
Loni Hill-Pirtle Director of Enhanced Care Management		

Date posted to public drive: _____

Date posted to website ("P" policies only): _____

Kern Family Health Care™

Risk Stratification & Tiering: KHS Population Health Management Program Priority



19.30-P Attachment A - Risk Stratification - Tiering Data Pyramid
Date Collected: 10/3/2023 MC