PRODUCTS AFFECTED:
- Medica DUAL Solution® – for Minnesota Senior Health Options (MSHO) enrollees
- Medica Choice Care℠ – for Minnesota Senior Care Plus (MSC+) enrollees
- Medica AccessAbility Solution® – for Special Needs Basic Care (SNBC) enrollees

DEFINITIONS
Most vulnerable beneficiaries: The members most likely to have an adverse event or who are more at risk than other member.

Impactability Report: Report that uses Johns Hopkins Adjusted Clinical Groups (ACG) predictive modeling software combined with other selected indicators, including utilization, claims experience, and member diagnostic information. Variables in the reporting tool include Cost Resource Index (CRI), total cost of care, multiple chronic conditions, poly pharmaceuticals or drugs, inpatient use, emergency room utilization and high risk mental health condition indicators.

PURPOSE:
To define Medica’s process for identification of its most vulnerable beneficiaries, expectations for review of most vulnerable beneficiaries, and develop an outreach process that Care Systems, Agencies, and Counties will utilize.

POLICY:
Care Systems, Agencies, and Counties that provide Care Coordination for Medica members will identify members that are considered most vulnerable beneficiaries and will identify an outreach process where more intensive management may be used to improve member health and safety or attempt to prevent adverse events.
PROCEDURE:
1. Medica will create a quarterly report of members that are identified as having a greater risk of adverse effects or intensive care coordination needs.

2. Medica will send the Impactability report to each Care System, Agency, or County through secure email each quarter.

3. Each Care System, Agency, or County will review and distribute the Impactability report to individual Care Coordinators (CC’s) for follow-up.

4. CC’s will follow-up with any member that has newly identified changes in their care needs. Follow-up with identified members needs to occur within four (4) weeks, this follow-up can be telephonic or in person, based on CC professional judgement.

5. CC’s will document the type of contact, any changes in the member’s status, and any follow-up actions that will be completed.

6. Medica Regulatory Oversight & Improvement will review the written process for each Care System, Agency, or County during their annual Delegation Oversight Review.

7. Medica may request examples of interventions initiated for members identified on Impactability report to meet Centers for Medicare and Medicaid Services (CMS) audit requirements.

8. Medica has a process to conduct reviews of members who have high utilization. This high cost claimant, internal interdisciplinary team completes case reviews of members twice per month to address needs including management of chronic and acute conditions, mental health needs, psychosocial concerns, medication use, emergency room use, and hospitalizations in the past year. Team members then reach out the member’s CC to provide consultation on best practices, clinical guidelines, resources, and suggestions to address the member’s needs and care. Members are monitored on an ongoing basis and may be reviewed by the team on a regular basis if their risk status and utilization continue to be flagged on the report.

CROSS REFERENCES
John Hopkin’s ACG software.