

Element	Regulatory Criteria & Policy	Methodology	Scope	Benchmark	Look-back Period	Data Source	Frequency
Care Gap alerts addressed	<i>MC_IPA Delegation Agreement-Medi-Cal</i> <i>IEHP Provider Policy and Procedure Manual Section 12. Coordination of Care</i>	Review of clinical documentation that demonstrates IPA reviewed and discussed all open Care Gaps with Member.	Medi-Cal Members with open care gap alerts	≥ 90%	From enrollment or reassessment due date	Care Management Documentation	Monthly
HRA was reviewed with Member to stratify and determine the appropriate level of care.	<i>DHCS APL 22-024: Population Health Management Guide</i> <i>MC_IPA Delegation Agreement-Medi-Cal</i> <i>IEHP Provider Policy and Procedure Manual Section 12. Coordination of Care</i>	Evidence of all of the following documentation: Review of CM case notes to assess that the Health Risk Assessment (HRA) is reviewed to identify SPD Members with higher risk to include their Threshold Language preferences and complex health needs.	SPD Members with a completed HRA during lookback period	≥ 90%	From enrollment or reassessment due date	Care Management Documentation	Monthly
Documentation of at least three (3) contact attempts made to Member within thirty (30) calendar days of HRA completion prior to determining Member is unable to be reached.	<i>IPA Delegation Agreement-Medi-Cal</i> <i>IEHP Provider Policy and Procedure Manual Section 12. Coordination of Care</i>	Evidence of all of the following documentation: Review of CM case notes that at a minimum three (3) contact attempts were made reach the Member within thirty (30) calendar days of HRA completion before determining the Member is unable to be reached. Attempts may be telephonic, by mail, by email etc. All contact attempts of the same type on the same day are considered one (1) attempt. All contact attempts must be documented clearly.	SPD Members with a completed HRA during lookback period	≥ 90%	From enrollment or reassessment due date	Care Management Documentation	Monthly
Referrals were coordinated for identified community resource needs, or relevant Community Supports, (housing, meals, energy assistance, intellectual and developmental disability services).	<i>DHCS APL 22-024: Population Health Management Guide</i> <i>MC_IPA Delegation Agreement-Medi-Cal</i> <i>IEHP Provider Policy and Procedure Manual Section 12. Coordination of Care</i>	Evidence of all of the following documentation: Review of CM case notes to ensure that referrals for community resources have been initiated when the need is identified including but not limited to referring to LTSS (HSS, CBAS, MSSP, etc.) and Community Supports.	Medi-Cal Members with identified coordination of care needs	≥ 90%	From enrollment or reassessment due date	Care Management Medical Management System	Monthly
Referrals were coordinated for identified behavioral health needs.	<i>DHCS APL 22-024: Population Health Management Guide</i> <i>MC_IPA Delegation Agreement-Medi-Cal</i> <i>IEHP Provider Policy and Procedure Manual Section 12. Coordination of Care</i>	Evidence of all of the following documentation: Review of CM case notes to ensure that referrals for appropriate behavioral health needs have been initiated, including referrals to the appropriate behavioral health care management (BHCM) team as appropriate, when the need is identified.	Medi-Cal Members with identified coordination of care needs	≥ 90%	From enrollment or reassessment due date	Care Management Medical Management System	Monthly
Referrals were coordinated for Members identified for potential Enhanced Case Management and/or Complex Case Management Program enrollment	<i>DHCS APL 22-024: Population Health Management Guide</i> <i>MC_IPA Delegation Agreement-Medi-Cal</i> <i>IEHP Provider Policy and Procedure Manual Section 12. Coordination of Care</i>	Evidence of all of the following documentation: Review of CM Case notes to ensure that Member was referred for potential Enhanced Case Management (ECM) and Complex Case Management (CCM) program enrollment.	Medi-Cal Members with identified coordination of care needs	≥ 90%	From enrollment or reassessment due date	Care Management Medical Management System	Monthly
Referrals were coordinated for identified health education needs including Advanced Directive.	<i>DHCS APL 22-024: Population Health Management Guide</i> <i>MC_IPA Delegation Agreement-Medi-Cal</i> <i>IEHP Provider Policy and Procedure Manual Section 12. Coordination of Care</i>	Evidence of all of the following documentation: Review of CM case notes to ensure that referrals to health education services have been initiated when the need is identified.	Medi-Cal Members with identified coordination of care needs	≥ 90%	From enrollment or reassessment due date	Care Management Medical Management System	Monthly
Referrals were coordinated for Members identified for potential California Children's Services (CCS), Early Start Services, Local Education Agency (LEA) services.	<i>DHCS APL 22-024: Population Health Management Guide</i> <i>MC_IPA Delegation Agreement-Medi-Cal</i> <i>IEHP Provider Policy and Procedure Manual Section 12. Coordination of Care</i>	Evidence of all of the following documentation: Review of clinical documentation to ensure that Members with CCS eligible diagnosis or condition is assessed for potential CCS, Early Start, LEA program enrollment. Documentation must also include evidence that all necessary documents were provided to the agency upon referral.	Medi-Cal Members with identified coordination of care needs	≥ 90%	From enrollment or reassessment due date	Care Management Medical Management System	Monthly
Hospitalizations addressed	<i>DHCS APL 22-024: Population Health Management Guide</i> <i>MC_IPA Delegation Agreement-Medi-Cal</i> <i>IEHP Provider Policy and Procedure Manual Section 12. Coordination of Care</i>	Review of clinical documentation that demonstrates IPAs review of recent inpatient admissions to ensure needs were addressed. Documentation must demonstrate discharge instructions were reviewed by IPA and there was effort to discuss discharge follow up which includes educating Member on prevention of inpatient re-admissions, such as symptom management, treatment, medications and any additional support needs etc. within a reasonable timeframe (45-90 days) using clinical judgement.	Medi-Cal Members with identified coordination of care needs	≥ 90%	From enrollment or reassessment due date	Care Management Medical Management System	Monthly
Care coordination for identified medical care needs (includes primary care, specialty care, DME, medications, children's services, preventative care, continuity of care referrals, and any other needs) are initiated and resolved to address any physical and/or cognitive barriers to timely access.	<i>DHCS APL 22-024: Population Health Management Guide</i> <i>MC_IPA Delegation Agreement-Medi-Cal</i> <i>IEHP Provider Policy and Procedure Manual Section 12. Coordination of Care</i>	Evidence of all of the following documentation: Review of CM case notes to ensure care coordination was facilitated to meet the identified medical care needs (includes primary care, specialty care, DME, medications, continuity of care referrals, grievances, as well as any other needs) are initiated, referred as appropriate and/or referrals were sent to and resolve any physical or cognitive barriers to timely access. Review of clinical documentation to ensure that care coordination needs were facilitated between Member, PCP/Specialist and family/caregiver in coordinating available services. This includes the review of documentation demonstrating care is established with an adult PCP when the Member is turning 21 years of age and transitioning out of CCS and Member's turning 36 months that are transitioning out of the Early Start Program Review of clinical documentation to ensure care coordinated for EPSDT Member benefits to include but not limited to, dental care.	Medi-Cal Members with identified coordination of care needs	≥ 90%	From enrollment or reassessment due date	Care Management Medical Management System	Monthly
Outreach made to Member timely to address concerns	<i>DHCS APL 22-024: Population Health Management Guide</i> <i>MC_IPA Delegation Agreement-Medi-Cal</i> <i>IEHP Provider Policy and Procedure Manual Section 12. Coordination of Care</i>	Review of clinical documentation that outreach was made to Member in an appropriate timeframe to address concerns and any other identified needs. This is based on clinical judgement by determining if the time/outreach was suitable based on specific needs of the Member.	Medi-Cal Members with identified coordination of care needs	≥ 90%	From enrollment or reassessment due date	Care Management Medical Management System	Monthly