Delegated IPA Medi-Cal Care Coordination Review Tool
Medi-Cal

IPA:			
Reviewer:			
Service Year:		**Service Month:**	
Review Year:		**Review Month:**	

Overall Score:	*No Applicable Files Reviewed*

	File Review: #1	Comments:	File Review: #2	Comments:	File Review: #3	Comments:	File Review: #4	Comments:	File Review: #5	Comments:
Member Name										
IEHP Member ID										
Current Stratification										
Care Coordination Identification Source										
Care coordination for identified medical care needs (includes primary care, specialty care, DME, medications, as well as any other needs) are initiated and referrals were sent to resolve any physical or cognitive barriers to timely access.										
Referrals were coordinated for identified community resource needs (housing, meals, energy assistance, intellectual and developmental disability services).										
Referrals were coordinated for identified behavioral health needs.										
Referrals were coordinated for Members identified for potential Enhanced Case Management and Complex Case Management Program enrollment.										
Referrals were coordinated for identified health education needs including Advanced Directive.										
Individual Score	*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*	
File Summary										

	File Review: #6	Comments:	File Review: #7	Comments:	File Review: #8	Comments:	File Review: #9	Comments:	File Review: #10	Comments:
Member Name										
IEHP Member ID										
Current Stratification										
Care Coordination Identification Source	EPSDT Member Report		EPSDT Member Report		EPSDT Member Report		EPSDT Member Report		EPSDT Member Report	
Care coordination for identified medical care needs (includes primary care, specialty care, DME, medications, as well as any other needs) are initiated and referrals were sent to resolve any physical or cognitive barriers to timely access.										
Referrals were coordinated for identified community resource needs (housing, meals, energy assistance, intellectual and developmental disability services).										
Referrals were coordinated for identified behavioral health needs.										
Referrals were coordinated for Members identified for potential Enhanced Case Management and Complex Case Management Program enrollment.										
Referrals were coordinated for identified health education needs including Advanced Directive.										
Individual Score	*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*	
File Summary	Member selected from EPSDT Member report.		Member selected from EPSDT Member report.		Member selected from EPSDT Member report.		Member selected from EPSDT Member report.		Member selected from EPSDT Member report.	

IEHP Care Management Delegation Oversight: Medi-Cal Care Coordination File Review - Data Dictionary

Element	Regulatory Criteria / Citations / Policy	Benchmark	Scope	Look-back Period	Data Source	Methodology	Frequency	Sample Size
Care Coordination and Care Management Services								
Care coordination for identified medical care needs (includes primary care, specialty care, DME, medications, as well as any other needs) are initiated and referrals were sent to resolve any physical or cognitive barriers to timely access.	DHCS Contract - Attachment 11 Case Management and Coordination of Care MC_25C2: Care Management Requirements IPA Responsibilities DHCS Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide DHCS APL 22-024: Population Health Management Guide	≥ 90%	Medi-Cal Members with identified medical care needs	9 Months from Date of Review	Care Management System	Review of CM case notes/ICP to ensure care coordination was facilitated to meet the identified medical care needs (includes primary care, specialty care, DME, medications, and any other needs) and referral was sent to resolve any physical or cognitive barriers to timely access.	Monthly	10
Referrals were coordinated for identified community resource needs (housing, meals, energy assistance, intellectual and developmental disability services).		≥ 90%	Medi-Cal Members with identified community resource needs		Care Management System	Review of CM case notes/ICP to ensure that referrals for community resources have been initiated when the need is identified	Monthly	10
Referrals were coordinated for identified behavioral health needs.		≥ 90%	Medi-Cal Members with identified behavioral health needs		Care Management System	Review of CM case notes/ICP 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	Monthly	10
Referrals were coordinated for Members identified for potential Enhanced Case Management and Complex Case Management Program enrollment.		≥ 90%	Medi-Cal Members with identified potential ECM and CCM needs		Care Management System	Review of CM Case notes/ICP to ensure that Member was referred for potential Complex Case management (CCM) program enrollment.	Monthly	10
Referrals were coordinated for identified health education needs including Advanced Directive.		≥ 90%	Members with identified health education needs		Care Management System	Review of CM case notes/ICP to ensure that that referrals to health education services have been initiated when the need is identified	Monthly	10