Inland Empire Health Plan

Delegated IPA Medi-Cal SPD Review Tool

Medi-Cal

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

Overall Score:	

	File Review: #1	Comments:	File Review: #2	Comments:	File Review: #3	Comments:	File Review: #4	Comments:	File Review: #5	Comments:
Date of Review										
Member Last Name										
Member First Name										
IEHP Member ID										
Current Stratification										
Post HRA Stratification										
HRA was reviewed with Member to stratify and determine the appropriate level of care.										
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.										
Care coordination for identified medical care needs (includes primary care, specialty care, DME, medications, and 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 Care Management Program enrollment.										
Referrals were coordinated for identified health education needs including Advanced Directive.										
Post-discharge care coordination was initiated prior to 30 calendar days from hospital discharge date.										
An Interdisciplinary Care Team (ICT) was offered to the high- risk Member when a need is demonstrated and in accordance with the Member's functional status, assessed need, and the ICP.										
ICT meetings are conducted periodically, including at the Member's request, and includes conference calls that are conducted with the providers, and the Member, as appropriate										
Member's ICT is comprised of all other individuals and providers who are actively involved in Member's care.										
An Individualized Care Plan (ICP) was developed for the newly enrolled high-risk SPD Member and re-evaluation of the ICP was conducted at least annually or upon a significant change in condition.										
Initial ICP was developed within 30 calendar days from HRA completion/CM referral creation date.										
The ICP was developed collaboratively with the PCP, the Member/caregiver, care manager and other members of the ICT as appropriate.										
The ICP includes plan for addressing Member concerns, preferences, and goals, including responsible person and due date for follow up.										
The ICP includes measurable objectives and timetables to meet physical health and LTSS needs as determined through the assessment process, IHSS assessment results, MSSP and CBAS records, and input from members of the ICT, as appropriate										
The ICP includes Member's prioritized goals according to the Member's preference.										
The ICP includes identification of barriers to meeting goals.										
The ICP includes coordination of carved-out and linked services, and referrals to appropriate community resources and other agencies, when appropriate.										
The Member was offered and provided, upon request, a copy (in alternative formats and/or preferred written or spoken language upon request) of the ICP and any amendments made to ICP.										
Individual Score										
File Summary										

IEHP Care Management Delegation Oversight: SPD File Review - Data Dictionary

Element	Regulatory Criteria / Citations / Policy	Benchmark	Scope	Look-back Period	Data Source	Methodology	Frequency	Sample Size
Identification and Risk Stratification								
HRA was reviewed with Member to stratify and determine the appropriate level of care.	DHCS APL 22-024: Population Health Management Guide MC_25C1: Care Management Requirements IPA Responsibilities	≥ 90%	SPD Members with a completed HRA during lookback period	From enrollment or reassessment due date	Care Management 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.	Monthly	5
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.	MC_25C1: Care Management Requirements IPA Responsibilities	≥ 90%	SPD Members with a completed HRA during lookback period	From enrollment or reassessment due date	Care Management 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.	Monthly	5
Care Coordination and Care Management Services								
Care coordination for identified medical care needs (includes primary care, specialty care, DME, medications, and 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 DHCS APL 22-024: Population Health Management Guide MC_25C1: Care Management Requirements IPA Responsibilities	≥ 90%	SPD Members with identified medical care needs		Care Management Medical 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, as well as any other needs) and referral was sent to resolve any physical or cognitive barriers to timely access.	Monthly	5
Referrals were coordinated for identified community resource needs (housing, meals, energy assistance, intellectual and developmental disability services).		≥ 90%	SPD Members with identified community resource needs		Care Management Medical Management System	Review of CM case notes/ICP to ensure that referrals for community resources have been initiated when the need is identified including but not limited to referring to LTSS and Community Supports.	Monthly	5
Referrals were coordinated for identified behavioral health needs.		≥ 90%	SPD Members with identified behavioral health needs		Care Management Medical 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	5
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 Medical Management System	Review of CM Case notes/ICP to ensure that Member was referred for potential Enhanced Case Management (ECM) and Complex Case Management (CCM) program enrollment.	Monthly	5
Referrals were coordinated for identified health education needs including Advanced Directive.		≥ 90%	Members with identified health education needs		Care Management Medical Management System	Review of CM case notes/ICP to ensure that referrals to health education services have been initiated when the need is identified.	Monthly	5
Post-discharge care coordination was initiated prior to 30 calendar days from hospital discharge date.	DHCS Contract - Attachment 11 Case Management and Coordination of Care NCQA Standard QI 5, Continuity and Coordination of Medical Care: HEDIS® Plan All-Cause Readmission measure	≥ 90%	SPD Members with an admission to the hospital or institution	From enrollment or reassessment due date	Care Management Medical Management System	Review of CM case notes/ICP to ensure that necessary care, services and supports are in place for an SPD member upon discharge from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the Member and/or caregiver.	Monthly	5

Interdisciplinary Care Team								
An Interdisciplinary Care Team (ICT) was offered to the high-risk Member when a need is demonstrated and in accordance with the Member's functional status, assessed need, and the ICP.	DHCS Contract - Attachment 11 Case Management and Coordination of Care DHCS APL 22-024: Population Health Management Guide IEHP Provider Policy and Procedure Manual - MC_25C1	≥ 90%	High-Risk SPD Members	From enrollment or reassessment due date	Care Management Medical Management System	Review of CM case notes/ICT section/ICP to ensure that an ICT has been offered.	Monthly	5
ICT meetings are conducted periodically, including at the Member's request, and includes conference calls that are conducted with the providers, and the Member, as appropriate		≥ 90%	High-Risk SPD Members		Care Management Medical Management System	Review of CM case notes/ICT section/ICP to ensure that an ICT meeting was conducted/offered including any conference calls with providers and the Member as appropriate.	Monthly	5
Member's ICT is comprised of all other individuals and providers who are actively involved in Member's care.		≥ 90%	High-Risk SPD Members		Care Management Medical Management System	Review of CM case notes/ICT section/ICP to ensure that the Member's ICT includes individuals or providers who are actively involved in the care of the Member, if approved by the Member and the individuals or providers are willing to participate in the ICT, when appropriate: hospital discharge planner; nurse, social worker, nursing facility representative, specialized providers, such as physician specialists, pharmacists, physical therapists, and occupational therapists; IHSS provider (if authorized by Member receiving IHSS), CBAS provider (if Member is participating in CBAS), MSSP coordinator (if Member is enrolled in MSSP waiver program), and other professionals, as appropriate.	Monthly	5
Individualized Care Plan								
An Individualized Care Plan (ICP) was developed for the newly enrolled high-risk SPD Member and re-evaluation of the ICP was conducted at least annually or upon a significant change in condition.	DHCS Contract - Attachment 11 Case Management and Coordination of Care DHCS APL 22-024: Population Health Management Guide IEHP Provider Policy and Procedure Manual- MC_25C1: Care Management Requirements IPA Responsibilities	≥ 90%	High-risk SPD Members	From enrollment or reassessment due date	Care Management Medical Management System	Review of CM case notes/ICP to ensure ICP was developed for newly enrolled high-risk SPD Members. The ICP must also be re-evaluated at least annually or upon a significant change in condition.	Monthly	5
Initial ICP was developed within 30 calendar days from HRA completion/CM referral creation date.	IEHP Provider Policy and Procedure Manual- MC_25C1: Care Management Requirements IPA Responsibilities	≥ 90%	Newly enrolled high-risk SPD Members with HRA with initial ICP development due on/after 5/1/20	From enrollment or reassessment due date	Care Management Medical Management System	Review of CM case notes/ICP to ensure that the initial ICP was developed within a timeframe that is appropriate to address the issues identified in the HRA or other presenting information, but at least within 30 days of the completion of the HRA or referral for care management.	Monthly	5
The ICP was developed collaboratively with the PCP, the Member/caregiver, care manager and other members of the ICT as appropriate.	DHCS Contract - Attachment 11 Case Management and Coordination of Care IEHP Provider Policy and Procedure Manual- MC_25C1: Care Management Requirements IPA Responsibilities	≥ 90%	High-risk SPD Members	From enrollment or reassessment due date	Care Management Medical Management System	Review of CM case notes/ICP to ensure that the ICP is developed with the Member/caregiver and Member's ICT.	Monthly	5
The ICP includes plan for addressing Member concerns, preferences, and goals, including responsible person and due date for follow up.	DHCS Contract - Attachment 11 Case Management and Coordination of Care DHCS APL 22-024: Population Health Management Guide IEHP Provider Policy and Procedure Manual- MC_25C1: Care Management Requirements IPA Responsibilities	≥ 90%	High-risk SPD Members	From enrollment or reassessment due date	Care Management Medical Management System	Review of ICP plan to ensure it addresses Member's concerns, preferences, Member specific goals (not system generated) and includes responsible person and due date for follow up.	Monthly	5
The ICP includes measurable objectives and timetables to meet physical health and LTSS needs as determined through the assessment process, IHSS assessment results, MSSP and CBAS records, and input from members of the ICT, as appropriate	DHCS APL 22-024: Population Health Management Guide IEHP Provider Policy and Procedure Manual- MC_25C1: Care Management Requirements IPA Responsibilities	≥ 90%	High-risk SPD Members	From enrollment or reassessment due date	Care Management Medical Management System	Review of ICP objectives to ensure they are measurable and include timetables to meet Member's needs.	Monthly	5
The ICP includes Member's prioritized goals according to the Member's preference.	DHCS APL 22-024: Population Health Management Guide IEHP Provider Policy and Procedure Manual- MC_25C1: Care Management Requirements IPA Responsibilities	≥ 90%	High-risk SPD Members	From enrollment or reassessment due date	Care Management Medical Management System	Review of ICP goals to ensure they are prioritized according to Member's preference.	Monthly	5
The ICP includes identification of barriers to meeting goals.	IEHP Provider Policy and Procedure Manual- MC_25C1: Care Management Requirements IPA Responsibilities	≥ 90%	High-risk SPD Members	From enrollment or reassessment due date	Care Management Medical Management System	Review of ICP to ensure barriers were identified.	Monthly	5
The ICP includes coordination of carved-out and linked services, and referrals to appropriate community resources and other agencies, when appropriate.	DHCS APL 22-024: Population Health Management Guide IEHP Provider Policy and Procedure Manual- MC_25C1: Care Management Requirements IPA Responsibilities	≥ 90%	High-risk SPD Members needing coordination of carved out or linked services and/or referrals to appropriate community resources and other agencies	From enrollment or reassessment due date	Care Management Medical Management System	Review of ICP to ensure coordination of carved out or linked services and/or referrals to appropriate community resources and other agencies were addressed when appropriate.	Monthly	5
The Member was offered and provided, upon request, a copy (in alternative formats and/or preferred written or spoken language upon request) of the ICP and any amendments made to ICP.	DHCS APL 22-024: Population Health Management Guide IEHP Provider Policy and Procedure Manual- MC_25C1: Care Management Requirements IPA Responsibilities	≥ 90%	High-risk SPD Members	From enrollment or reassessment due date	Care Management Medical Management System	Review of clinical documentation to show that the Member was offered a copy of the initial/updated ICP and was made available in Member's preferred format.	Monthly	5