IEHP
Inland Empire Health Plan

Delegated IPA Medi-Cal Care Coordination File Review Tool

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

Overall Score: *No Applicable Files Reviewed*

	File Review #1	Comments/Notes	File Review #2	Comments/Notes	File Review #3	Comments/Notes	File Review #4	Comments/Notes	File Review #5	Comments/Notes	File Review #6	Comments/Notes	File Review #7	Comments/Notes	File Review #8	Comments/Notes	File Review #9	Comments/Notes	File Review #10	Comments/Notes	File Review #11	Comments/Notes	File Review #12	Comments/Notes	File Review #13	Comments/Notes	File Review #14	Comments/Notes	File Review #15	Comments:	File Review #16	Comments/Notes	File Review #17	Comments/Notes	File Review #18	Comments/Notes	File Review #19	Comments/Notes	File Review #20	Comments/Notes	File Review #21	Comments/Notes	File Review #22	Comments/Notes	File Review #23	Comments/Notes	File Review #24	Comments/Notes	File Review #25
Date of File Review																																																		
Member Name																																																		
CIN# Member ID																																																		
Care Coordination Target Type																																																		
File Selection Source																																																		
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 in order to encourage Member to participate in the visit.																																																	
Referrals were coordinated for identified community resource needs, or relevant Community Supports, (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 Care Management and/or Complex Care Management services																																																	
Referrals were coordinated for identified health education needs including Advanced Directive																																																	
Referrals were coordinated for Members identified for potential California Children's Services (CCS), Early Start Services, Local Education Agency (LEA) services																																																	
Care coordination for identified medical care needs (includes primary care, specialty care, behavioral health, ancillary services, preventative care, etc. and any other needs) are initiated and reviewed to address any physical and/or cognitive barriers to timely access																																																	
Individual Score	*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*
File Summary																																																	

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

Element	Regulatory Criteria / Citations / Policy	Benchmark	Scope	Look-back Period	Data Source	Methodology		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_IPA Delegation Agreement-Medi-Cal	≥ 90%	SPD Members with a completed HRA during lookback period	From enrollment or reassessment due date	Care Management Documentation	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.	Yes = 1	15
						Documentation does not demonstrate the necessary elements listed above	No = 0	
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.	IPA Delegation Agreement-Medi-Cal		SPD Members with a completed HRA during lookback period	From enrollment or reassessment due date		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.	Yes = 1	15
						Documentation does not demonstrate the necessary elements listed above	No = 0	
Care Coordination Services								
Referrals were coordinated for identified community resource needs, or relevant Community Supports, (housing, meals, energy assistance, intellectual and developmental disability services).	DHCS APL 22-024: Population Health Management Guide MC_IPA Delegation Agreement-Medi-Cal	≥ 90%	Medi-Cal Members with identified community resource needs	From enrollment or reassessment due date	Care Management Medical Management System	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 (IHSS, CBAS, MSSP, etc.) and Community Supports.	Yes = 1	15
						Documentation does not demonstrate the necessary elements listed above	No = 0	
Referrals were coordinated for identified behavioral health needs.						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.		15
						Documentation does not demonstrate the necessary elements listed above	No = 0	
Referrals were coordinated for Members identified for potential Enhanced Case Management and/or Complex Case Management Program enrollment						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.		15
						Documentation does not demonstrate the necessary elements listed above	No = 0	
Referrals were coordinated for identified health education needs including Advanced Directive.						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.		15
						Documentation does not demonstrate the necessary elements listed above	No = 0	
Referrals were coordinated for Members identified for potential California Children's Services (CCS), Early Start Services, Local Education Agency (LEA) services.						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. Doucmenation must also include evidence that all necessary documents were provided to the agency upon referral.		15
						Documentation does not demonstrate the necessary elements listed above	No = 0	
Care coordination for identified medical care needs (includes primary care, specialty care, DME, medications, children's services, preventative care, and any other needs) are initiated and resolved to address any physical and/or cognitive barriers to timely access.						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, as well as any other needs and/or grievances) are initiated, referred as appropriate and/or referrals were sent to 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.		15
						Documentation does not demonstrate the necessary elements listed above	No = 0	