Technical Assistance Guide

for Medical Audits

Category 2 –
Case Management and
Coordination of Care

TABLE OF CONTENTS

Introduction

In accordance with California Welfare and Institutions Code Section 14456, the Department of Health Care Services (DHCS) conducts medical audits of Medi-Cal managed care plans (MCPs) on an annual basis. Medical audits evaluate MCPs' compliance with the DHCS contractual requirements and applicable laws and regulations. DHCS' Managed Care Quality and Monitoring Division (MCQMD) is responsible for ensuring overall monitoring and oversight of MCPs. MCQMD designates the Medical Review Branch (MRB) of DHCS' Audits and Investigations Division (A&I) to perform the mandated audits. The audit scope encompasses the following six categories of review:

- Category 1 – Utilization Management
- Category 2 – Case Management and Coordination of Care
- Category 3 – Access and Availability
- Category 4 – Member's Rights
- Category 5 – Quality Improvement
- Category 6 – Administrative and Organizational Capacity

Guidance on Using the Technical Assistance Guide (TAG)

MCQMD and A&I have partnered together to create Technical Assistance Guides (TAG) for each category of review. The TAGs are designed to identify key elements that will be commonly evaluated to inform MCPs of the audit process and increase transparency. To this end, each TAG is broken down by subcategories and includes the following components, as applicable:

- **Contract Language:** This section identifies "key" contract provisions[1] that are the focus of review for each subcategory. While references to specific provisions may assist the MCP with narrowing the scope of review in preparation for the audit, it does not preclude the audit team from investigating the MCP's compliance with other contract requirements not explicitly named. MCPs are ultimately responsible for ensuring compliance with *all* provisions of the DHCS contract as well as any applicable All Plan Letters (APLs) and Plan Letters (PLs). The contract provisions included in the TAG are intended to serve as guidance only as well as a quick point of reference.

- **Documentation Reviewed:** The items listed in this section reflect common *initial* documentation requests and not subsequent follow-up requests that may be warranted after initial review and interviews with the MCP. The initial documentation request includes, but is not limited to: policies and procedures, organizational charts, committee meeting minutes, monitoring reports, data logs, etc. While the documentation provides the audit team with a general overview of the operational structure and the team may glean insight regarding compliance with some contractual requirements, it is not all encompassing. Therefore, to ease the burden of further document requests made onsite, the MCP is advised to submit

[1] The TAGs cite language from the general Two-Plan Boilerplate Contract. Each MCP should reference its own Plan-specific contract to confirm requirements.

additional pre-onsite documentation for review (even if not explicitly requested) if the MCP believes that review of such information would assist the audit team with assessing compliance in any of the subcategories.

- **Verification Study (if applicable):** This section appears within a designated subcategory when a verification study (i.e., review of specific files such as grievances, prior authorizations, claims, etc.) may be used to assist with measuring compliance. The MCP is instructed to provide data in a prescribed format (i.e., spreadsheet containing all files for the audit review period). The log will assist the audit team with selection of specific files for onsite review. The audit team is neither precluded from conducting additional verification studies as needed nor expected to consistently conduct all verification studies listed in this TAG.

- **Examples of Best Practices:** This section details examples of best practices. The examples listed include strategies that some MCPs have implemented to either demonstrate compliance with a given standard or successfully remediate an identified deficiency. Every MCP and every audit is unique and best practices do not always transfer seamlessly. While the audit team does not audit to best practices, the burden is on the MCP to demonstrate that it is meeting its contractual obligations. To this end, examples of best practices emphasize the MCP's ability to produce *documented evidence* to substantiate that the MCP is in compliance with the contract requirements. When monitoring efforts reveal patterns of non-compliance, the MCP should similarly be able to produce documented evidence of barrier analysis and remedial actions enacted to substantiate efforts to bring the MCP into compliance.

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1 BASIC CASE MANAGEMENT

CONTRACT REQUIREMENT	DOCUMENTATION REVIEWED	VERIFICATION STUDY	EXAMPLES OF BEST PRACTICES
Exhibit A, Attachment 11 – CASE MANAGEMENT AND COORDINATION OF CARE **1. Comprehensive Case Management Including Coordination of Care Services** Contractor shall ensure the provision of Comprehensive Medical Case Management to each Member. Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all Medically Necessary services delivered both within and outside the Contractor's provider network. These services are provided through either basic or complex case management activities based on the medical needs of the member.	-Policies and procedures -Reports to track in and out-of-network service delivery		-The Plan maintains policies and procedures that address case management and coordination of care. -The Plan's policies and procedures address the delivery of medically necessary services both within and outside the Plan's network. The policy includes ongoing monitoring activities to ensure the coordination of care (e.g., referral tracking reports for both in and out of network referrals/services, generation and review of reports regarding unused authorizations, discussion of findings/trends in committee in meeting minutes, etc.). -The Plan's policies and procedures address the provision of basic or complex case management for all members.
A. Basic Case Management Services are provided by the Primary Care Provider, in collaboration with the Contractor, and shall include: 1) Initial Health Assessment (IHA); 2) Individual Health Education Behavioral Assessment (IHEBA); 3) Identification of appropriate providers and facilities (such as medical, rehabilitation, and support services) to meet Member care needs; 4) Direct communication between the provider and Member/family; 5) Member and family education, including healthy lifestyle changes when warranted; and 6) Coordination of carved out and linked services, and referral to appropriate community resources and other agencies.	-Policies and procedures -Provider Manual -Provider newsletters	-An onsite verification study of case management files may be conducted to confirm the provision of basic case management including documented evidence of each of the required components (i.e., IHA, IHEBA, provider/facility accessibility, communication between providers and members/family, education, and coordination with outside services).	-The Plan maintains policies and procedures for the provision of basic case management. -The Plan's policies and procedures include processes to ensure the provision of each of required components of basic case management (i.e., IHA, IHEBA, provider/facility accessibility, communication between providers and members/family, education, and coordination with outside services). -The Plan's policies and procedures delineate processes for ongoing monitoring for the provision of basic case management (e.g., periodic audits at a set frequency that assess for each of the required components of basic case management, generation and review of IHA/IHEBA completion reports, tracking of unused authorizations and referrals, etc.). -The Plan's policies and procedures delineate how collaboration between the PCP and Plan will occur in delivering basic case management. (e.g., the Plan generates and provides PCPs with a list of newly enrolled members to assist with the identification of those members in need

2.1	BASIC CASE MANAGEMENT		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
			of the IHA/IHEBA, the Plan provides PCPs a list of members or who receive carved out services or utilizes other methods of identification to inform PCPs of identified members who receive carved out services to improve coordination of care, etc.). The Plan readily produces documentation to support these collaborative efforts. -PCPs receive initial and ongoing training and education and are well informed of their responsibility to provide basic case management services to members (e.g., Provider Manual, provider newsletters, fax blasts, ongoing training, etc.), including the Plan's role in assisting with the provision of these services. -The Plan regularly reviews monthly data uploaded by DHCS (e.g., encounter data, FFS claims data, TARs, etc.) to assist with the identification of members who receive carved out services (e.g., CCS, mental health, carved out prescription drugs, LTSS, etc.). The Plan utilizes this data to improve care coordination for members.

2.2	CALIFORNIA CHILDREN'S SERVICES		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
Exhibit A, Attachment 11 – CASE MANAGEMENT AND COORDINATION OF CARE **5. Out-of-Plan Case Management and Coordination of Care** Contractor shall implement procedures to identify individuals who may need or who are receiving services from out of plan providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management for services presented in Provisions 6 through 17 below.	-Policies and procedures		-The Plan's policies and procedures include processes for the identification of members who receive services from out of Plan providers and/or programs (e.g., CCS, etc.). -The Plan provides PCPs with a list of all members who receive CCS or utilizes other methods of identification of members who receive CCS to assist with the coordination of services. -The Plan regularly reviews and utilizes monthly FFS CCS data uploaded by DHCS to assist with the identification of CCS members.
9. California Children's Services (CCS) Services provided by the CCS program are not covered under this Contract. Upon adequate diagnostic evidence that a Medi-Cal Member under 21 years of age may have a CCS-eligible condition, Contractor shall refer the Member to the local CCS office for determination of eligibility. A. Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program. The policies and procedures shall include, but not be limited, to those which: 1) Ensure that Contractor's providers perform appropriate baseline health assessments and diagnostic evaluations which provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member has a CCS-eligible medical condition;	-Policies and procedures -Provider Manual		-The Plan maintains policies and procedures for identifying and referring children with CCS-eligible conditions to the CCS program. -The Plan's policies and procedures address the provider's role in conducting appropriate baseline health assessments and diagnostic evaluations to identify potentially eligible CCS members for referral. -Providers receive initial and ongoing education and training regarding CCS including the referral process (e.g., Provider Manual, provider newsletters, fax blasts, ongoing training, desktop procedures, flow charts, etc.). -The Plan provides documentation to support that providers are knowledgeable regarding the referral process (e.g., evidence of referrals, etc.). -The Plan provides documentation to support effective implementation of its policies and procedures (e.g., tracking sheets/logs of members who have been referred to CCS, criteria for eligibility, assessments, etc.).
2) Assure that contracting providers understand that CCS reimburses only CCS-paneled providers and CCS-approved hospitals within Contractor's network; and only from the date of referral;	-Policies and procedures -Provider Manual		-The Plan's policies and procedures include provisions to ensure that providers understand that CCS reimburses only CCS-paneled providers and CCS-approved hospitals within the Plan's network and only from the date of the referral. -The Plan provides documentation to support that these processes are communicated to providers (e.g., Provider Manual, provider

2.2	CALIFORNIA CHILDREN'S SERVICES		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
			newsletters, fax blasts, ongoing training, desktop procedures, flow charts, etc.).
3) Enable initial referrals of Member's with CCS-eligible conditions to be made to the local CCS program by telephone, same-day mail or fax, if available. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the local CCS program.	-Policies and procedures -Monitoring/tracking reports		-The Plan's policies and procedures specify that initial referrals of members with CCS-eligible conditions may be made to CCS by telephone, same-day mail or fax, if available. The initial referral will be followed by the submission of supporting medical documentation. -The Plan provides documentation to support adherence to its own policies and procedures (e.g. tracking sheets/logs of all members who have been referred to CCS, including notes/fields indicating the method of referral as well as timeframes for referral and submission of follow-up documentation).
4) Ensure that Contractor continues to provide all Medically Necessary Covered Services to the Member until CCS eligibility is confirmed.	-Policies and procedures -Monitoring/tracking reports	-An onsite verification study of CCS prior authorization and/or claims files may be conducted to confirm that the Plan does not unnecessarily defer, deny, or delay the provision of medically necessary services for members due to pending CCS eligibility determination.	-The Plan's policies and procedures include provisions to ensure that the Plan continues to provide all medically necessary covered services until CCS eligibility is confirmed. -The Plan's policies and procedures delineate processes for ongoing monitoring to assess adherence to the contractual requirements and specify frequency of monitoring (e.g., random audits and/or periodic review of prior authorization and claims data for potential CCS-eligible members, tracking sheets/logs of members referred to CCS, etc.).
5) Ensure that, once eligibility for the CCS program is established for a Member, Contractor shall continue to provide all Medically Necessary Covered Services that are not authorized by CCS and shall ensure the coordination of services and joint case management between its Primary Care Providers, the CCS specialty providers, and the local CCS program.	-Policies and procedures -Provider Manual -Meeting minutes	-An onsite verification study of CCS files may be conducted to confirm documented evidence to support coordination of care between PCPs, specialty providers, and CCS (e.g., documented case notes in the medical record, documented phone calls, evidence of referrals, etc.).	-The Plan's policies and procedures include provisions to ensure that once CCS eligibility is established, the Plan will continue to provide all medically necessary services that are not authorized by CCS. -The Plan's policies and procedures include provisions for coordination of services between PCPs, CCS specialty providers, and CCS. -The Plan implements ongoing monitoring efforts to support coordination of services between PCPs, CCS specialty providers, and CCS (e.g., the Plan sends a list to PCPs of all members receiving CCS services, the Plan conducts documented outreach to CCS-eligible members informing them of the Plan's case management

2.2	CALIFORNIA CHILDREN'S SERVICES		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
			services, the Plan generates and reviews referral tracking reports, the Plan holds meetings with CCS at a set frequency and meeting minutes clearly document coordination of care for specific cases discussed, the Plan conducts random audits of CCS files to assess collaboration between the PCP, specialty providers, and CCS, etc.).
6) If the local CCS program does not approve eligibility, Contractor remains responsible for the provision of all Medically Necessary Covered Services to the Member. If the local CCS program denies authorization for any service, Contractor remains responsible for obtaining the service, if it is Medically Necessary, and paying for the service if it has been provided.	-Policies and procedures	-An onsite verification study of CCS prior authorization and/or claims files may be conducted to confirm that the Plan does not unnecessarily defer, deny, or delay the payment or provision of medically necessary services if CCS has denied authorization.	-The Plan's policies and procedures include provisions to ensure that the Plan remains responsible for the payment and provision of all medically necessary services if CCS denies authorization for any service.
B. Contractor shall execute a Memorandum of Understanding (MOU) with the local CCS program as stipulated in Exhibit A, Attachment 12, Provision 2, for the coordination of CCS services to Members. **Exhibit A, Attachment 12 – LOCAL HEALTH DEPARTMENT COORDINATION** **2. Subcontracts or Memoranda of Understanding** If reimbursement is to be provided for services rendered by the following programs or agencies, Contractor shall execute a Subcontract with the LHD or agency as stipulated in Provision 1 above. If no reimbursement is to be made, Contractor or agency shall negotiate in good faith and execute a Memorandum of Understanding (MOU) for services provided by these programs and agencies. A. California Children Services (CCS)	-MOU		-The Plan maintains a signed and executed MOU with CCS. -The Plan adheres to all provisions of the MOU and readily produces documentation to support that responsibilities of both the Plan and CCS are carried out (e.g., submitted reports at indicated frequencies, quarterly meeting minutes that document discussion and coordination of care, etc.).

2.3	EARLY INTERVENTION SERVICES / DEVELOPMENTAL DISABILITY SERVICES		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
Exhibit A, Attachment 11 – CASE MANAGEMENT AND COORDINATION OF CARE **5. Out-of-Plan Case Management and Coordination of Care** Contractor shall implement procedures to identify individuals who may need or who are receiving services from out of plan providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management for services presented in Provisions 6 through 17 below.	-Policies and procedures		-The Plan's policies and procedures include processes for the identification of members who receive services from out of Plan providers and/or programs (e.g., Early Start, services for members with developmental disabilities, etc.). -The Plan provides PCPs with a list of all members who receive services from the Early Start program and Regional Center or utilizes other methods of identification of members to assist with the coordination of services.
11. Early Intervention Services Contractor shall develop and implement systems to identify children who may be eligible to receive services from the Early Start program and refer them to the local Early Start program. These children would include those with a condition known to lead to developmental delay, those in whom a significant developmental delay is suspected, or whose early health history places them at risk for delay. Contractor shall collaborate with the local Regional Center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start program, with Primary Care Provider participation.	-Policies and procedures -Monitoring/tracking reports -Provider Manual -Meeting minutes -MOU		-The Plan maintains policies and procedures for the identification of children who may be eligible for receiving Early Start services, including those with a condition known to lead to developmental delay, those in whom a significant developmental delay is suspected, or whose early health history places them at risk for delay. -The Plan produces documentation to support effective implementation of its policies and procedures regarding the identification of children who may be eligible for receiving Early Start services (e.g., tracking sheets/logs of members who have been referred to Early Start, criteria for eligibility, assessments, etc.). -Providers receive initial and ongoing education and training regarding the Early Start program including the referral process (e.g., Provider Manual, provider newsletters, fax blasts, ongoing training, desktop procedures, flow charts, etc.). -The Plan's policies and procedures describe how the Plan collaborates with the Regional Center or Early Start program in development of treatment plans with PCP participation. -The Plan provides documented evidence to support coordination efforts between the Plan, Early Start program, and PCP (e.g., the Plan sends a list to PCPs of all members receiving Early Start services, the Plan conducts documented outreach to Early Start-eligible members informing them of the Plan's case

2.3	EARLY INTERVENTION SERVICES / DEVELOPMENTAL DISABILITY SERVICES		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
			management services and assignment to a case manager, case files include documented notes and follow-up on referrals by the case manager, the Plan conducts random audits of files to assess collaboration between the PCP and Early Start program, etc.).
10. Services for Persons with Developmental Disabilities A. Contractor shall develop and implement procedures for the identification of Members with developmental disabilities.	-Policies and procedures -Monitoring/tracking reports -Provider Manual	-An onsite verification study of Regional Center files confirms documented evidence to support coordination of care with the Regional Center (e.g., documented case notes in the medical record, documented phone calls, evidence of referrals, etc.).	-The Plan maintains procedures for the identification of members with developmental disabilities. -The Plan provides documentation to support effective implementation of its policies and procedures regarding the identification of members with developmental disabilities (e.g., tracking sheets/logs of members who receive Regional Center services, criteria for eligibility, assessments, etc.). -Providers receive initial and ongoing education and training regarding Regional Center services including the referral process (e.g., Provider Manual, provider newsletters, fax blasts, ongoing training, desktop procedures, flow charts, etc.). -The Plan implements ongoing monitoring efforts to support coordination of services with the Regional Center (e.g., the Plan sends a list to PCPs of all members receiving Regional Center services, the Plan conducts documented outreach to members receiving Regional Center services to inform them of the Plan's case management services, the Plan generates and reviews referral tracking reports, the Plan holds meetings with the Regional Center at a set frequency and meeting minutes clearly document coordination of care for specific cases discussed, etc.).
B. Contractor shall maintain a dedicated liaison to coordinate with each regional center operating within the plan's service area to assist Members with developmental disabilities in understanding and accessing services and act as a central point of contact for questions, access and care concerns, and problem resolution as required by W & I Code Section 14182(c)(10).	-Policies and procedures -Meeting minutes -MOU		-The Plan's policies and procedures require that the Plan maintain a dedicated liaison to coordinate with each Regional Center operating within the Plan's service area. The policies and procedures delineate the specific duties of the liaison as required in the contract. -The Plan's MOU with the Regional Center also details the responsibilities of the liaison in

2.3	EARLY INTERVENTION SERVICES / DEVELOPMENTAL DISABILITY SERVICES		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
			coordinating care between the Plan and Regional Center. -The Plan provides documentation to support that the designated liaison assists members with accessing services and acts as a central point of contact for questions, access and care concerns, and problem resolution (e.g., documented case notes, phone calls, participation in meeting minutes, etc.).
C. Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers, such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall participate with Regional Center staff in the development of the individual developmental services plan required for all persons with developmental disabilities, which includes identification of all appropriate services, including medical care services and Medically Necessary Outpatient Mental Health Services, which need to be provided to the Member.	-Policies and procedures -Meeting minutes -MOU		-The Plan's policies and procedures address the referral of members with developmental disabilities to the Regional Center for evaluation and access to *non-medical services* (e.g., respite, out-of-home placement, and supportive living). The policy requires the Plan to participate with Regional Center in the development of the individual developmental services plan. -The Plan's MOU with the Regional Center also details the coordination efforts between the Plan and Regional Center in development of the individual developmental services plan. -The Plan produces documentation to support efforts to participate with the Regional in the development of the individual developmental services plan (e.g. documented outreach, case notes, phone calls, etc. by the case manager and/or dedicated liaison, meeting minutes that include documented discussion of cases and input from Plan staff, etc.).
E. Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers as stipulated in Exhibit A, Attachment 12, Provision 2, for the coordination of services for Members with developmental disabilities. **Exhibit A, Attachment 12 – LOCAL HEALTH DEPARTMENT COORDINATION** **2. Subcontracts or Memoranda of Understanding** If reimbursement is to be provided for services rendered by the following programs or agencies, Contractor shall execute a Subcontract with the LHD or agency as stipulated in Provision 1	-MOU		-The Plan maintains a signed and executed MOU with the Regional Center. -The Plan adheres to all provisions of the MOU and readily produces documentation to support that responsibilities of both the Plan and Regional Center are carried out (e.g., submitted reports at indicated frequencies, quarterly meeting minutes, etc.).

2.3	EARLY INTERVENTION SERVICES / DEVELOPMENTAL DISABILITY SERVICES		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
above. If no reimbursement is to be made, Contractor or agency shall negotiate in good faith and execute a Memorandum of Understanding (MOU) for services provided by these programs and agencies. F. Regional Centers for services for persons with developmental disabilities.			

2.4	INITIAL HEALTH ASSESSMENT		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
Exhibit A, Attachment 10 – SCOPE OF SERVICES **3. Initial Health Assessment (IHA)** An IHA consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA) that enables a provider of primary care services to comprehensively assess the Member's current acute, chronic and preventive health needs and identify those Members whose health needs require coordination with appropriate community resources and other agencies for services not covered under this contract. A. Contractor shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with Title 22 CCR Section 53851(b)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.		-An onsite verification study of IHA files may be conducted to confirm that the IHA consists of a history and physical examination and an IHEBA that enables the PCP to comprehensively assess the member's current needs.	
B. Contractor shall ensure that the IHA includes an IHEBA as described in Exhibit A, Attachment 10, Provision 8, Paragraph A, 10) using an age appropriate DHCS approved assessment tool. **8. Services for All Members** A. Health Education 10) Contractor shall ensure that all new Members complete the individual health education behavioral assessment within 120 calendar days of enrollment as part of the initial health assessment; and that all existing Members complete the individual health education behavioral assessment at their next non-acute care visit. Contractor shall ensure: 1) that primary care providers use the DHCS standardized "Staying Healthy" assessment tools, or alternative approved tools that comply with DHCS approval criteria for the individual health education behavioral assessment; and 2) that the individual health education behavioral assessment tool is: a) administered and reviewed by the primary care provider during an office visit, b) reviewed at least annually by the	-Policies and procedures -Provider Manual -Provider newsletters -Member Handbook/EOC -Tracking reports -Audit tools -Committee meeting minutes	-An onsite verification study of IHA files may be conducted to confirm that IHEBAs are consistently completed as part of the IHA within 120 calendar days of enrollment.	-The Plan's policies and procedures indicate that the IHA includes an IHEBA as part of the initial health assessment. The timeframes indicated are aligned with the contractual requirements and specify that all new members receive the IHEBA within 120 calendar days of enrollment, and all existing members complete the IHEBA at their next non-acute care visit. -The Plan's policies and procedures require that PCPs utilize the SHA tool or alternative tools approved by DHCS for the IHEBA. The IHEBA must be administered and reviewed with the PCP during an office visit, reviewed at least annually by the PCP with members who present for a scheduled visit, and re-administered by the PCP at the appropriate age-intervals. -The Plan's policies and procedures delineate processes for ongoing monitoring to ensure the provision of the IHEBA (e.g., random validation audits, etc.). The Plan does not rely solely on FSRs that occur every three years but instead conducts monitoring at a set frequency (e.g., quarterly, monthly, etc.) to ensure continual oversight.

2.4	INITIAL HEALTH ASSESSMENT		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
primary care provider with Members who present for a scheduled visit, and c) re-administered by the primary care provider at the appropriate age-intervals.			-The Plan utilizes audit tools that specifically incorporate the component being measured (i.e., completion of the IHEBA for both timeliness and content). -When audit results demonstrate instances of non-compliance, the Plan takes follow-up action as necessary and can substantiate this through documentation (e.g., re-training, provider outreach, discussion in Committee meeting minutes, etc.). The Plan conducts re-measurement activities as necessary to monitor progress. -Providers receive initial and ongoing education and training regarding the requirements of the IHEBA (e.g., Provider Manual, provider newsletters, fax blasts, ongoing training, desktop procedures, flow charts, etc.). -The Plan communicates to enrollees the requirements of the IHEBA (e.g., Member Handbook/EOC, etc.).
B. Contractor is responsible for assuring that arrangements are made for follow-up services that reflect the findings or risk factors discovered during the IHA and IHEBA.	-Policies and procedures	-An onsite verification study of IHA files may be conducted to confirm that the Plan arranges for follow-up services as a result of findings identified during the IHA and IHEBA.	-The Plan's policies and procedures include processes to ensure that arrangements are made for follow-up services that reflect findings or risk factors identified by the IHA or IHEBA. -The Plan's policies and procedures delineate processes for ongoing monitoring to ensure the provision of follow-up services based on results of the IHA/IHEBA (e.g., periodic audits, etc.). The Plan utilizes auditing tools that specifically measure this component. -When audit results demonstrate instances of non-compliance, the Plan takes follow-up action as necessary and can substantiate this through documentation (e.g., re-training, provider outreach, discussion in Committee meeting minutes, etc.). The Plan conducts re-measurement activities as necessary to monitor progress.
C. Contractor shall ensure that Members' completed IHA and IHEBA tool are contained in the Members' medical record and available during subsequent preventive health visits.			-The Plan's policies and procedures include processes to ensure that the completed IHA and IHEBA tool are contained in the member's medical record and available during subsequent preventive health visits.

2.4	INITIAL HEALTH ASSESSMENT		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
D. Contractor shall make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA shall be considered evidence in meeting this requirement.	-Policies and procedures -Tracking logs	-An onsite verification study of IHA files may be conducted to confirm that reasonable attempts to contact members to schedule the IHA are made and clearly documented (e.g., case notes in the health record, tracking logs, etc.).	-The Plan's policies and procedures delineate a set process to ensure that reasonable attempts are made to contact members to schedule the IHA (e.g., the number of telephone and written attempts made to the member are specified, call attempts are made during various times of the day, etc.). The policy further specifies that all attempts be clearly documented.
5. Services for Members under Twenty-One (21) Years of Age A. Provision of IHAs for Members under Age 21 1) For Members under the age of 18 months, Contractor shall ensure the provision of an IHA within 120 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less. 2) For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment.	-Policies and procedures -Provider Manual -Provider newsletters -Member Handbook/EOC -Tracking reports -Audit tools -Committee meeting minutes	-An onsite verification study of IHA files may be conducted to confirm that IHAs are consistently completed within 120 calendar days of enrollment.	-The Plan's policies and procedures are aligned with the contractual requirements and require provision of the IHA within 120 calendar days of enrollment for members under the age of 21. -The Plan's policies and procedures delineate processes for ongoing monitoring to ensure the timely completion of IHAs. The Plan does not rely solely on FSRs that occur every three years but instead conducts monitoring at a set frequency (e.g., quarterly, monthly, etc.) to ensure continual oversight. The Plan relies on a methodology that has been tested (e.g., use of CPT codes in combination with audits to validate that the correct codes are being used, random audits that measure timeliness of completion, etc.). -When audit results demonstrate instances of non-compliance, the Plan takes follow-up action as necessary and can substantiate this through documentation (e.g., re-training, provider outreach, incentives, discussion in Committee meeting minutes, work plans, etc.). The Plan conducts re-measurement activities as necessary to monitor progress. -The Plan utilizes various tools and strategies to assist with the tracking of IHA completion (e.g., tracking sheets/logs that calculate the IHA completion deadline 120 calendar days from enrollment, lists of newly enrolled members that are sent to PCPs to trigger IHA completion, etc.).

2.4	INITIAL HEALTH ASSESSMENT		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
			-Providers receive initial and ongoing education and training regarding the requirements of the IHA (e.g., Provider Manual, provider newsletters, fax blasts, ongoing training, desktop procedures, flow charts, etc.). -The Plan communicates to enrollees the requirements of the IHA, including timeliness of completion (e.g., Member Handbook/EOC, etc.).
6. Services for Adults A. IHAs for Adults (Age 21 and older) 1) Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.	-Policies and procedures -Provider Manual -Provider newsletters -Member Handbook/EOC -Tracking reports -Audit tools -Committee meeting minutes	-An onsite verification study of IHA files may be conducted to confirm that IHAs are consistently completed within 120 calendar days of enrollment.	-The Plan's policies and procedures are aligned with the contractual requirements and require provision of the IHA within 120 calendar days of enrollment for members age 21 and older. -The Plan's policies and procedures delineate processes for ongoing monitoring to ensure the timely completion of IHAs. The Plan does not rely solely on FSRs that occur every three years but instead conducts monitoring at a set frequency (e.g., quarterly, monthly, etc.) to ensure continual oversight. The Plan relies on a methodology that has been tested (e.g., use of CPT codes in combination with audits to validate that the correct codes are being used, random audits that measure timeliness of completion, etc.). -When audit results demonstrate instances of non-compliance, the Plan takes follow-up action as necessary and can substantiate this through documentation (e.g., re-training, provider outreach, incentives, discussion in Committee meeting minutes, work plans, etc.). The Plan conducts re-measurement activities as necessary to monitor progress. -The Plan utilizes various tools and strategies to assist with the tracking of IHA completion (e.g., tracking sheets/logs that calculate the IHA completion deadline 120 calendar days from enrollment, lists of newly enrolled members that are sent to PCPs to trigger IHA completion, etc.). -Providers receive initial and ongoing education and training regarding the requirements of the IHA (e.g., Provider Manual, provider newsletters,

2.4	INITIAL HEALTH ASSESSMENT		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
			fax blasts, ongoing training, desktop procedures, flow charts, etc.). -The Plan communicates to enrollees the requirements of the IHA, including timeliness of completion (e.g., Member Handbook/EOC, etc.).
2) Contractor shall ensure that the performance of the initial complete history and physical exam for adults includes, but is not limited to: a) blood pressure, b) height and weight, c) total serum cholesterol measurement for men ages 35 and over and women ages 45 and over, d) clinical breast examination for women over 40, e) mammogram for women age 50 and over, f) Pap smear (or arrangements made for performance) on all women determined to be sexually active, g) Chlamydia screen for all sexually active females aged 21 and older who are determined to be at high-risk for chlamydia infection using the most current CDC guidelines. These guidelines include the screening of all sexually active females aged 21 through 25 years of age, h) screening for TB risk factors including a Mantoux skin test on all persons determined to be at high risk, and, i) IHEBA.	-Policies and procedures -Provider Manual -Provider newsletters -Member Handbook/EOC -Tracking reports -Audit tools -Committee meeting minutes	-An onsite verification study of IHA files may be conducted to confirm that IHAs consistently include a complete history and physical exam with all required age-appropriate components for adults.	-The Plan's policies and procedures are aligned with the contractual requirements and specify all required components of the IHA including a complete history and physical exam. -The Plan's policies and procedures delineate processes for ongoing monitoring to ensure the provision of a complete history and physical exam (e.g., random validation audits, etc.). The Plan does not rely solely on FSRs that occur every three years but instead conducts monitoring at a set frequency (e.g., quarterly, monthly, etc.) to ensure continual oversight. -The Plan utilizes audit tools that specifically incorporate the component being measured (i.e., complete history and physical exam). -When audit results demonstrate instances of non-compliance, the Plan takes follow-up action as necessary and can substantiate this through documentation (e.g., re-training, provider outreach, discussion in Committee meeting minutes, etc.). The Plan conducts re-measurement activities as necessary to monitor progress. -The Plan communicates to providers the requirement to provide a complete history and physical exam as part of the IHA (e.g., Provider Manual, provider newsletters, fax blasts, documented outreach by Provider Services, documented trainings, etc.). -Providers receive initial and ongoing education and training regarding the requirement to provide a complete history and physical exam as part of the IHA (e.g., Provider Manual, provider newsletters, fax blasts, ongoing training, desktop procedures, flow charts, etc.). -The Plan communicates to enrollees the requirements of the IHA, including a complete

2.4	INITIAL HEALTH ASSESSMENT		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
			history and physical exam (e.g., Member Handbook/EOC, etc.).

2.5	COMPLEX CASE MANAGEMENT		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
Exhibit A, Attachment 11 – CASE MANAGEMENT AND COORDINATION OF CARE **1. Comprehensive Case Management Including Coordination of Care Services** Contractor shall ensure the provision of Comprehensive Medical Case Management to each Member. Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all Medically Necessary services delivered both within and outside the Contractor's provider network. These services are provided through either basic or complex case management activities based on the medical needs of the member. B. Complex Case Management Services are provided by the Contractor, in collaboration with the Primary Care Provider, and shall include, at a minimum: 1) Basic Case Management Services 2) Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team 3) Intense coordination of resources to ensure member regains optimal health or improved functionality 4) With Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually	-Complex Case Management Program Description -Policies and procedures -Provider Manual -Provider newsletters -Job Description of Complex Case Manager	-An onsite verification study of case management files may be conducted to confirm the provision of complex case management including documented evidence of each of the required components (i.e., basic case management, involvement of the multidisciplinary case management team, intense coordination of services, and individualized care plans with member and PCP input).	-The Plan maintains policies and procedures for the provision of complex case management. -The Plan's Complex Case Management Program Description and/or policies and procedures address each of required components of complex case management (i.e., basic case management, involvement of the multidisciplinary case management team, intense coordination of services, and individualized care plans with member and PCP input). -The Plan's Complex Case Management Program Description and/or policies and procedures delineate how collaboration between the PCP and Plan will occur (e.g., outreach efforts from the Plan's case manager to the PCP, PCP input and involvement with care plan development, etc.). The Plan can further produce documentation to support these collaborative efforts (e.g., documented case notes in the health record, phone calls, etc.). -The Plan's Complex Case Management Program Description and/or policies and procedures delineate the role of the case managers, including the responsibility to collaborate with the PCP. -The Plan's Complex Case Management Program Description and/or policies and procedures delineate processes for ongoing monitoring for the provision of complex case management (e.g., periodic audits that assess each of the required components of complex case management including review of care plans, coordination of referrals and follow-up by the case manager, involvement of the multidisciplinary team, etc.). -PCPs receive initial and ongoing training and education regarding the Plan's Complex Case Management program, including the referral process, criteria for eligibility, and coordination responsibilities (e.g., Provider Manual, provider newsletters, fax blasts, ongoing training, etc.).

2.5	COMPLEX CASE MANAGEMENT		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
C. Contractor shall develop methods to identify Members who may benefit from complex case management services, using utilization data, the Health Information Form (HIF)/Member Evaluation Tool (MET), clinical data, and any other available data, as well as self and physician referrals. Complex case management services for SPD beneficiaries must include the concepts of Person-Centered Planning.	-Complex Case Management Program Description -Organizational charts		-The Plan's Complex Case Management Program Description and/or policies and procedures include the criteria for identifying members who may benefit from complex case management. The methodology relies on utilization data, HIF/MET, clinical data, and any other available data. Physicians can make refer members and members can self-refer. -The Plan's organizational charts indicate adequate clinical staffing to support the provision of complex case management. Criteria is based on members' needs and is not driven by staffing limitations. -The Plan can readily produce a list of those members eligible for receiving complex case management and delineate those members who actually receive services. -The Plan can produce documentation to support that reasonable outreach efforts have been made to inform those members who qualify for complex case management that services are available (e.g., tracking log with documented phone call attempts, letters, etc.).