BlueCross BlueShield of Illinois

Medicare Advantage Delegated HMO Utilization Management and Population Health Management Plan 2023

Approved BCBSIL UM Work Group: November 7, 2022
Approved BCBSIL MA Clinical Quality Committee: November 15, 2022

Blue Cross Medicare Advantage Basic (HMO)SM
Blue Medicare Advocate Health (HMO)SM
Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM
Blue Cross Medicare Advantage Premier Plus (HMO-POS)SM
of Blue Cross and Blue Shield of Illinois

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

Table of Contents

Definitions

Adherence Audit - The utilization management (UM) delegation oversight audit conducted by HMO Clinical Delegation Coordinators (CDCs). This audit encompasses all delegated UM responsibilities as outlined in the Medical Service Agreement (MA MSA) and/or as outlined within this MA HMO Utilization Management Plan.

Adverse Determinations - A denial of services for the requested treatment of a member that does not meet medical necessity criteria and cannot be medically certified based on the information provided by the treating clinician, or the treating clinician's designated representative. Services can be partially denied (which is a partially adverse determination) or completely denied which is an adverse determination.

American Society of Addiction Medicine (ASAM) - Nationally recognized evidence-based medical criteria established for substance use disorders.

Appeal - The review of adverse organization determinations on the health care services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service as defined in 42 CFR 422.566 (b). These procedures include reconsideration by the Medicare health plan and if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.

CAHPS® Survey -The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). CAHPS is a survey tool used for monitoring the quality of care in health plans and is utilized in HEDIS® reporting. Surveys are designed to capture accurate and reliable information from consumers about their experiences with health care.

Centers for Medicare and Medicaid Services (CMS) - the federal government's agency responsible for oversight of all Medicare and Medicaid programs. CMS is responsible for creating regulations, guidance, and oversight of all Medicare Managed Care Programs.

Chronic Care Improvement Program (CCIP) – Per 42 CFR 422.152(a)(2) and (c); statutory and regulatory intention of the CCIP includes the promotion of effective chronic disease management and the improvement of care and health outcomes for enrollees with chronic conditions (CMS.gov.CCIP)

Complaint - Any expression of dissatisfaction to a Medicare health plan, provider, facility, or Quality Improvement Organization (QIO) by an enrollee made orally or in writing. This can include concerns about the operations of providers or Medicare health plans such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to enrollees, the claims regarding the right of the enrollee to receive services or receive payment for services previously rendered. It also includes a plan's refusal to provide services to which the enrollee believes he or she is entitled. A complaint could be either a grievance or an appeal, or a single complaint could include elements of both. Every complaint must be handled under the appropriate grievance and/or appeal process.

Complex Case Management (CCM) - The systematic assessment and coordination of care and services provided to members who are experiencing multiple complex and/or high-cost conditions requiring assistance with coordination of multiple services and/or health needs with significant barriers to self-care. The organization coordinates services for its highest risk members with complex conditions and helps them access needed resources. The goal of complex case management is to help members regain optimum health or improved functional capability, in the right setting and in a cost effective manner (cms.gov).

Condition Management - Program targeted at condition monitoring and education, aimed at improving the member's health status and self-management of specific chronic conditions. Focus is on prevention, closing care gaps, and promoting healthy lifestyles.

Cotiviti- Data Analytics Tool made available to IPAs by the HMO, which allows the IPAs to review member utilization patterns and gaps in care.https://pophealthproducts.cotiviti.com/

Denial – An adverse determination for the requested treatment and/or services for a member. A denial may be issued either based upon lack of medical necessity or non-covered benefit status.

Depression Screening Tool - For purposes of the Population Health Management Programs, any evidence-based depression screening tool may be used. Depression screening should be provided for members who are 12 years of age or older and who do not already have a diagnosis of depression or dysthymia in the past 12 months.

Detailed Explanation of Non-Coverage (DENC) -The DENC is a standardized written notice that provides specific and detailed information to enrollees concerning why their SNF, HHC, or CORF services are ending. A Detailed Explanation of Non-Coverage (DENC) is issued by the facility or agency providing ongoing services only if a beneficiary requests an expedited determination. The DENC must be issued to an enrollee whenever an enrollee appeals a termination about their SNF, HHC, or CORF services. (cms.gov)

Grievance - Any complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee or their representative may make the complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration or invoked an extension to an organization determination or reconsideration time frame.

Health Equity – Health equity is achieved when every person has the opportunity to 'attain his or her full health potential' and no one is 'disadvantaged from achieving this potential because of their social position or other socially determined circumstance.' [CDC; Health Equity Institute of San Francisco University]

HEDIS®- Healthcare Effectiveness Data & Information Set, an initiative by the National Committee on Quality Assurance to develop, collect, standardize, and report measures of health plan performance.

HMO - **Health Maintenance Organization** - Four (4) Medicare Advantage (MA) Health Maintenance Organizations exist within the managed care structure of Blue Cross and Blue Shield of Illinois (BCBSIL): Blue Cross Medicare Advantage Basic (HMO)^{SM}, Blue Medicare Advocate Health (HMO)^{SM}, Blue Cross Medicare Advantage Basic Plus (HMO-POS) ^{SM}, Blue Cross Medicare Advantage Premier Plus (HMO-POS)^{SM}

Independent Review Entity (IRE) -An Independent Entity contracted by CMS to review Medicare health plans adverse reconsiderations of organizational determinations.

Initial Assessment (IA) - The documentation of a contact with a member that is completed after determination of the member's eligibility for Complex Case Management. The assessment is comprehensive and includes, but is not limited to: medical history, social history, mental health status, functional capacity, and caregiver resources. The Initial Assessment must be ***initiated*** within 30 days of eligibility/identification for Complex Case Management. The initial assessment must be ***completed*** within 60 calendar days of identification. If a member cannot be reached within 30 days, it must be documented that either the member was hospitalized, **OR** that the member was unable to be reached after (3) three or more attempts within a (2) two-week period within those first 30 days of eligibility/identification.

Inquiry - Any oral or written request to a Medicare plan, provider, or facility, without expression of dissatisfaction: i.e., a request for information or action by an enrollee. Inquiries are routine questions about benefits (i.e., inquiries are not complaints) and do not automatically invoke the grievance, appeal, or complaint process.

Integrated Denial Notice (IDN) - Medicare health plans are required to issue the Notice of Denial of Medical Coverage (or Payment), also known as the Integrated Denial Notice (IDN), upon denial, in whole or in part, of an enrollee's request for coverage and upon discontinuation or reduction of a previously authorized course of treatment. (cms.gov) This process is delegated to the contracted IPAs.

IPA - The overarching terminology utilized in this document which refers to an Independent Practice Association, Independent Physician Association, organized Medical Group, Physician Hospital Organization, or other legal entity organized to arrange for the provision of professional medical services.

Local Coverage Determinations (LCD)s – Describes local coverage policy and provides educational tools to assist providers in their jurisdiction (Medicare Integrity Manual, Chap 13 §13.1.3).

Medical Service Agreement (MA MSA) - The "Agreement" between HMO and IPA to facilitate the provision of prepaid health care for members of the HMO.

Medical Director (MD) Review Requirements –Requirements applied to the utilization review of cases based on their severity of illness or intensity of medical services required. The degree of illness or services determines the frequency for PA/Medical Director review.

Mental Health Parity: The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits (CMS.gov).

National Coverage Determinations (NCD) -A NCD sets forth the extent to which Medicare will cover specific services, procedures, or technologies on a national basis. Medicare contractors are required to follow NCD's. CMS-NCDs are developed by CMS to describe the circumstances for Medicare coverage nationwide for a specific medical service procedure or device. NCDs generally outline the conditions for which a service is considered to be covered (or not covered) and usually issued as a program instruction. In rare instances, if there is contradicting information in the NCD and LCD, the NCD overrides the LCD (cms.gov)

Notice of Non-discrimination - The Centers for Medicare & Medicaid Services (CMS) is the federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Programs, and the federally facilitated Marketplace. CMS doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CMS directly.

Notice of Medicare Non-Coverage (NOMNC)- The NOMNC is an Office of Management and Budget (OMB) - approved standardized notice designed to inform Medicare enrollees in writing that services in a SNF, CORF, or home health care have been terminated. The NOMNC informs enrollees on how to request an expedited determination from their Quality Improvement Organization (QIO) and gives enrollees the opportunity to request an expedited determination from a QIO. A Detailed Explanation of Non-Coverage (DENC) is given only if a beneficiary requests an expedited determination. Enrollees receiving the services listed above must receive the NOMNC prior to such termination of services even if they agree that such services should end. The notice may be delivered earlier but must be delivered no later than two days prior to the proposed termination of services.

Organization Determination – If a decision is made to deny services in whole or in part-the enrollee must receive a written notice of its determination. Any determination made by a Medicare health plan, or its delegate, with respect to any of the following:

a) Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;
b) Payment for any other health services furnished by a provider other than the Medicare health plan that the enrollee believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare health plan;
c) The Medicare health plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the Medicare health plan;
d) Reduction, or premature discontinuation of a previously authorized ongoing course of treatment;
e) Failure of the Medicare health plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

Population Health Management (PHM) - Programs to address the large-scale social, economic, and environmental issues that impact the health outcomes of groups of people. (David B. Nash, MD, MBA) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447747/

Quality Improvement Organization (QIO) - Organizations comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare enrollees. QIOs review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, and ambulatory surgical centers. The QIOs also review continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs and CORFs. A quality of care complaint may be filed through Medicare health plan's grievance process and/or QIO. A QIO must determine whether the quality of services (including inpatient and outpatient services) provided by a Medicare health plan meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

Reconsideration –An enrollee's first step in the appeal process after an adverse organization determination, Medicare health plan or Independent Review. The entity may re-evaluate an adverse organization determination, the finding upon which it was based, and any other evidence submitted or obtained. The reconsideration consists of a review of an adverse organization determination or termination of services decision, the evidence, and findings upon which it was based, and any other evidence that the parties submit or that is obtained.

Representative - An individual appointed by an enrollee or other party or authorized under State or applicable law, to act on behalf of an enrollee or other party involved in an appeal or grievance. Unless otherwise stated, the representative will have all the rights and responsibilities of an enrollee or party in obtaining an organization determination, filing a grievance, or in dealing with any of the levels of the appeal process.

SMART Goals - Specific, measurable, achievable, results-focused, and time- bound goals.

Social Determinants of Health (SDoH) - The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world. (Social Determinants of Health Key Concepts, World Health Organization https://www.cdc.gov/socialdeterminants/)

Utilization Management Committee - A group of individuals with qualifications as specified in the MA HMO Utilization Management Plan responsible for implementing and enforcing UM policies as well as providing oversight of delegated IPA components and addressing UM concerns.

Utilization Management Plan- The plan that contains the essential requirements for the establishment and implementation of a utilization management process and care coordination. This plan ensures that quality, appropriateness and efficiency of care and resources furnished by the IPA and IPA Providers, and all delegated UM and PHM functions assigned to Contract Management Firms (CMF) or Behavioral Health Vendors, if applicable, remain in compliance with the plan and its requirements. The purpose of the Utilization Management Plan is to ensure that MA HMO members utilize services are utilized appropriately and members receive necessary care.

Utilization Review Organization (URO) - An entity that conducts utilization review, which includes using formal techniques to monitor and evaluate the medical necessity, appropriateness and efficiency of health care services and procedures.

-Please reference the MA Medical Services Agreement (MSA) for additional definitions not found here-

Introduction

Blue Cross Medicare Advantage Basic (HMO)[SM], Blue Medicare Advocate Health (HMO)[SM], Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM], Blue Cross Medicare Advantage Premier Plus (HMO-POS) [SM] of Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, grants full delegation of the Utilization Management Program (UM) to duly constituted Medical Groups, Individual Practice Association, or Physician Hospital Organizations (hereinafter the "IPA").

Through this delegation arrangement, the HMO partners with the IPAs for the establishment and implementation of Utilization Management and Care Management processes to ensure the quality, appropriateness, and the efficiency of care and resources furnished by the IPA Providers for BCBSIL Medicare Advantage (MA) HMO members.

Appointment of a new IPA to the network or appointment of an existing IPA into new HMO products within BCBSIL is contingent upon a number of factors, including IPA adherence to the following HMO MA Utilization Management Plan delegation criteria:

a) Valid Utilization Review Organization (URO) License with the state of Illinois;
b) Demonstration of ability to effectively manage utilization within the MA HMO product;
c) Demonstration of satisfactory performance on UM and Population Health delegation oversight adherence and site visit audits;
d) Demonstration of compliance with all other MA HMO UM requirements;
e) Demonstration of an effective Population Health Program;
f) Demonstration of the functional ability and process of the IPAs to carry out the mandates of UM Programs; and
g) Demonstrated ability to meet all regulatory requirements (CMS, IDOI, IDPH).

Note: The HMO shall exercise its best efforts to provide requirements under this agreement, however, the HMO shall reserve the right to revise/adjust in the event of any disaster, epidemic or pandemic that substantially disrupts the normal operations of the HMO.

HMO Delegation Oversight

The HMO delegates performance of Utilization Management and Population Health Management Plan responsibilities to the IPAs in the HMO network. The Medicare Advantage HMO Medical Service Agreement (MSA) and MA HMO UM Plan delineates the responsibilities of the IPAs, as well as the HMO's responsibility and mechanisms for oversight. With oversight of the MA Utilization Management Plan responsibilities, the objective of the HMO is to monitor the IPA UM processes including decision-making compliance with the standards as set forth in the 2023 MA HMO Utilization Management Plan, and CMS regulations. An ongoing assessment of the IPA's capacity to implement the HMO's MA Utilization Management Plan mandates will continually be assessed. The HMO provides ongoing oversight by conducting adherence audits to ensure that delegated processes and procedures are compliant with HMO regulatory and accreditation standards.

Delegated MA Utilization Management Plan responsibilities must be consistently performed within the parameters set forth in the 2023 HMO Medical Services Agreement (MA MSA) and the 2023 MA HMO Utilization Management Plan. Within this structure and its own process capabilities, the IPA has the opportunity to design a Utilization Management Program that is suited to its unique practice environment as long as all HMO minimum requirements, as outlined in the HMO MA Utilization Management Plan, are met and reflect CMS regulatory standards.

The HMO delegated Utilization Management functions include the management of Behavioral Health (BH) and Substance Use Disorders (SUD). IPAs may coordinate BH/SUD services through the Primary Care Physician (PCP), a BH Practitioner, or sub-delegated BH vendor.

The HMO delegates the selection of nationally recognized clinical criteria to the IPA and specifies procedures for selection, annual review, application, and dissemination of the criteria. Evidence based clinical practice guidelines are utilized to assist IPA Physicians in making utilization management determinations. The guidelines are not a substitute for the sound medical judgment of the physician. The physician must make the final determination about what treatment or services are appropriate for the member based upon the specific medical condition of the member.

The HMO provides oversight and conducts ongoing review through adherence audits to ensure that delegated processes and procedures are compliant with HMO, CMS, regulatory and accreditation standards.

Blue Cross and Blue Shield of Illinois (BCBSIL) monitors the performance of each contracted HMO Individual Practice Association (IPA). An IPA who does not meet the acceptable performance threshold, as determined by BCBSIL, is required to submit and enter into a Corrective Action Requirement (CAR) process.

Non-compliance with the Utilization Management

Non-compliance with plan requirements will result in corrective action until compliance is achieved. Any failure of the HMO Adherence Audit requires a written Corrective Action Requirement (CAR) and immediate remediation of the failing components of the Audit.

The CAR should address all indicators specified in the notification letter.
CAR format must include the following components:

- IPA Number and Name
- IPAs Medical Director's Name
- IPAs Administrator's Name
- Root cause determinant(s) for each indicator's failed performance
- Corrective action - to improve each indicator's performance
- Designated Person(s) Entity(ies) to manage corrective action, including requirements/objective(s)
- Delivery Date(s) of corrective action, including requirements/objective(s)

The IPA must submit the CAR to BCBSIL by the due date specified in the notification letter. If the CAR is not received by BCBSIL by the notification letter's due date, then a HMO Administered Complaint may be issued.

The received CAR will be reviewed by the HMO for completeness and compliance with HMO Requirements. The BCBSIL Clinical Delegation Coordinator (CDC) may request, via follow-up communication, that the IPA address incomplete and/or insufficient CAR components. An amended CAR must be submitted by the due date specified in this follow-up communication. An amended CAR not received by the due date will be subject to the same HMO Administered Complaint as described above.

Once the CAR has been approved by the HMO, a letter of acceptance of the CAR is sent to the IPA by the Clinical Delegation Coordinator and copied to the HMO Medical Director, HMO Director, Network Programs, Department Managers and the Provider Network Consultant. IPA compliance needs to be documented in the UM Workgroup minutes.

A monthly audit will be performed for a period of time determined by BCBSIL after the date of the initial audit, based on the deficiencies and recommendations identified.

Non-compliance with the MA Utilization Management Plan requirements will result in HMO taking corrective action until compliance is achieved. The HMO may terminate the delegation agreement with the IPA for non-compliance depending on the severity of the infraction, or for any continued non-compliance with the Plan.

IPA Sub-Delegation Requirements and Responsibilities

If an IPA chooses to sub-delegate or outsource any Utilization Management functions to another entity, (e.g., Contract Management Firm (CMF), hospital UM department, BH facility or group), the entity must be named, specific contact information must be documented in the IPA MA Utilization Management Plan, and BCBSIL prior approval must be obtained prior to delegation taking place.

Pre-delegation Audit Requirements

Before sub-delegation begins, the IPA must perform a pre-delegation audit to review and approve any sub-delegates program components prior to submitting the IPA MA UM Management Plan and completed compliance tool to the HMO Provider Portal by February 15, 2023. Only one (1) IPA MA UM - Management Plan and one (1) Compliance Tool which documents all IPA (medical and behavioral health) delegated or non-delegated UM Management Plan components will be accepted by the HMO. The HMO Clinical Delegation Coordinator reviewing the IPA MA Utilization Management Plan will notify the IPA of the need for any revisions with an assigned due date for submission of revision(s). Failure to meet the revision due date may result in an HMO administered complaint, or de-delegation of UM services.

If an IPA changes contract management firms, or initiates sub-delegation mid-year, the HMO must be notified, in writing, at least 180 days in advance of the date the new entity will assume the delegation oversight. A pre-delegation audit of the prospective delegate must be performed prior to the delegation implementation date to ensure compliance with HMO and IPA requirements. The HMO will request a new MA Utilization Management Plan from the IPA and/or sub-delegate. The IPA must submit the new updated MA Utilization Management Plan to the HMO within 30 days of the change in delegation.

Pre-delegation Agreement Requirements

The IPA MA Utilization Management Plan must describe any sub-delegated responsibilities of the MA Utilization Management Plan. There must be a contract that defines accountability of the IPA and the sub-delegate, as well as the mechanisms for oversight by the IPA.

At a minimum, the sub-delegation contract must:

a) Describe the delegated activities and the respective responsibilities of the IPA and the sub-delegate;
b) Require at least semi-annual reporting by the sub-delegate to the IPA;
c) Describe the process by which the organization evaluates the sub-delegate's performance;
d) Describe the process for providing member experience and clinical performance data to the sub-delegate when requested; and
e) Describe the remedies available to the IPA if the sub-delegate does not fulfill its obligations, including revocation of the delegation agreement.

The sub-delegated entity is responsible for performing all IPA MA UM activity for which it is contracted with the IPA. Sub-delegates must meet the HMO MA UM standards set forth in the MA HMO Utilization Management Plan and be clearly documented within the IPAs MA Utilization Management Plan.

The IPA is responsible for oversight of any sub- delegates. Mechanisms for oversight must include, but are not limited to:

a) Annual approval of the sub-delegate MA UM - Management Plan components;
b) Annual evaluation of sub-delegate performance against HMO and IPA requirements;
c) Review of monthly, quarterly, semi-annual and/or annual submissions and any related reports;
d) Identification of any deficiencies with corrective action;
e) Confirmation of the sub-delegates current, effective URO certificate;
f) Annual UM and CCM file review;
g) Oversight of the sub-delegates UM/QI Committee activities; and
h) Semi-annual Inter-rater reliability audits for all sub-delegated responsibilities (March and September).

Any delegated Contract Management Firm (CMF), Management Service Organization (MSO) or Behavioral Health Organization must also be licensed with the state of Illinois as a Utilization Review Organization (URO). A current URO license must be in effect at all times and evidence of renewals must be submitted in a timely manner to the HMO. Proof of current URO licensure must also be submitted to the Clinical Delegation Coordinator with the IPA MA UM Plan documents on an annual basis, and at time of renewal.

Medicare Advantage (MA) HMO Utilization Management Program

IPA physicians are solely responsible for the provision of all health care services to HMO members and all decisions regarding member treatment and care are the sole responsibility of the IPA physician. Such decisions are not directed or controlled by the health plan. The health plans' decision about whether any medical service or supply is a covered benefit under the member's MA HMO benefit plan are benefit decisions only and are not the provisions of medical care. It is the physician's responsibility to discuss all treatment options with the member, regardless of whether such treatment is a covered benefit under the member's benefit plan. The IPA and IPA physicians shall provide services to members in the same manner and quality as those services that are provided to other patients who are not MA HMO members.

HMO Structure, Resources and Goals

The HMO is a licensed Utilization Review Organization in the state of Illinois. The URO license is renewed every two years.

The HMO's MA Utilization Management Plan is approved annually by the BCBS MA Clinical Quality Committee.

HMO is contracted with multiple IPAs and fully delegates the functions of the Utilization Management Program. This delegation includes Behavioral Health and Substance Use Disorder management. The delegated Behavioral Health UM Program includes specifics related to triage and referral processes and includes all levels of BH services, as applicable.

MA HMO Committee Structure

Multiple committees provide oversight of all HMO and delegation activities. The UM Workgroup meets quarterly and is chaired by the HMO Medical Director. The MA HMO Clinical Quality Committee (CQC) is chaired by the Sr. Medical Director for MA HMO and the MA HMO Delegation Oversight Committee (DOC) is chaired by the Divisional Vice President (DVP), Delegation Oversight. The CQC will approve the MA HMO UM Plan annually and review MA statistics on a quarterly basis.

The DOC will review all delegate operation audits and clinical adherence audits on a quarterly basis. Committee members include representatives from MA HMO Quality Improvement and Data and Reporting, MA HMO Health Management, and IL Network Management. Final approval of all MA HMO UM delegated activities is provided by the MA Clinical Quality Committee.

The MA HMO CQC and DOC perform an important role in the MA Plan UM Program. The responsibilities of the committees include, but are not limited to, the following:

a) Annual review and revision of MA HMO UM goals and UM Program documents, including the Blue Cross Medicare Advantage MA HMO Utilization Management Plan and UM sections of the Blue Medicare Advantage HMO Medical Service Agreement (MA MSA);
b) Oversight of MA HMO UM policies and procedures to ensure compliance and annual review and revision of UM policies, if appropriate;
c) Oversight of IPA MA HMO UM Plans, UM adherence audits, utilization case files, including components related to behavioral health, chemical dependency, selected case management files and IPA corrective action;
d) Oversight of IPA complaint, grievance, denial/appeal, case management and referral processes, including annual audit of IPA Organization Determination files including denial files and case management files;
e) Review of annual HMO survey results, with specific reference to referrals and review of interventions for any identified issues;
f) Review of IPA MA UM data to identify potential utilization issues; and
g) Annual evaluation of the Blue Cross Medicare Advantage MA HMO UM program.

Physician Involvement

The MA HMO UM Plan is developed by BCBSIL and is compliant with the Centers for Medicare & Medicaid Services (CMS), State and other regulatory agencies. The MA HMO UM Plan, including BH/SUD, is evaluated and revised annually by the MA HMO UM Clinical Quality Committee (CQC) which includes BH representation.

Medicare Advantage (MA) HMO Staff

The following staff is employed by the HMO to provide oversight of the delegated UM functions performed by the IPA:

a) Licensed physician(s), including the HMO Medical Director, are directly responsible for oversight of the MA HMO UM Plan;
b) The Executive Director of Clinical Programs Strategy & Oversight is a licensed IL Registered Nurse providing oversight of all MA UM Program functions;
c) The Manager of Network Clinical Programs is a licensed IL Registered Nurse, responsible for monitoring the activities of the UM staff, tracking network performance, designing UM interventions, and reporting IPA UM Program compliance and UM and network activity; and
d) Clinical Delegation Coordinators (CDCs), all of whom are licensed IL Registered Nurses, are responsible for monitoring each IPA's MA Utilization Management Plan delegated activities and performance.

Medicare Advantage (MA) HMO Monitoring and Oversight of IPA

The HMO Staff will review required IPA submissions monthly, quarterly, semi-annually, and annually as outlined in the MA HMO Utilization Management Plan.

a) The HMO will provide regular feedback to the respective IPA. HMO Staff will review specific utilization trends including medical, surgical, outpatient surgery, home health, and mental health and Substance Use Disorder with IPA Staff. Individual IPA performance is compared to its previous performance and to the performance of other IPAs within the network;

b) An IPA may request that the HMO provide educational interventions to assist their progress. These interventions may include comprehensive and detailed UM in-services, focused educational activities targeted to specific problem areas, document review and/or on-site UM or PHM assessment;
c) The HMO provides an opportunity for discussion of important utilization issues during practitioner conferences. In this forum, best practices are discussed, and IPA input is obtained. The HMO may conduct focus groups with the IPAs;
d) The HMO monitors the network for issues relating to over-utilization and/or under-utilization of services. This review, discussion and monitoring includes utilization data across practices and practitioner sites. This monitoring information is used to evaluate effectiveness of the processes used to achieve appropriate utilization. Where specific outcomes are relevant to a single IPA, this is communicated to the IPA Medical Director and considered in the re-credentialing and reappointment process;
e) IPAs are identified for face-to-face visits based on various factors considered by the HMO, including the following: potentially avoidable days, admits/1,000, days/1,000, average length of stay, or any other identified potential issue.
f) IPA is required to hold at least eleven (11) monthly UM/QI Committee meetings per year. By contract, the HMO reserves the right to have HMO staff attend these required UM/QI Committee meetings to observe and assess the IPA's internal processes and activities, and then to provide feedback to the IPA about these processes and activities. The HMO reserves the right to monitor and assess whether the delegated MA UM activity is performed according to the HMO's Plan requirements. However, such oversight shall not relieve the IPA of its obligations to perform the MA UM functions in accordance with all applicable HMO policies, procedures, and agreements;
g) The HMO UM Workgroup and Delegation Oversight Committee reviews reports and identifies potential issues. Also, claims payment data, denial files, customer service issues, quality of care issues, diagnosis, referrals, case detail, assessment of member and Provider experience, and appeals are utilized to identify potential problems. Any significant substandard performance from the HMO requirements will be reported to HMO management; and
h) When deemed appropriate, a corrective action requirement is requested from the IPA. It may include any of the following components: additional data collection, written requests for action, meeting with the network consultant and the IPA, and/or a meeting with the HMO Medical Director and IPA Medical Director and/or Administrator.

Under the supervision of the HMO Medical Director, the HMO Clinical Delegation Coordinators provide oversight of UM delegated functions on an ongoing basis. Oversight includes but is not limited to:

a) Annual review and approval of IPA MA Utilization Management Plan;
b) Review of random sample of Complex Case Management and Diabetes Condition Management files;
c) Monthly review of **All** Denials (including ODAG, Medical Necessity *and* Non-Covered Benefits);
d) Monthly review of referral source IPA submissions;
e) Quarterly review of MA UM statistical reports; and
f) Performing IPA Adherence Audits

Adherence Audits

A Clinical Delegation Coordinator performs an audit of the IPA MA Utilization Management Program and meets with the IPA UM and CM staff, including the IPA Medical and/or Physician Champion, as indicated. The Adherence Audit Site Visit Tool is used to measure compliance with the HMO MA Utilization Management requirements. The IPA must score at least 90% to achieve a passing score.

Any IPA that receives a failing score is required to submit a corrective action requirement (CAR) within 30 days of the date on the audit results letter. The corrective action requirement must meet minimum guidelines as established by the HMO. The Clinical Delegation Coordinator monitors receipt of the corrective action requirement and reviews it for completeness. The Clinical Delegation Coordinator will either approve the CAR or request re-submission for areas that do not meet CAR submission requirements. A re-audit is performed to measure compliance with HMO requirements. IPAs that do not meet corrective action requirements or fail the re-audit may be placed in default of the MSA. Should this occur specific default provisions of the MSA are enforced.

The following elements will be addressed at the MA Utilization Management Semi-Annual Adherence Audit:

a) Review of UM Committee Meeting Minutes;
b) MA Case File Review including emergent and concurrent cases for both medical and behavioral health, skilled nursing, home health, long stay, and cases not meeting criteria that have been referred to the Physician Advisor;
c) Interview of the IPA's UM and Staff to discuss the Utilization Management processes; and
d) Discussion of audit results and any pertinent data reflecting the IPA performance.

*Case File scores and resulting audit scores are final and not eligible for appeal once the Clinical Delegation Coordinator has completed the on-site audit. Please work with the Clinical Delegation Coordinator to demonstrate compliance prior to completion of the audit. The administrator's designee from the IPA and BCBSIL Clinical Delegation Coordinator will sign a confirmation letter that they agree that all items have been reviewed and discussed.

HMO Utilization Management Program Oversight

Overview

The HMO's MA UM Program is designed to ensure that MA Medical and Behavioral Health services are medically necessary and appropriate, as well as in compliance with the benefits of the plan and state and regulatory requirements. The Program encompasses services rendered in ambulatory, inpatient and transitional settings. The Program is monitored and evaluated to identify trends and opportunities to improve healthcare services and member experience. The core components of the HMO's MA UM Program include but are not limited to structure, goals, and processes to ensure appropriate utilization, measurement, and assessment of member experience.

Ensuring Appropriate Utilization

The HMO reviews and evaluates the following data, and any other information that the HMO deems appropriate to identify any patterns of potentially under or over utilization:

a) Inpatient admissions/1,000 member;
b) Inpatient days/1,000 member;
c) Average length of stay (LOS);
d) ER visits/1,000 member;
e) Mental health days/1,000 member;
f) Substance Use Disorder days/1,000 member;
g) IPA 30-day re-admission rate (HEDIS® methodology);
h) Avoidable days; and
I) Home Health Utilization.

Data is collected at the network and individual IPA levels. Thresholds for intensified review by the HMO UM Workgroup are established based on statistical analysis of an IPA's performance in relation to overall network performance. MCG benchmark performance data for moderately managed health plans are used as a guide.

New and Existing Medical Technology

Medical Policies represent guidelines for use in making health care benefit coverage determinations for specific clinical issues, including new treatment approaches and medical technologies. The HMO evaluates emerging medical technologies as well as new applications of existing technologies through BCBSIL's corporate medical policy development process. The evaluation process is applied to new technologies, products, drugs, medical and surgical procedures, BH procedures, medical devices and any other such services as may come under policy and claims review. The New and Existing Medical Technology Policy outlines the process for evaluation of technology. IPAs are required to contact the HMO with any questions regarding medical technologies.

IPA Delegation Requirements and Responsibilities

IPA MA Utilization Management Plan

Each IPA must have a formal, written MA Utilization Management Plan that meets, at a minimum, all MA HMO requirements, and includes a description of the IPA staff, resources, and the process by which the IPA provides Utilization Management services to its members.

The IPA MA Utilization Management Plan must:

a) Be reviewed and approved annually with approval documented in the IPA UM Committee minutes; and
b) Describe the Behavioral Health (including substance use disorder) and non-BH aspects of the UM Plan;

All IPA PCPs must be notified about how to obtain the IPA MA Utilization Management Plan and the process for notification must be stated in the IPAs MA Utilization Management Plan.

IPA Physician UM Program Staff Requirements

The IPA must clearly identify the staff responsible for specific activities in their Utilization Plan. The IPA must have a Medical Director, Physician Advisor, Physician Champion, UM Coordinator, Case Manager, Board Certified specialists or consultants, Behavioral Health Medical Director, and a UM Committee. A description of the UM staff's title and professional designation should be detailed in the IPA UM Plan. For example, the plan should indicate which level of staff are responsible for care coordination, inpatient concurrent review, outpatient authorizations, discharge planning, behavioral health (mental health and substance use disorder), denials, etc.

IPA's must have appropriate staff to perform UM functions. A roster of the IPA staff documenting name, title, license number, and credentials is required with the annual submission of the MA UM Plan. Any change in the IPA staff needs to be reported, in writing, to the MA HMO within 30 days of the change.

All practicing physicians participating within an IPA must be currently licensed, without restriction to practice medicine in the state of licensure. All practicing physicians must be currently credentialed by BCBSIL. The IPA Medical Director, PA and BH Practitioners must be currently licensed in the state in which the IPA operates. Annually, a listing of the IPA Medical Director and all PAs licenses (including license number and expiration dates) must be submitted with the IPA MA UM Plan. Copies of licenses are not required. The HMO will verify the physician licenses from a list provided by the IPA. The minimum staffing requirements are as follows:

1. **IPA Medical Director**

   The IPA Medical Director is a board certified, Illinois licensed physician (MD or DO) who:

   a) Must be contracted with the IPA;
   b) Supervises all UM decision-making, including denials;
   c) Monitors the implementation of IPA MA Utilization Management Plan;
   d) Makes the final decision regarding utilization determinations;
   e) Consults as appropriate with the PCP in utilization decisions;
   f) Oversees the analysis of trends, profiling, and long-term IPA planning;
   g) Oversees all Case Management Program activities;
   h) Is responsible for satellite and CMF oversight, if applicable; and
   i) Is responsible for the proper functioning of the IPA UM and Quality Improvement Committees.

2. **IPA Behavioral Health Medical Director**

   The IPA Behavioral Health Medical Director is a board certified, Illinois licensed Psychiatrist who is responsible for oversight of the Behavioral Health (BH) and Substance Use Disorder (SUD) program as follows:

   a) Must be contracted with the IPA;
   b) Supervises all Behavioral Health and SUD UM decision-making, including denials;
   c) Monitors the implementation of IPA UM Plan;
   d) Makes the final decision regarding BH and SUD utilization determinations;
   e) Consults as appropriate with the PCP in utilization decisions;
   f) Oversees the analysis of trends, profiling, and long-term IPA planning;
   g) Oversees all BH Case Management Program activities;
   h) Is responsible for satellite and CMF oversight, if applicable; and
   i) IPA BH Medical Director is responsible for the proper functioning of the IPA UM and Quality Improvement Committees Behavioral Health and SUD activities.

3. **Physician Champion**

   A physician who provides leadership for the IPA's Complex Case Management Program and Condition Management Program. The Physician Champion may be the IPA Medical Director, Physician Advisor, or another physician appointee. This role entails hands-on involvement in the workings of the program. The Physician Champion promotes the Complex Case Management Program within the organization by educating peers and discussing the program's relevance. The Physician Champion must be identified in the IPA MA UM and Population Health Management Plan. The Physician Champion is required to provide a quarterly update to the IPA UM Committee which includes discussion of ongoing initiatives to support the IPA Population Health Management Programs.

4. **Physician Advisor**

   The Physician Advisor (PA) is the licensed physician most directly involved with individual MA Utilization Management case review (i.e., Preauthorization, Concurrent Review). The IPA Medical Director may act as the Physician Advisor. This physician reviews all cases that do not meet the medical necessity guidelines or are long stay cases (defined as greater than seven days).

5. **Specialist**
   Board certified specialists, Illinois licensed MD/DO, including a BH Practitioner (for mental health and Substance Use Disorder), must be available as needed to assist in making determinations of medical necessity. The IPA must maintain and annually update a list of available board-certified specialists utilized for this purpose. This list of specialists must be submitted to the HMO Clinical Delegation Coordinator with the annual submission of the MA Utilization Management Plan. There must be a board-certified psychiatrist or licensed clinical psychologist available as needed for BH MA UM. In addition, the IPA may utilize a certified addiction medicine specialist for Substance Use Disorder.

   Note: Pediatricians are considered primary care providers. Pediatric Sub-specialists are required to be available, as needed, for pediatric medical necessity determinations.

6. **UM Lead/Supervisor/Manager**
   The UM Supervisor is a health professional who possesses an active, unrestricted IL professional license and supervises UM activities including day-to-day supervision of UM activities, participates in staff training, monitors for consistent application of UM criteria by UM staff, for each level and type of UM decision, monitors documentation for adequacy and is available to UM staff on-site or by telephone.

7. **UM Nurse**
   The UM Nurse is a health professional and possesses an active, unrestricted IL professional license, is responsible for the day-to-day utilization review activities. Utilization case review and application of criteria to approve initial and continued inpatient services must be performed by a licensed professional nurse and supervised by a licensed professional nurse or physician. Professional staff licensure will be verified annually by the HMO. Registered Nurse license numbers and expiration dates and any other professional licenses must be submitted to the HMO Clinical Delegation Coordinator with the UM Plan. The UM Nurse is proficient in the use of medical terminology and nationally recognized medical criteria and can communicate accurately with the IPA Medical Director, PA and /or PCPs. There must be sufficient UM Nurse staffing to perform necessary reviews and to discuss cases with the appropriate physician(s). The UM Nurse usually serves as the primary UM contact for the HMO.

8. **UM Coordinator**
   The UM Coordinator is a non-licensed staff member responsible for processing pre-service authorization requests and has authority to approve the requests based on use of nationally recognized medical criteria and/or IPA Medical Group guidelines. Any pre-service authorization requests not meeting authorization criteria must be referred to the UM Nurse and/or IPA Medical Director for review and determination.

9. **Case Manager (CM)**
   The Case Manager is an unrestricted IL licensed health professional (RN, NP, PA, MD/DO, LCSW, LCPC, Pharmacist), or other professional approved by the HMO) who may be certified in Case Management. The Case Manager provides individualized care to members in the CCM and Diabetes Condition Management Programs.

Job descriptions and Staff Training

The IPA must have written job descriptions, including practitioner qualifications, for practitioners who review denials. Qualifications should include education, training, or professional experience in medical or clinical practice. The job description must include the responsibilities for that position. The job description(s) must be submitted with the annual MA UM Plan. A BH Practitioner (which includes mental health and substance use disorder) job description must also be included with the annual MA UM Plan.

IPA Utilization Management Program

IPA UM/QI Committee Requirements

The IPA is required to hold a minimum of eleven (11) monthly UM and/or QI Committee meeting with Behavioral Health and Medical Specialist (MD/DO licensure) representation, (Note: Family Medicine, General Practice, Internal Medicine, Obstetrician/Gynecologists, and Pediatricians are not considered specialists for this purpose).

The purpose of the IPA UM Committee includes, but is not limited to, the review and approval of the annual IPA MA Utilization Management Plan, review of ambulatory and inpatient services, behavioral health services, and Complex Case Management Program services provided to the MA HMO members.

The minutes of the committee meeting must document the following:

a) Date of the meeting;
b) Medical Director/Chairman, BH Medical Director (at minimum quarterly) and members present, including at least one specialist and one BH Practitioner (monthly); and
c) Minutes must be signed by the IPA Medical Director/Chair within five weeks of the date of the last meeting (not stamped). If electronically signed, evidence of signature controls must be documented and demonstrated.

The IPA's UM Committee may also serve as the QI Committee. If the UM committee also serves as the QI Committee, oversight of both QI and UM functions, as specified in the HMO MA Utilization Management Plan, must be evident in all meeting minutes. Only one set of meeting minutes will be audited for HMO compliance purposes.

The IPA MA Utilization Management Plan must identify the UM Committee chairperson, its membership, the committee structure, and meeting schedule. The UM Committee must include broad physician representation, including the following: IPA Medical Director, IPA BH Medical Director, actively practicing primary care physicians, and at least one board certified specialist. A roster of the Committee members must include each Committee member's professional degree, license number and specialty, and be submitted with the IPA UM Plan. Any revisions to the committee membership must be submitted to the MA HMO within 30 days of change. The MA UM Plan must include a description of the process for its development (i.e., which persons or Committees are responsible for the MA UM Plan review, revision, and the final approval). A designated BH physician or doctoral-level behavioral health practitioner must be involved in the implementation of the behavioral health aspects of the IPA MA UM Plan and is responsible for reporting behavioral health activities to the IPA UM Committee.

IPA UM Targets

The IPA must ensure appropriate utilization through the analysis of past trends. The IPA will develop its own specific goals and set targets including but not limited to:

a) Inpatient admissions/1,000 member;
b) Inpatient days/1,000 member; and
c) Average length of stay (LOS);

Program Scope

The scope of the Program includes, but is not limited to, oversight of delegated inpatient and outpatient services as follows:

- Organization Determinations
- Diagnostic testing
- Therapies
- Behavioral Health (BH) which includes mental health and substance use disorder
- Skilled nursing services
- Rehabilitation services
- Home health care services
- Certifications
- Denials
- Case Management, Complex Case Management (CCM), and Condition Management

Inter-Rater Reliability

Inter-Rater Reliability (IRR) testing is utilized to evaluate the consistency and accuracy in the application of nationally recognized medical criteria to requests for medical services.

Semi-annually, the UM Committee must review inter-rater reliability results and document its findings in the UM Committee meeting minutes. Every physician and UM staff member involved in MA UM decision making must be evaluated for inter-rater reliability compliance. Inter Rater Reliability files must be redacted for protected health information (PHI). Both redacted and unredacted versions of the files are to be uploaded to the HMO Provider Portal semi-annually (March and September). The IRR report must include a summary of findings and corrective actions (if applicable) in addition to detail on each staff member's results.

The UM Committee Minutes must address:

1. The number of Physical Medicine Physician (MD/DO) and UM Staff Reviewers (clinical and non-clinical) who passed on the first attempt and address any necessary re-education and the plan for the re-education and subsequent re-evaluation.
2. The number of Behavioral Health/SUD (MD/DO) and UM Staff Reviewers who passed on the first attempt and address any necessary re-education and the plan for re-education and subsequent re-evaluation.

All Physicians, Practitioners and Providers (including BH licensed providers, i.e., PhD, LPC, MSW, PsyD and LCSW), Physician Advisors, IPA Medical Directors, and all UM Staff (licensed and non-licensed) who are involved in the UM process must be included in this assessment. Inter-rater reliability testing must be performed by a licensed professional peer of the individual being reviewed.

IPA's which sub-delegate either Medical or BH/SUD utilization management services must submit all required documentation for the sub-delegate to BCBSIL (Individual Inter-Rater Reliability staff case results, documented discussion of results in the IPA Committee meeting minutes, which include follow-up corrective action requirements as needed, and aggregate IPA results documented according to the table below).

Consistency in the Application of Nationally Recognized Medical Criteria Review
Discussion regarding the IPA's results must be evident in the IPA UM Committee meeting minutes. The minutes must reflect any inconsistent application(s) of criteria, along with evidence of corrective action, if applicable.

IPA IRR results must be submitted and addressed on the applicable quarterly CMF report and must indicate any need for follow up.

Inter-Rater Methodology

All medical directors and staff must be evaluated utilizing an 8/30 methodology for conducting the IRR's, which includes both inpatient and outpatient case reviews.

a) Initially, a random sample of eight files for each physician and staff member must be reviewed;
b) If each physician and UM staff member passes all eight files, the process is complete;
c) If a physician or staff member does not pass all eight files with 100% accuracy, an additional 22 files must be reviewed for this staff member(s) for a total of 30 files.
d) Using the template below, please report number of staff who passed the inter-rater (numerator) and the number of staff who took the inter-rater (denominator) and percentage of staff who passed on first attempt vs. required re-education and 2nd attempt. Also, report the staff breakdown for BH and Non-BH, Physician vs. Non-Physician (clinical UM Staff) and non-clinical UM staff.

FIRST ATTEMPT						
	Medical Director/PA (MD/DO) (Numerator/ Denominator)	**Medical Director/PA (MD/DO) Percentage**	**Clinical UM Staff (PsyD, LCSW, CPC, PhD) (Numerator/ Denominator)**	**Clinical UM Staff (RN, LPN, PsyD, LCSW, CPC, PhD) Percentage**	**Non-Clinical UM Staff (Numerator/ Denominator)**	**Non-Clinical UM Staff Percentage**
Medical Inpatient						
Medical Outpatient						
BH/SUD Inpatient						
BH/SUD Outpatient						

ADDITIONAL ATTEMPTS (Denote number of attempts per clinician)						
	Medical Director/PA (MD/DO) (Numerator/ Denominator)	**Medical Director/PA (MD/DO) Percentage**	**Clinical UM Staff (RN, LPN, PsyD, LCSW, CPC, PhD) (Numerator/ Denominator)**	**Clinical UM Staff (RN, LPN, PsyD, LCSW, CPC, PhD) Percentage**	**Non-Clinical UM Staff (Numerator/ Denominator)**	**Non-Clinical UM Staff Percentage**
Medical Inpatient						
Medical Outpatient						
BH/SUD Inpatient						
BH/SUD Outpatient						

Timeframe Adherence Review

The UM Committee must, on an annual basis, review UM staff adherence to all time frames established for making UM decisions including urgent and non-urgent pre-service review, initial review, concurrent review, member complaints, denials post-service reviews, and referral case review. Every UM staff member must be included in the testing and the results must be documented in the UM Committee meeting minutes, along with any corrective action if applicable.

Ensuring Appropriate Utilization

The IPAs are required to track and trend utilization data at least semi-annually during the year. Utilization data must be analyzed and discussed as part of the IPA UM Committee meeting, and minutes documenting this discussion are reviewed by the HMO during the audit review process. The IPAs are required to track specialty referrals in aggregate, BH (mental health and Substance Use Disorder separately) referrals in aggregate and all out-of-network referrals (in detail). In addition, the IPAs are required to track the following, including one for BH: (mental health and Substance Use Disorder separately), inpatient days/1000 member, admits or discharges/1000 member, and average length of stay.

BCBSIL specific MA HMO Inpatient Targets

- Admits/1,000: 221
- Days/1,000: 1,111.63
- LOS: 5.03
- Readmission rate: 17%

IPAs are required to develop a methodology to identify and track utilization trends for over and underutilization practice patterns and avoidable inpatient days. A policy must be in place to obtain corrective action from IPA Physicians with identified avoidable days.
The UM Committee must discuss a 6-month summary of avoidable days, the reason for the delayed discharge and any IPA physician patterns. This must be documented in the minutes semi-annually, with corrective action noted for any physician identified patterns.

PCP Site Visit Results

There must be annual review and documentation in the UM Committee meeting minutes, results of any HMO PCP site visit results, as posted on the HMO Provider Portal, with discussion of any non-compliance, including corrective action when indicated.

UM Plan Supporting Documentation Requirements

URO Registration: Illinois Department of Insurance

Utilization Management, including but not limited to prospective, initial, concurrent, and retrospective review, referrals, and/ or discharge planning, must be performed by a Utilization Review Organization (URO) that is registered, every two years with the Illinois Department of Insurance. The IPA may not delegate URO registration requirements. Any delegated Contract Management Firm (CMF), Management Service Organization (MSO) or Behavioral Health (BH) delegate must also be licensed with the state as a URO. A current URO must be always in effect and renewals must be submitted timely to the HMO. Proof of current URO licensure must also be submitted to the HMO Clinical Delegation Coordinator with the IPA UM Plan documents on an annual basis.

Policies and Procedures

The IPAs must review, revise, and submit all required MA UM Plan related policies and procedures annually. Policies must include, at a minimum: IPA name, name of policy and number for policy, effective date, review date, most current revision date, and signature of reviewing and approving authority.

Required Policies Include:

1. **UM staff hospital Onsite Concurrent Review-** at facility, (if applicable). If the IPA MA UM Coordinator performs on-site concurrent review at facilities, the IPA must have a documented process that includes the following elements:
    a) Guidelines for identification of IPA staff at the facility (in accordance with facility policy);
    b) A process for scheduling the on-site review in advance (unless otherwise agreed upon);
    c) A process for ensuring that IPA staff follows facility rules; and
    d) If no on-site review is performed, this must be documented in the UM Plan.
2. **Staff orientation/ training/ performance review -** The IPA must have a written policy and procedure for training, orientation, and ongoing performance monitoring of clinical and non-clinical utilization review staff. The policy must be submitted to the HMO Clinical Delegation Coordinator annually, at the time of submission of the MA UM Plan.
3. **Diagnoses, Procedures, Physicians not requiring Pre-certification and/or Concurrent Review -** if applicable. (Ambulatory, Inpatient)
4. **Additional Clinical Decision-Making Criteria -** Clinical pathways, guidelines used for UM decision-making and the process for development and approval, if applicable.
5. **Inter-Rater Reliability (IRR)-** The IPA will have a written policy stating the frequency (semi-annual) of the IRR to be conducted for all staff making UM decisions, the tool being used to audit, the methodology of audit, and plan of action if results fall below required standards. The results and any plans of action must be discussed in the UM/QI Meeting semi-annually. (March and September)
6. **IPA Referral and Denial Process -** The IPA must have a policy describing their process for approving and denying pre-service and concurrent referral requests. The denial process must describe the distinction and management of both medical necessity versus non-covered benefit denials.
7. **Standing Referrals -** A listing of Referral Diagnoses/ procedures/ services/ physicians that do not require review based on historical MA UM data. Member having a disease or condition requiring an ongoing course of treatment from a specialist or other health care provider may request a standing referral from his/her PCP. This is a single referral, provided at the discretion of the PCP, specifying duration, type and frequency of specialist services to complete an ongoing course of treatment.
8. **Appeals -** (not delegated, referred to the MA HMO Customer Service Department)
9. **Protected Health Information -** The HMO adheres to the Health Insurance Portability and Accountability Act (HIPAA) provisions for the use of Protected Health Information (PHI) and requires the IPA and any sub-delegates, in turn, to follow these provisions: The IPA must:
    a) Use PHI (any member identifiers that can be linked to a member) only to provide or arrange for the provision of medical and BH (which includes mental health and Substance Use Disorder) benefits administration and services;
    b) Provide a description of appropriate safeguards to protect the information from inappropriate use or further disclosure;
    c) Ensure that sub-delegates have similar safeguards;
    d) Provide individual members with access to their PHI;
    e) Inform the HMO if inappropriate uses or disclosures of the PHI occur; and
    f) Ensure that PHI is returned, destroyed, or protected upon termination of the MA MSA.

10. **Confidentiality -** of all medical information maintained by the IPA or sub-delegated providers is protected from unauthorized use and disclosure.
11. **Tracking Avoidable Days -** for IPA physicians and method for corrective action and non-compliance.
12. **PCP Notification to Member -** of approved certification decisions, if applicable.
13. **Hospital Transition of Care Policy-** IPAs are required to provide a policy that identifies the IPA process of meeting or exceeding the following minimal requirements: Review inpatient logs (and Emergency Department logs, if available) every business day, for potential high-risk transition cases. Contact Hospital Discharge Planner as appropriate. Case Manager bi-directional contact with consenting members, who are determined by the IPA to be at high-risk and those who are enrolled in a CCM program, within 2 days of discharge, the transition of care call must include a medication reconciliation assessment.
14. **Transition to Other Care -** Describing the IPA process for notifying member of an exhausted benefit, transition of care and/or exhaustion of limited benefit.
15. **Population Health Management Program Policy -** Describing the Diabetes Condition Management Program and Complex Case Management programs processes and required documentation and timeframes.
16. **Organization Determinations-** The policy must address the process which includes timeliness for making organization determinations regarding the benefits that an enrollee is entitled to receive under the plan.
17. **Out-of-Network Referral Policy-** Describing the process for ensuring that medical criteria is reviewed by the Medical Director to ensure the member can indeed be treated for their condition at the in-network provider office prior to issuing a denial redirecting the member back in-network.
18. **Denial Controls Policy** - The IPA has a documented policy and procedure describing internal system controls specific to UM denial notification and receipt dates. The policy must describe how the system controls are established, monitored, and what actions are taken should an instance of system over-ride is found. HMO will maintain an internal policy and review delegate policies for compliance.
19. **Wellness and Prevention Program Policy** describing the process for IPA Practitioners and Office Staff to educate members regarding preventive health screenings, tracking gaps in care and outreaching to members in order to close gaps in care on an annual basis.

The IPA must provide a document listing all IPA Policies and Procedures, signed by the IPA Medical Director, attesting that the policies and procedures have been reviewed and approved by the Utilization Management Committee, at minimum, annually (no later than February 15th each calendar year). This list must be submitted with the MA Utilization Management Plan following the IPA UM Committee approval and documentation of their approval in the meeting minutes. All Policies and Procedures must be submitted with the annual MA Utilization Management Plan.

IPA Utilization Management Requirements

Requirements for UM Decisions

The IPAs shall meet the following UM decision-making requirements for Medical, Behavioral Health and Substance Use Disorder UM decisions:

a) UM decisions are made within the time frames established by the HMO using clinical information; **(See Appendix B:** 2023 **UM Timeframes and Requirements)**
b) A process is identified for UM concurrent reviews performed on-site at facilities, such as hospitals and skilled nursing facilities; and

c) Transition of care is provided when benefits end, member is transitioning from Pediatrics to Adult Practitioner, and when a pregnant adolescent is in their transition from pediatrics to an adult PCP, OB/GYN, Family Practitioner or Internist.

IPA Behavioral Health Requirements

The HMO delegates Behavioral Health care to the IPAs. IPAs must describe their member process for obtaining BH (which includes mental health and Substance Use Disorder) services, including written standards for ensuring appropriate BH triage and referral decisions. IPAs may coordinate BH services through the PCP, a BH Practitioner, or the IPA may sub-delegate BH to a specialist vendor. Any delegation of BH must be described in the IPA MA Utilization Management Plan. Triage and referral standards are only applicable when an IPA sub-delegates BH to a Contract Management Firm (CMF, vendor or BH specialty group) who provides centralized triage and referral services.

Any IPA that delegates BH must also ensure that these standards are followed in the delegate's processes. They must include the following:

a) Triage and referral protocols address the level of urgency and the appropriate setting;
b) Triage and referral protocols are based on sound clinical evidence and currently accepted practices, and are reviewed or revised annually;
c) Triage and referral decisions that require clinical judgement are made by licensed BH Practitioners with appropriate experience;
d) Triage and referral staff are supervised by a licensed BH practitioner with a minimum of a master's degree and five years of post-master's clinical experience; and
e) Triage and referral decisions are overseen by a licensed psychiatrist or an appropriately licensed doctoral-level clinical psychologist. In addition, a certified addiction medicine specialist may oversee decisions related to Substance Use Disorder.

In addition, the following are requirements for triage and referral when BH services are delegated:

a) Telephone answered by a non-recorded voice within 30 seconds; and
b) Abandonment rate (the percentage of phone calls where member disconnected before the call was answered) less than 5%.

All IPA BH services must be provided in accordance with the following access standards with documentation, including written notification of the process, for meeting those standards in the MA HMO UM Plan:

a) Access to care for non-life-threatening emergency within 6 hours;
b) Access to urgent care within 24 hours;
c) Access to an appointment for a routine office visit within 10 business days or two weeks, whichever is less.

Any delegated BH Organization or IPA providing BH services with a centralized triage and referral process, must submit telephone reports quarterly to the HMO QI Department. The reports must include the average speed of answer and the call abandonment rate. BH calls include mental health and/or Substance Use Disorder related calls. Combined mental health and Substance Use Disorder telephone stats are acceptable. Quarterly review and discussion of any sub-delegate, CMF, or BH delegate including review of any submissions, or reports from the sub-delegates, if applicable, must be documented and approved in the IPA UM Committee Meeting minutes. CMF quarterly reporting must include reference to telephone statistics and compliance with HMO standards.

IPAs' must submit their BH Prior-Authorization Requirements to the HMO along with their Utilization Management/Population Management Plan on an annual basis. If the IPA does not require Prior-Authorization for Behavioral Health/SUD services, the self-referral process should be described within the IPA's Utilization Management and Population Health Management Plan.

UM Criteria for UM Decisions

IPA Clinical Criteria for UM Decisions

The IPA MA HMO UM Plan must describe the hierarchy for clinical decision-making, which is as follows:

1) Medicare manuals;
2) CMS National Coverage Determinations (NCD), CMS Local Coverage Determinations (LCD) as the first guide in determining coverage. The IPA is responsible for checking the CMS.gov website for any LCD/NCD changes to ensure utilization of the most current guidelines; and
3) For coverage determinations where there is no guidance on coverage in Medicare manuals, NCD, or LCD, the IPA may use additional coverage policies such as nationally recognized medical criteria or the BCBS Medical Policy (in Medicare Managed Care Manual Chapter 4. Benefits and Beneficiary Protection, section 90.1-90.6) The additional coverage policies the IPA uses for such coverage determinations must be outlined in the IPA MA HMO UM Plan.

For cases that do not meet the nationally recognized medical criteria, LCD, NCD or legislative requirements, the IPA Medical Director and/or PA must make a determination considering the individual patient's circumstances including age, co-morbidities, and psychosocial considerations. For all diagnoses and procedures that are not listed in the IPA's nationally recognized medical criteria set, the case must be reviewed by the Medical Director and/or PA for determination of medical necessity. For long-stay cases (greater than seven (7) days), the cases must be reviewed weekly by the Medical Director and/or PA for determining medical necessity and appropriateness of setting. The physician review must be documented.

When a diagnosis specific criterion is available, that criterion must be applied to the case. Case files will be audited to ensure the appropriate criteria guideline was applied.

For situations where NCD, LCD, or nationally recognized criteria, are not available, the IPA may utilize additional guidelines created by the IPA, provided that the guidelines are developed from an objective and/ or authoritative evidence-based process based upon:

a) Studies from the government;
b) Evaluations performed by independent assessment groups; and/or
c) Well-designed controlled clinical studies that have appeared in peer-review journals. (Medicare Managed Care Manual Chapter 4. Benefits and Beneficiary protection, section 90.5)

These must be reviewed and approved annually, including any procedures for their use, through the IPA UM Committee. The development process of the criteria must include appropriate board-certified specialists.

Every year, the criteria and procedure(s) must be submitted to the HMO with the IPA MA HMO UM Plan. Documentation of review and approval must be in the UM Committee minutes. The IPA may adopt additional objective criteria, clinical pathways and/or guidelines. They must be reviewed by the UM Committee and chosen based on scientific medical evidence. Discussion of how the additional criteria, clinical pathways and/or guidelines were chosen must be identified in the UM Plan as part of the criteria approval process.

Notification of Availability of Clinical Criteria

On an annual basis, a written statement must be distributed to all IPA Practitioners notifying them of the availability of the IPA's nationally recognized criteria and any additional guidelines, the method for requesting the criteria, and the format in which the criteria will be provided. A sample of this annual written statement is to be attached to the annual MA Utilization Management Plan for submission to the HMO Clinical Delegation Coordinator.

IPA cannot reverse an adverse certification decision unless it receives new information not available at the time of the initial determination. An approval decision cannot be reversed.

If the requested service (pre-service, initial review, concurrent stay) does not meet nationally recognized medical criteria, the following must also be documented:

a) Date sent to Physician Advisor;
b) Documentation of Physician Advisor reason for continued stay approval or denial;
c) Date additional clinical information requested, date received;
d) Determination (approval or denial);
e) Physician Advisor (name);
f) Member notification and date (IPA policy may include statement that PCP notifies member of approved certification or defines the member notification process); and
g) Physician Notification and date

The IPA must provide the number of MA PA referrals per month in aggregate, and the number of MA PA referrals resulting in denial in aggregate. This must be reported at the UM Committee meetings.

Relevant Clinical Information

To support UM decision-making, the UM Coordinator and/or Physician Advisor must gather and document relevant clinical information including information from the attending physician.

The HMO Clinical/Pre-Certification/Pre-Service/Initial Review Form must be utilized, or an equivalent IPA form that includes all required documentation which must be submitted with the MA UM Plan. Relevant clinical information may include, but is not limited to, lab tests, physician's progress notes, x-ray reports, and individual patient circumstances as listed below:

a) Age;
b) Co-morbidities;
c) Complications;
d) Progress of treatment;
e) Psychosocial situation; and
f) Home environment assessment upon admission, for discharge planning purposes, to include caregiver support and availability.

The UM decision-maker must also consider characteristics of the local delivery system that are available for the specific patient, including:

a) The availability of skilled nursing facilities or home care in the IPA's service area to support the patient after hospital discharge;
b) The coverage of benefits for skilled nursing facilities or home care when needed; and
c) The ability of local hospital(s) to provide all recommended services within the estimated length of stay.

Medical Necessity and Benefit Determination

The IPA MA Utilization Management Plan must describe the process of making medical necessity (including out-of-network) determinations and benefit determinations and the information/criteria utilized in making determinations must be described. Non-covered benefit determinations may only be issued when the service requested is never approved for any member, regardless of diagnosis or medical necessity.

UM Affirmation Statement

Annually, all IPAs are required to distribute an affirmation statement to all Members, Practitioners, Providers and Employees who make UM decisions affirming that:

a) UM decisions are based on medical necessity, which includes appropriateness of care and services, and the existence of available benefits;
b) The organization does not specifically reward health plan staff, Providers, or other individuals for issuing denials of coverage, care or service; and
c) Incentive programs are not utilized to encourage decisions that result in under-utilization.

A statement regarding conflict of interest must also be included with the affirmation statement.
This statement can be made via the member welcome letter, or member newsletters. Practitioner and employee notification can be made via memos or posted on the IPA internet site. The IPA is required to document the method of how the IPA informs members and practitioners of this requirement and must also submit this with the annual IPA MA Utilization Management Plan.

Access to UM Staff

The IPA must provide the following communication services for Practitioners and Members:

a) At least eight hours a day, during normal business hours, staff must be available for inbound calls regarding UM issues;
b) UM staff must have the ability to receive inbound after business hours communication regarding UM issues (i.e., voice mail or answering service);
c) There must be outbound communication from staff regarding UM inquiries during normal business hours;
d) Calls must be returned within one business day of receipt of communication;
e) Staff must identify themselves by name, title and organization name when initiating or returning calls;
f) There must be a toll-free number or staff that accepts collect calls regarding UM issues;
g) Callers must have access to UM staff for questions;
h) The IPA offers access to TDD (telecommunications device for the deaf)/TTY (telephone typewriter, or teletypewriter) services to deaf, hard of hearing or speech impaired member. The IPA provides a separate phone number for receiving TDD/TTY messages or uses the State/711 Relay Services; and
i) The IPA offers language assistance for member to discuss UM issues (during office hours).

The IPA must document their inbound and outbound communication process in the annual MA Utilization Management Plan. The method for receiving after hours communication must be included. Practitioners and members must be notified of their access to UM staff for questions and the acceptance of collect calls or the availability of a toll-free number. Practitioners and members may be notified via the member welcome letter, newsletter, or memo posted in the PCP office.

Pre-certification/Pre-Service Documentation

Prospective, Pre-Certification, Pre-Service Processes include determination of medical necessity and appropriateness of service and site of care for inpatient and outpatient services.
Prospective, Pre-Certification review is performed by the Utilization Review (UR) Coordinator and/or the PA using the nationally recognized, evidence based, medical criteria selected by the IPA. IPAs may develop written policy and procedures indicating services not requiring pre-certification. The policy may include diagnoses, procedures, and/or physicians that do not require prior authorization and/ or concurrent review.

The IPA is required to submit a copy of its prior-authorization requirements to the HMO at least annually (along with the annual UM Plan and supporting documents by February 15th each year).

A member non-discrimination notice should be provided with all medical group approvals and denials pursuant to Section 1557 of the Affordable Care Act. The notice is available on the HMO Provider Portal. This member notice is subject to change at the sole discretion of BCBSIL. In the event of a change to the notice, medical groups can expect BCBSIL to provide an updated notice for use.

Pre-Certification/Pre-Service review includes documentation of the following:

a) Sources of relevant clinical information utilized (medical record, physician information, labs/test results/X-rays, other);
b) Estimated length of stay (LOS) (admission);
c) Medical criteria met including criteria code (admission);
d) Non-urgent pre-service determination (approval and denial) within 14 calendar days of receipt of request, including the collection of all necessary information (no additional time is allowed for obtaining information);
e) Non-urgent pre-service member notified within 14 calendar days of the receipt of request;
f) Non-urgent pre-service practitioner notified within 14 calendar days of the receipt of request;
g) Urgent/expedited pre-service determination (approval and denial) within 72 hours of receipt of request, including the collection of all necessary information (no additional time is allowed for obtaining information);
h) For urgent/expedited cases, member notified within 72 hours of receipt of request (IPA policy may include statement that PCP notifies member of approved certification); and
i) For urgent/expedited cases, practitioner notified within 72 hours of receipt of request.

If the request was received as an “expedited case” then the IPA needs to decide if it agrees with the “expedited” rationale. If the physician requests the determination is completed in the urgent “expedited” time frame because any delay would put the member’s health or life in danger, then the case must be handled as an urgent “expedited” case and completed in 72 hours. If the service request was not made by the physician but is made by the member and does not meet the criteria for having an expedited timeframe, the IPA may determine that the case will be handled as a standard case.

If an “expedited” request is determined to be handled as a “standard” request, the member must be notified and provided with the “Right to Expedited Grievance Letter”. Members may grieve this determination on an expedited basis.

Also, the IPA may determine that the determination for either an expedited request or a standard request may be resolved in the member’s favor if an extension is granted. The extension can be for up to 14 calendar days. In this case also, if the IPA grants itself an extension, the member must be notified through the “Right

to Expedited Grievance" letter. Members have the right to file an expedited grievance if they disagree with the time extension.

For practitioner notification, if initial notification is made by telephone, IPA must record time and date of call, and document name of IPA employee who made the call.

For member notification of an extension, if initial notification is made by telephone, the IPA must record the time and date of the call and document the name of the IPA employee who made the call. The notification provides the member with a right for an expedited grievance if they do not agree with this extension. The notification includes information on how to submit the grievance.

For all denials, confirmation of the decision must be provided, by the IPA, via mail, fax, or e-mail to both the ordering provider and the member. The ordering provider may inform the member verbally and document their notification in the EHR while the IPA concurrently sends the written notification.

Certification/Initial Review Process

Certification/Initial Review Process for emergent/urgent admissions is to be completed within *72 hours* of admission or notification of admission and includes documentation of the following:

a) UM decision (approval or denial) made within *72 hours* of receipt of the request;
b) NCD, LCD, or other nationally recognized medical criteria being met (code documented) in justification of medical necessity issues;
c) Assigned length of stay (LOS);
d) Notification of member within *72 hours* of receipt of request (IPA policy may include statement that PCP notifies member of approved certification);
e) Notification of practitioner(s) within *72 hours* of the receipt of request; and
f) Discharge planning/case management needs addressed.

Initial Review for pre-certified/pre-service non-urgent (elective) admissions may be deferred until assigned length of stay for that approved admission has reached its limit, but never greater than four (4) days after admission.

The completed certification form for admissions (excluding those identified by the IPA as not requiring review) must include the following:

a) Name of patient and patient identifier;
b) Date of review, admit date;
c) Name of physician – PCP (or admitting physician) and/or specialists;
d) Diagnosis and procedure – date of procedure;
e) Facility/Agency name;
f) Relevant clinical Information – supporting the admission and clinical information source;
g) LCD, NCD, or other nationally recognized medical criteria being met (code documented);
h) Anticipated Length of Stay (LOS);
i) Physician notification date;
j) Member notification date (IPA policy may include statement that PCP notifies member of approved certification);
k) Social, family, home assessment for discharge planning;
l) Potential discharge plan, discharge needs; and
m) CCM referral, if applicable

Admissions must be submitted on the IPAs admission log semi-annually with the patient's name, facility, date of admit, diagnosis/ procedures performed, PCP or admitting physician and discharge date. The same log may be used for all admissions (including hospital, SNF, HHC and rehabilitation*)*. A sample admission log must be submitted annually with the UM/PHM Plan and required documents.

Concurrent Review Process

Concurrent Review is the established process which provides for review of all continued stay situations (excluding those identified by the IPA as not requiring review) and includes the following documentation:

a) UM decision (approval or denial) made within 24 hours of receipt of request;
b) Sources of relevant clinical information utilized (medical record, physician information, labs/test results/X- rays, other);
c) LCD, NCD, or other nationally recognized medical criteria being met (code documented);
d) Additional criteria used in decision-making;
e) Additional assigned LOS that is consistent with criteria;
f) Notification of practitioner(s) within 24-hour time frame (If the IPA states in their UM Plan that the practitioner assumes approval of continued stay, then the practitioner does not need to be notified of continued stay approval);
g) Discharge planning/case management needs addressed;
h) Case review on the 7th day after admission (for patients remaining admitted) to determine need for continued stay or change in discharge plan. If the 7th day occurs on a weekend, the concurrent review is required to be performed on the Friday preceding the weekend. Each additional 7-day period that a member remains inpatient requires additional Medical Director review (Acute hospital, Acute behavioral health hospital, Acute Rehabilitation hospital, Long Term Acute Care (LTAC) hospital and Skilled Nursing Facility (SNF); and
i) All reviews for members who remain in an OON hospital must be reviewed with the IPA Medical Director to discuss if transfer back in-network should be initiated, or continued stay is required.

For cases not requiring review as documented in the IPA's policies, after the assigned length of stay is determined and a discharge date is determined, the IPA must check for discharge on the designated discharge date. If the member has not been discharged and the case reaches the fourth (4^{th}) day, concurrent review must begin with brief documentation of the events since admission. The case should be referred to the PA for a long stay review. An initial review form does not need to be completed. If the member stays for another 7 days after the 1^{st} review, additional information is needed for the continued stay or change in discharge plan and referred to the PA.

For concurrent review of BH services, the IPA makes decisions regarding inpatient program, partial hospitalization program, intensive outpatient program and residential behavioral care program within 24 hours of the receipt of the request.

The IPA must provide the number of MA PA referrals per month in aggregate, and the number of MA PA referrals resulting in denial in aggregate.

In the event the UM staff cannot render a coverage decision within the required timeframe, staff shall notify the enrollee or the enrollee's authorized representative in writing, describing the specific information required and stating that HCSC will be extending the review decision by an additional 14 working days. UM staff must send the required CMS letter to the member. UM staff shall extend a review decision by 14 working days if:

- It can be demonstrated that the delay will not result in increased medical risk to the member; and
- It can be demonstrated that the extension is in the best interest of the member.

There are additional requirements for all inpatient, Rehabilitation, SNF or home health care cases (HHC) for when the member is already receiving services that no longer meet criteria. The date the denial is effective must be 48 hours after the notice of denial is provided to the member. Additionally, the member has the right to appeal the denial to the state's Quality Improvement Organization (QIO) for review.
The QIO will request from the MA Plan (and the MA Plan from the IPA) all the case files and the rationale for the denial. This information is generally requested the same day as the QIO is involved. The members' services must be covered until the QIO decision is obtained. The QIO determination is final.

Skilled Nursing Care

The Medicare Program covers skilled nursing care and skilled therapy services under Medicare's skilled nursing facility, home health and outpatient therapy benefits when a beneficiary needs skilled care to maintain function or to prevent slow decline or deterioration, provided that all other coverage criteria are met. (CMS Jimmo Settlement Agreement - January 2013). The Jimmo Settlement Agreement is consistent with the Medicare program's regulations governing maintenance nursing and therapy in skilled nursing facilities, home health services, and outpatient therapy (physical, occupational, and speech) and nursing and therapy in inpatient rehabilitation hospitals for beneficiaries who need the level of care that such hospitals provide.

Hospice

The term "hospice care" means the following items and services provided to a terminally ill individual by, or by others under arrangements made by, a hospice program under a written plan (for providing such care to such individual) established and periodically reviewed by the individual's attending physician and by the medical director of the program:

a) Nursing care provided by, and under the supervision of, a registered professional nurse;
b) Physical or occupational therapy or speech-language pathology services;
c) Medical social services under the direction of a physician;
    i. services of a home health aide who has successfully completed a training program
    ii. homemaker services
d) Medical supplies;
e) Physician services;
f) Short term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management) in an inpatient facility may be provided only on an intermittent, nonroutine, and occasional basis and my not be provided consecutively over longer than five days;
g) Counseling (including dietary counseling) with respect to care of the terminally ill individual and adjustment to his/her death; and
h) Any other item or service which is specified in the plan and for which payment may otherwise be made under this title(cms.gov).

Once the BCBS MA member elect's hospice, the member's hospice coverage reverts to traditional Medicare. Any additional non-hospice services continue to remain in benefit with BCBSIL MA.

Discharge Planning

A UM Coordinator or Case Manager at the IPA is responsible for assisting with identifying the member needs and implementing a discharge plan. Each IPA must have written guidelines or protocols showing effective and timely discharge planning/Case Management with documentation as part of the concurrent review process, which include the following:

a) Assessment of member's needs including cultural preferences and social determinants of health (e.g., housing, housing security, access to food markets, exposure to crime/violence, discrimination, access to media, social support, access to transportation and/or financial barriers);
b) Development of discharge treatment plan; and
c) Documentation of SNF transfer, HHC service and treatment plan.

Potential discharge needs should be evaluated on admission and continuously as part of the concurrent review process.

For Mental Health follow-up, the date of appointment with a specific psychiatric practitioner/provider is to be scheduled prior to discharge and documented on the discharge instruction sheet. All appointments must be scheduled within seven days of discharge, or documentation must state why the 7-day appointment was not made. It is encouraged but not required that a member in treatment for Substance Use Disorder also set a date for a follow up visit within 7 days of discharge with a BH Practitioner.

BCBSIL MA HMO Organization Determination Detail and Summary Logs

a) For Blue Cross Medicare Advantage members, there are specific BCBS MA HMO Organization Determination Logs, (both universe and summary) for pre-service/concurrent review, which must be completed and sent to the HMO on a monthly basis via the IPA Portal. Samples of these Logs are attached.
b) Organization Determination Universe (Detail) and Summary log have additional specific requirements for denials or partial denials. All denials must be clearly identified by type on the log by the IPA, i.e. medical necessity, benefit, out-of-network, etc. and must identify if the request was partially denied or completely denied. NOTE: Referrals written by the PCP to an out-of-network provider (clinical in nature), then redirected to an in-plan provider, are considered clinical denials, and must be documented on the denial log. The HMO denial process must be followed for these out-of-network denied referrals.
c) Pre-Service Organization Determination Data Collection Tools –both the universe and the summary and medical necessity denial files must be submitted to the Clinical Delegation Coordinator by the 10th day of the month following the end of the previous month. Failure to meet this deadline will result in an HMO Administered Complaint. The HMO will review the Organization Determination Pre-Service Universe and Summary Tools and the denial files and contact the IPA with the results. Additional documentation may be requested for review. The additional files must be submitted to the MA Plan Clinical Delegation Coordinator within 7 calendar days of the request.
d) If the IPA uses a BH organization or CMF, the IPA's Organization Determination Pre-Service Universe and Summary Tools must include all approvals and denials from the BH or CMF organization. The HMO will review the Organization Determination Pre-Service Universe and Summary Logs and denial documentation and contact the IPA with any additional BH denial documentation needed for review. The additional documentation must be submitted to the MA Plan Clinical Delegation Coordinator within 7 calendar days of the request.

Referrals

For Blue Cross Medicare Advantage members CMS requires a referral decision for specialist referrals to be rendered, and the Member and Practitioner(s) notified of the decision within 14 calendar days of the request and within 72 hours of the request for urgent "expedited" cases.

IPA staff manages standard and expedited decisions. An ***expedited decision*** is required when:

a) The life or health of a covered person would be jeopardized;
b) The member's ability to regain maximum function would be jeopardized;
c) The provider reasonably requests an expedited decision; or
d) The medical exigencies of the case require an expedited decision;
e) If the physician requests the determination is completed in the urgent "expedited" time frame because any delay would put the member's health or life in danger, then the case must be handled as an urgent "expedited" case and completed in 72 hours.
f) If the service request was not made by the physician but is made by the member and does not meet the criteria for having an expedited timeframe, the IPA may determine that the case will be handled as a standard case. However, member notification must be provided with the member right for an expedited grievance if they do not agree with this time frame. The Notice to be provided is the Right to an Expedited Grievance Letter.

If the referral is ***denied***, the Member and Practitioner(s) must be notified in writing or electronically within the fourteen calendar days for standard cases and within 72 hours for expedited cases.

All written referrals must include the following elements:

a) Documentation of the date received by IPA;
b) Documentation of the member's name and patient identifier;
c) Documentation of the reason for referral;
d) Documentation of the number of visits or extent of treatment;
e) Referral form must be signed and dated by PCP/PCP office; and
f) Referral must include a statement that referral does not authorize benefits for non-covered services.

Additional requirements related to referrals include:

a) Maintenance of all referral determinations on the Organization Determination Data Collection Tool including all approvals and denials;
b) Providing the member with a copy of the referral (the IPA or PCP must mail, or fax copy to member, if requested by the member);
c) Documentation of communication with PCP if referral is denied (including member-requested referrals); and
d) It must be documented that the PCP agrees with the denial decision. If the PCP does not agree with the denial, a denial cannot be issued.

Written denial letters are required for all denials even if the member did not receive a written referral.

The IPA must issue the CMS approved Adverse Determination letters which are, available on the HMO Provider Portal, to members including appeal language and comply with Medicare-approved NDP/plan information notification on mailing envelopes. The HMO Provider Portal should be checked frequently for letter changes.

Referrals including, but not limited to, therapies, diagnostics, durable medical equipment (DME) and specialists, must be monitored by the IPA for quality of care, appropriate utilization, and compliance with UM decision-making time frames.

IPAs must submit monthly, to the HMO Clinical Delegation Coordinator, the number of total MA referrals including: the number approved, the number denied and the number of partial denials. This documentation is required to be submitted on the Organization Determination Pre-Service Universe and Summary data collection tools. The logs should be submitted via upload to the HMO Provider Portal.

MA Referrals, including but not limited to, therapies, diagnostics, durable medical equipment (DME), and specialists, must be monitored by the IPA for quality of care, appropriate utilization, and compliance with UM decision-making timeframes.

Referral Inquiry Logs

On a quarterly basis, IPA will report the number of out of network referrals received for all MA HMO members. Detail must include the number of referrals approved and the number denied; which must be documented on a log and uploaded to the HMO Provider Portal by the 5th day of the month following the end of the quarter. Out of network referrals are defined as follows:

a) For HMO risk services (Home Health, DME, etc.)- Any requests for services/vendors not listed on the HMO approved list of in-network vendors;
b) For IPA risk services (Tertiary Providers, Specialists, Physical Therapy, Lab, etc.)- Any requests for services/providers not considered par, in-network for the IPA. Please note par/preferred tertiary providers should not be considered out-of-network.

Standing Referrals

Member diagnosed with a disease or condition requiring an ongoing course of treatment from a specialist or other health care provider may request a standing referral from his/her PCP. This is a single referral, provided at the discretion of the PCP, specifying duration, type, and frequency of specialist services to complete an ongoing course of treatment. The IPA must provide the HMO with a written policy and procedure addressing processes related to standing referrals. The standing referral should be updated at least once per year to review continued eligibility and benefit plan updates.

IPA Denials/ Organization Determinations

The IPA must have a plan that describes the method for processing Organization Determinations including medical necessity and benefit denials. This process applies to all services included in the UM Plan and must meet the following requirements:

a) All cases that do not meet LCD, NCD, or other nationally recognized medical criteria, and legislative guideline requirements, must be reviewed by the Medical Director and/or PA.
b) Medical criteria must be reviewed by the Medical Director and/or PA with the decision rendered and documented within the appropriate UM time frame (non-urgent pre-service: within 14 calendar days of the receipt of request; urgent pre-service: within 72 hours of the receipt of request; and concurrent: within 24 hours of the receipt of request).
c) The Medical Director or PA must determine whether the care should be approved or denied in medical, non-behavioral health care situations. This denial decision can be made only with agreement from the member's PCP.
d) A psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist must be responsible for denial of BH care that is based on lack of medical necessity.

e) For all denied cases, including concurrent review, practitioner(s) and member must be informed of the CMS appeals process and this must be noted by IPA staff member making the call if initial notification was made by telephone. The member and practitioner(s) must be sent confirmation by mail, fax or email of the original notification within the appropriate time frame with inclusion of information on the expedited appeal process.
f) All appeals must be processed according to language in the denial notification.
g) All appeals (and expedited grievances for declining a service request as expedited or an extension) are referred to the MA Plan as previously described. A member or their representative may file an appeal, orally or in writing, through the Medicare Advantage Customer Service Department at 877-774-8592, or mail to:

Blue Cross Medicare Advantage HMO Appeals and Grievances
PO Box 4555
Scranton, PA 18505

h) The denial must include documentation of the relevant clinical information supporting the decision and its source(s) (e.g., medical record, lab results, information from the PCP). Clinical information (in addition to the diagnosis) utilized in order to make the denial decision must be included in the denial file. Communication with the PCP regarding the decision must be documented (including member requested referrals). It must be documented that the PCP agrees with the denial decision.
i) The denial must be issued on the appropriate denial letter template.
j) The Integrated Denial Notice (IDN) is for all denials of service and claims except for the concurrent denials listed below
   - The Notice of Medicare Non-Coverage (NOMNC) is for all continued stay denials for SNF, Rehabilitation and home health care. (Attach NOMNC Letter)
   - The Important Notice from Medicare (IM) for all continued stay denials for acute inpatient hospitalizations and are normally delivered by the hospital to the member.
   - Once an NOMNC letter is issued and the member requests an expedited appeal, the facility or provider has one day to issue the Detailed Notice of Non-Coverage (DENC) letter to the member.
k) The denial letter needs to have these elements: Relevant clinical information in layman's terms and the criteria used to make the determination.
l) If additional clinical information is requested to make a denial decision, document the date information was requested and received.
m) Medical Director/PA/Behavioral Health Practitioner(s) denial documentation must include one of the following: physician's handwritten signature, email documentation from the physician, or unique electronic identifier on the letter or a signed or initialed note from a UM staff person, co-signed by the specific physician/behavioral health practitioner. For BH denials, the title/specialty of the BH/SUD practitioner making the decision must be included with the signature.
n) A PA must be available by telephone for the practitioner(s) to discuss denial decisions (behavioral health and non-behavioral health denials). The IPA must notify practitioners of its policy for making a reviewer available to discuss any UM denial decisions in a newsletter, direct mailing, or orientation.
o) The IPA must issue MA Plan/ CMS-approved denial letters to members and comply with appropriate Medicare-approved Letter and the information notification mailing on envelopes (available on www.bcbsil.com).
p) It is the IPAs responsibility to check the Health Plan website for any letter content changes.

Organization Determination-Reporting

The IPA is required to report organization determinations, as described in this section, regardless of whether the request was filed by an enrollee, the enrollees 'representative, a physician or a non-contract provider who signed a Waiver of Liability. The Organization Determination Data Collection Tool contains information required for CMS Part C reporting and for a CMS audit.

1. An organization determination is the IPA's response to a request for coverage (payment or provision) of an item or service – including auto-adjudicated claims, prior authorization requests, and requests to continue previously authorized ongoing courses of treatment. It includes requests from both contract and non-contract providers.
2. An approved decision means an item or service was covered and paid in whole.
3. A partially adverse decision means an item or service was partially covered or paid (e.g., if a claim has multiple line items, some of which were paid and some of which were denied, it would be considered partially adverse; if a pre-service request for 10 therapy services was processed, but only five were authorized, this would be considered partially adverse).
4. An adverse decision means an item or service was denied in whole.

The IPA should report both a prior authorization request and a claim for the same service separately as an organization determination.

The IPA is to include an initial request for an organization determination as separate from any additional requests to extend the coverage.

Reporting Exclusions/Do not report:

a. Duplicate requests concerning the same service or item; or
b. A Quality Improvement Organization (QIO) review of an individuals' request to continue Medicare-covered services (e.g., a SNF stay)

Organization Determination: Summary Data Collection Tool

Data Elements for Pre-Service Organization Determinations - Summary Tool

Number of Organization Determinations	Approved
Number of Organization Determinations	Partially Adverse
Number of Organization Determinations	Adverse

Data Elements for Pre-Service Organization Determinations: Universe Tool

The following are fields required for the pre-service organization determinations - universe tool:
Member demographics; PAR status of provider; date/time request received; member diagnosis; type of service requested; if expedited request, was it processed as an expedited request; if time extension granted, date the member was informed; date/time determination made; date/time verbal notification to member; date/time written notification to member; date/time determination entered in the system; if denied reason of denial; type of denial letter issued; date denial effective; date DENC letter issued, if applicable.

a) A Pre-Service Organization Determination Summary Tool and Universe Tool must be maintained, updated, and submitted to the HMO Provider Portal monthly. All denials must be included in the form found in the HMO Provider Portal with the reason for denial identified. All denials must be clearly identified by type on the form by the IPA, i.e., lack of medical necessity, non-covered benefit, out-of-network/non-participating provider services.

b) Referrals written by the PCP to an out-of-network provider (clinical in nature), then redirected to an in-plan provider, are considered medical necessity denials, and must be documented on the universe log. The HMO denial process must be followed for all MA denials.
c) If no denials have been issued for the specified month, this must be documented on the IPA denial log.
d) These tools (and medical necessity denial files) must be submitted to the HMO Clinical Delegation Coordinator by the 5th day of the month following the end of the previous month. Failure to meet this deadline will result in an HMO Administered Complaint.
e) The HMO will review the tools, denials documentation, and contact the IPA with the results. Additional documentation may be requested for review. The additional files must be submitted to the HMO within seven calendar days of the request. The HMO will send quarterly results to each IPA.
f) If the IPA uses a BH organization or CMF, the organization determination logs must be completed and maintained by the BH organization and submitted to the HMO. BH medical necessity denial files (including out-of-network) must be submitted to the HMO with the organization tools. The HMO will review the tools and contact the IPA with any additional BH documentation needed for review. The additional documentation must be submitted to the HMO within seven calendar days of the request.

Reconsiderations

The Medicare health plan's denial notice must inform the enrollee of his/her right to a reconsideration and the right to be represented by an attorney or other representative in the reconsideration process. Instructions on how and where to file a request for reconsideration must also be included. In addition, the member handbook or other materials must include information about free legal services available for qualified individuals. The reconsideration consists of a review of an adverse organization determination or termination of services decision, the evidence, and findings upon which it was based, and any other evidence that the parties submit or that is obtained by the Medicare health plan, the QIO, or the independent review entity. (CMS.gov.MA Denial Notices).

Written Denial Notification Notice of Non-Coverage

Written Denial Notification Notice of Non-Coverage *(*Integrated Denial Letter and Notice of Medicare Non-Coverage) - All partially favorable or unfavorable decisions must be communicated to the member and practitioner in writing within one business date of the determination using appropriate MA Plan /CMS approved denial letter which is available on the Provider website.
Maintain all documentation on all denials for 10 years. Documentation includes a copy of the original member or provider request with date and time of receipt and a copy of the appropriate denial letter with the date and time the letter was delivered.

IPAs without denials in any given month (Medical Necessity Denial ***or*** Benefit Denial) must document "No Denials" in the denial section of the HMO Provider Portal.

Denial Letters

The CMS model denial letter that includes instructions about appeal rights and resources must be used for all denials as posted on the Provider website. The appropriate letter must be utilized. There are three denial letters:

a) Integrated Denial Letter for pre-service and claims denials (IDN).
b) Continued stay denial letter to be used for denial of ongoing services at Skilled Nursing Facilities (SNF), Rehabilitation Facilities, and ongoing home health care services (NOMNC).
c) Detailed explanation of non-coverage is used when an independent review is requested by the member for SNF, Rehabilitation Facilities, and ongoing home care services (DENC).

Quarterly Denial File Audit

The HMO audits the IPAs' denial files monthly and reports any deficiencies to the IPA. As part of the monthly file review process, the MA HMO Clinical Delegation Coordinator will:

a) Review Illinois Medicare Advantage HMO Delegated Medical Group submitted denial letters against established CMS denial reason criteria.
b) Discuss submitted denial letters to the designated Enterprise Medical Director for final denial review and decision findings.
c) For any deficiency, education will be provided to the IPA as an opportunity for improvement. If there is no improvement after two documented educational opportunities, a Corrective Action Requirement (CAR) letter will be issued to the IPA.
d) Complete a BCBSIL Government Program CAR template for each denial letter deemed as failing Medical Director Denial Review after the IPA has been given two opportunities for improvement.
e) Issue a CAR Letter to the assigned IL Delegated MA Medical Group documenting the reasons for the failure and required timeline for correction.

All CAR communications are to be e-mailed to the Delegated MA Medical Group Medical Director listed on the IHAAC contact form. The ODAG Quality Management Delegation Oversight Coordinator and the Senior Manager, Delegated Oversight are to be copied on the CAR correspondences.

A Quarterly denial file audit findings letter is sent to the IPA Medical Director detailing the results of the audit. The IPA must discuss the findings and document the findings in the UM Committee Meeting minutes, including any corrective action required (CAR), if applicable.

Integrated Denial Notice Process

The IDN letter is now used for both claims and for all pre-service denials except concurrent denials for ongoing inpatient, rehabilitation, SNF or home health care.

The PCP contacts the attending physician within one business day of the notification of the admission to the facility. In the event the member is determined by the attending physician and the PCP to be medically stable for transfer but the member refuses to transfer to an in-plan hospital, the following process is begun:

a) The IPA UM Coordinator must report the case to the HMO through their HMO Clinical Delegation Coordinator or MA HMO UM Manager;
b) The IPA should issue HMO and CMS-approved denial letters to members and comply with Medicare-approved IDN information notification on mailing envelopes (available on bcbsil.com);
c) **Maintain notice of IDN documentation for 10 years**. Documentation includes a copy of the original member or provider request with date and time of receipt and a copy of the NOMNC letter with the date and time the letter was delivered; and
d) The IPA submits a copy of all adverse determinations monthly to the HMO Clinical Delegation Coordinator with their pre-service organization determination data collection tool.

Denial of Continuation of Care Process

(Notice of Medicare non-coverage for SNF, CORF and HHC-NOMNC)

The PCP must contact the attending physician within one business day of the notification of the admission to determine medical necessity. If it is determined that services are no longer medically necessary, the following process is begun:

a) The IPA should issue HMO and CMS approved denial letters to members and comply with Medicare approved NDP/Plan information notification on mailing envelopes (available on bcbsil.com);

b) **Maintain notice of NOMNC documentation for 10 years.** Documentation includes a copy of the original member or provider request with date and time of receipt and a copy of the NOMNC letter with the date and time the letter was delivered;
c) The IPA submits a copy of all adverse determinations monthly to the HMO Clinical Delegation Coordinator with their pre-service organization determination log; and
d) The IPAs must keep a log of all the NOMNCs provided to members. This log will be reviewed by the Clinical Delegation Coordinator at the time of the IPA's Utilization Management Adherence Audit.

Right to Expedited Grievance Letter given to members for either of the two situations listed below:

a) When a member requests an "expedited determination" and the IPA determines it does not meet that criteria and will be processed as a "standard request," or
b) When the IPA determines to delay the determination decision by up to 14 days because it will be in the best interest of the member (to obtain more documentation that may result in an approval instead of a denial.)

In either of these situations the member has a right to file an expedited grievance if they disagree with the IPA decision.
These letter templates can be found under the MA HMO Resources section of the Provider Manual online.

Complaints and Grievances

The MA Plan retains full responsibility for the processing and resolution of member complaints and grievances. These services are not delegated. Member and provider literature gives explicit instructions to our members advising them to send all grievances to Blue Medicare Advantage HMO for resolution.

A member or their representative may make a complaint, orally or in writing, through the Blue Cross Medicare Advantage Customer Service Department at 877-774-8592, or mail to:

Blue Cross Medicare Advantage Appeals and Grievances
PO Box 4555
Scranton, PA 18505

Despite these instructions, a small number of members may choose to go directly to their PCP or selected IPA to voice a complaint or grievance. **In the event a contracted IPA receives a member complaint or grievance, either orally or in writing, the IPA must advise the member to contact the MA Plan directly** to file an official appeal or grievance. If the member complaint or grievance is received by telephone, the IPA may warm transfer the call or provide the member with the MA Plan HMO Customer Service telephone. Member complaints or grievance received by the IPA via mail will be faxed to the MA Plan Customer Service.

Additional Appeals Rights

The MA Plan retains full responsibility for the processing and resolution of appeals. Appeals are not delegated to the IPA. Additional appeal rights are identified in the MA Plan Appeal Policies and Procedures. Requests from the practitioner(s) and/or member for further information on an appeal should be directed to the MA Customer Service Department at A member or their representative may make an appeal, through the Blue Cross Medicare Advantage Customer Service Department at 877-774-8592, or mail to:

Blue Cross Medicare Advantage Plan Appeals and Grievances
PO Box 4288
Scranton, PA 18505

Other UM Requirements

1. **Transition of Care**
   Transition of care is applicable when a member is new to the HMO, is displaced by physician de-participation, or is displaced by termination of an IPA contract. New members must request transition of care services within 15 days of eligibility and existing member within 30 business days after receiving notification of displacement. Members in one of these situations who are receiving frequent or ongoing care for a medical condition or pregnancy beyond the first trimester may request assistance to continue with established specialists for a defined timeframe.
   Such members should be directed to the Medicare Advantage Customer Service Department at 877-774-8592 for help in this matter.

2. **Exhaustion of a Limited Benefit**
   Some Benefits Plans have limited benefits for outpatient rehabilitation therapies. Once a member has exhausted a limited benefit, the IPA must document this in writing to the member within two business days. The written communication must include:
   a) The fact that benefits are exhausted;
   b) PCP name;
   c) Appeal rights and procedure;
   d) Reminder that the charges incurred beyond the contract limits are the member's financial responsibility; and
   e) An offer to educate member about alternatives to continuation of care and ways to obtain further care as appropriate.

Point of Service Plans

A point of service option exists for members in two of the four HMO plans- the Plans are the following: Blue Cross Medicare Advantage Basic Plus (HMO-POS) [SM] and Blue Cross Medicare Advantage Premier Plus (HMO-POS) [SM].

Members may elect to use this POS benefit to go out of the IPA network for specific services. The IPA cannot deny if the member elects POS. (Please refer to the MA HMO Provider Manual for POS payment and claims processing related denial/approval language)

A travel benefit exists for members in all MA HMO plans, when requested by the member prior to traveling out of the area. Members may have their services covered while out-of-area and these services will not be authorized by the IPA. The IPA will be responsible for receiving any member materials obtained by the MA Plan while the member was using their travel benefit.

As soon as the IPA becomes aware of the admission, the IPA UM Coordinator will obtain an initial inpatient review which includes the following:

- Monitoring of care to determine when the member is stable;
- When stable, facilitates the transfer of the member to an in-plan or in-network facility; and
- Contacts the member concerning the decision to transfer.

Emergency Services

The HMO contractually requires IPAs to follow the "prudent layperson" standard set forth in the MA UM Plan in making MA UM decisions related to emergency services. Emergency services are covered if an authorized representative, acting for the organization, authorizes the provision of emergency services.

Maternity Discharge Program

The HMO requires that each IPA develop and adhere to a maternity discharge program to help manage utilization. This program should be included within the Utilization Review process.

The following elements are required for an acceptable HMO OB Discharge Plan:

a) Documentation of pre-natal education with the mother and information about the OB Discharge Program during the first and second trimester;
b) Documentation of eligibility criteria related to the OB Discharge Program; and
c) Arrangements for an infant examination either by a Practitioner or by a Nurse visit to the home within 48 hours after discharge from the hospital must be offered if the infant is discharged less than 48 hours after vaginal delivery or less than 96 hours after Cesarean delivery.

Termination of Pregnancy

Currently, Medicare will cover abortion procedures in the following situations;

1) If the pregnancy is the result of an act of rape or incest,
2) In the case where a woman suffers from a physical disorder, physical injury, or physical illness, Including a life-threatening condition caused by the pregnancy itself that would place the woman in danger of death unless an abortion is performed.

Organ Transplants

IPAs are responsible for monitoring all aspects of clinical care including referral, pre-certification, and concurrent review related to organ transplants. The IPA should verify that the requested transplant facility is a Medicare approved transplant network facility. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Blue Cross Medicare Advantage Basic (HMO) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. Members that are referred for, or that receive, organ transplants should be evaluated for inclusion in the IPA's Complex Case Management Program.

Out of Area / Out of Network Admissions

Out of Area Admissions

The HMO is financially responsible for out-of-area admissions where member is admitted for an emergency condition or life-threatening situation more than a 30-mile radius of the IPA or IPA affiliated hospital in which the member is enrolled. The IPA retains responsibility for monitoring clinical aspects of care and for arranging the transfer of the member back into an in-network facility once clinically appropriate. When the treating physician determines that the member is medically stable for transfer, the IPA notifies the PCP that the member can be brought back into an in-network facility within one business day of IPA notification.

Out of Network Admissions

Out-of-Network admissions are urgent or emergent admissions that are within a 30-mile radius of the contracting IPA or IPA affiliated hospital in which the member is enrolled and occur without prior IPA approval. IPA's responsibilities include: As soon as the IPA becomes aware of the admission, the UM Coordinator will obtain an initial review and patient information including the following:

a) Monitoring of care to determine when the member is stable;

b) All reviews for members who remain in an OON hospital for greater than two (2) midnights must be reviewed with the IPA Medical Director to discuss if transfer back in-network should be initiated, or continued stay is required;
c) When stable, the IPA facilitates the transfer of the member to an in-network facility; and
d) Coordinates notification to the member concerning the decision to transfer.

Infertility

Either the PCP or the Woman's Principal Health Care Provider (WPHCP) may establish a diagnosis of infertility. Once this diagnosis has been made, either the PCP or the WPHCP may refer the member for global infertility services to an HMO contracted infertility provider. Such a referral is required for these services to be in benefit.

Clinical Trials

Not all clinical research studies are open to members as the clinical trial must be Medicare approved. Should the member participate in a clinical trial that Medicare has not approved, the member will maintain responsibility for all costs of participation in the study. Should a member plan to participate in a clinical research study, the member should be instructed to refer to their health plan's certificate of coverage for additional guidance.

Record Retention

The IPA shall maintain all records necessary to allow HMO to audit and review IPA's performance and compliance with the terms of the Agreement. IPA shall require all subcontractors, agents or delegates working for, or on behalf of, IPA to comply with the terms of this provision. For purposes of this provision, "record(s)" shall mean all written or electronic material, video or CD-ROM, computer diskette or any other media that is used to store information, including but not limited to medical, administrative, financial, telephonic, and technical records. IPA shall maintain such records for a minimum of ten (10) years from the date of termination of this Agreement. This provision shall survive termination of the Agreement.

CMS Required Chronic Care Improvement Program (CCIP)

Each Medicare Advantage Organization (MAO) is required by CMS to develop and perform a Chronic Care Improvement Program project. As part of the CMS Quality Improvement Plan, the goal is to implement initiatives that promote effective chronic disease management, and the improvement of care and health outcomes for enrollees with chronic conditions. Effective management of chronic disease can achieve positive outcomes, including slowing disease progression, prevention of complications / comorbidities, reducing preventable inpatient stays and improving quality of life.

Blue Cross Medicare Advantage Plans comply with CMS requirements. The CCIP project will be conducted by Blue Cross Medicare Advantage Quality Improvement Department over a three-year period.

Complex Case Management Program

The Complex Case Management Program aims to address the needs of members with multiple, complex and/or high-cost conditions requiring assistance with coordination of multiple services and/or health needs, including significant barriers to self-care. Complex Case Management is an intervention uniquely effective in managing the health care needs of these members. A comprehensive assessment should be completed for members with medical, as well as BH and/or SUD, diagnoses to determine the potential need for complex case management services. All members should also be evaluated for SDoH factors that may impact the member's health outcomes and their ability to access care.

Members with catastrophic or multiple complex conditions, including the disabled, whose care is often complicated by severe Behavioral Health/SUD, SDoH or health equity barriers may benefit from CCM services. Case Management involves the systematic assessment and coordination of care and services provided to members who are experiencing a complex clinical situation and are at the highest risk within the population. All members with a BH/SUD diagnosis should be evaluated for inclusion in the IPA's Complex Case Management Program). A complex clinical situation involves one or more critical or catastrophic events or diagnoses that require extensive use of resources and help navigating the system to facilitate appropriate delivery of care and services. **Appendix A: Complex Case Management Referral Guidelines** outlines conditions appropriate for Complex Case Management services. These guidelines were created with oversight of the HMO Medical Director, HMO UM Work Group and Case Management Society of America (CMSA) website.

The degree and complexity of the member's illness or condition is typically severe, the level of Case Management and/or the number of resources required for the member is extensive. Through the IPA Case Management process, these members are assisted in the access to care and services and their care is coordinated with the assistance of the IPA. The goals are to help the member regain optimal health, provide assistance in obtaining multiple services, learn self-management skills, and/or help gain improvements in level of functioning.

IPA MA Complex Case Management Requirements

Eligibility for the Complex Case Management Program is defined as the date that the member is identified for the complex case management program. IPAs should utilize referral sources to identify members who should be screened for the program: Member or Caregiver Referral, Practitioner Referral, Discharge Planner Referral, or Medical Management Program Referral.
Members who are identified as eligible for Complex Case Management must have an Initial Assessment (IA) initiated within 30 days and completed within sixty (60) days of the eligibility date. **The date that the Initial Assessment is completed is the date the member is enrolled in the Complex Case Management Program.**

I. Initial Assessment

The Initial Assessment (IA), documented in the HMO Provider Portal, must include the following:

a) Document the date the member's eligibility for CCM was determined. The eligibility date is the date the member was identified by either data or referral source. The IA must be ***initiated*** within 30 days of eligibility;
b) Document the date the Initial Assessment was completed. The IA must be ***completed*** within 60 days of eligibility/identification. If the Initial Assessment is initiated greater than 30 days after eligibility, user must attest that the information is current and complete;
c) If an IA is not initiated within 30 days after member is determined by the IPA to be eligible for CCM, the IPA must demonstrate they attempted to contact the member at least three times over a two-week period within the first 30 days of eligibility, to complete the Initial Assessment. Case should be closed if unable to contact the member after three attempts are documented (ideally on different days at different times of day);
d) The IPA Case Manager must provide conclusions and information in their documentation on the following required elements for the Initial Assessment:
    1. Initial assessment of the member's health status and condition specific issues (including the Case Managers conclusion regarding the members health status ***and*** the members self-

reported health status);

2. Diagnoses – acute and chronic conditions, including behavioral health and substance use disorder diagnoses, must include both current and past history.
3. Procedures – relevant, historical and current, including inpatient stays, or document "none";
4. Current status of acute and chronic conditions/diagnoses documented, include mental health and/or Substance Use Disorder conditions/diagnoses. Behavioral health and substance use disorder diagnoses must include both current status and past history;
5. Clinical and treatment history – include disease onset, history from the onset of the condition(s) leading to the current health status;
6. Medications *including dosage, schedule, and history of all current* ***and discontinued medications***;
7. Ability and/or barriers to performing activities of daily living (ADLS) and instrumental activities of daily living (IADLs) including, at minimum, the assessment of eating, bathing, hygiene, ambulation, toileting, transportation, money management, meals, laundry, housekeeping, use of assistive devices (e.g. wheelchair, walker, etc.), dressing, transferring or functional mobility, medication management and physical disability. If a member needs assistance with any ADL or IADL, the documentation must describe the type of assistance and reason for the need for assistance.
8. Current behavioral health status including any mental health conditions or substance use disorders, current or historical.
9. Assessment of cognitive functioning including the member's ability to communicate and understand instructions and the member's ability to process information about an illness;
10. Language Assessment including primary language member uses to communicate and health literacy assessment;
11. Assessment of Cultural Preferences and cultural health beliefs, practices or limitations. Documentation must identify potential barriers to effective communication or care and acceptability of specific treatments;
12. Assessment of Behavioral Health status. Assess if the member with Behavioral Health/SUD diagnosis has signed a Release of Information allowing communication Initial Assessment between the PCP and Behavioral Health Specialist;
13. Initial assessment of Social Determinants of Health (housing, housing security, access to food markets, exposure to crime/violence, personal safety, discrimination, access to media, social support, access to transportation and/or financial barriers, economic stability, education) and their potential impact on the member's ability to meet their goals;
14. Assessment of life planning activities and documentation of collaboration with PCP if appropriate. If life planning activities are determined to be appropriate, the case manager documents what activities the member has taken and what documents are in place. If determined not to be appropriate, the case manager documents the reason.
15. Documentation of hearing and vision limitations and identification of potential barriers to care, or "no limitations";
16. Evaluation of linguistic needs or preferences including health literacy. Documentation must include specific needs to include in the case management plan and barriers to effective communication of care.
17. Evaluation of the adequacy of caregiver resources, involvement, and understanding of care plan. Documentation must describe the resources in place, whether they are sufficient for the member's needs, and note any specific gaps to address.
18. Documentation of benefits, and benefit limitations including an assessment of the adequacy of

the member's benefits to fulfill the treatment plan (Available benefits must be specific and adequate to meet the member needs and documentation must state member's understanding of the benefit). Example: member with a diagnosis of acute CVA with secondary hemiplegia. Documentation of available benefits should reference whether the member's benefits cover the required treatments and prescriptions. 60-session limitation of PT/OT and ST per calendar year. Documentation must state that the member is aware of this;

19. Documentation must include the case manager's evaluation of the member's eligibility for community resources, the availability of those resources and which resources the member may need. At minimum, the following community resources must be assessed: community mental health programs, transportation, wellness programs, nutritional support and palliative care programs; (ex.- Meals on wheels, township services, legal aid), or not (document reason if not needed);
20. Assessment of life planning activities; and
21. Member self-management plan. The member self- management plan is verbally communicated to the member and agreed upon by the member.

e) Process for collecting dates as part of the clinical history.

1. The case manager will record dates of disease onset, current and past medications, test and lab results, procedures, and all other clinical history.
2. Dates may be obtained from the member or member's caregiver and/or extracted from the electronic health record or other clinical documents. If a date is not available, the case manager notes that in the member's file.

II. Complex Case Management Care Plan Requirements

The Case Manager assists, educates, and counsels the member. Non-Case Managers may support the IPA Case Manager, however establishing, revising, and assessing goals must be conducted by the Case Manager. Monthly contacts are to be conducted by the Case Manager. The IPA Case Manager must develop a care plan in collaboration with the member and the member's PCP or Specialist.

As the following services are provided, the Plan of Care is updated:

a) Prioritized goals selected by the Case Manager and member must be in SMART (Specific, Measurable, Achievable, Relevant, Time-Bound) Goal format;
b) Progress and assessment toward goals as levels of interventions are implemented;
c) Assessment of Barriers toward achieving the goals of the care management plan.
A barrier analysis can assess:
    - Language or literacy level.
    - Access to reliable transportation.
    - Understanding of a condition.
    - Motivation.
    - Financial or insurance issues.
    - Cultural or spiritual beliefs.
    - Visual and hearing impairment.
    - Psychological impairment.
d) Social Determinants of Health incorporated into the Complex Case Management Care Plan;
e) Assessment of Community Resources incorporated into the Complex Case Management Care Plan;
f) Revising goals and treatment plan as appropriate; ongoing collaboration and planning with the member, family/caregiver, the PCP and other health care providers. The Case Manager must apprise the PCP of the member's progress at least every 6 months;

g) Educating the member and the family/caregiver, about treatment options and available resources to improve quality of care; and
h) Transitioning the member to the next level of care when outcomes have been attained or when the needs of the member change.

III. Member Contact

The IPA must perform and document at least one-member bi-directional contact monthly between member and Case Manager unless member's condition or preference is noted otherwise. The documentation must meet the following criteria:

a) Monthly contact clearly documented as a contact between member and Case Manager;
b) Contact must be face to face or telephonic and must be bi-directional. The exchange of voice mail or email messages will not be considered bi-directional;
c) Automatic documentation of the member contact with staff including member Name, member ID, and the date, time, and duration of the contact;
d) Documentation of assessment of barriers (including environmental barriers) to existing goals; See **Assessment of Barriers** in the previous **Complex Case Management Care Plan Requirements** section for barrier assessment requirements.
e) Documentation of three (3) member's centric goals, including a minimum of one self-management goal, related to the member's specific current needs whether medical or BH related, approved by the PCP or BH Specialist upon enrollment and every 6 months. SMART goals must be prioritized, numbered by priority, attainable, measurable, current, reviewed and revised before the expiration date and considers member and caregiver preferences and desired involvement;
f) Documentation of member progress against goals with each member contact;
g) Achievement of goals, revision of goals or goal dates, if applicable;
h) Documentation of progress toward self-management;
i) A schedule for follow-up and communication with the member, including the development and discussion of their self-management plan. This will also include the date for next follow- up, mode for follow-up (phone, in-person) and the reason for follow-up;
j) Assessment of medication adherence;
k) Documentation of any follow-up after a hospitalization;
l) Estimated case savings at the close of the case, if applicable; and
m) Documentation of referrals to resources and follow-up to determine if member acted on referral(s).

In addition, members enrolled in Complex Case Management must have at least one (1) PCP face-to-face visit with a physician every six (6) months. (May be a telemedicine visit in 2023 due to pandemic)

For members identified with Behavioral Health or Substance Use Disorder needs, the CM will assess if the member has a Release of Information (ROI), allowing coordination of care between the BH and PCP providers. If the member does not have a ROI, the CM will attempt to facilitate the process to promote communication, coordination of care, treatment compliance and optimal health benefits.

A random sample of Complex Case Management files will be audited, at minimum, for the following elements:

a) Monthly submission of members enrolled in the CCM Program;
b) Members appropriately stratified in Complex Case Management Program;

c) Timeframes Met (IA, Monthly Contact);
d) Appropriate Goal Setting (Follow-Up, Member Self-Management Goal, SMART Goals);
e) Barriers to Achievement of Goals;
f) Assessment of Member Benefits;
g) Assessment of Community Resources;
h) Assessment of Social Determinants of Health;
i) Transition of Care (TOC) Calls made within 48 hours of discharge (all cause) when hospitalized;* and
j) Eligible members who keep a follow-up appointment with PCP or Specialist within 7 days of discharge from the hospital.
k) One half percent (0.5%) of members should be enrolled in the IPA's Complex Case Management Program. If fewer than 0.5% of members are enrolled at the end of the year, a Corrective Action Requirement (CAR) may be issued addressing how the IPA intends to increase the numbers identified for management in the program.

* Transition of Care (TOC) Calls will not be audited but are encouraged as best practice.

Diabetes Condition Management Program

Both Type 1 and Type 2 diabetes are chronic diseases that can lead to serious complications such as heart disease, stroke, blindness, kidney failure, and lower-limb amputation. Some complications, especially microvascular (e.g., eye, kidney, and nerve) disease, can be reduced with optimal glucose control.

Adherence to treatment plans and proper medication regimen, and improvements in patient self-management has been linked to positive clinical outcomes. With effective education and adherence to evidence based clinical practice guidelines, members with diabetes can positively impact their long-term health status and quality of life through self-care and lifestyle management. Better self-management may also reduce the cost of care.

The goals of the Diabetes Condition Management Program are to improve diabetes care by increasing the percentage of diabetic members:

a) Whose Diabetes is well controlled;
b) Who have a face-to-face visit with their physician to review diabetes care if diabetes in not well controlled;
c) Who are screened for depression, when appropriate (Any evidence-based depression screening tool is acceptable);
d) Who receive post hospital transition of care calls in order to decrease readmission rates (all cause readmissions).

Eligible Diabetic Population

Member's age 18 to 75 who met any of the following during a rolling 14-month period are identified as eligible for the program:

a) Two face-to-face claims or encounters on different dates of service in an outpatient setting, emergency room setting or non-acute inpatient setting with a diagnosis of diabetes;
b) One face-to-face claim or encounter in an acute inpatient setting with a diagnosis of diabetes;
c) Dispensed insulin or oral hypoglycemic and/or antihyperglycemics in an ambulatory basis;
d) Enrolled in the Complex Case Management (CCM) program and have a diagnosis of diabetes;
e) Referred by their practitioner for the Diabetes Condition Management Program;

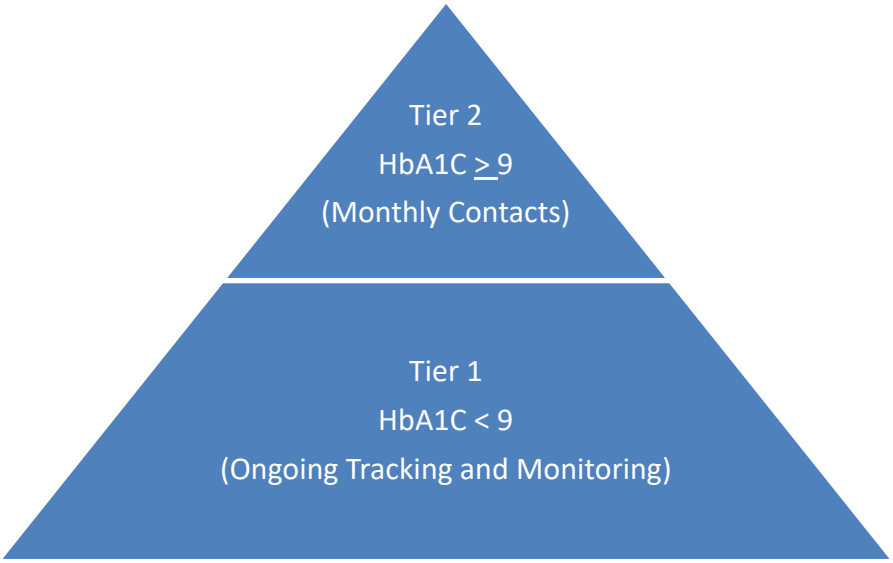
f) Completed an HRA and self-reported having a diagnosis of diabetes; or
g) Self-referred into the Diabetes Condition Management Program.

For 2023, the IPA will perform outreach to all Tier 2 diabetic members identified using the IPA's specific disease registry and/or BCBSIL data source reports. All members in the Diabetes Condition Management Program should also be screened for diabetes related care gaps which will be documented according to BCBSMA QI Department requirements.

Diabetes Condition Management Stratification and Program Content

The Diabetes Condition Management Program provides interventions to members based on assessment and condition risk stratification. The levels of condition stratification for Condition Management include:

Diabetes Condition Management Program



Severity Stratification	Clinical Status	Interventions
Tier 2	HbA1C ≥ 9	-IPA Care Management monthly Bi-Directional Phone Contact -Ongoing monthly monitoring for changes in status of Diabetes condition and HbA1C levels -Screened for Depression at least once per calendar year -Transition of Care calls
Tier 1	HbA1C < 9	-Ongoing quarterly Monitoring for changes in status of Diabetes condition and HbA1C levels -Screened for Depression at least once per calendar year -Transition of Care calls

Tier 2

a) All Tier 1 Services; PLUS
b) Monthly bi-directional communication with an IPA Case Manager:
    - Individualized Condition Management Care Plan;
c) Post Hospital Phone Call within 48 hours of Discharge from Hospital (All cause hospitalizations), if hospitalized; and
d) Depression Screening (with BH referral when indicated) within calendar year for Any evidence-based depression screening tool is acceptable for use.

Tier 1

a) BCBSIL HMO mailings
b) Diabetes Condition Management Welcome Letter;
c) Newly Identified Member Letter;
d) Depression Screening- (with BH referral when indicated) within calendar year for members. Any evidence-based depression screening tool is acceptable for use; and
e) IPA continuous monitoring for changes in Diabetic HbA1C Control level which would require that the member be moved to the Tier 2 Condition Management Program, if necessary.

Member Information:

The IPA welcome letter and each subsequent mailing to members includes:

a) A brief description of how members were identified for the program, referencing member identification using claims, pharmacy data, health risk assessment, physician referral, case management records, or self-referral;
b) The IPA phone number for members to call if they want to opt out of the program; and
c) Information about how to use the program.

Measurement of Diabetes Condition Management Program Effectiveness

The current performance measurement goals for the Diabetes Condition Management Program are:

Performance Measure	Performance Threshold
-HbA1C <8	69%

A summary of the program's results and qualitative and quantitative analysis of data, as well as planned interventions to improve the program's effectiveness, is reported at the HMO QI Committee on an annual basis.

-END-

APPENDIX A: 2023 Complex Case Management Guidelines

These guidelines offer suggestions for members who may be appropriate for referral to Complex Case Management (CCM) services based not solely on their condition but also the Complexity level, and/or Psychosocial needs of the member. The organization coordinates services for its highest risk members with complex conditions and helps them access needed resources.

Note the following:

a) The IPA must provide clear documentation in the complex case management care plan the clinical rationale for the member's complexity and need for CCM;
b) The PCP's support of member's CCM need and care plan must be documented; and
c) The care plan interventions must support the member's Complex Case Management needs.

The following two (2) categories of members are required to be enrolled in the HMO Complex Case Management Program:

a) All HMO members approved to receive CAR T services; and
b) All Transplant candidates are required to be enrolled in Complex Case Management (pre/post-transplant).

Multiple Chronic Conditions	Chronic medical or mental health/SUD conditions with complex needs, COVID-19 sequelae and/or Impaired quality of life (i.e. uncontrolled type 2 diabetes with neuropathic and nephropathic progression, high risk CAD with other comorbid – LVAD with diabetes, RA with diabetes)
Complex Medical Conditions	MVA, trauma, chronic pain or current medical condition with multiple complex needs, Cystic Fibrosis and Muscular dystrophy
Transportation Needs	Limited accessibility, economic burdens
Acute Hospital Admissions	Unplanned in recent 12 months + Complex need, LOS >14 days New dx oncology or diabetes, ICU
High-Risk Hospital Discharges	Complex needs post discharge (DME, multiple therapies, psycho-social, re-admission risk)
Emergency Dept. Visits	At least 3 in past 6 months
Multiple admissions (Physical Health, BH, SUD)	3 unplanned inpatient admissions within 6 months for the same or related condition (exclude scheduled chemotherapy)
Social Determinants of Health (SDoH)	Socioeconomic, education/employment, accessibility, safe neighborhoods, food insecurity
Specific Diagnosis	
Advanced Rheumatologic Disease	Services rendered in an Infusion Center, acute/chronic decline in functional status
Amyotrophic Lateral Sclerosis (ALS)	Symptoms that affect ADLs, new or existing vent dependency
Anorexia Nervosa or Bulimia	Admission to acute hospital or residential facility, new dx or repetitive admissions
Autism Spectrum Disorders or other developmental disabilities or cognitive impairments	New or existing diagnosis, existence of other comorbidities, BH co-morbidity
Substance Use Disorders	May include tobacco, e-cigs, opioids, illicit drug use, etc.
Burns	Severity of 2nd degree and higher with a total body burn of > 20% in adults & > 10% in children under eighteen (18) years of age
Cancer	Metastatic, End-Stage, new diagnosis, chemo regime complications
Chronic Kidney Disease	Stage 3b, 4 or 5, acute admissions w/worsening renal function
Chronic Obstructive Pulmonary Disease	Oxygen-dependent, frequent hospitalizations, noncompliance w/medications
Cognitive and Intellectual Disability	Environmental and functional impairments
Complex Wound Care	Wound Vacuum & Stage III, IV. IV antibiotic therapy. Hx of nonhealing wounds despite POC

Diabetes Mellitus	Complications including neuropathy, retinopathy, or nephropathy, newly diagnosed renal failure, new amputation and/or HbA1c 10 or greater.
Dialysis	Any member new to dialysis or member currently receiving dialysis (hemodialysis or peritoneal dialysis)
End of Life Care	Hospice, Advance Directives, Living Will, Palliative Care
High Risk Obstetric and Neonatal care	Premature births, complex discharge, multiple gestation, Medical co-morbidities of mother, pre-eclampsia, OB plan of care requires close surveillance.
HIV/AIDS/ARC	Complications, challenges w/ maintaining a pharma regime, financial challenges w/medications
Multiple Sclerosis	New diagnosis, Chronic w/relapsing or deteriorating functional status, symptoms that are affecting ADL's.
Oral Health	Impaired hygiene, chronic disease, and frequent hospitalizations
Spinal Cord Injury	Recent-onset or chronic complications (skin, urinary, respiratory)
Severe and Persistent Mental Illness	Including schizophrenia, schizoaffective disorder, and bipolar disorder
Sickle Cell Disease	New Onset and/or Exacerbation, uncontrolled pain management, or chronic complications
Stroke	Acute onset, residual impairments, medication non-adherence, inconsistent family support or resources
Suicide Attempt	Initial/multiple attempts. Complex SDoH challenges, any inpatient admission
Transgender	Individuals considering gender reassignment, psychosocial needs
Traumatic brain Injury	Acute injury requiring extended inpatient admissions and/or complex rehab needs.
Physical, Sexual, Emotional Violence/Abuse/Neglect	May include: Child Abuse, Spousal Abuse/Domestic Violence, Elder Abuse, Gun Violence

APPENDIX B: 2023 Utilization Management Timeframe Requirements

(Medicare Advantage HMO line of business)

MEDICAL AND BEHAVIORAL HEALTH UM DECISION TYPE	UM DECISION- MAKING / NOTIFICATION TIME FRAME
Non-urgent pre-service determination *(approval and denial)*	Within 14 calendar days of receipt of request, including the collection of all necessary information; including notification to practitioner and member. In a situation beyond the IPAs control, (e.g., waiting for an evaluation by a specialist), it may extend the non-urgent pre-service time frames once, for up to 14 calendar days. Within 14 calendar days of pre- service request, the organization notifies the member (or the member's authorized representative) of the need for an extension and the expected date of the decision.
Urgent Pre- certification/Pre-Service includes Specialist Referrals *(approval and denial)*	Within 72 hours of receipt of request, including the collection of all necessary information (no additional time is allowed for obtaining information), including notification to practitioner and member. Members or their authorized representative may agree to extend decision-making time frames for urgent, pre-service, and post-service requests.
Certification and Initial Review Process for emergent/urgent Admissions	Within 72 hours of admission or notification of admission.
Concurrent *(approval and denial)*	Within 24 hours of receipt of request, notification of practitioner(s) within 24-hour timeframe. If the IPA states in their UM Plan that the practitioner may assume approval of continued stay unless they are informed otherwise, then the practitioner does not need to be notified of continued stay approval. Excludes those identified by the IPA as not requiring review. Include additional criteria used in decision-making.
Retrospective/ Post-service	Within 30 (thirty) calendar days of receipt of the request. If the decision results in a denial, the member and practitioner(s) must be notified in writing by mail, fax, or e- mail within 30 calendar days of the receipt of request. In a situation beyond the IPAs control, (e.g., waiting for an evaluation by a specialist), it may extend the non-urgent pre-service time frames once, for up to 15 calendar days. Within 30 calendar days of post-service request, the organization notifies the member (or the member's authorized representative) of the need for an extension and the expected date of the decision.
Appeals	Refer to the language included in the denial letter. ***Not delegated to the IPA's for any line of business***
Note: Timeframes are monitored and audited during the IPA Annual Adherence Audit. IPA policies and procedures must address timeframes, and reference controls in place to monitor and correct any discrepancies identified.	

APPENDIX C: 2023 HMO and Delegate Responsibility Matrix (UM & Population Health Management)

BCBSIL HMO Utilization Management Delegation Matrix			
Delegated Activity	**Health Plan Responsibilities**	Delegate Responsibilities	**Delegate Reporting Requirements**
Program Structure	Health Plan retains accountability for the structure of the UM Program, including the HMO Program Description. HMO ensures the involvement of HMO Medical Directors in design and structure of the UM program. All medical necessity decisions are delegated to the member's Primary Care Physician. HMO oversight activities are reported at Health Plan UM Workgroup and Health Plan Quality Improvement Committee.	Delegate will develop its own MA Utilization Management Plan and submit to the Health Plan for approval annually. Delegate will implement its MA UM Program, in alignment with Health Plan MA UM Program structure. Delegate will ensure IPA Medical Director involvement and, as applicable, BH Medical Director involvement in the delegates UM program. Delegate is responsible for all medical necessity and clinical decision- making activities.	Annually, the delegate will provide HP with the delegates MA UM Program Description, policies, and procedures, and required 'UM Plan Attachments' relating to all delegated functions. The delegate will upload their monthly UM/QI Committee meeting minutes. Meeting Minutes must document active involvement of physical medicine and Behavioral Health/SUD Medical Directors in the UM program
Clinical Criteria for UM Decisions	The HMO delegates the selection, annual review, application, and dissemination of nationally recognized clinical criteria to the IPA. HMO Clinical Practice guidelines are available to additionally assist Delegate in making determinations.	The IPA will follow CMS guidelines (NCD and LCD). If NCD and LCD guidelines do not address the request, delegate maintains responsibility for selection of nationally recognized clinical criteria (including behavioral health and substance use disorder), the development of additional UM criteria, if necessary and for informing all practitioners of the availability of criteria upon request. Delegate will evaluate consistency in the application of UM criteria, and timeliness for all staff involved in the UM process semi-annually.	Annually, Delegate will provide evidence of notice sent to practitioners advising about the availability of criteria. Annually, the delegate will provide HP with tracking log indicating when they have provided criteria to practitioners upon request. Semi-annually, delegate will provide a report on the consistency of application of criteria.

Communication Services	HMO delegates responsibility of notification of members and practitioners regarding access to UM staff for questions related to UM.	Delegate maintains responsibility for notification of members and practitioners regarding access to UM staff for questions about UM . Delegate maintains responsibility for notifying members of all programs available to them.	IPA will provide evidence of notices on an annual basis.
Appropriate Professionals	HP delegates the policies and procedure requirements for: • Appropriate Use of Professionals for UM Decision Making • Denials and Adverse Determinations, including Benefit Denials. • Use of Board-certified Specialists • Notification of Staff, Members, and Providers of its Affirmation Statement on an annual basis.	Delegate ensures that all MA UM decisions are made by appropriate professionals, per HP policies. This includes all medical and behavioral health determinations. Delegate will ensure that board-certified consultants are used, as needed, for medical necessity decisions, following HP policies Delegate will notify its own staff, existing and newly employed practitioners, and new members of is affirmative statement regarding incentives.	Annually, Delegate will upload their Policies and Procedures for Appropriate Professionals and use of Board-Certified Consultants. Annually, IPA will provide evidence of its Affirmation Statement.
Timeliness of UM Decisions	HMO monitors Delegate Timeliness of UM Decisions. This is done through oversight of adverse determination timeframes monthly, and review of Delegate Inter-Rater Reliability Adherence to Timeframe Audits.	Delegate will ensure that all MA UM decisions (medical and behavioral health) are made within timeliness standards (as outlined in the Utilization Management Timeframe Requirements section of this plan.) Delegate maintains responsibility for timeliness of all MA UM decisions.	Adherence to Timeframe Audits must be conducted and documented as having been discussed in the UM/QI Committee Meeting Minutes.
Clinical Information	Health Plan does not make any medical necessity decisions based on clinical information.	Delegate will ensure that all UM decisions (medical and behavioral health) are made with appropriate clinical information.	Delegate will submit appropriate UM Criteria and relevant clinical information of each denial via the HMO Provider Portal

Denial Notices	The HMO conducts monthly oversight of Delegate Denials and provides feedback and education and requests for corrective action as needed.	Delegate is responsible for ensuring the following for all denial's notices (medical and behavioral health): ▪ The right to discuss the denial with a reviewer ▪ Written notification to the member and practitioner of the reason for denial in easy-to-understand language and specific to the member ▪ The specific criteria used to make the decision ▪ The right to obtain a copy of the criteria upon request. ▪ Appeal rights, including timeframes to appeal, timeframes for completing the review, and member rights to submit documentation, be represented, IRO review and how to use state department of insurance to support them in the appeal. ▪ A member non-discrimination notice should be provided with all medical group approvals and denials pursuant to Section 1557 of the Affordable Care Act. ▪ Review by appropriate practitioner. BH denials must be reviewed and signed by the BH Medical Director.	Quarterly report of Denials which includes: ▪ Total number of denials by type
Appeals	HP maintains accountability for all first and second level member appeals, including maintenance of appeals policies and procedures. Livanta utilized as indicated. (Livanta is a Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO). BFCC-QIOs are responsible for medical case review, which supports the rights of people on Medicare. These rights include protecting you when you get health	Delegate is responsible for informing members regarding appeal rights. Appeal rights are included in the denial letter. Delegate must also explain member appeal rights in the New Member Welcome Letter.	None.

	care and making sure you get the health care services the law says you can get. BFCC-QIOs can help you if you have a concern about the care you have been receiving or if you want to request a review (appeal) of your discharge from a health care facility.)		
Evaluation of New Technology	HP maintains accountability for evaluation of all new technology for incorporation as a benefit.	To contact the HP for information related to New Technology benefit requests.	None.
UM Denial System Controls	Health Plan Provides a Denial Management Documentation Platform to the IPA via the HMO Provider Portal. The Health Plan will have a written policy and/or procedure describing internal system controls specific to UM denial notification and receipt dates. BCBSIL HMO also uses the delegates' approved policies and procedures to support UM structural requirements. HMO Clinical Delegation Coordinators will audit UM Denial System Controls during the case file review portion of the Utilization Management and Population Health Management Plan Semi-Annual Adherence Audit	Annually, the Delegate will submit their policy/procedure describing internal system controls specific to UM denial notification and receipt dates. Quarterly, the IPA audits their internal denial system controls by: • Analyzing all changes to receipt dates and decision notification dates, including reasons for the change; • Analyzing instances of date changes that did not meet the modification criteria; • Taking actions based on findings related to changes made to the date of receipt and date of written notification. Audit results will be discussed in the IPA UM/QI Committee meeting and the discussion will be documented in the minutes and uploaded to the IPA Provider Portal with the audit report and any corrective actions, if indicated.	Annually, the Delegate will upload the UM Denial System Controls Policy/procedure to the HMO Provider Portal. Findings will be discussed at the delegate's UM/QA Committee Meeting with discussion documented in the Meeting Minutes. Denial system audit reports are to be submitted quarterly to the HMO Provider Portal. If audit results require intervention, the IPA will upload an improvement plan to the IPA Provider Portal.

Oversight of Delegated Activities	HP reviews Delegate UM activity monthly, quarterly, semi-annually, and annually as outlined in the MSA and the HMO UM and Population Health Plan. The HMO provides feedback, educational interventions and/or requests for corrective action for any deficiencies identified.	Delegate shall cooperate and fully participate in audits, site visits and other monitoring of delegated activities conducted by the HP. Deficiencies and Corrective Action Requirement: In the event deficiencies are noted during audit or within required report submissions, delegate shall develop a corrective action requirement for the specific Delegated Activity that is determined by HP to be deficient, and which shall include specifics of and timelines for correcting the deficiency and shall be provided to HP within 14 calendar days of HP report of its findings. The corrective action shall be implemented by delegate within the specified timeframes listed therein.	Annually, the delegate will provide HP its MA Utilization Management and Population Health Management Program Description as well as their policies and procedures. Annually, the delegate will provide HP with all documents required to conduct the annual audit of the MA UM and Population Health Management Program.