*HMOs of BLUE CROSS AND BLUE SHIELD OF ILLINOIS

2017
Utilization Management and
Care Coordination Plan

Approved BCBSIL UM Workgroup: November 22, 2016
Approved BCBSIL Quality Improvement Committee: November 30, 2016

HMO Illinois®, Blue Advantage HMO℠, Blue Precision HMO℠
BlueCare Direct HMO℠, Blue Focus Care HMO℠

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 .................................................................................................................. 4
- Introduction .................................................................................................................. 6
- HMO Delegation Oversight .......................................................................................... 7
  - IPA Delegation Requirements and Responsibilities .................................................. 8
  - IPA Utilization Management and Care Coordination Plan .......................................... 8
  - IPA Sub-Delegation Requirements and Responsibilities ............................................. 8
- HMO Structure, Resources and Goals .......................................................................... 9
- HMO 2017 Utilization Management and Care Coordination Plan Goals .......................... 10
- HMO Utilization Management Program and Oversight ................................................. 13
  - Appeals ...................................................................................................................... 14
- HMO Care Coordination Program Oversight ................................................................ 16
- IPA Utilization Management and Care Coordination Structure and Resources ............... 16
  - IPA Physician and Staff Requirements ..................................................................... 16
  - Job descriptions and Staff Training .......................................................................... 18
- IPA Utilization Management Program ........................................................................ 19
  - IPA UM Committee Requirements ........................................................................... 19
  - Complaints ............................................................................................................... 20
  - Inter-rater Reliability .................................................................................................. 20
  - Time Frames Adherence Review ................................................................................ 21
  - Ensuring Appropriate Utilization .............................................................................. 21
  - PCP Site Visit Results ............................................................................................... 21
  - Assessing Member and Practitioner Experience with the UM and Care Coordination Programs .................................................................................................................. 21
- IPA Utilization Management and Care Coordination Plan: Supporting Documentation Requirements .................................................................................................................. 22
- URO Registration: Illinois Department of Insurance ..................................................... 22
- Policies and Procedures ............................................................................................... 22
- IPA Utilization Management Requirements ................................................................ 24
  - Requirements for UM Decisions ................................................................................ 24
  - UM Criteria for Decision Making .............................................................................. 24
  - Notification of Availability of Clinical Criteria ............................................................. 25
  - Services not Meeting Medical Criteria ...................................................................... 25
  - Medical Necessity and Benefit Determinations ........................................................... 26
UM Affirmation Statement .............................................................................................................. 26
Access to UM Staff .......................................................................................................................... 26
Prospective/Pre-Certification/Pre-Service Process ....................................................................... 27
Initial Review- Emergent/Urgent Certification ............................................................................... 27
Initial Review-Non-Urgent Precertification .................................................................................... 28
Concurrent Review .......................................................................................................................... 28
Discharge Planning .......................................................................................................................... 29
IPA Referral Process ....................................................................................................................... 30
Required Elements in the Referral ................................................................................................. 30
IPA Denial Process for Medical and BH Services ........................................................................... 31
IPA Behavioral Health Requirements .............................................................................................. 32
Termination of Benefits (TOB) ........................................................................................................ 33
Transition of Care ............................................................................................................................ 35
Emergency Services ........................................................................................................................ 35
Maternity Discharge Program ........................................................................................................ 35
Organ Transplants ........................................................................................................................... 36
Out of Area / Out of Network Admissions ..................................................................................... 36
Infertility ............................................................................................................................................ 36
ACSC Analysis .................................................................................................................................. 36
IPA Care Coordination Programs Structure and Resources ............................................................ 37
Disease Management Programs ..................................................................................................... 39
Asthma Disease Management Program ....................................................................................... 42
Diabetes Disease Management Program ........................................................................................ 45
Case Management Program ........................................................................................................... 48
Complex Case Management Program ............................................................................................. 49
Complex Case Management Program Referral and Data Sources ................................................ 50
IPA Complex Case Management Requirements ................................................................................ 51
APPENDIX A: 2017 Complex Case Management Guideliiens .......................................................... 55
APPENDIX B: 2017 Utilization Management Timeframe Requirements .......................................... 56
APPENDIX C: Care Coordination Incentive Program Targets and Weight ....................................... 57
APPENDIX D: HMO and IPA Delegation Responsibility Matrix ..................................................... 58
Definitions

ACSC- Is the abbreviation for Ambulatory Care Sensitive Conditions.

Adherence Audit- The delegation oversight audit conducted by HMO Nurse Liaisons. This audit encompasses all IPA delegated responsibilities as outlined in the Medical Service Agreement (MSA) and HMO Utilization Management and Care Coordination Plan.

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

CAHPS Survey- The Consumer Assessment of Healthcare Providers and Systems 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.

Care Coordination Program (CCP)- The overarching terminology which refers to the Disease Management, Case Management and Complex Case Management programs.

Case Management (CM)- Is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy to meet an individual and family’s comprehensive health needs through communication and available resources to promote quality and cost effective outcomes (CMSA).

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.

Denial- A denial of services for the requested treatment of a member that does not appear to 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.

Depression Screening- For purposes of the Disease Management Program, the following types of Depression Screens are acceptable: PHQ, M3, HAMD and MADRS. 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.

Disease Management (DM)- A 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 healthy lifestyle. Members are stratified into two tiers based on the severity of their condition, and indicate the type of interventions that are required.

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- Five health maintenance organizations exist within the managed care structure of Blue Cross and Blue Shield of Illinois (BCBSIL). They are HMO Illinois (HMOI), Blue Advantage HMO (BA HMO), Blue Precision HMO, Blue Care Direct HMO and Blue Focus Care HMO. Except where distinctions are made, the five programs will be referred to as the HMO.
HMO Medical Director- The HMO Medical Director oversees all aspects of the HMO clinical programs. At times, the HMO Medical Director may temporarily appoint an additional BCBS Medical Director(s) to assignments in order to ensure continuous and/or specialty coverage, when needed.

Initial Assessment (IA) - Means 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 take place within 30 days of eligibility for Complex Case Management. 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 the eligibility period.

IPA - The overarching terminology utilized in this document which refers to an Individual 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.

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

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

Utilization Management and Care Coordination Plan - Is the plan that contains the essential requirements for the establishment and implementation of a utilization management process and Care Coordination to ensure the quality, appropriateness and efficiency of care and resources furnished by the IPA and IPA Providers, and documents all delegated UM and CM functions to entities such as a Contract Management Firms (CMF) or Behavioral Health Vendors, if applicable. The purpose of the Utilization Management and Care Coordination Plan is to ensure that HMO member utilize services appropriately and receive necessary care provided by the DM, CM and CCM process.

Verscend (Formerly Verisk Health) - Data Analytics Tool made available to IPAs by the HMO, which allows the IPAs to review member utilization patterns and gaps in care.

Wellness Program - Refers to the process of supporting members in actively making decisions to achieve optimal physical, mental and social well-being. This includes, but is not limited to education and tracking of preventive health screenings. Closure of ‘care gaps’ is accomplished by outreaching and educating members of the need for preventive and health maintenance services.

-Please reference your Medical Services Agreement (MSA) for additional definitions that may not be found here-
Introduction

HMO Illinois®, Blue Advantage HMOSM, Blue Precision HMOSM BlueCare Direct HMO SM, and Blue FocusCare HMO SM (hereinafter the "HMO") of Blue Cross and Blue Shield of Illinois (BCBSIL), a Division of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, grants full delegation of the Utilization Management Program (UM) and partial delegation to the Complex Case Management (CCM), Case Management (CM) and Disease Management (DM) programs 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 Coordination processes to ensure the quality, appropriateness, and the efficiency of care and resources furnished by the IPA Providers for BCBSIL HMO members.

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 HMO. The HMO’s decision about whether any medical service or supply is a covered benefit under the member’s 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 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 Utilization Management and Care Coordination 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 other HMO products in which it participates;
c) Demonstration of successful implementation of the IPA UM and Care Coordination Plan while striving for improvement in member and practitioner experience, as demonstrated in the HMO PCP and member surveys, with identified areas for improvement addressed by the IPA;
d) Demonstration of satisfactory performance on Quality, UM and Care Coordination delegation oversight Adherence and site visit audits;
e) Demonstration of compliance with all other HMO UM requirements;
f) Demonstration of an effective Care Coordination Program;
g) Demonstration of the functional ability and process of the IPA’s to carry out the mandates of the UM and Care Coordination Programs; and
h) Demonstrated ability to meet all regulatory and accreditation requirements of the HMO.
HMO Delegation Oversight

The HMO delegates performance of Utilization Management and Care Coordination Plan responsibilities to the IPAs in the HMO network. The Medical Service Agreement (MSA) and HMO UM and Care Coordination Plan delineate the responsibilities of the IPAs, as well as the HMO’s responsibility and mechanisms for oversight. With oversight of the Utilization Management and Care Coordination Plan responsibilities, the objective of the HMO is to monitor the IPA UM decision-making processes and to ensure compliance with the standards as set forth in the 2017 HMO Utilization Management and Care Coordination Plan. An ongoing assessment of the IPA’s functional capacity to implement the HMOs Utilization Management and Care Coordination Plan mandates will continually be assessed.

Delegated Utilization Management and Care Coordination Plan responsibilities must be consistently performed within the parameters set forth in the 2017 HMO Medical Services Agreement (MSA) and the 2017 HMO Utilization Management and Care Coordination Plan. Within this structure and its own process capabilities, the IPA has the opportunity to design a Utilization Management and Care Coordination Plan that is suited to its unique practice environment as long as all HMO minimum requirements, as outlined in the HMO Utilization Management and Care Coordinator Plan are met.

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

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. Clinical practice guidelines are designed to assist IPA Physicians. 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 Scope of Benefits, detailed within the HMO Provider Manual, describes the benefits available to HMO member, not the medical appropriateness of the benefit for the individual. Therefore, the HMO Scope of Benefits should only be utilized as a reference for the IPA to develop their policies and procedures for UM decision making. The HMO Scope of Benefits may not be cited in denials or adverse determinations.

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

Non-compliance with the Utilization Management and Care Coordination Plan requirements will result in corrective action until compliance is achieved. Any failure of the HMO Adherence Audit requires a written Corrective Action Plan (CAP) and immediate remediation of the failing components of the Audit. Non-compliance with the Utilization Management and Care Coordination Plan requirements may additionally result in the IPAs ineligibility to earn certain incentive payments as outlined in the MSA. The HMO may terminate the delegation agreement with the IPA for non-compliance with the Utilization and Care Coordination Plan depending on the severity of the infraction, or continued non-compliance with the Plan.
IPA Delegation Requirements and Responsibilities

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

The IPA Utilization Management and Care Coordination Plan must:

a) Be reviewed and approved annually with approval documented in the IPA UM Committee minutes;
b) Describe the Behavioral Health (including substance use disorder) and non-BH aspects of the UM Plan;
c) Designate a licensed, board certified psychiatrist to be involved in the implementation of all BH aspects of the IPA Utilization Management and Care Coordination Plan.

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

IPA Sub-Delegation Requirements and Responsibilities

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

It is the responsibility of the IPA to review and approve any sub-delegates program components prior to submitting the IPA UM and Care Coordination Plan and completed compliance tool to the HMO Provider Portal by February 15, 2017. Only one (1) IPA UM and Care Coordination Plan and one (1) Compliance Tool which documents all IPA (medical and behavioral health) delegated or non-delegated UM and Care Coordination Plan components will be accepted by the HMO. The HMO Nurse Liaison reviewing the IPA Utilization Management and Care Coordination 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 (both the Nurse Liaison and HMO Provider Network Consultant) must be notified, in writing, at least 30 days in advance of the date the new entity will assume the delegation oversight. A pre-delegation evaluation of the prospective delegate must be performed prior to delegation to ensure compliance with HMO and IPA requirements. The HMO will request a new Utilization Management and Care Coordination Plan from the IPA and/or sub-delegate. The IPA must submit the new updated Utilization Management and Care Coordination Plan to the HMO within 30 days of the change in delegation.

The IPA Utilization Management and Care Coordination Plan must describe any sub-delegated responsibilities of the Utilization Management and Care Coordination 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. The sub-delegated entity is responsible for performing all IPA UM activity for which it is
contracted with the IPA. Sub-delegates must meet the HMO UM standards set forth in the HMO Utilization Management and Care Coordination Plan and be clearly documented within the IPAs Utilization Management Care Coordination 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 UM and Care Coordination Plan components;
b) Annual evaluation of sub-delegate against HMO and IPA requirements;
c) Review of monthly, quarterly, semi-annual 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) Oversight of the sub-delegates UM/QI Committee activities.

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 renewals must be submitted timely to the HMO. Proof of current URO licensure must also be submitted to the HMO Nurse Liaison with the IPA UM and Care Coordination Plan documents on an annual basis.

**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 Utilization Management and Care Coordination Plan is evaluated and revised annually by the HMO UM Workgroup. The HMO Utilization Management and Care Coordination Plan is approved annually by the HMO Quality Improvement 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. HMO partially delegates its Care Coordination Programs: Disease Management (Asthma and Diabetes), Case Management and Complex Case Management. (See Appendix D: HMO and IPA Delegation Responsibility Matrix)

**HMO Quality Improvement Committee**

The HMO Quality Improvement (QI) Committee is chaired by a BCBS-IL Medical Director. The HMO QI Committee has representation from across the BCBS-IL organization. Medical and Behavioral Health Physicians are present at all QI Committee Meetings. The HMO QI Committee is accountable for the oversight of all UM and QI activities managed by the BCBS-IL Plan. All Utilization Management and Care Coordination Plan reports are presented to this Committee. Corrective Action Plans are monitored by this Committee. The identified Utilization Management trends shape future Quality Improvement activities and interventions. Approval of the HMO Utilization Management and Care Coordination Plan is made by the QI Committee.

**HMO UM Workgroup**

The HMO UM Workgroup is chaired by the HMO Medical Director. A BH Medical Director is in attendance along with other members which include the Director of Network Programs, Sr. Manager of Network Programs, UM Nurse Liaisons and HMO Provider Network Consultant(s).
The UM Workgroup’s responsibilities include, but are not limited to, the following:

a) Annual development, review and revision of the HMO UM and Care Coordination Plan, including revision of annual goals; and consideration of the following:
   i. Analysis of the results of HMO UM and Care Coordination Program oversight activities;
   ii. Analysis of previous utilization patterns and related cost;
   iii. Provider and member feedback, communication and complaints;
   iv. Changes in regulatory and accreditation requirements.

b) Oversight of HMO UM and Care Coordination Program policies and procedures to ensure compliance with BCBSIL, Regulatory and Accreditation standards;

c) Oversight and monitoring of all UM and Care Coordination functions delegated to the IPAs, which include but are not limited to IPA UM and Care Coordination Plan compliance, IPA UM and Care Coordination Plan Adherence Audit results, UM and Care Coordination Program case file reviews, IPA submissions and corrective action as applicable;

d) Oversight of IPA monthly complaints and denials;

e) Oversight of the IPA Care Coordination Program requirements with specific reference to the program structure, resources and compliance with HMO requirements;

f) Review of HMO’s Annual Satisfaction Surveys which include Practitioner, Member and Annual Care Coordination Program surveys;

g) Review of IPA UM data to identify potential over or underutilization patterns;

h) Review and analysis of UM information collected for QI purposes;

i) Reporting HMO UM and Care Coordination Program trends and outcomes to the QI Committee for review and approval.

HMO 2017 UM and Care Coordination Plan Goals

a) Receive Utilization Management and Care Coordination Plans from all contracting IPAs via the HMO Provider Portal by February 15, 2017;

b) Ensure all IPA UM and Care Coordination Plans meet or exceed the HMO requirements by April 30, 2017;

c) Ensure all IPA UM and Care Coordination Plans meet legislative, regulatory and accreditation requirements;

d) Provide effective educational programs related to perceived and documented needs of the IPAs;

e) Improve member and PCP experience with the referral process;

f) Improve IPA Physicians awareness of the IPA Care Coordination Programs (Disease Management, Case Management and Complex Case Management);

g) Improve HMO Network Inpatient Utilization; 2017 Targets: Days 258, Admits 64.5, LOS 4.0

h) Evaluate utilization through IPA monitoring of avoidable inpatient days;

i) Ensure compliance with BH triage, including Substance Use Disorder and referral requirements;

j) Improve HMO Network Behavioral Health Utilization; 2017 Targets: Days 30.34, Admits 4.1, LOS 7.4
k) Meet Accreditation Standards (NCQA, URAC) and pertinent federal and state legislative and regulatory requirements (Illinois Department of Public Health, Illinois Department of Insurance).

**HMO Staff**
The following staff is employed by the HMO to provide oversight of the delegated UM and Care Coordination functions performed by the IPA:

a) Licensed physician(s), including the HMO Medical Director, are directly responsible for oversight of the HMO UM and Care Coordination Plan;

b) The Director of Network Programs is a licensed Registered Nurse providing oversight of all UM and Care Coordination Program functions;

c) The Sr. Manager of Network Programs is a licensed Registered Nurse, responsible for monitoring the activities of the UM staff, tracking network performance, designing UM interventions, and reporting IPA UM and Care Coordination Program (CCP) compliance and UM and CCP network activity;

d) Nurse Liaisons, all of whom are licensed Registered Nurses, are responsible for monitoring each IPA’s Utilization Management and Care Coordination Plan delegated activities and performance.

**HMO Monitoring and Oversight of IPA**
The HMO Staff will review required IPA submissions monthly, quarterly, semi-annually and annually as outlined in the MSA and the HMO Utilization Management and Care Coordination Plan.

a) The HMO provides regular feedback to the IPAs with monthly paid claims and quarterly utilization reports. HMO Staff 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) For selected IPAs, the HMO will voluntarily provide educational interventions to assist their progress. These interventions may include comprehensive and detailed UM or CCP in-services, focused educational activities targeted to specific problem areas, document review and/or on-site UM or CM 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) Through selected QI indicators and studies, the HMO has the opportunity to monitor 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, Disease Management, Case Management and Complex Case Management Program
performance or any other identified potential issue. In addition, member Survey and PCP Survey
data are reviewed annually for each identified IPA;
f) By contract, the HMO reserves the right to have HMO staff attend the IPA’s UM/QI Committee
meetings in order 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 UM activity is performed according to the HMO’s
Plan requirements and the MSA, however, such oversight shall not relieve the IPA of its
obligations to perform the UM functions in accordance with all applicable HMO policies,
procedures, and agreements;
g) The HMO UM Workgroup 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;
h) When deemed appropriate, a corrective action plan 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 BCBSIL HMO Medical Director, the HMO Nurse Liaisons provide oversight
of UM and Care Coordination Program delegated functions on an ongoing basis. Oversight includes
but is not limited to:
a) Annual review and approval of IPA Utilization Management and Care Coordination Plan;
b) Review of random sample of Disease Management, Case Management and Complex Case
Management files;
c) Monthly review of Disease Management and Case Management Logs;
d) Monthly review of complaint submissions;
e) Monthly review of Medical Necessity Denials;
f) Monthly review of data sources and referral source IPA submissions;
g) Quarterly review of Blue Precision, Blue Care Direct, and Blue Focus Care HMO referral logs;
h) Oversight of the Termination of Benefit (TOB) process;
i) Quarterly review of UM statistical reports;
j) Review of IPA Ambulatory Care Sensitive Condition annual analysis;
k) Performing IPA Adherence Audits.

Adherence Audits
A Nurse Liaison performs an audit of the IPA Utilization Management and Care Coordination 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 Utilization
Management and Care Coordination Plan requirements. Audit scores are reviewed with the IPA at the
time of the audit. The IPA must score at least 90% in order to achieve a passing score.

Any IPA that receives a failing score is required to submit a corrective action plan (CAP) within 30 days of
the date on the audit results letter. The corrective action plan must meet minimum guidelines as
established by the HMO. The Nurse Liaison monitors receipt of the corrective action plan and reviews it
for completeness. 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 Utilization Management and Care Coordination Plan Adherence Audit:

a) Case File Reviews (DM, CM, CCM);
b) Review of UM Committee Meeting Minutes;
c) 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;
d) Interview of the IPA’s UM and Care Coordination Staff to discuss the DM, CM, and CCM processes;
e) Discussion of audit results and any pertinent data reflecting the IPA performance.

**HMO Utilization Management Program Oversight**

**Overview**
The HMO UM Program is designed to ensure that Medical and Behavioral Health services are medically necessary and appropriate, as well as in conformance 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 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 in order 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) Outpatient surgery/1,000 member;
e) ER visits/1,000 member;
f) Mental health days/1,000 member;
g) Substance Use Disorder days/1,000 member;
h) Assessment of member and PCP experience with the referral process (Annual survey);
i) IPA 30-day re-admission rate (HEDIS methodology);
j) Ambulatory-Care-Sensitive Conditions (ACSC) Program;
k) Avoidable days.

Data is collected at the network and individual IPA levels. Thresholds for intensified review by the HMO UM Workgroup are established based on a statistical analysis of an IPA’s performance in relation to overall network performance. The HMO UM Program contains utilization goal benchmarks that are set based on all BCBSIL products. In addition, MCG benchmark performance data (for moderately managed
health plans) are used as a guide.
The HMO additionally collects a variety of member and practitioner data including, but not limited to, Member and Practitioner experience with the IPA referral process using data collected from the HMO annual member and practitioner satisfaction surveys.

**Appeals**
The HMO does NOT delegate any appeals to the IPA.

The HMO will facilitate the appeal process according to Legislative Requirements (DOI, CMS) and National Committee of Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC). The IPA is responsible for explaining all levels of appeal (pre-service, post-service, expedited and external) and the appeal process to the HMO member. IPA instructions and procedures for member initiated appeals with the HMO must be listed within the new member welcome letter.

All levels of appeal may be initiated by either the member, the member’s attorney, the Practitioner(s) acting on behalf of the member, or other member representatives. Retrospective (post-service) member appeals are permitted.

The HMO requires that the IPA provide Practitioner(s) with an appeals process in addition to a member appeals process for all denied services. The IPAs are required to use the HMO denial letter template and required attachments that include instructions about appeal rights. The Appeals attachment is based on the member Plan:

a) HMOI, Blue Advantage HMO, Blue Precision HMO and Blue Care Direct HMO – R (Group Plan)
b) Blue Precision HMO, Blue Care Direct HMO and Blue Focus Care HMO – I (Individual Plan)

Please note that the correct Appeals attachment must be used for all denials and termination of benefit letters.

Continued coverage must be provided to the member pending the outcome of an internal appeal for covered services.

The HMO reserves the right to modify or amend the denial and appeals policies or procedures in order to meet any legislative or regulatory requirements, as determined by the HMO.

**Standard Appeals (Pre and Post Service)**
The IPA denial letter states that the HMO has written policies and procedures regarding appeals that address the following:

a) Allowing at least 180 calendar days after receipt of notification of the denial for the member to file an appeal;
b) Documentation of the substance of the appeal and action taken;
c) Full investigation of the appeal, including aspects of any clinical care involved;
d) The opportunity for the member to submit written comments, documents or other information relating to the appeal;
e) Appointment of a new person for review of the appeal who was not involved in, or a subordinate to anyone involved in the previous review;
f) For medical necessity appeals, the case must be reviewed by a Practitioner of the same or similar specialty as the managing Practitioner;
g) The decision and notification to the member or Provider must be made within 15 business days
of receipt of the request for standard appeals;
h) There must be notification about further appeal rights including the appeal process and notification of the contact information for the Department of Insurance;
i) There must be procedures for providing the member access and copies of all documents relevant to the appeal, free of charge and upon request;
j) An authorized representative, or attorney must be able to act on the member’s behalf;
k) Procedures for expedited pre-service appeals, which include the initiation, decision and notification process; and
l) Policies for providing notices of the appeals process to member in a culturally and linguistically appropriate manner.

**Expedited Appeals**
An expedited appeal may be requested if proposed or continued services pertain to a medical condition that may seriously jeopardize the life or health of a member or if the member has received emergency services and remains hospitalized. If the member is hospitalized, the member may continue to receive services with no financial liability until notified of the decision.

The HMO has procedures for registering and responding to expedited appeals which include:
a) Allowance of oral or written initiation of an expedited appeal by the member, his/her authorized representative, physician, facility, or other health care provider acting on behalf of the member;
b) Decision and notification to the party filing the appeal and Practitioner as quickly as the medical condition requires, but in no event more than 24 hours after the submission of the appeal, or collection of the information that the HMO requires to evaluate the appeal;
c) Electronic or written confirmation of the decision must be made within this timeframe;
d) Notification that expedited external review can occur concurrently with the internal appeals process for urgent care and ongoing treatment.

**External Appeals**
Requests from the Practitioner(s) and or member for an external appeal should be directed to the HMO Customer Assistance Unit, by calling, (312)-653-6600.

**New and Existing Medical Technology**
Medical Policies represent guidelines for use in making health care benefit coverage determinations on particular clinical issues, including new treatment approaches and medical technologies. HMO evaluates emerging medical technologies as well as new applications of existing technologies through BSBCIL’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.

**Pharmaceutical Management**
Pharmacy benefits are administered by Prime Therapeutics, BCBSIL’s Pharmacy Benefit Manager, for member’s having this benefit.
HMO Care Coordination Program Oversight

Overview
Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care. (AHRQ- Agency for Healthcare Research and Quality)

The HMO Care Coordination Programs are designed to assist members in navigating the healthcare continuum from wellness through end of life care. Objectives match those of The Triple Aim: Improving Quality, Improving Member Experience and Decreasing Costs. The programs place the member at the center of the healthcare system. The programs employ a population health approach striving to accurately identify and stratify members to ensure appropriate interventions for the right patient, in the right setting, at the right time. The HMO Care Coordination programs include Disease Management, Case Management and Complex Case Management.

The HMO Care Coordination Programs are delegated to each of its participating IPA’s. The health plan offers assistance in achievement of delegated activities by providing health plan claim and encounter data reporting and pharmacy data reporting to the IPA’s on a monthly basis.

The health plan monitors Member Satisfaction with the Disease Management, Case Management and Complex Case Management Programs on an annual basis by sending mailed surveys to all members enrolled in the programs. This portion of the Care Coordination Programs is not delegated to the IPA.

Lastly, the HMO monitors the Effectiveness of the Disease Management, Case Management and Complex Case Management Programs on an annual basis. Analyses of the effectiveness of these programs shape the structure of the programs in subsequent years. (See Appendix D: HMO and IPA Delegation Responsibility Matrix)

IPA Utilization Management and Care Coordination Program Structure and Resources

IPA Physician, UM and Care Coordination Program Staff Requirements
The IPA must clearly identify the staff responsible for specific activities in their Utilization and Care Coordination 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 UM Committee. A description of the UM staff’s title and professional designation should be detailed in the IPA UM and Care Coordination 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.

IPAs must have appropriate staff to perform UM and Care Management functions. A roster of the IPA staff documenting name, title and credentials is required with the annual submission of the UM and Care Coordination Plan. Any change in the IPA staff needs to be reported, in writing, to the HMOs within 30 days of the change.
All physicians practicing participating within an IPA must be currently licensed, without restriction to practice medicine in the state of practice and 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 must be submitted with the IPA UM and Care Coordination Plan. Copies of licenses are not required. The HMO will verify physician licenses from a list provide by the IPA.

The minimum staffing requirements are as follows:

1. **IPA Medical Director**
   The IPA Medical Director is a board certified, licensed physician who:
   a) Supervises all UM decision-making, including denials
   b) Monitors the implementation of IPA Utilization Management and Care Coordination Plan;
   c) Makes the final decision regarding utilization determinations;
   d) Consults as appropriate with the PCP in utilization decisions;
   e) Oversees the analysis of trends, profiling, and long term IPA planning;
   f) Oversees all Care Coordination Program activities;
   g) Is responsible for satellite and CMF oversight, if applicable;
   h) 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, licensed physician who is responsible for oversight of the Behavioral Health (BH) and Substance Use Disorder (SUD) program as follows:
   a) Supervises all Behavioral Health and SUD UM decision-making, including denials;
   b) Monitors the implementation of IPA UM and Care Coordination Plan;
   c) Makes the final decision regarding BH and SUD utilization determinations;
   d) Consults as appropriate with the PCP in utilization decisions;
   e) Oversees the analysis of trends, profiling, and long term IPA planning;
   f) Oversees all BH Care Coordination Program activities;
   g) Is responsible for satellite and CMF oversight, if applicable;
   h) 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 Care Coordination Programs: Disease Management, Care Management and Complex Case Management. 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 Care Coordination Programs within the organization by educating peers and discussing the program’s relevance. The Physician Champion must be identified in the IPA UM and Care Coordination 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 Care Coordination Programs.

4. **Physician Advisor**
   The Physician Advisor (PA) is the licensed physician most directly involved with individual
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, 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 Nurse Liaison with the annual submission of the UM and Care Coordination Plan. There must be a board-certified psychiatrist or licensed clinical psychologist available as needed for BH UM. In addition, the IPA may utilize a certified addiction medicine specialist for Substance Use Disorder.

6. **UM Lead/Supervisor/Manager**
   The UM Supervisor is a health professional who possesses an active 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, who is a health professional and possesses an active 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 or supervised by a licensed professional nurse or physician. Professional staff licensure will be verified annually by the HMO. Registered Nurse license numbers and any other professional licenses must be submitted to the HMO Nurse Liaison with the UM and Care Coordination Plan. The UM Nurse is proficient in the use of medical terminology and nationally recognized medical criteria and is able to 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, usually a medical assistant or nursing assistant, 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.

8. **Case Manager (CM)**
   The Case Manager is a 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, CM and DM 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 UM and Care Coordination Plan. A BH Practitioner (which includes mental health and substance use disorder) job description must also be included with the annual UM and Care Coordination Plan.

The IPA must have a written policy and procedure for training, orientation, and ongoing performance monitoring of clinical and non-clinical utilization review staff. This policy must be submitted to the HMO Nurse Liaison annually, at the time of submission of the UM and Care Coordination Plan.

IPA Utilization Management Program

IPA UM Committee Requirements
The IPA is required to have a UM Committee meeting, with BH and specialist representation, which meets monthly. The purpose of the IPA UM Committee includes, but is not limited to, the review and approval of the annual IPA Utilization Management and Care Coordination Plan, review of ambulatory and inpatient services, behavioral health services, and Care Coordination Program services provided to the HMO members. The minutes of the committee meeting must document the following:

a) Date of the meeting;
b) Chairman and member present, including at least one specialist and one BH Practitioner;
c) Minutes signed by the IPA Medical Director/Chair within five weeks of the date of the last meeting.

The IPA Utilization Management and Care Coordination 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 and Care Coordination Plan. Any revisions to the committee membership must be submitted to the HMO within 30 days of change. The UM and Care Coordination Plan must include a description of the process for its development (i.e. which persons or Committees are responsible for the UM and Care Coordination 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 UM and Care Coordination Plan and is responsible for reporting behavioral health activities to the IPA UM Committee.

The IPA must also have a Quality Improvement (QI) Committee. The UM and QI Committees may be combined as one Committee. Trends and opportunities for improvement identified during the utilization management process assist in shaping future quality improvement activities and interventions.

The scope of the HMO Utilization Management and Care Coordination Plan includes, but is not limited to, oversight of Utilization Management and Care Coordination Plan requirements, including delegated inpatient and outpatient services as follows:

a) Referrals;
b) Inpatient Admissions (Admits/Days/LOS), Transition of Care, Discharge Planning;
c) Diagnostic testing, Therapies;
d) Behavioral Health (BH) which includes mental health and Substance Use Disorder (Acute, PHP, IOP, Residential);
e) Skilled nursing services;
f) Rehabilitation services;
g) Home health care services;
h) Denials;
i) Complaints;
j) Care Coordination Programs: Disease Management (Asthma and Diabetes), Case Management (CM) and Complex Case Management (CCM) and;
k) Termination of benefits.

Complaints
The IPA UM Committee must discuss all complaints (Medical, BH and Substance Use Disorder) received by the IPA related to a HMO member or practitioner. Complaint types include, but are not limited to, Quality of Care, Administrative complaints, or complaints regarding the IPA Complex Case Management Program, CM Program, or DM Programs.

a) Complaints must be submitted to the HMO Provider Portal with reference to specific complaint categories. Discussion of monthly complaints must be documented in the IPA UM Committee minutes. If there are no complaints for the month, that is to be documented in minutes.
b) Quarterly review and discussion at the IPA UM Committee meeting of all complaints must be in summary format using categories of complaints; such as, access, quality of care, PCP issues, CCM, CM, DM, etc. The report must reflect quarterly and year to date findings, and whether or not any trends have been identified.
c) All complaints must be resolved within 30 days. Resolution of the complaints and the timeframe must be documented on the HMO Provider Portal.

Inter-rater Reliability
Semi-annually, the UM Committee must review inter-rater reliability results and document its findings in the UM Committee meeting minutes. All Physicians, Physician Advisors, IPA Medical Directors and UM Staff must be included in this assessment. Inter-rater reliability testing must be performed by a licensed professional peer of the individual being reviewed. Every physician and UM staff member involved in UM decision making must be evaluated for inter-rater reliability.

Inter-Rater Methodology
a) Initially, 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.

- **Consistency in the Application of Nationally Recognized Medical Criteria Review**
  If the application of criteria is not consistent across staff, there should be discussion in the UM Committee meeting minutes regarding the files and any inconsistent application(s) of criteria, along with corrective action, if applicable.
**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 on-site 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.

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 of the HMO PCP site visit results, as posted on the HMO Provider Portal, with discussion of any non-compliance, including corrective action when indicated.

**Assessing Member and Practitioner Experience with the UM and Care Coordination Programs**
The HMO mails satisfaction surveys to a statistically significant number of members and practitioners in order to evaluate their experience with the UM process and IPA Care Coordination Programs. In addition, CAHP survey results, member complaints, and appeals data are reviewed to evaluate satisfaction. The IPAs are not delegated to perform their own surveys. The IPAs are required to discuss the HMO survey results annually in the UM Committee meeting, develop interventions, and evaluate the results of the intervention, specific to PCP and member referral experience, along with the PCP’s knowledge of how to obtain the IPA UM and Care Coordination Plan and UM Criteria. In addition, IPAs are required to implement and document in the UM Committee minutes, intervention plans when non-compliant with the following network goals for the member and PCP surveys:

a) Member referral satisfaction 85% and above;
b) Member satisfaction with the IPA CCM Program 90% and above;
c) PCP referral satisfaction 90% and above;
d) PCPs knowledge of how to obtain the IPAs UM and Care Coordination Plan must be 75% and above;
e) PCPs knowledge of how to obtain the IPAs UM criteria must be 75% and above; and
f) PCPs knowledge of how to refer a member to the IPA CCM Program 75% and above.
IPA UM and Care Coordination 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) or Management Service Organization (MSO) must also be licensed with the state as a URO. A current URO must be in effect at all times and renewals must be submitted timely to the HMO. Proof of current URO licensure must also be submitted to the HMO Nurse Liaison with the IPA UM and Care Coordination Plan documents on an annual basis.

Policies and Procedures
The IPAs must review and revise all UM and Care Coordination Plan related policies and procedures annually. Policies must include, at a minimum: IPA name, name of 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 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;
   d) If no on-site review is performed, this must be documented in the UM and Care Coordination Plan.

2. **Staff orientation/ training/ performance review**

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. **UM Case Closure** due to insufficient information for UM Decision making.
The closure of the case must meet the time frames identified for the type of case being considered.

6. **IPA Referral and Denial Process**
Standing Referrals - A listing of Referral Diagnoses/ procedures/ services/ physicians that do not require review based on historical 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.
   a) Referrals for Out of Network Services (OON) resulting in a denial;
   b) Referrals for Medical Necessity resulting in a denial;
c) Referrals for Benefit Determinations resulting in a denial; and
d) Referrals for all Behavioral Health Specialty services.

7. **Appeals** (not delegated, referred to the HMO Customer Services Department)

8. **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.
   f) Ensure that PHI is returned, destroyed or protected upon termination of the MSA.

9. **Confidentiality** of all medical information maintained by the IPA or Sub-delegated providers is protected from unauthorized use and disclosure.

10. **Information Systems**, security, integrity, storage, disaster recovery.

11. **Tracking avoidable days** forIPA 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> 50% of consenting members, who are determined by the IPA to be at high-risk and those who are enrolled in a DM, CM and 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 transition of care from Pediatric to Adult Care.

15. **Care Coordination Program Policy** describing the IPA Disease Management, Case Management and Complex Case Management programs.

16. **Wellness 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. This list must be submitted with the Utilization Management Committee at minimum, annually.
Management and Care Coordination Plan following the IPA UM Committee approval and documentation of their approval in the meeting minutes. Only new or revised Policies and Procedures must be submitted with the annual Utilization Management and Care Coordination Plan documents.

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: 2017 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;

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.

UM Criteria for UM Decisions
Annually, the IPA UM Committee must review, select, and approve nationally recognized medical criteria used for medical necessity and LOS determinations and document this in the UM Committee Meeting Minutes. The clinical (medical and BH) criteria must be the current version of the selected nationally recognized criteria. The selection process must include credentialed or licensed actively practicing physicians from at least one specialty in each of the IPA high volume specialty areas.

For Substance Use Disorder in accordance with Illinois State Law under HB1530 Enrolled Public Act 097-0437 Section 5, the Illinois Insurance Code Section 370c.1 (on page 7, number 3) states: "Medical necessity determinations for Substance Use Disorders shall be in accordance with appropriate patient placement criteria established by the American Society of Addiction Medicine (ASAM)." Every IPA or delegated BH vendor must purchase and be trained in the use of ASAM criteria for Substance Use Disorder management.

IPA staff must use the most current criteria set that encompasses all medical services including, but not limited to, the following:

a) Medical;
b) Surgical;
c) Outpatient surgery;
d) Behavioral Health which includes mental health and ASAM criteria for Substance Use Disorder;
e) Rehabilitation;
f) Home health care (HHC);
g) Skilled nursing facility (SNF).

In situations where nationally recognized criteria are not available, the IPA may utilize additional guidelines created by the IPA, provided that the guidelines are reviewed and approved annually, including any procedures for their use. The development process of the criteria must include appropriate specialists. Every year, the criteria and procedure(s) must be submitted to the HMO Nurse Liaison with the IPA Utilization Management and Care Coordination Plan. Documentation of review and
approval must be in the IPA UM Committee meeting minutes. The IPA may adopt additional objective criteria, clinical pathways, and/or guidelines that 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 IPA Utilization Management and Care Coordination 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 Utilization Management and Care Coordination Plan for submission to the HMO Nurse Liaison.

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.

Services not Meeting Medical Criteria
For cases that do not meet the nationally recognized medical criteria or for which criteria is unavailable, the IPA Medical Director and/or PA must make a determination taking into account 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 IPA Medical Director and/or PA for determination of medical necessity. For long stay cases (greater than seven days), the cases must be reviewed weekly by the IPA Medical Director and/or PA for continued medical necessity and appropriateness of setting. The physician review must be documented.

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)
g) Physician Notification and date

The IPA must provide the number of PA referrals per month in aggregate, and the number of 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 UM and Care Coordination 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  
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 particular 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 Determinations**

The IPA Utilization Management and Care Coordination Plan must describe the process of making medical necessity (including out-of-network) determinations and benefit determinations and the information utilized in making determinations.

**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, newsletters, or memos to practitioners and employees 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 Utilization Management and Care Coordination 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/TTY services to deaf, hard of hearing or speech impaired member;
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 Utilization Management and Care Coordination 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.

**Prospective, Pre-Certification, Pre-Service Processes**

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

**Pre-Certification and Pre-Service 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) for inpatient admission;
c) Medical criteria met including criteria code for inpatient admission;
d) Non-urgent pre-service determination (approval or denial) within five 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 notification within five calendar days of the receipt of request;
f) Non-urgent pre-service Practitioner notification within five calendar days of the receipt of request;
g) Urgent 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 cases, member notification within 72 hours of receipt of request (IPA policy must state the process for member notification); and
i) For urgent cases, Practitioner notification within 72 hours of receipt of request.

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 all denials, confirmation of the decision must be provided by mail, fax, or secure e-mail.

**Initial Review, Emergent/Urgent Certification**

Certification and Initial Review Process for emergent/urgent admissions is to be completed within
24 hours of admission or notification of admission and includes documentation of the following:
   a) UM decision (approval or denial) made within 24 hours of receipt of the request;
   b) 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 24 hours of receipt of request (IPA policy must state the process for member notification);
   e) Notification of Practitioner(s) within 24 hours of the receipt of request;
   f) Discharge planning needs to be documented within 24-48 hours of admission; and
   g) Home, family, environmental assessment within 24 hours prior to discharge.

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 all denials, confirmation of the decision must be provided by mail, fax, or e-mail.

Initial Review, Non-Urgent Pre-Certification
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.

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) Medical Criteria (nationally recognized) met and Code;
   h) Anticipated Length of Stay (LOS);
   i) Physician Notification Date;
   j) Member Notification Date;
   k) Social, family, caregiver support and home assessment for discharge planning;
   l) Potential Discharge Plan, discharge needs, identification of any barriers (e.g. has no family support, is unable to pay for prescription drugs, discharged to home, but is unable to ambulate and lives on the 2nd floor); and
   m) Case Management Referral, if applicable.

Admissions must be included on the admission log with the patient 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, Skilled Nursing Facility, Home Health Care, and Rehabilitation Facility). A sample admission log must be submitted if the HMO form is not used by the IPA.

Concurrent Review
Concurrent Review Process is the established process that 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) Nationally recognized medical criteria being met (code documented);
d) Additional criteria used in decision-making;
e) Additional assigned length of stay that is consistent with criteria;

f) Notification of member and Practitioner(s) within 24-hour time frame (If the IPA states in their UM and Care Coordination 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 needs to be documented within 24-48 hours of admission and confirmed at discharge; and

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.

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 seventh 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.

For concurrent review of BH (which includes mental health and Substance Use Disorder) 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.

**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 psychosocial factors (ex: housing, financial, caregiver needs);

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.
**IPA Referral Process**

Initiation of the Referral Process requires a written request for all services (as required by the IPA).

The HMO requires the member and Practitioner(s) be notified of the referral decision, within five calendar days of receipt of the request, (including time necessary for any requests for additional information). If the referral is denied, the member and Practitioner(s) must be notified in writing or electronically within the five calendar days.

**Required Elements in the Referral**

All written referrals must include the following elements:

a) Documentation of the date received by IPA;

b) Documentation of the member 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 Referral Requirements**

a) Maintenance of a Referral Inquiry Log by the IPA*;

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). 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. A written denial letter is not required if the member does NOT receive a written referral;

d) The number of inpatient referrals to the Physician Advisor or IPA Medical Director and the number resulting in denial, must be documented in the UM Committee meeting minutes on a monthly basis; and

e) The UM Committee must discuss referral trends and interventions, if indicated, semi-annually and documented in the minutes. Referral data must be tracked and trended by specialty (including BH), with a two quarter comparison for six months of data. This must be documented in the UM Committee minutes semi-annually.

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: (Blue Precision, Blue Care Direct, Blue Focus Care)*

On a quarterly basis IPA will report the number of out of network referrals received for Blue Precision, Blue Care Direct, and Blue Focus Care 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 10th day following the end of the quarter.
Standing Referrals
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. 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 Denial Process for Medical and BH Services
The IPA must have a plan that describes the method for processing all IPA denials (including medical necessity and benefit denials). This process applies to all services included in the Utilization Management and Care Coordination Plan and must meet the following requirements:

a) All cases that do not meet nationally recognized medical criteria must be reviewed by the IPA Medical Director and/or PA with the decision rendered and documented within the appropriate UM time frame (non-urgent pre-service - within five 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). The IPA Medical Director or PA must determine whether the care should be approved or denied in medical necessity, non-BH care situations. This denial decision can be made only with agreement from the member’s PCP, following bi-directional discussion with the IPA Medical Director.

b) A psychiatrist, doctoral level clinical psychologist, or certified addiction medicine specialist must be responsible for denial of BH (which includes mental health and Substance Use Disorder) care that is based on lack of medical necessity. Please note: A psychiatrist or psychologist may deny both mental health and Substance Use Disorder cases. However, if the Addictions Specialist is not a psychiatrist or psychologist they cannot deny mental health cases but may deny Substance Use Disorder cases.

c) The IPA must use the most recent HMO approved denial letter, which includes the reason for the denial based on specific guideline source, specific benefit provisions within the guideline and reference to the member’s condition. 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. An alternative to the denied service must be provided to the member. The written denial notification must include an explanation of the HMO’s appeal process in the body of the denial letter, including the member’s right to attorney representation and must include the correct Appeals Attachment based on the member’s Group number:

- **Group policies**: HMO Illinois (H), Blue Advantage HMO (B), Blue Precision® HMO (R), Blue Care Direct (A)
- **Individual policies**: All start with the letter “I” (Blue Precision HMO, Blue Care Direct and Blue Focus Care)

d) For all denied cases, including concurrent review, Practitioner(s) and member must be informed of the expedited 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 e-mail of the original notification within the appropriate time frame with inclusion of information on the expedited appeal process. For urgent pre-service or urgent concurrent denials, the member must be informed that an expedited external review can occur concurrently with the internal appeal process for urgent care and ongoing treatment. All
appeals must be forwarded to the HMO Customer Service Department upon appeal request.

e) If more clinical information is requested in order to make a referral determination, document the date information was requested and received. If the additional information will not be received within the required 5-day timeframe, the denial file review case should be closed awaiting this information. Denial decision must be agreeable to the PCP with agreement documented in the denial file. For BH denials, the title/specialty of the BH Practitioner making the decision must be included with the signature. In addition, all Denial letters sent to the member require IPA Medical Director signature.

f) The IPA Medical Director must be available by telephone for the Practitioner(s) to discuss denial decisions for both BH (which includes mental health and Substance Use Disorder) and non-BH 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 Provider orientation;

g) The IPA should not send a denial letter for Not Group Approved Services to the member where the IPA received notification after the service had already been provided. Claims received for services previously rendered that are Not Group Approved should be forwarded to the HMO claims department for claims review;

h) The IPA UM Committee must review and discuss denials to insure denials have been appropriately managed according to IPA’s established procedures and HMO policies and this must be documented in the Committee minutes monthly;

i) Denial discussion must include a summary of the category of denial;

j) For BH: document mental health and Substance Use Disorder separately;

k) For non-BH: medical necessity, out-of-network, and benefit, number in each category, timeframe compliance and resolution, number of PA referrals and number resulting in a denial.

**Monthly Denial File Audit**

Denial logs and denial files (medical and BH), including Benefit Denials, are reviewed monthly after submission to the HMO. Denial logs and files must be submitted to the HMO Provider Portal by the 10th of each month (or the next business day if the date falls on a weekend). If the IPA does not have any denials for the month, this must be noted and submitted on a log.

**Quarterly Denial File Audit**

The HMO audits the IPAs denial files monthly and reports any deficiencies to the IPA. 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 plans, if applicable. If the IPA fails the quarterly denial file review, the IPA is required to submit a written corrective action plan. This corrective action must include a detailed description of how the IPA will correct the identified deficiencies in the denial process. The corrective action plan (CAP) must be received within 15 days from the date of the quarterly denial file results letter. The UM portion of the QI Fund will be impacted by failure of the quarterly denial file review, if the IPA does not meet or exceed an average 90% overall compliance by the end of the year (Q1-Q4).

**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 Utilization Management and Care Coordination 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;

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 UM and Care Coordination 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.

**Termination of Benefits (TOB)**

An IPA may not terminate inpatient benefits of any type without the concurrent authorization of the HMO. This applies to medical as well as BH (mental health and Substance Use Disorder) admissions.
There are two (2) types of TOB’s:

1. Termination of Benefits for Services at a Group Approved Facility that are NOT Medically Necessary;
2. Services at a Non-Group Approved Facility, where the PCP has recommended transfer in-network but the member refuses.

When an IPA PCP is notified of a member’s admission to a group-approved facility or to a non-group approved facility, the PCP must contact the attending physician within one business day of the notification of the admission to determine medical necessity. If after discussion with the attending physician, the PCP determined that services no longer meet medically necessary guidelines at the group approved facility, and the member refuses to discharge, or if the member refuses to transfer from the out of network facility to an in-network facility despite being stable to transfer, the TOB process is initiated:

a) The PCP communicates the member’s discharge needs or refusal to transfer to the IPA UM Coordinator and/or IPA Medical Director. A written statement from the PCP must indicate that the PCP discussed member’s care with the attending and continued services for the member are no longer medically necessary or that the member is stable for transfer. The statement must include the alternative plan of treatment recommended by the PCP.

b) The IPA UM Coordinator must report the case to the HMO through the HMO Customer Service Unit (CAU): 312-653-6000.

c) The CAU must receive, via fax, the current PCP written statement with signature, a diagnosis, clinical summary and patient’s current medical condition/status, recommendation(s) for transfer or discharge and the IPA TOB letter prior to acting on the IPA request to terminate benefits.

d) The BCBSIL HMO Medical Director will review the submitted documentation to provide an approval for the IPA to issue the Denial Letter to the member.

e) The member must receive written notification from the IPA stating that the PCP has determined that continued services are no longer medically necessary or that the patient is stable to transfer in network and services are therefore not group approved after a stated date. This date must reflect that the member may remain inpatient for a period no greater than 24-hour following the member’s receipt of the determination.

f) The IPA submits a copy of the letter to the business office of the facility, the PCP, the IPA Medical Director and the HMO Nurse Liaison.

g) Upon receipt of the letter, HMO notifies the member of the denial of benefits via the TOB letter.

h) The CAU will send a copy of this letter to the business office of the facility, the PCP, IPA Medical Director, IPA UM Coordinator, HMO UM Manager, HMO Provider Network Consultant, HMO Medical Director, and HMO Claims Department.

i) For a BH termination of benefits denial:
   i. The PCP may agree to defer the denial decision and termination of benefits to the BH specialist. A written PCP statement of agreement must be provided to the IPA for the termination of benefits decision to be completed.
   ii. The BH specialist would like to communicate with the PCP, but the member will not allow communication with their PCP: A statement from the member must be obtained stating they will not allow communication with their PCP.
Transition of Care

1. **Transition to Other 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 HMO Customer Assistance Unit (CAU) at (312) 653-6600 for help in this matter.

2. **Transition of Care from Pediatric to Adult Care**
   Transition of Care from Pediatric to Adult Care is applicable for member reaching adulthood and/or for pregnant adolescents. The IPA must periodically assess its membership for member reaching adulthood and those who have not chosen an adult PCP, and provide the member with assistance in selecting a PCP.

3. **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. A copy of the communication must be submitted to the HMO Nurse Liaison. 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
   - e) An offer to educate member about alternatives to continuation of care and ways to obtain further care as appropriate.

   The organization must have a Policy and Procedure on Transition to Other Care describing the IPA’s process for notifying member of an exhausted benefit, transition of care and/or transition of care from Pediatric to Adult Care.

**Emergency Services**
The HMO contractually requires IPAs to follow the “prudent layperson” standard set forth in the MSA in making 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;
   - 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.

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 notify the HMO Transplant Coordinator prior to the member’s evaluation at a BCBS transplant network facility. The HMO Transplant Coordinator will confirm that the facility is currently in the HMO transplant network for the relevant organ. If the member is accepted as a transplant candidate, the IPA forwards required documents to the HMO Transplant Coordinator for a HMO medical review. These documents include the member’s history, the reason for transplant, a letter from the PCP indicating his/her approval, and a letter from the transplant facility confirming the member’s transplant candidate status. After the HMO review, the HMO Transplant Coordinator will provide the IPA with a letter of authorization or a written denial to the IPA, as applicable.

Out of Area Admissions
The HMO is financially responsible for out-of-area admissions where member is admitted for an emergency condition or a life-threatening situation more than 30 miles away from 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. Refer to Termination of Benefits (TOB) section for protocol of issuing TOB if member refuses to transfer in-plan.

Out of Network Admissions
Out-of-Network admissions are urgent or emergent admissions that are within 30 miles 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) When stable, facilitates the transfer of the member to an in-network facility;
   c) 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 a HMO contracted infertility provider. Such a referral is required for these services to be in benefit. Reference may be made to the MSA, HMO Infertility Policy and/or the HMO Scope of Benefits for further information.

Ambulatory Care Sensitive Conditions (ACSC) Analysis
On an annual basis, HMO will provide the IPA with a list of members who were admitted with Ambulatory Care Sensitive Conditions. IPA must perform a clinical review and analysis for no fewer than ten (10) outpatient records pertaining to the admissions. Focus should center on the quality and completeness of the outpatient care preceding each admission. The IPA must use the Verscend Data Analytics Tool in their analysis. A discussion of this review must be performed annually with discussion
at the IPA UM Committee meeting and documentation of discussion and findings in the UM Committee Meeting Minutes.

**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 any and 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 any and 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.

**IPA Care Coordination Program Structure and Resources**

IPAs must have appropriate staff to perform all Care Coordination Program functions. A roster of the IPA staff documenting name, title and credentials is required with the annual submission of the UM and Care Coordination Plan. Any change in the IPA staff needs to be reported, in writing, to the HMOs within 30 days of the change. (Please reference IPA Utilization Management and Care Coordination Structure and Resources earlier in this document (pg. 16) for a list of all Care Coordination Team Member requirements)

The IPA is required to submit documentation of the IPA Care Coordination Program staff utilized to support the IPA DM, CM and CCM services. Documentation may include a flow diagram and a roster of staff names, titles, certification or licensure, if applicable and the role and responsibility of the staff in supporting the IPA Care Coordination Programs. Any revisions to the IPA staff or process must be provided to the NL within 30 days of the change.

**The Care Coordination Programs include the following:**

**Disease Management Program**- Currently, HMO requires two separate and distinct Disease Management Programs: Diabetes Mellitus and Asthma. Each Disease Management Program includes two levels of stratification: Tier 1 and Tier 2.

**Case Management Program**- Case Management addresses the needs of members who require education related to management of their health care, behavioral health and/or social needs. Case Management members typically consist of those persons with multiple chronic conditions, need assistance during transitions in care, or need shorter term assistance in navigating the health care system.

**Complex Case Management Program**- Complex Case Management addresses the needs of members with 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 delegated IPA is required to establish Care Coordination Programs designed to provide support and coordination for a Member’s care in collaboration with the Member’s PCP and interdisciplinary care team. All Complex Case Management services integrate with other IPA programs (UM, DM, CM) as well as other services available to the member within the community.
Members are identified as being eligible for the Care Coordination Programs on a monthly basis.

All Care Coordination Programs are opt-out programs.

The cumulative number of members enrolled in the DM, CM and CCM Programs must average 0.50% of the IPA membership on an annual basis. (See the 2017 MSA for additional information)

The Primary Care Physicians (PCP) collaboration with the Case Manager is critical. In many ways, the Case Manager acts as an extension of the PCP in further educating the member and facilitating the coordination of the member’s care. The PCP is required to be informed of members newly enrolled in CCM, see CCM members at a face-to-face visit at least every 6 months and participate in communication with the Case Manager as needed during the intervention with the member.

Care Coordination Documentation Requirements
Documentation requirements for the Care Coordination Program Member Care Plans differ in that the Care Plans for the Complex Case Management Program are documented in the HMO Provider Portal; however the Case Management and Disease Management Member Care Plans are documented in the IPA EMR or IPA Complex Case Management system rather than in the HMO Provider Portal. Documentation requires that there is automatic documentation of the staff member’s ID and date, and time of action on the case or when interaction with the member occurred. Automated prompts for next follow-up are also required. The IPA must document the process for how they automate prompts for next follow-up.

Care Coordination Programs Requirements
IPAs are required, on a monthly basis, to upload to the HMO Provider Portal Case Management and Disease Management logs. These logs identify members enrolled in the IPA Care Coordination Program. (Please note, for Complex Case Management, logs are not required as the care plans for members in CCM are documented directly in the HMO Provider Portal)

Submission of members included in the CM and DM Programs are required monthly, in the required format.

a) The IPA must have the appropriate resources to support the program and systems to provide the analysis, evaluation and reporting of IPA DM, CM, and CCM results.

b) The IPA must have a process in place to report to HMO any feedback received from the member regarding their Care Coordination experience, including but not limited to complaints and inquiries related to the program.

c) A quarterly summary of IPA Care Coordination Program results, must be reviewed by the UM Committee and reflected in the UM Committee Minutes, addressing goal setting, citing barriers, benefit coverage and community resources as applies to member. Identification of trends and interventions are to be documented, if applicable.

Identification of members for Disease Management (DM) and Case Management (CM)

a) The Sources used to identify members for CM and DM must be identified and uploaded to the HMO Provider Portal on a monthly basis;

b) In addition to appropriate review and identification of member on a monthly basis, members must meet criteria for appropriate stratification in each program. Stratification is based on
severity of the member’s condition, which includes information provided by the member along with clinical information available to the practitioner;
c) Depression Screening is required for members in the Disease Management Tier 2 program, CM, and CCM programs;
d) The Case Manager provides support, education and intervention based on each member’s level of stratification.

Care Coordination Program Policy and Procedure:
a) A written policy of the IPA’s CCP is required. Components of the Policy must include:
b) How member is notified of the CCP, how to become eligible, and how to Opt-out of the program;
c) How Providers are notified of the IPA CCP and how the program can impact their patients;
d) How member is identified for the CCP (e.g. referral / data sources, etc.);
e) A written description of the CCP structure and goals along with the components of each level of care;
f) Description of the IPA process for member assessment and disease stratification for the DM Program along with the process for determining program effectiveness;
g) Process for transitioning member through the Care Coordination continuum, as their condition changes.

Disease Management Programs
The Disease Management (DM) Programs aim to improve the member’s health status and self-management of specific chronic conditions through the use of condition monitoring, coaching, education, and behavioral strategies. The Focus is on prevention, closing care gaps and healthy lifestyle. Disease Management services are provided by licensed clinical professionals.

Program Goals
a) Providing member with an advocate within the health care system;
b) Improving communication among the member and physician;
c) Enhancing the member’s self-management skills;
d) Improving the member’s compliance with the physician’s treatment plan;
e) Reducing the intensity and frequency of disease-related symptoms;
f) Enhancing the member’s quality of life and functional status;
g) Reducing work disability and absenteeism;
h) Implementing interventions to close gaps in care and meet the member’s centric goals; and
i) Demonstrating impact savings by reducing hospitalizations and emergency department visits.

Member Identification and Enrollment
Candidates are identified, on a monthly basis, by the following sources:
a) Claim or encounter data;
b) Pharmacy data;
c) Health appraisal results;
d) Laboratory Results;
e) Data collected through the UM process, case management process, or care management process;  
f) Data from health management, wellness or health coaching programs;  
g) Information from EHR's;  
h) Member and Practitioner Referrals.

Members eligible for the Asthma or Diabetes Disease Management program will be stratified by the IPA Case Manager and automatically enrolled into one of two (2) tiers based on their severity of illness. Tier one includes members whose condition is less severe than that of tier two. Tier one members receive educational materials from their health plan, and are monitored by the IPA for change in clinical status requiring movement to tier two services and intervention. Tier two members receive IPA intervention and care planning services.

Members may be enrolled in both the Asthma as well as the Diabetes Disease Management Programs, when appropriate. However, once a Member is enrolled in either the Case Management or Complex Case Management Program, the Disease Management case should be closed until the member is discharged from the Case Management or Complex Case Management Program.

HMO utilizes Verscend as their data analytics vendor in order to enhance clinical intelligence and benchmarking capabilities. This web-based software currently integrates data from multiple sources (i.e., BCBSIL claims, IPA encounters, Pharmacy data, etc.) in order to identify and target risk and costs at both the population and individual member level. The system uses data-mining algorithms and evidence-based clinical rules to help identify and target gaps in the care of high-risk, high-cost members for clinical interventions and care-management programs. It is also used to track outcomes through sophisticated cohort tools.

Each contracted IPA has access to their population of members in the Verscend tool, available on the HMO Provider Portal. IPAs are encouraged to use the Verscend data for members in the programs to assist in integrating information for Utilization Management, Complex Case Management and Wellness programs.

**Opt-Out**  
The HMO Disease Management Program is an opt-out program, meaning that all identified eligible members are included in the program, unless the member specifically states that they do not wish to receive any further Disease Management Services (Opt-out). The IPA is responsible for submitting their active Disease Management members and those that have chosen opt-out to the HMO on a monthly basis.

The HMO measures program participation rates on an annual basis. Participation rates are calculated by including all eligible members in the denominator, and all members with at least one interactive contact in the numerator. Interactive contacts include either phone calls or surveys/quizzes completed by the member. Participation rates are reported and documented annually in the UM Committee Meeting Minutes.

Additionally, all HMO mailings instruct the member that they can opt-out of receiving HMO mailings by contacting the HMO Clinical Outcomes Management and Research Department at 312-653-3465.
Program Components

Outreach
Targeted outreach to members may include but is not limited to:
   a) Instructions on how to use the services;
   b) How they were identified for the services;
   c) How to opt-out of the program;
   d) Reference to clinical practice guidelines;
   e) Details and contact information regarding the program;
   f) Condition-specific informational brochures and mailings.

Integration of Member Information Across all Care Coordination Programs:
The Disease Management Program integrates with other Care Coordination Programs such as:
   a) Other Disease Management Programs;
   b) Case Management Program;
   c) Complex Case Management Program;
   d) Utilization Management Program (if applicable); and
   e) Wellness Program.

Communication with Practitioner
The IPA provides its practitioners with written information about the organizations Disease Management Programs. Information must include instructions on how to use the Disease Management Services and how the IPA works with the practitioner to manage the patients in the program.

Member Experience
The Health Plan annually evaluates the members experience with the Disease Management Program. Satisfaction Survey questions include satisfaction with the overall program, the helpfulness of program staff, the usefulness of the information disseminated, and the members experience in adhering to their treatment plans. An analysis of the survey results is reported to the HMO Quality Improvement Committee annually. Member complaints regarding the Disease Management Program are reported to the IPA UM Committee and HMO QI Committee on an annual basis to further assess member experience with the program.

Measurement and Reporting of Program Effectiveness
The IPA will measure performance of each Disease Management Program (Asthma and Diabetes) annually. Measurement must:
   a) Addresses a relevant process or outcome;
   b) Produce a quantitative result;
   c) Be population based;
   d) Use data and methodologies that are valid for the process or outcome being measured;
   e) Have been analyzed in comparison with a benchmark or goal.
Asthma Disease Management Program

People with asthma require frequent interaction with the health care system to manage their asthma. Although asthma cannot be cured, symptoms can be controlled with appropriate medical care, combined with efforts to control exposure to triggers. When asthma is properly managed, inpatient hospitalizations and emergency department visits can be prevented. Improvements in patient self-management, adherence to treatment plans and proper medication regimen have been linked to positive clinical outcomes. With effective education and adherence to evidence based clinical practice guidelines, asthmatic members can improve their health status and quality of life through self-care and lifestyle management.

The goals of the Asthma Disease Management Program are:

To improve asthma care by increasing the percentage of asthmatic members:

- a) Who receive a written Asthma Action Plan;
- b) Whose asthma is Well Controlled (demonstrated by use of ACT, ATAQ or ACQ testing);
- c) Who have a face-to-face visit with their physician to review asthma care if asthma is Not Well Controlled;
- d) Who achieve compliance with the HEDIS indicator for medication management for people with Asthma;
- e) Who achieve compliance with the HEDIS Asthma Medication Ratio indicator;
- f) Whose physicians provide asthma care in accordance with the National Asthma Education and Prevention Program (NAEPP) guidelines;
- g) Who are screened for depression when greater than twelve (12) years old, when appropriate;
- h) Who receive post hospital transition of care calls in order to decrease readmission rates when hospitalizations are necessary (all cause admissions);
- i) Who report >90%-member satisfaction with the Asthma Disease Management Program.

Eligible Asthma Population

Members age 5 to 64 who met at least one of the following during a rolling 24-month period are identified as eligible for the program:

- a) At least one Emergency Department visit with asthma as the principal diagnosis;
- b) At least one acute inpatient discharge with asthma as the principal diagnosis;
- c) At least four outpatient visits with asthma as one of the diagnoses and at least two asthma medication dispensing events;
- d) At least four asthma medication dispensing events plus at least one claim or encounter in the outpatient setting with asthma as one of the listed diagnoses;
- e) Enrolled in the Complex Case Management (CCM) program and have a diagnosis of asthma;
- f) Completed an HRA and self-reported having a diagnosis of asthma;
- g) Self-referred into the Asthma Disease Management Program;
- h) Practitioner referred member to the Asthma Disease Management Program.
Asthma Disease Management Stratification and Program Content

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

<table>
<thead>
<tr>
<th>Severity Stratification</th>
<th>Clinical Status</th>
<th>Interventions</th>
</tr>
</thead>
</table>
| Tier 2                  | Moderate Persistent/Severe Persistent Asthma | - Semi-Annual Doctor Visit  
- HMO Mailings  
- IPA Care Management Monthly Bi-Directional Phone Contact  
- Asthma Action Plan updated once per calendar year.  
- Asthma Control, as evidenced by ACT, ATAQ or ACQ testing.  
- Screened for Depression at least once per calendar year (>12 years old) |
| Tier 1                  | Mild Intermittent/Moderate Intermittent Asthma | - Annual Doctor Visit  
- HMO Mailings  
- IPA Ongoing Monitoring for changes in status of Asthma condition |

**Tier 2**

a) All Tier 1 Services; PLUS
b) Monthly bi-directional communication with an IPA Case Manager:
   - Individualized Disease Management Care Plan
c) Asthma Action Plan within calendar year 2017;
d) Asthma Control, demonstrated by use of an Asthma Control Test (ACT), ATAQ or ACQ test within calendar year 2017;
e) Post Hospital Phone Call within 48 hours of Discharge from Hospital (All cause hospitalizations), if hospitalized.
f) Depression Screening-(with referral when indicated) within calendar year 2017 for members >= twelve (12) years of age. (PHQ, M3, HAMD, MADRS)

Tier 1
a) BCBS Mailings:
   ▪ Mailings for children identified with asthma are addressed to the parents of the child and letters to the parents of the children have been adapted to reflect that the recipient is a caregiver and not the patient.

b) Welcome Letter;
c) Newly Identified Member Letter;
d) Personal Asthma Management Brochure which includes:
   ▪ Condition Monitoring (including self-monitoring and medical testing);
   ▪ Adherence to Treatment Plans (including medication adherence);
   ▪ Medical and Behavioral Comorbidities of Asthma (e.g., cognitive deficits, physical limitations);
   ▪ Health Behaviors;
   ▪ Psychosocial Issues that may impact Asthma Care;
   ▪ Depression Screening and Asthma Care
   ▪ Providing Information about the patient’s condition to caregivers who have the patient’s consent;
   ▪ Encouragement to see their doctor;
   ▪ Provides References to External Asthma Resources such as: The American Lung Association (http://www.lung.org/lung-disease/asthma/) and The National Heart, Lung, and Blood Institute (http://www.nhlbi.nih.gov/health/health-topics/topics/asthma/)

e) IPA continuous monitoring for changes in Asthma Control, which would require that the member be moved to the Tier 2 Disease Management Program.

Member Information:
BCBSIL provides all eligible members identified for the Asthma Disease Management Program with information about this program. The welcome letter and each subsequent mailing to members include:
   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 phone number for members to call if they want to opt out of the program
   c) Information about how to use the program.

Examples include:
   ▪ A recommendation to take the Asthma Action Plan to their physician for completion
   ▪ A recommendation to get an annual flu shot
   ▪ A recommendation for asthmatics to use information in the enclosed brochure to evaluate asthma control
   ▪ How to obtain information about asthma on Blue Access for Members, the secure member web portal
The mailings encourage members to work with their doctor for management of their asthma. All members with gaps in care for asthma services during the current year receive outreach from their IPA. The goal is to encourage members to see their physicians for recommended asthma services at least twice per year.

**Measurement of Asthma Disease Management Program Effectiveness**

The current performance measurement goals for the Asthma Disease Management Program are:

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Performance Threshold</th>
<th>Weighted Point Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Asthma Action Plan</td>
<td>90%</td>
<td>5</td>
</tr>
<tr>
<td>-Asthma Control</td>
<td>70%</td>
<td>5</td>
</tr>
<tr>
<td>-HEDIS: Medication Mgmt. for People with Asthma</td>
<td>51%</td>
<td>2.5</td>
</tr>
<tr>
<td>-HEDIS: Asthma Medication Ratio</td>
<td>81.75%</td>
<td>2.5</td>
</tr>
<tr>
<td>-Depression Screening (&gt; age 12 y/o)</td>
<td>70%</td>
<td>5</td>
</tr>
<tr>
<td>-Member Satisfaction with the CCM and DM Programs</td>
<td>90%</td>
<td>8</td>
</tr>
<tr>
<td>-Transition of Care Call within 48 hrs. of hospitalization</td>
<td>90%</td>
<td>8</td>
</tr>
</tbody>
</table>

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.

**Diabetes Disease Management Program**

**Diabetes Disease Management Stratification and Program Content**

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 good 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, diabetic members 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 Disease 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 is not well controlled;
c) Who are screened for depression when greater than twelve (12) years old, when appropriate;
d) Who receive post hospital transition of care calls in order to decrease readmission rates when hospitalizations are necessary (all cause admissions);
e) Who report ≥90%-member satisfaction with the Diabetes Disease Management Program.
Eligible Diabetic Population

Members 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 hypoglycemics and/or antihyperglycemics on 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 Disease Management Program;
f. Completed an HRA and self-reported having a diagnosis of diabetes; and
g. Self-referred into the Diabetes Disease Management Program.

Diabetes Disease Management Stratification and Program Content

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

![Disease Management Stratification Diagram](image-url)
<table>
<thead>
<tr>
<th>Severity Stratification</th>
<th>Clinical Status</th>
<th>Interventions</th>
</tr>
</thead>
</table>
| Tier 2                  | HbA1C ≥ 9       | - HMO Mailings
                      |                 | - IPA Care Management Monthly Bi-Directional Phone Contact
                      |                 | - Ongoing Monitoring for changes in status of Diabetes condition and HbA1C levels
                      |                 | - Screened for Depression at least once per calendar year (>12 years old) |
| Tier 1                  | HbA1C < 9       | - HMO Mailings
                      |                 | - Ongoing Monitoring for changes in status of Diabetes condition and HbA1C levels |

**Tier 2**

a) All Tier 1 Services; PLUS

b) Monthly bi-directional communication with an IPA Case Manager:
   - Individualized Disease Management Care Plan

c) Post Hospital Phone Call within 48 hours of Discharge from Hospital (All cause hospitalizations), if hospitalized.

d) Depression Screening-(with referral when indicated) within calendar year 2017 for members > twelve (12) years of age. (PHQ, M3, HAMD, MADRS)

**Tier 1**

a) BCBS HMO Mailings:
   - Mailings for children identified with diabetes are addressed to the parents of the child and letters to the parents of the children have been adapted to reflect that the recipient is a caregiver and not the patient.

b) Welcome Letter;

c) Newly Identified Member Letter;

d) Diabetes Brochures and Mailings Address all of the following:
   - Condition Monitoring (including self-monitoring and medical testing);
   - Adherence to Treatment Plans (including medication adherence);
   - Medical and Behavioral Comorbidities of Diabetes (e.g., cognitive deficits, physical limitations);
   - Health Behaviors;
   - Psychosocial Issues that may impact diabetes Care;
   - Depression Screening and diabetes Care;
   - Providing Information about the patient’s condition to caregivers who have the patient’s consent;
   - Encouragement to see their doctor;
   - Provides References to External Diabetes Resources such as the American Diabetes Association web site [www.diabetes.org](http://www.diabetes.org) or sites such as [www.flu.org](http://www.flu.org).
e) IPA continuous monitoring for changes in Diabetic HbA1C Control which would require that the member be moved to the Tier 2 Disease Management Program.

**Member Information:**
BCBSIL provides all eligible members identified for the Diabetes Disease Management Program with information about this program. The welcome letter and each subsequent mailing to members include:

- 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
- The phone number for members to call if they want to opt out of the program
- Information about how to use the program. While the specific content varies depending upon the mailing, examples include:
  - A reference to the mailings about diabetes that the member will receive;
  - How to obtain a free glucose meter;
  - Use of the diabetes care card to track diabetes services and lab results, weight and blood pressure;
  - How to obtain information about diabetes on the bcbsil.com *My Health on Blue Access for Members*, the secure member web portal.

Some of the mailings also provide information about BCBSIL collaboration with IPAs, and all encourage members to work with their doctor for management of their diabetes.

**Measurement of Diabetes Disease Management Program Effectiveness**
The current performance measurement goals for the Diabetes Disease Management Program are:

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Performance Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>-HbA1C &lt; 8</td>
<td>63.5%</td>
</tr>
<tr>
<td>-Depression Screening</td>
<td>85%</td>
</tr>
<tr>
<td>-Member Satisfaction with the CCM and DM Programs</td>
<td>90%</td>
</tr>
<tr>
<td>-Transition of Care Call within 48 hrs. of hospitalization</td>
<td>90%</td>
</tr>
</tbody>
</table>

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.

**Case Management Program**
The Case Management (CM) Program is an integral part of the Care Coordination Program. Case Management addresses the needs of members who require education related to management of their health care, behavioral health and/or social needs. Case Management members typically consist of those persons with multiple chronic conditions, need assistance during transitions in care, or need shorter term assistance in navigating the health care system.

To assist with the identification of eligible Case Management members, HMO shall provide the IPA with a data source report on a monthly basis. The data source report provided by the HMO will be the same report provided for Complex Case Management. Should a member not meet the intensity of illness...
requirements for the Complex Case Management Program (See Appendix A), the Case Management Program should be considered as an alternative. The IPA’s must also produce their own data and referral source reports on a monthly basis. **Eligibility for the Case Management Program is defined as the date that the member is identified by either a HMO or IPA data source or referral source.**

Members who are identified as eligible for Case Management must have an Initial Assessment (IA) completed within thirty (30) days of the eligibility date. **The date that the Initial Assessment is completed is the date the member is enrolled in the Case Management Program.**

Members in the Case Management Program will receive monthly bi-directional communication from their Case Manager.

A random sample of Case Management files will be audited for the following elements:

a) Monthly submission of members enrolled in the CM Program;
b) Members appropriately stratified in Case Management rather than Complex Case Management;
c) Timeframes Met (IA, Monthly Contact);
d) Appropriate Goal Setting (Follow-Up, Member Self-Management Goal);
e) Barriers to Achievement of Goals;
f) Assessment of Member Benefits;
g) Assessment of Community Resources
h) Transition of Care (TOC) Calls made within 48 hours of discharge (all cause) when hospitalized;

Additionally, Member Satisfaction with the CM Program will be assessed by the HMO on an annual basis.

**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.

Members with catastrophic or multiple complex conditions, include the disabled, along with children and adolescents, whose care is often complicated by severe Behavioral Health or social challenges. It involves the systematic assessment and coordination of care and services provided to members who are experiencing a Complex clinical situation. 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 Committee 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 amount 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.

To assist with the identification of eligible Complex Case Management members, HMO shall provide the IPA with data source reports on a monthly basis. The IPA’s must also produce their own data and referral source reports on a monthly basis, this data sources is driven by use of Verscend predictive modeling software. Eligibility for the Complex Case Management Program is defined as the date that the member is identified by either a HMO or IPA data source or referral source.

Members who are identified as eligible for Complex Case Management must have an Initial Assessment (IA) completed within thirty (30) 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.

Assessing the Needs of the member Population
Annually, the HMO uses available data sources to assess the needs of the member population and sub-populations and updates the HMO and IPA Care Coordination Programs accordingly. This includes but is not limited to assessing the needs of children and adolescents, individuals with disabilities and individuals with serious and persistent mental illness.

HMO
- The HMO UM Workgroup evaluates the data, which includes, but is not limited to US Census Data, Enterprise Data Warehouse (EDW) data, Provider Cost and Utilization reports from Actuarial data, Verscend Analytics data and prior years Care Coordination data.
- The HMO UM Workgroup analyzes the data to identify any gaps in care and any member needs and updates its Care Coordination processes and resources as needed. (This includes updating the Care Coordination Program requirements of the HMO Delegates)

IPA
- The IPA UM/QI Committee is responsible to discuss their specific member population based on identified criteria and data and upon evaluation and analysis of that data, updates their Care Coordination Plans annually as described in their Utilization Management and Care Coordination processes and resources as needed.

Complex Case Management Program Referral and Data Sources
To further assist the IPA, the HMO will provide IPA with monthly data source reports identifying eligible members for CCM services. This information will be made available on a monthly basis via the HMO Provider Portal. The HMO uses a method of identifying members with potential complex care needs using predictive modeling software and paid claims data for the most current annual period for which such data exists. Should an Eligible Member, identified by a data source, not meet the HMO guidelines for Complex Case Management (Appendix A) or if the Case Manager uses his/her clinical judgement and determines that the member does not have complex care needs, the member should be evaluated to determine if they are appropriate for enrollment in the IPA Case Management (rather than Complex Case Management) Program.
IPA’s are required to identify members eligible for Complex Case Management services using all of the following referral and data sources:

<table>
<thead>
<tr>
<th>Referral Source</th>
<th>Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital discharge planners</td>
<td>Claims or encounter data, Versend tool</td>
</tr>
<tr>
<td>Self-referral from member/caregiver</td>
<td>UM Process Data</td>
</tr>
<tr>
<td>UM Referral</td>
<td>Pharmacy data</td>
</tr>
<tr>
<td>Physicians, PCP and their office staff referrals</td>
<td>Data supplied by member or caregiver</td>
</tr>
<tr>
<td>DM Program Referral</td>
<td>Data supplied by purchasers or HMO employee groups</td>
</tr>
<tr>
<td></td>
<td>Hospital Discharge Data</td>
</tr>
<tr>
<td></td>
<td>Practitioner Data</td>
</tr>
</tbody>
</table>

IPA Referral and Data Source Reports must be posted to the HMO Provider Portal on a monthly basis and will be monitored by the HMO.

IPA Complex Case Management Requirements

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;

b) Document the date the Initial Assessment was completed. Initial Assessment must be completed within 30 days of eligibility. If Initial Assessment completion occurs greater than 30 days after eligibility, user must attest that the information is current and complete;

c) Within the first 30 days after member is determined by the IPA to be eligible for CCM, the IPA must attempt to contact the member at least three times over a two-week period to complete the Initial Assessment. Case should be closed if unable to contact the member after three attempts are documented;

d) Document the following required elements for the Initial Assessment:

1. Initial assessment of the members health status and condition specific issues;
2. Diagnoses – acute and chronic conditions;
3. Procedures – historical and current, including inpatient stays, or document “none”;
4. Current status of diagnoses documented, include mental health and/or Substance Use Disorder diagnoses;
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 and schedule;
7. Ability and/or barriers to perform activities of daily living;
8. Current mental health status;
9. Assessment of cognitive functioning;
10. Language Assessment including primary language member uses to communicate;
11. Assessment of Behavioral Health status. Assess if the member with Behavioral Health/SUD diagnosis has signed a Release of Information allowing communication
between the PCP and Behavioral Health Specialist;

12. Initial Assessment of psychosocial issues and cultural (e.g. member’s living situation, finances, employment, support system, history of recent loss, cultural beliefs and whether they interfere with treatment);

13. Assessment of life planning activities and documentation of collaboration with PCP if appropriate;

14. Documentation of hearing or vision limitations, or “no limitations”;

15. Evaluation of linguistic needs or preferences;

16. Evaluation of caregiver resources, involvement, understanding of care;

17. Documentation of available benefits, limitations (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 the 60 session limitation of PT/OT and ST per calendar year. Documentation must state that the member is aware of this;

18. Documentation of available community resources needed (ex. - Meals on wheels, township services, legal aid), or not (document reason if not needed);

19. Assessment of life planning activities; and

20. Member self-management plan.

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;
   b) Progress and assessment toward goals as levels of interventions are implemented;
   c) Barriers toward achieving the goals;
   d) 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;
   e) Educating the member and the family/caregiver, about treatment options and available resources to improve quality of care; and
   f) 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;
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. Goals
must be prioritized, numbered, attainable, measureable, current, reviewed and revised
before the expiration date;
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.

For member’s 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.

IV. Case Closure

When a member’s Complex Case Management goals have been met or progress is no longer anticipated,
the Case Manager should close the case. The member may then be followed in the IPA Case
Management or Disease Management Programs, if appropriate. The case must also be closed upon
member request (Opt-Out) or if the member does not respond to CCM Monthly Contacts for more than
two (2) consecutive months (It will be assumed that the member wished to Opt-Out, and will need to be
documented as such). The Case Manager must document the date and reason(s) for the closure of the
case. This includes documenting the status of all goals and whether they were achieved. There must be
documentation that the member was notified that their case was closed.

If there has been no documentation in the HMO Provider Portal for greater than 60 days, the case will
be automatically closed by the HMO.
Member and Practitioner Communication
Members and practitioners must be aware of the IPA’s Care Coordination Programs. Notification methods may include, but are not limited to, the member Welcome Letter, Physician mailings, and Website or HMO Provider Portal postings.

- Member notification must address how the member will use services provided by the IPA’s Care Coordination Programs, how to become eligible to participate as well as how to opt-out of the programs.
- Practitioner notification must include how the CCP, including CM and DM and is utilized and how the IPA works with patients in the Program.

IPA’s are required to include information related to how the IPA member and physicians are notified of the IPA’s Care Coordination Programs in the IPA’s Utilization and Care Coordination Plan.
APPENDIX A: 2017 Complex Case Management Referral 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, Psychosocial and the needs of the member.

Note the following:
  a) The IPA must provide clear documentation in the HMO Provider Portal of the clinical rationale of the member’s Complexity and need for CCM.
  b) An attestation and documentation of the PCP support of member’s CCM need and plans must be documented.
  c) The care plans interventions must support the member’s Complex Case Management needs.

<table>
<thead>
<tr>
<th>Multiple Chronic Conditions</th>
<th>Chronic medical or mental health conditions with complex needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex Medical Conditions</td>
<td>MVA, trauma, or current medical condition with multiple challenges</td>
</tr>
<tr>
<td>Transplant</td>
<td>Pre and Post-Transplant Care</td>
</tr>
<tr>
<td>Acute Hospital Admissions</td>
<td>Unplanned in recent 12 months + Complex need</td>
</tr>
<tr>
<td>High-Risk Hospital Discharges</td>
<td>Complex needs post discharge (DME, multiple therapies, psych-social and medical issues)</td>
</tr>
<tr>
<td>Emergency Dept. Visits</td>
<td>At least 3 in past 12 months</td>
</tr>
<tr>
<td>Mental Health Admissions (Acute or Residential)</td>
<td>At least 2, in past 12 months</td>
</tr>
<tr>
<td>Mental Health Re-admission</td>
<td>Re-admission within 30 days</td>
</tr>
<tr>
<td>Substance Use Disorder Admissions (Acute or Residential)</td>
<td>At least 2, in past 12 months</td>
</tr>
</tbody>
</table>

Specific Diagnoses

<table>
<thead>
<tr>
<th>Amyotrophic Lateral Sclerosis (ALS)</th>
<th>Symptoms that affect ADLs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anorexia Nervosa or Bulimia</td>
<td>Admission to acute hospital or residential</td>
</tr>
<tr>
<td>Burns</td>
<td>Severity of 2nd degree and higher with a total body burn of &gt; 20% in adults &amp; &gt; 10% in children under eighteen (18) years of age</td>
</tr>
<tr>
<td>Cancer</td>
<td>Metastatic End-Stage</td>
</tr>
<tr>
<td>Chronic Kidney Disease</td>
<td>Stage 4 or 5</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>Edema or oxygen-dependent</td>
</tr>
<tr>
<td>Complex Wound Care</td>
<td>Wound Vac &amp; Stage III, IV</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>Complications including neuropathy, retinopathy or nephropathy that have a substantial impact on ADLs and HBA1c 10 or greater</td>
</tr>
<tr>
<td>High Risk Obstetric and Neonatal care</td>
<td>Premature infants discharge planning until stable at home</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Complications</td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td>Symptoms that are starting to affect ADLs</td>
</tr>
<tr>
<td>Paraplegia or Quadriplegia</td>
<td>Recent-onset or complications</td>
</tr>
<tr>
<td>Stroke</td>
<td>Acute onset until rehab completed</td>
</tr>
<tr>
<td>Suicide attempt</td>
<td>Serious attempt</td>
</tr>
<tr>
<td>Traumatic brain Injury</td>
<td>Acute onset until rehab completed</td>
</tr>
</tbody>
</table>
## MEDICAL AND BEHAVIORAL HEALTH UM DECISION TYPE

<table>
<thead>
<tr>
<th>UM DECISION MAKING TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-urgent Pre-certification/Pre-Service includes Specialist Referrals (approval and denial)</strong></td>
</tr>
<tr>
<td><strong>Urgent Pre-certification/Pre-Service includes Specialist Referrals (approval and denial)</strong></td>
</tr>
<tr>
<td><strong>Certification/ Initial for emergent admissions (approval and denial)</strong></td>
</tr>
<tr>
<td><strong>Concurrent (approval and denial)</strong></td>
</tr>
<tr>
<td><strong>Retrospective/ Post-service</strong></td>
</tr>
<tr>
<td><strong>ALL Appeals</strong></td>
</tr>
<tr>
<td><strong>Member Complaints</strong></td>
</tr>
</tbody>
</table>
### Appendix C: Care Coordination Incentive Program Targets and Weights

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Performance Target</th>
<th>Weighted Point Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accurate Identification and Stratification of Members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCM Monthly Data Source Reports</td>
<td>90%</td>
<td>8</td>
</tr>
<tr>
<td>CCM Monthly Referral Source Reports</td>
<td>90%</td>
<td>8</td>
</tr>
<tr>
<td>Monthly Submission of CM and DM Enrollees</td>
<td>100%</td>
<td>8</td>
</tr>
<tr>
<td>Members Stratified Appropriately (CM vs. CCM and DM Tier 1 vs. Tier 2)</td>
<td>90%</td>
<td>8</td>
</tr>
<tr>
<td>Complex Case Management File Review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timeframes Met (IA, Monthly Contacts)</td>
<td>90%</td>
<td>8</td>
</tr>
<tr>
<td>Goal Setting (Follow-Up, Member Self Mgmt. Goal)</td>
<td>90%</td>
<td>8</td>
</tr>
<tr>
<td>Barriers to Achievement of Goals</td>
<td>90%</td>
<td>2</td>
</tr>
<tr>
<td>Assessment of Member Benefits</td>
<td>90%</td>
<td>2</td>
</tr>
<tr>
<td>Assessment of Community Resources</td>
<td>90%</td>
<td>2</td>
</tr>
<tr>
<td>Performance Metrics: DM, CM and CCM Programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Transition of Care Call within 48 hrs. of hospitalization</td>
<td>90%</td>
<td>8</td>
</tr>
<tr>
<td>-Member Satisfaction with CM, CCM and DM Programs</td>
<td>90%</td>
<td>8</td>
</tr>
<tr>
<td>Asthma Disease Management Program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Asthma Action Plan</td>
<td>90%</td>
<td>5</td>
</tr>
<tr>
<td>-Asthma Control</td>
<td>70%</td>
<td>5</td>
</tr>
<tr>
<td>-HEDIS: Medication Mgmt. for People with Asthma</td>
<td>51%</td>
<td>2.5</td>
</tr>
<tr>
<td>-HEDIS: Asthma Medication Ratio</td>
<td>81.75%</td>
<td>2.5</td>
</tr>
<tr>
<td>-Depression Screening (&gt; age 12 y/o)</td>
<td>70%</td>
<td>5</td>
</tr>
<tr>
<td>Diabetes Disease Management Program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-HbA1C ≤ 8</td>
<td>63.5%</td>
<td>5</td>
</tr>
<tr>
<td>-Depression Screening (&gt; age 12 y/o)</td>
<td>85%</td>
<td>5</td>
</tr>
<tr>
<td>TOTAL POINTS</td>
<td>N/A</td>
<td>100</td>
</tr>
</tbody>
</table>

- **Case Management and Complex Case Management** scoring is inclusive of all members enrolled in the program at any time throughout the year.

- **Disease Management** scoring is inclusive of all Tier 2 members enrolled in the program any time throughout the year, with the following three exceptions which include all members enrolled in Tier 1 and Tier 2 of the program:
  - Asthma: Medication Mgmt. for People with Asthma & Asthma Medication Ratio
  - Diabetes: HbA1C ≤ 8 for Diabetics
**Appendix D: HMO and IPA Delegation Responsibility Matrix (UM, CM, DM)**

### BCBSIL HMO Utilization Management Delegation Matrix

<table>
<thead>
<tr>
<th>Delegated Activity</th>
<th>Health Plan Responsibilities</th>
<th>Delegate Responsibilities</th>
<th>Delegate Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program Structure</strong></td>
<td>Health Plan retains accountability for the structure of the UM Program, including the HMO Program Description. HMO ensures the involvement of HMO Medical Director(s) in design and structure of the UM program. The Health Plan is not responsible for any medical necessity decisions. Delegation oversight activities are reported at Health Plan UM Workgroup and Health Plan Quality Improvement Committee.</td>
<td>Delegate will develop its own Utilization Management and Care Coordination Plan and submit to the Health Plan for approval annually. Delegate will implement its UM Program, in alignment with Health Plan 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.</td>
<td>Annually, the delegate will provide HP with the delegates UM Program Description, policies and procedures, and required ‘UM Plan Attachments’ relating to all delegated functions.</td>
</tr>
<tr>
<td><strong>Clinical Criteria for UM Decisions</strong></td>
<td>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.</td>
<td>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 for all staff involved in the UM process semi-annually.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Communication Services</strong></td>
<td>HMO delegates responsibility of notification of members and practitioners regarding access to UM staff for questions related to UM.</td>
<td>Delegate maintains responsibility for notification of members and practitioners regarding access to UM staff for questions about UM.</td>
<td>IPA will provide evidence of notices on an annual basis.</td>
</tr>
</tbody>
</table>
### Appendix D: HMO and IPA Delegation Responsibility Matrix (UM, CM, DM)

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</table>
| **Appropriate Professionals** | Health Plan 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 UM decisions are made by appropriate professionals, per Health Plan 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 Health Plan policies  
Delegate will notify its own staff and employed practitioners of its affirmation statement regarding incentives. | Adherence to Timeframe Audits must be conducted and documented as having been discussed in the UM/QI Committee Meeting Minutes. |
| **Timeliness of UM Decisions** | HMO monitors Delegate Timeliness of UM Decisions. This is done through oversight of adverse determination timeframes on a monthly basis, and review of Delegate Inter-Rater Reliability Adherence to Timeframe Audits. | Delegate will ensure that all UM decisions (medical and behavioral health) are made within NCQA timeliness standards (as defined by the current standards year). Delegate maintains responsibility for timeliness of all UM decisions. | None. |
| **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. | None. |
| **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 denials 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 | Quarterly report of Denials which includes:  
- Total number of denials by type |
Appendix D: HMO and IPA Delegation Responsibility Matrix (UM, CM, DM)

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</thead>
<tbody>
<tr>
<td><strong>Appeals</strong></td>
<td>Health Plan maintains accountability for all first and second level member appeals, including maintenance of appeals policies and procedures.</td>
<td>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.</td>
<td>None.</td>
</tr>
<tr>
<td><strong>Evaluation of New Technology</strong></td>
<td>Health Plan maintains accountability for evaluation of all new technology for incorporation as a benefit.</td>
<td>To contact the HP for information related to New Technology benefit requests.</td>
<td>None.</td>
</tr>
<tr>
<td><strong>Procedures for Pharmaceutical Management</strong></td>
<td>Health Plan delegates Pharmacy Benefit Management to Prime Therapeutics.</td>
<td>None.</td>
<td>None.</td>
</tr>
<tr>
<td><strong>Triage and Referral for BH Management</strong></td>
<td>The HMO delegates BH triage and Referral to the IPAs.</td>
<td>IPAs must describe their process for members requesting BH services (which include mental health and Substance Use Disorder); including written standards for ensuring appropriate BH triage and referral decisions.</td>
<td>Any delegated BH Organization or IPA providing BH Services with a centralized triage and referral process must submit telephone reports quarterly to the HMO.</td>
</tr>
<tr>
<td><strong>Oversight of Delegated Activities</strong></td>
<td>Health Plan reviews Delegates UM activity monthly, quarterly, semi-annually and annually as outlined in the MSA and the HMO UM and Care Coordination Plan. The HMO provides feedback, educational interventions and/or requests for corrective action for any deficiencies identified.</td>
<td>Delegate shall cooperate and fully participate in audits, site visits and other monitoring of delegated activities conducted by the HP. Deficiencies and Corrective Action Plan: In the event deficiencies are noted during audit or within required report submissions, delegate shall develop a corrective action plan for the specific Delegated Activity that is determined by HP to be deficient, and which shall include specifics of and</td>
<td>Annually, the delegate will provide HP its Utilization Management and Care Coordination Program Description as well as their policies and procedures. Anually, the delegate will provide HP with all documents required to conduct the annual audit of the UM and care Coordination Program.</td>
</tr>
</tbody>
</table>
### Appendix D: HMO and IPA Delegation Responsibility Matrix (UM, CM, DM)

<table>
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<tr>
<th>Delegated Activity</th>
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<th>Delegate Responsibilities</th>
<th>Delegate Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>timelines for correcting the deficiency, and shall be provided to HP within 30 calendar days of HP report of its findings.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The corrective action plan shall be implemented by delegate within the specified timeframes listed therein.</td>
<td></td>
</tr>
</tbody>
</table>
### BCBSIL HMO Case Management Delegation Matrix

<table>
<thead>
<tr>
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<th>Delegate Responsibilities</th>
<th>Delegate Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population Assessment</strong></td>
<td>Health Plan retains responsibility for conducting annual assessments of the member population.</td>
<td>Delegate will collaborate with HP to make adjustments to its CCM programs, processes and resources, as needed, based on the annual HP population assessment.</td>
<td>Annual discussion and documentation in UM/QI Committee Meeting Minutes.</td>
</tr>
<tr>
<td><strong>Identifying Members for Complex Case Management</strong></td>
<td>Health Plan will provide the IPA a list of members eligible for the Complex Case Management Program on a monthly basis. The Health Plan list of members are identified using the following data sources:  - Claims Data  - Pharmacy Data  - Data Supplied by Purchaser</td>
<td>Delegate will identify members for the Complex Case Management Program on a monthly basis. Data sources will include:  - Claims or Encounter Data  - Hospital Discharge Data  - Data from UM Programs  - Data supplied by members or caregivers  - Data supplied by Practitioners Referral Sources will include:  - Hospital Discharge Planner Referral  - Member/Caregiver Self-Referral  - Practitioner Referral  - UM Referral  - DM Program Referral</td>
<td>Monthly Data/Referral Sources updated to the HMO Provider Portal.</td>
</tr>
<tr>
<td><strong>Case Management Systems</strong></td>
<td>Health Plan provides Complex Case Management Documentation Platform to IPA via the HMO Provider Portal.</td>
<td>Delegate will manage members eligible for CCM within the HMO Provider Portal:  - Includes evidence-based guidelines for conducting assessments and ongoing management.  - Staff members document name, date and time of each interaction.</td>
<td>Documented procedure for automated prompts to remind staff of next follow-up interaction.</td>
</tr>
</tbody>
</table>
## Appendix D: HMO and IPA Delegation Responsibility Matrix (UM, CM, DM)

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<th>Delegate Responsibilities</th>
<th>Delegate Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>- Automatically prompts the staff for follow-up based on the case management plan.</td>
<td>Document discussion of results of the HP member satisfaction survey in UM/QI committee minutes on an annual basis. Monthly submission of all IPA Complaints.</td>
</tr>
<tr>
<td>Experience with Case Management</td>
<td>The health plan monitors Member Satisfaction with the Complex Case Management Program on an annual basis by sending mailed surveys to members enrolled in the program. Health Plan analyzes participant feedback with the CCM Program from the surveys and shares the results with the delegate.</td>
<td>Delegate maintains accountability for review and management of all member complaints. Any complaints regarding the delegates CCM Program will be forwarded to the Health Plan via the HMO Provider Portal.</td>
<td></td>
</tr>
<tr>
<td>Measuring Effectiveness</td>
<td>The HMO monitors the Effectiveness of the Complex Case Management Program on an annual basis. The HMO analyzes the effectiveness of the program and shapes the structure for subsequent years.</td>
<td>Delegate must annually discuss HMO results of the effectiveness of the CCM Program using three measures. Identifies opportunities for improvement, and incorporates those improvements into their UM and Care Coordination Plan in subsequent years.</td>
<td>Document discussion of CCM Program Effectiveness in the UM/QI Committee on an annual basis.</td>
</tr>
<tr>
<td>Action and Re-measurement</td>
<td>Health Plan Re-measures based on Delegates interventions: - Re-measures to determine impact on clinical performance. - Re-measures to determine impact on member experience.</td>
<td>Based on Health Plan results of measuring the effectiveness and satisfaction of CCM programs, the delegate: - Implements one intervention to improve clinical performance - Implements one intervention to improve member experience</td>
<td>Discusses and documents interventions annually in the UM/QI Committee Meeting Minutes.</td>
</tr>
</tbody>
</table>
### Appendix D: HMO and IPA Delegation Responsibility Matrix (UM, CM, DM)

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<th>Delegate Responsibilities</th>
<th>Delegate Reporting Requirements</th>
</tr>
</thead>
</table>
| Oversight of Delegated Activities | HP will conduct an annual review of CCM Program Description or policies/procedures for all CCM program activities.  
HP shall conduct an annual review of delegates performance against HP expectations and NCQA standards. Delegate will be notified in advance of all documentation required for annual audits.  
In the event a corrective action plan is not developed and/or implemented where required by HP, delegation of the specific Delegated Activity which is subject to the corrective action plan may be revoked. | Delegate shall cooperate and fully participate in audits, site visits and other monitoring of delegated activities conducted by the HP.  
Deficiencies and Corrective Action Plan. In the event deficiencies are noted during the annual audit or within required reports, delegate shall develop a corrective action plan 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 30 calendar days of HP report of its findings.  
The corrective action plan shall be implemented by delegate within the specified timeframes listed therein. | Annually, the delegate will provide HP its CCM Program Description or policies and procedures.  
Annually, the delegate will provide HP with all documents required to conduct the annual audit of the CCM programs. |
## BCBS HMOIL Disease Management Delegation Matrix

<table>
<thead>
<tr>
<th>Delegated Activity</th>
<th>Health Plan Responsibilities</th>
<th>Delegate Responsibilities</th>
<th>Delegate Reporting Requirements</th>
</tr>
</thead>
</table>
| **Disease Management Program Content** | Provide oversight of program content for two (2) Disease Management Programs: Asthma and Diabetes by reviewing:  
- Policies and procedures/Program Description  
- HMO mail materials to all members in the Disease Management Program which includes the following:  
  - Condition monitoring  
  - Adherence to treatment plans  
  - Medical and BH comorbidities  
  - Health behaviors  
  - Psychosocial issues  
  - Depression screening  
  - Information about the patients’ condition that is provided to caregivers (with consent documented)  
  - Encouraging patients to communication with their practitioners  
  - Additional resources external to the organization. | Delegate will manage two (2) Disease Management Programs: Asthma and Diabetes.  
Delegate will maintain policies and procedures, and a DM program description that describes the program content. | Annually, the delegate will provide HP its DM Program Description or policies and procedures. |
| **Identifying Members for Disease Management** | Health Plan shares responsibility for identification of members for the Disease Management Program, using the following data sources on a monthly basis:  
- Claims Data  
- Pharmacy Data  
- Health Appraisal Results  
- Data from the CCM Program | Delegate maintains the responsibility of identifying members for the Disease management Program on a monthly basis from the following data and referral sources:  
- Claims Data  
- Laboratory Results  
- Data from UM, CM and CCM Programs  
- Data from Wellness Programs  
- Information from the EMR  
- Member Self-Referral  
- Practitioner Referral | Delegates shares its Disease management Identification Sources via the HMO Provider Portal on a monthly basis.  
Monthly documentation of all members enrolled in the Program.  
Monthly report of all members Opt-Out of Program. |
## Appendix D: HMO and IPA Delegation Responsibility Matrix (UM, CM, DM)

<table>
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<th>Delegate Reporting Requirements</th>
</tr>
</thead>
</table>
| Providing Members with Information       | Health Plan mails member educational materials addressed above in the Disease Management Program Content section. | Delegate will provide eligible members with the following written information about the program:  
  - How to use the services  
  - How members become eligible to participate  
  - How to opt out of the program                                                                                 | Delegate will include this information in the New Member Welcome Letter.                               |
| Interventions Based on Assessment         | Health Plan will set the indicators, matrix and required intervention for each tier of the DM program on an annual basis. | Delegate will appropriately stratify and provide interventions to members based on its assessment of the member’s risk level. | Delegate will demonstrate appropriate stratification of members and that appropriate interventions are provided for members in the Program. This will be assessed during random audits of case files. |
| Eligible Member Active Participation      | Health Plan will calculate the network participation rate for each DM Program.  
  For opt-out programs, this is calculated as:  
  - Denominator: # of identified eligible members  
  - Numerator: # of eligible members with at least one interactive contact |                                                                                                 | Delegate will document Opt-Out members and submit to the HMO Provider Portal on a monthly basis.      |
| Informing and Educating Practitioners    |                                                                                               | Delegate is responsible for communicating (in writing) to practitioners within its organization, the following information regarding the DM programs:  
  - Instructions for how to use the DM services  
  - How the DM program works with a practitioner’s patients in the program. | Delegate will share documentation of how this was pushed to all IPA Practitioners.                     |
### Appendix D: HMO and IPA Delegation Responsibility Matrix (UM, CM, DM)

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<tr>
<th>Delegated Activity</th>
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<th>Delegate Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrating Member Information</td>
<td>The delegate maintains accountability for integration of member information from all programs. Members referred to DM Programs will be flagged by the IPA in order to alert staff managing other program activities as to their participation in the program. Once a member is enrolled in CM or CCM Programs, the DM case should be closed until which time the member is no longer enrolled in the CM or CCM Program.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience with Disease Management</td>
<td>The Health Plan Monitors Member Satisfaction with the Disease Management Program on an annual basis by mailing surveys to members enrolled in the program. Health plan analyzes participant feedback with the DM Program from the surveys and shares the results with the delegate.</td>
<td>Delegate maintains accountability for review and management of all member complaints. Any complaints regarding the delegates DM Program will be forwarded to the Health Plan on the HMO Complaint Log.</td>
<td>Document discussion of results of the HP Member Satisfaction Survey in UM/QI Committee Minutes on an annual basis. Monthly submission of all IPA Complaints.</td>
</tr>
<tr>
<td>Measuring Effectiveness</td>
<td>The HMO monitors the Effectiveness of the Disease Management Programs on an annual basis. The HMO analyzes the effectiveness of the program and shapes the structure for subsequent years.</td>
<td>Delegate must annually discuss HMO results of the effectiveness of the DM Program using three measures. Identifies opportunities for improvement, and incorporates those improvements into their UM and Care Coordination Plan in subsequent years.</td>
<td>Document discussion of DM Program Effectiveness in the UM/QI Committee on an annual basis.</td>
</tr>
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