BlueCross BlueShield of Illinois

BLUE CROSS AND BLUE SHIELD OF ILLINOIS
MEDICARE ADVANTAGE HMO PROCEDURE

DEPARTMENT: IL Provider Performance Management	**POLICY NUMBER** GCS-IL-MA-05B	**ORIGINAL EFFECTIVE DATE (IF KNOWN): 1-1-2013**
POLICY TITLE: Complex Case Management		**EFFECTIVE DATE:**
		LAST REVISION DATE: 4-21-21
EXECUTIVE OWNER: Executive Director, Clinical Programs Strategy and Oversight	**BUSINESS OWNER:** Executive Director, Clinical Programs Strategy and Oversight	**LAST REVIEW DATE:** 4-21-21

I. SCOPE

This Procedure applies to Provider Performance Management government product Medicare Advantage HMO.

This Procedure applies to the following lines of business and products:

Line of Business / Product Scope / Plan Scope / Contract Number (if applicable)	In Scope [x]
Medicare MAPD H3822/H8547	X

II. POLICIES IMPLEMENTED BY PROCEDURE

This Procedure implements the following Policies:

Complex Case Management Policy, GCS-IL-MA-05A. This procedures document ensures there is a documented process for Complex Case Management.

III. PROCEDURE

1. A list of potential CCM members is posted monthly to the IPA Provider Portal by the HMO. The members are identified through review of claims and Cotiviti Predictive Modeling Reports as potential candidates for CCM.

2. The IPA's CCM process should be documented in the UM Plan and include the following:

    - The IPA will perform CCM services for members identified through either BCBSIL data and/or IPA referral sources. The date that the member is identified by either a data or referral source is the member's eligibility date for Complex Case Management program. BCBSIL's CCM Program is an Opt-out program. Opt-out information must be documented by the IPA in the Provider Portal with the date the member made the decision to opt-out of the program.

3. IPAs must utilize the Provider Portal to document their CCM cases. The CCM documentation must include:

<u>CCM Initial Assessment Process and Requirements:</u>

<u>CCM Case Management Care Plan Requirements:</u>

IPA Case Manager must develop a Case Management Plan in collaboration with the member that includes the following:

a. Prioritized goals - at least three; one of which is a self-management goal.
b. Time frame for goals to be met with revision or completion dates, as applicable
c. Development and communication of self-management plan

Monthly Communication between the Case Manager and Member (Bi-Directional Communication) must be documented in the care plan which meets 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. SMART goals must be prioritized, numbered, attainable, measurable, current, reviewed and revised before the expiration date and considers member and caregiver preferences and desired involvement;
f) Documentation of member progress against goals with each member contact;
g) Achievement of goals, revision of goals or goal dates, if applicable;
h) Documentation of progress toward self-management;
i) A schedule for follow-up and communication with the member, including the development and discussion of their self-management plan. This will also include the date for next follow- up, mode for follow-up (phone, in-person) and the reason for follow-up;
j) Assessment of medication adherence;
k) Documentation of any follow-up after a hospitalization;
l) Estimated case savings at the close of the case, if applicable; and
m) Documentation of referrals to resources and follow-up to determine if member acted on referral(s).

4. The IPA must have a documented policy and procedure which addresses all required components related to CCM as stated in the BCBSIL and IPA UM Plan.

5. The Nurse Liaison reviews and audits a random sample of case management cases annually. If the IPA fails their audit they are placed on a CAR until improvement is noted.

6. The Nurse Liaisons evaluate the Population Health (Complex Case Management Program) on an annual basis, and based on the populations assessment, enhancements to the program are made if needs are identified.

7. Oversight and audit of the IPA CCM process are performed by the HMO on an annual basis.

IV. CONTROLS/MONITORING

Control Document or Control Description	Control Owner
Review of Data being Reported Quarterly	Executive Director, Clinical Programs Strategy & Oversight
Oversight of data collection, analyses and reporting as well as development of Annual Program Evaluation.	Executive Director, Clinical Programs Strategy & Oversight

V. SOURCES/REFERENCES

Federal/State	Regulatory Requirements & References
N/A	Blue Cross Medicare Advantage (HMO) Provider Manual - MA HMO Policy and Procedure: https://www.bcbsil.com/pdf/standards/manual/ma_hmo_policy_and_procedure.pdf

VI. AUTHORITY AND RESPONSIBILITY

Stephanie White, Director, Delegation Oversight

VII. PROCEDURE REVIEWERS

Person Responsible for Review	Title	Date of Review
Tammy Wald, RN	Executive Director, Clinical Programs Strategy and Oversight	4-21-2021

VIII. PROCEDURE REVISION HISTORY

Description of Changes	Revision Date
Annual Review: New Template/removed language from section 3 #2	4-21-2021

IX. PROCEDURE APPROVALS

Company, Division, Department and/or Committee	By: Name	Title	Approval date
Illinois Provider Performance	Tammy Wald	Executive Director, Clinical Programs Strategy and Oversight	4-21-2021