



BlueCross BlueShield
of Illinois

Blue Cross Community Health PlansSM
Provider Manual
2025

Confidential and Proprietary

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Overview

The Blue Cross Community Health Plans is a program developed and administered by Blue Cross and Blue Shield of Illinois intended to support delivery of integrated and quality managed care services to enrollees (hereafter referred to as “Members”), supporting seniors, persons with disability, families and children (including special needs children), and adults qualifying for the Illinois Department of Healthcare and Family Services (HFS) Medicaid Program under the Affordable Care Act (ACA). BCBSIL has a network of independently contracted providers including physicians, hospitals, skilled nursing facilities, ancillary providers, Long-Term Services and Support (LTSS) and other health care providers (hereafter referred to as “Providers”) through which BCCHPSM Members may obtain covered services.

BCCHP is available to individuals eligible for Medicaid in the approved service area in the State of Illinois. BCCHP will furnish Members with a Member handbook that will include a summary of the terms and conditions of its plan.

BCBSIL is committed to working with Providers and our Members to achieve a high level of satisfaction with the delivery of quality health care services. One of the goals of BCCHP is breaking down the financial, cultural, and linguistic barriers preventing low-income families and individuals from accessing health care.

About the Provider Manual

This Provider Manual and related Policies and Procedures are designed to provide information regarding BCCHP operations and plan benefits. BCBSIL shall notify Providers of any changes to the Provider Manual.

Questions regarding the information outlined in this Provider Manual may be directed to Provider Network Services.

Key Contact Information

The provider manual is a reference for contracted Providers to use while working with BCBSIL. Providers who have questions may refer to the following chart for a listing of additional resources and related information, such as important telephone, website, and fax numbers. Additional detail may be located on our [Medicaid web page](#).

	Phone	Fax/Email/URL
Availity® Essentials	Availity Client Services 800-282-4548	Availity Essentials
ERA/EOB/EOP <i>if unable to locate in Availity Essentials</i>		https://www.docusign.net/Member/PowerFormSigning.aspx?PowerFormId=7d08cfc4-b2f7-4508-9656-9fd13149f58e&env=na1&acct=beab3a5b-1a85-4b70-bccf-c7372074b491&v=
Customer Services and Eligibility Verification	877-860-2837 Available weekdays: 8 a.m. to 5 p.m. CT	855-297-7280
Provider Data Management: Demographic Change Form Provider Onboarding Form Roster Requests and Submissions		Verify and Update Your Information
Provider Network Services	877-860-2378	855-297-7280
Electronic Claims Submission Facility and Professional claims Payer ID: MCDIL	877-860-2837	855-297-7280
Provider Claims Dispute	877-860-2837	Dispute: 855-322-0717 Claims Inquiry: 855-756-8727 Medicaid Claims Inquiry or Dispute Request Form
Prior Authorizations: eviCore healthcare (eviCore)	855-252-1117 Available weekdays: 7 a.m. to 7 p.m. CT	eviCore Web Portal
Medical Management <i>including prior authorization requests, care management and discharge planning</i>	877-860-2837	312-233-4060
Inpatient Admissions	877-860-2837	
Member Medical Appeals and Grievances Blue Cross Community Health Plans Appeals & Grievances PO Box 660717 Dallas, TX 75266-0717	877-860-2837	866-643-7069 Expedited Appeals: 800-338-2227
Medicaid Service Authorization Dispute Resolution Request		312-653-9443 Medicaid Service Authorization Dispute Resolution Request Form
Medicaid Quality Department for BCBSIL		il_medicaid_qi@bcbsil.com

	Phone	Fax/Email/URL
Pharmacy Prior Authorization	800-285-9426	877-243-6930
Pharmacy Help Desk	855-457-0173	
Pharmacy Appeals Prime Therapeutics Appeals Department 2900 Ames Crossing Road Eagan, MN 55121	855-457-0173	855-212-8110 Electronic: MyPrime.com or CoverMyMeds.com
Behavioral Health	877-860-2837	Utilization Management 312-233-4099
Dental Care	888-281-2076	855-674-9192
ModivCare Inc, transportation provider	877-917-4149	888-513-1610
Heritage Vision Plans Inc, powered by VSP	800-615-1883	
TTY number for the Hearing Impaired	711	711
Language Interpreter Services <i>including sign language and special services for the hearing impaired</i>	877-860-2837	855-297-7280
BCBSIL Secured Email Lockout Assistance	888-706-0583	
Additional Helpful Contacts		
Adult and Children's Mental Health Crisis Hotline	CARES Hotline 800 345-9049 (TTY) 866-794-0374	
HFS Provider notices	https://www2.illinois.gov/hfs/MedicalProviders/notices/Pages/default.aspx	
IAMHP <i>(Illinois Association of Medicaid Health Plans)</i>	https://iamhp.org/providers	
State of Illinois Client Enrollment Services	1-877-912-8880	
Compliance Reporting		
Fraud, Waste, and Abuse Reporting	800-543-0867	
Department of Public Health	800-252-4343	
Illinois Office of Inspector General	800-368-1463	
Elder Abuse Hotline	866-800-1409	

Member Rights and Responsibilities

BCBSIL is committed to the goal of ensuring that enrolled Members are treated in a manner that respects their rights as individuals entitled to receive health care services. BCBSIL also strives to support the cultural, linguistic, ethnic preferences and needs of our Members. BCBSIL policies are designed to help address the issues of Members participating in decision-making regarding their treatment, confidentiality of information, treatment of Members with dignity, courtesy and a respect for privacy, and Members' responsibilities in the practitioner-patient relationship and the health care delivery process.

BCBSIL also holds forth certain expectations of Members with respect to their relationship to the managed care organization and the contracted health care Providers participating in BCCHP. These rights and responsibilities are reinforced in Member and Provider communications, such as the BCBSIL website. As a Provider, you need to be aware of what we communicate to our Members in the Member handbook. These rights, as stated below, should be enforced by you and your staff.

Member Rights:

- *Be treated with respect and dignity at all times.*
- *Have your personal health information and medical records kept private except where allowed by law.*
- *Be protected from discrimination.*
- *Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.*
- *Receive information from BCBSIL in other languages or formats such as through an interpreter or in Braille.*
- *Receive information on available treatment options and alternatives, regardless of cost or benefit coverage.*
- *Receive information necessary to be involved in making decisions about your healthcare treatment and choices.*
- *Refuse treatment and be told what may happen to your health if you do.*
- *Receive a copy of your medical records and in some cases request that they be amended or corrected.*
- *Choose your own primary care provider (PCP) from BCCHP. You can change your PCP at any time.*
- *File a grievance or appeal without fear of mistreatment or backlash of any kind.*
- *Make recommendations regarding the organization's Member rights and responsibility policy.*
- *Request and receive, in a reasonable amount of time, information about your Health Plan, its providers, and policies.*

Member Responsibilities:

- *Treat your doctor and the office staff with courtesy and respect.*
- *Carry your BCCHP ID card with you when you go to your doctor appointments and to the pharmacy to pick up your prescriptions.*
- *Keep your appointments and be on time for them.*
- *If you cannot keep your appointments, cancel them in advance.*
- *Follow the instructions and treatment plan you get from your doctor and comply with agreed-upon goals to provide better care for your health.*
- *Tell your health plan and your caseworker if your address or phone number or any other information changes.*
- *Understand your health status and participate in developing mutually agreed-upon treatment goals to the degree possible.*
- *Read your Member handbook so you know what services are covered and if there are any special rules.*

Nondiscrimination

BCBSIL and the Provider may not deny, limit, or condition enrollment to individuals eligible to enroll in BCCHP on the basis of any factor that is related to health status, including, but not limited to the following:

- Claims experience
- Receipt of health care
- Medical history
- Medical conditions arising out of acts of domestic violence
- Evidence of insurability including conditions arising out of acts of domestic violence and disability

Additionally, BCBSIL and its Providers must:

- Comply with the provisions of the Civil Rights Act, Age Discrimination Act, Rehabilitation Act of 1973, Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act of 2008.
- Confirm that procedures are in place to ensure that Members are not discriminated against in the delivery of health care services, consistent with the benefits covered in their policy, based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

Third-Party Premium Payments

Premium payments for individual plans are a personal expense to be paid for directly by individual and family plan subscribers. In compliance with federal guidance, BCBSIL will accept third-party payment for premium directly from the following entities:

- (1) the Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act; (2) Indian tribes, tribal organizations or urban Indian organizations; and (3) state and federal government programs.

BCBSIL may choose, in its sole discretion, to allow payments from not-for-profit foundations, provided those foundations meet nondiscrimination requirements and pay premiums for the full policy year for each of the covered persons at issue. Except as otherwise provided above, third-party entities, including hospitals and other health care providers, shall not pay BCBSIL directly for any or all of a Member's premium.

Confidentiality of Member Information

Providers must comply with all state and federal laws concerning minor consent and confidentiality of health and other information about Members. Providers must have policies and procedures in place regarding use and disclosure of health information that comply with applicable laws. BCCHP Members have the right to privacy and confidentiality regarding their health care records and information. Providers and each Member of their staff must sign an Employee Confidentiality Statement to be placed in the staff member's personnel file.

Basic Rule

BCBSIL and its Providers must provide or arrange for the provision of all Medicaid services to BCCHP Members. Members must have access to all covered medically necessary items and services.

Uniform Benefits

All plan benefits must be offered uniformly to all Members residing in the service area of the plan. Please note: some Long-Term Supports and Services benefits may vary based upon the type of Home and Community Based (HCBS) Waiver received by the Member.

Access and Availability

Providers are expected to provide coverage for Members twenty-four (24) hours a day, seven (7) days a week. In addition, Providers must maintain a twenty-four (24)-hour answering service and ensure that each PCP provides a twenty-four (24)-hour answering arrangement, including a twenty-four (24)-hour on-call PCP arrangement for all Members. An answering machine does not meet the requirements for a twenty-four (24)-hour answering service arrangement. Hospital emergency rooms or urgent care centers are not substitutes for covering Providers.

After-hours access shall be provided to help ensure a response to after-hours phone calls. Members who believe they have an emergency medical condition should be directed to seek emergency services immediately.

The following appointment availability and access guidelines should be used to help ensure Members have timely access to medical care and behavioral health care services. Members requesting other than routine/preventive services will be triaged by the Provider(s) medical staff to determine which appointment type is needed.

Overall Compliance Appointment Type	Provider Type (can be matched to data file)	Compliance
Routine/Preventive	PCP (Adult)	5 weeks
Routine/Preventive	PCP Ped (<6 Months)	2 weeks
Non-urgent / Requires Medical Attention	PCP (Adult)	3 weeks
Non-urgent / Requires Medical Attention	PCP Ped	3 weeks
Urgent/ Medically Necessary	PCP (Adult)	1 Business Day
Urgent/ Medically Necessary	PCP (Ped)	1 Business Day
Next Available Appointment (Non-Urgent)	All HV/HI	3 weeks
Next Available Appointment (1 st Trimester)	HI/HV OBGYN	2 weeks
Next Available Appointment (2 nd Trimester)	HI/HV OBGYN	1 week
Next Available Appointment (3 rd Trimester)	HI/HV OBGYN	3 days
Emergency Care BH	All BH	6 hours
Initial Visit for Routine Care BH	All BH	10 Business Days
Follow-Up Routine Care BH	All BH	20 Business Days
Urgent / Non-emergent BH	BH Non-Prescribing	48 hours
Urgent / Non-emergent BH	BH Prescribing	48 hours
❖ BH = Behavioral Health		
❖ HI = Endocrinology, Hematology/Oncology, Infectious Disease		
❖ HV = Cardiovascular, OB/Gyn, Ophthalmology, Orthopedic Surgery		

Additionally:

- There shall be a response to the Member by the Provider within 30 minutes of an emergency call.
- An after-hours phone call shall be made to the Member from an appropriate practitioner within an hour of the Member contacting the Provider.
- Provider shall offer hours of operation that are no less favorable than the hours of operation offered to persons who are not Members.
- In addition, to help ensure that enrolled Members have reasonable access to the Provider, hours of operation must include:
 - Evening or early morning office hours three or more times per week;
 - Weekend office hours two or more times per month; and
 - Notification to the Member when the anticipated office wait time for a scheduled appointment may exceed 30 minutes.

BCBSIL requires Providers to provide access to necessary specialist care, and in particular, gives Members the option of direct access to a women's health specialist within the BCCHP network for women's routine and preventive health care services.

Adherence to Member access guidelines will be monitored through follow up regarding grievances related to access and availability, which are reviewed by the Clinical Quality Improvement Committee. Such follow up may occur via phone, email, US Mail and/or an in-person evaluation of the physical location. If you have any questions regarding your site visit, please contact Provider Network Services.

PCP Panel Size Requirement

For BCCHP Members, Contractor's maximum PCP panel size shall be one thousand eight hundred (1800) Members. An additional maximum of nine hundred (900) of such Members is allowed for each resident Physician, Nurse Practitioner, Physician Assistant, and Advanced Practice Nurse who is 100% FTE.

Services Provided in a Linguistically and Culturally Competent Manner

BCBSIL is obligated to ensure that services are provided in a linguistic and culturally competent manner to all Members, including those with limited English proficiency or reading skills and from diverse cultural and ethnic backgrounds, physical disabilities, developmental disabilities, and differential abilities. BCBSIL is committed to the development, strengthening, and sustainability of healthy Provider and Member relationships. Providers are obligated to meet this requirement and can direct Members to BCCHP resources when in need of cultural and linguistic support and services. The BCCHP Customer Service Department (phone number is listed on the back of the Member's ID card) has available the following services for BCCHP Members:

- Teletypewriter (TTY) services
- Language services
- Bi-lingual-speaking Customer Service Representatives

Preventive Services

Members may access certain preventive services from any provider. BCCHP benefits include all covered preventive services. BCCHP Members may directly access in-network screening mammography and administration of common preventive vaccines including but not limited to influenza and COVID-19.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

EPSDT is a mandatory set of services and benefits for all individuals under age 21 who are enrolled in Medicaid. Screening EPSDT includes a comprehensive health and developmental history, an unclothed physical exam, appropriate immunizations, laboratory tests, and health education. Providers shall notify child's parent, designated legal guardian, or adult caretaker of the next scheduled EPSDT screening periods not less than ten (10) working days before the date on which the screening period begins as determined by the child's birthday, the periodicity schedule, and the date of the child's eligibility for services.

Advance Directives

Advance directives are written instructions such as living wills or durable powers of attorney for health care, recognized under the laws of the State of Illinois and signed by a patient, that explain the patient's wishes concerning the provision of health care if the patient becomes incapacitated and is unable to make those wishes known.

BCBSIL is committed to ensuring its Members are aware of and are able to avail themselves of their right to execute an advance directive. BCBSIL is equally committed to ensuring that Providers and staff are aware of and comply with their responsibilities under federal and state law regarding advance directives.

Providers delivering care to BCBSIL Members must ensure that all Members receive information on advance directives and are informed of their right to execute advance directives. Providers must document in a prominent part of the Member's current medical record whether or not the Member has executed an advance directive.

If an advance directive exists, the Provider should discuss potential medical emergencies with the Member as well as a designated family member/significant other (if named in the advance directive and if available) and with the referring physician, if applicable. Any such discussion should also be documented in the medical record.

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Americans with Disabilities Act (ADA) and Civil Rights Act of 1964

Providers are required to comply with the ADA and Civil Rights Act of 1964 to promote the success of BCCHP and support better health outcomes for Members. In particular, successful person-centered care requires physical access to buildings, services and equipment and flexibility in scheduling and processes. BCBSIL also recognizes that access includes effective communication. BCBSIL requires that Providers communicate with Members in a manner that accommodates their individual needs, which includes

- Providing interpreters for those who are deaf or hard of hearing or who do not speak English;
- Accommodating Members with cognitive limitations; and
- Utilizing clear signage and wayfinding, such as color and symbol signage, throughout facilities.

In addition, BCBSIL recognizes the importance of staff training on accessibility and accommodation, independent living and recovery models, cultural competency, and wellness philosophies. BCBSIL will continue to work with Providers to help further develop learning opportunities, monitoring mechanisms and quality measures to promote compliance with all requirements of the ADA.

For more information about the ADA, please visit the ADA website or call the toll-free ADA information line Monday, Tuesday, Wednesday, and Friday 9:30 a.m. to noon and 3 to 5:30 p.m., or Thursday 12:30 to 5:30 p.m. ET to speak with an ADA Specialist. All calls are confidential.

ADA website
www.ada.gov

ADA Information Line
800-514-0301 (voice)
833-610-1264 (TTY)

Section 504 of the Rehabilitation Act of 1973 is a national law that protects qualified individuals from discrimination based on their disability. For more information about Section 504, visit the Department of Health and Human Services Office for Civil Rights website at: www.hhs.gov/ocr.

A list of HHS Office for Civil Rights (OCR) regional offices near you can be found at: <https://www.hhs.gov/about/agencies/regional-offices/index.html>.

Section 504's requirements for new construction and alterations to buildings and facilities are found at 45 C.F.R. Part 84, Subpart C for recipients of federal financial assistance. The regulations are available at: <https://www.hhs.gov/ocr/index.html>.

Provider Orientation and Training

BCBSIL will make available orientation and training to all Providers and their office staffs regarding the requirements of BCCHP.

Provider Orientation

BCBSIL will make available an initial provider orientation within 30 calendar days of the Provider becoming effective with BCCHP. Orientation sessions will be made available for all Providers and their office staffs. Ongoing educational opportunities will be provided to help ensure compliance with plan program requirements. Providers will be made aware of these ongoing educational opportunities through correspondences, website postings and Provider Network Consultant meetings. The sessions may cover, but are not limited to, the following topics:

- Program Overview
- Care Model Overview
- Member Information
- Benefits and Beneficiary Rights
- Critical Incident Reporting

Provider Education and Training

BCBSIL will make available cultural competency, cross cultural communication, and disability literacy training programs to all Providers. The goals of the training programs include, but are not limited to, helping Providers:

- Improve care and simplify the processes for Members to access the items and services they are entitled to under the Medicaid program.
- Improve care continuity and help ensure safe and effective care for both Acute and Long-Term Supports and Services (LTSS).

Disability Literacy training is a requirement for all BCCHP Providers. In this training, the following topics may be covered:

- The Medicaid population, barriers the population may encounter, and prevalent chronic conditions within the population
- Personal prejudices against persons with disabilities
- ADA requirements and the legal obligations of Providers
- Various access requirements (communication, equipment, physical, and program access)
- Person-centered planning and self-determination
- Independent Living and Wellness philosophies and the recovery model
- Evidence-based practices and quality outcomes
- Working with Members with mental health diagnoses regarding crisis prevention and treatment

BCBSIL is committed to helping to ensure that Providers and their office staffs are culturally competent to work with and address the diverse needs of BCCHP Members. BCBSIL will make available ongoing education and training workshops, including but not limited to the topics outlined below, and will require all providers and office staffs to participate in training at least once per calendar year. Such training may include, but is not limited to the following topics:

- Medicaid Overview
- Model of Care/Medical Home (Person-Centered Practice)
- Fraud, Waste, and Abuse (FWA)
- Abuse, Neglect, Exploitation/Critical Incidents
- Cultural Competency
- Americans with Disabilities Act (ADA)/Independent Living
- Medicare Part C and D General Compliance Training

The Provider can complete the required annual compliance training online at https://www.bcbsil.com/provider/network/training_medicaid.html or submit an online or paper BCBSIL/Illinois Association of Medicaid Health Plans (IAMHP) Attestation that certifies completion of the annual compliance training from another Managed Care Organization (MCO). The online attestation can be found here: https://forms.office.com/Pages/ResponsePage.aspx?id=RLYMLpTA10GrPUMgHaJE0AX1cUBQw_NNqHbW8a0yFIUQjBSVFpZU1dTMFJDMUdPNIFRV0k3MUVLNIQICN0PWcu

Provider Education on Waiver Members

The Care Coordination Department will be responsible for distributing to Members with waivers the provider packets for Individual Illinois Department of Human Services (DHS) Home and Community Based Services (HCBS) providers. Care Coordinators will educate Members regarding the Member's responsibility to provide the provider packets to Personal Assistants and other individual providers who provide services under the Persons with Disabilities HCBS Waiver, Persons with HIV/AIDS HCBS Waiver or Persons with Brain Injury HCBS Waiver. Members will be educated that Personal Assistants and individual providers cannot begin providing services until the packets are fully completed. These packets must also be returned to and accepted by the local Division of Rehabilitation Services (DRS) office before services may be provided. If you are a Personal Assistant or individual provider, and have questions about this process, please contact the BCBSIL Care Coordination Department.

BCBSIL will also make available for Providers training about Care Coordination. This training includes:

- The roles and responsibilities of the Interdisciplinary Care Team (ICT)
- Communication pathways between providers and the ICT
- Care plan development
- Consumer direction
- Utilization of Health Information Technology and awareness of available electronic options to support care coordination

Health Education for Members

BCBSIL encourages Providers to provide health education to Medicaid Members. Provider Network Consultants will make available training to help support Member education on topics such as preventive care, disease-specific and plan services information. The goal of this education will be to promote compliance with treatment and encourage self-direction from Members.

Coordination with Other Service Providers

BCBSIL encourages Providers to cooperate and communicate with other service providers who serve Medicaid Members. Such other service providers may include but are not limited to WIC programs, Head Start programs, Early Intervention programs, day care programs, and school systems. Such cooperation may include performing annual physical examinations for school and the sharing of information (with the consent of the Member, parent, or legal guardian if the Member is underage). Annual health examinations for school include an age-appropriate developmental screening, and an age-appropriate social and emotional screening, as required by Public Act 99-927.

Provider and Health Plan Education at Provider Locations

Providers and their staff shall ensure that a client is aware of all plan choices and shall use materials approved by BCBSIL and HFS in educating individuals. At the request of a Provider, a flyer/letter template will be provided to Providers to use in their offices which will require the Provider to include all health plans that they are contracted with.

If a Provider chooses to *prefer* a health plan in the flyer/letter (the preference must be a benefit to the recipient, not only to the Provider), Providers may add a paragraph to the flyer/letter indicating their preference. The paragraph must make no false or disparaging statements about other health plans and must be presented in a positive way. Any flyer/letter that has a preferred provider paragraph must be submitted through BCBSIL for HFS approval. You may contact your Provider Network Consultant (PNC) to assist with the approval process.

The Provider template flyer/letter, including those with a preferred health plan paragraph, must have a statement at the bottom that states, “Illinois Client Enrollment Services will send you information about your health plan choices when it is time for you to make a health plan choice and during your Open Enrollment period.”

Provider offices are prohibited from providing client access to the Client Enrollment Services Enrollment Portal to make an online enrollment choice within any provider setting. This includes all Health Plan primary care provider offices, health fairs, or other health plan functions where enrollment may be discussed. If a potential Member is not currently enrolled with a Health Plan, you may refer them to the Illinois Client Enrollment Services at 877-912-8880 for information about their health plan choices. An individual that is not enrolled in a health plan may also be excluded from participating in a managed care program. These individuals should be referred to HealthChoice Illinois (<https://enrollhfs.illinois.gov/en/contact>) for assistance in finding providers for needed services.

In addition to the above guidelines and in accordance with the Provider Agreement, Providers may not utilize BCBSIL name(s) or symbol(s) without prior written approval by BCBSIL.

Pharmacy

- BCCHP uses a Preferred Drug List (PDL). The PDL is provided by the Illinois Department of Healthcare and Family Services (HFS).
- BCCHP must follow the HFS provided PDL. This is to help the Member’s doctor choose which drugs to provide. As of 12/2023 HFS has not provided any unique PDL requirements for this population.
- Covered drugs on the PDL have a \$0 copay if filled at in-network pharmacies.
- Certain drugs on this list need approval or have limits based on medical necessity.
- Members will use the same pharmacy network as for BCCHP.

Enrollment

Immigrant Adults (HBIA)

Must meet all 4 requirements:

1. At least 42 years old and not over age 64.
2. One of the following:
 - a. A lawful permanent resident (LPR) for a minimum of five years, or
 - b. An undocumented immigrant (including individuals in a Temporary Protected Status)
3. Resident of Illinois
4. 2022 annual household income is at or below \$18,754 for one person; at or below \$25,268 combined income for a household size of two. The income limit differs depending on the number of household members

Immigrant Seniors (HBIS)

Must meet all 4 requirements:

1. 65 years old or older
2. One of the following:
 - a. A lawful permanent resident (LPR) for less than five years, or
 - b. An undocumented immigrant (including individuals in a Temporary Protected Status)
3. Resident of Illinois
4. 2022 annual income is at or below \$13,590, or a couple with annual income at or below \$18,310. An individual with assets below \$2,000, or a couple with assets under \$3,000* CURRENTLY WAIVED FOR COVID-19

Provider Data Management

It is the responsibility of the Provider to submit accurate demographic and indicative data upon request for participation, to submit any changes 90 days prior to the effective date of those changes, and to periodically review, correct and/or attest to the accuracy of their data in our systems through roster reconciliations or other means of verification as directed by BCBSIL. Such data will include, but is not limited to, all fields included on the Universal Standardized Roster as well as additional telehealth data.

Information about the ways to submit and verify Provider demographic and indicative data can be found here: <https://www.bcbsil.com/provider/network/network/information-update>

In event of practice closure, Providers may submit with at least 90 days' notice the details of that closure in writing, on letterhead. Letter should include the circumstances and effective date of closure, the practicing address(es), TIN(s), and NPI(s) affected, as well as the name, title, email and contact phone for the submitter as well as the practice's contract signatory.

Program Compliance

BCCHP Providers are required to cooperate and comply with BCBSIL medical policies as well as BCBSIL policies, procedures and programs for quality improvement, performance improvement and medical management, including, as applicable, drug utilization management, medication therapy management and e-prescribing programs. Contractors shall require that all contracted hospitals and birthing centers have policies in place that safely reduce c-sections and early elective deliveries (EED). Cooperation and compliance includes, but is not limited to, making all records and information regarding medical services rendered, medical management and quality improvement activities available to BCBSIL and Illinois Department of Healthcare and Family Services (HFS) upon request, and providing BCCHP data, as may be necessary, for BCBSIL to implement and operate any and all quality improvement and medical management programs.

Cultural Competency and Diversity

Providers must understand cultural competency as it pertains to Members they may see in their practice. Cultural competency refers to a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals, that enables them to work effectively in cross-cultural situations. Cultural competency involves the integration and transformation of knowledge, information and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques and marketing programs that match an individual's culture and which are intended to increase the quality and appropriateness of health care and outcomes. Providers are expected to take into consideration the Member's racial and ethnic group, including their language, histories, traditions, beliefs, and values when rendering or referring Members for medical services.

Providers are also encouraged to respect and value human diversity and make a good faith, reasonable effort to utilize minority, women, and disabled owner business enterprises in the performance of services provided under BCCHP.

Providers are required to provide an interpreter when the Member does not speak or understand the language that is being spoken. BCBSIL offers Language Interpreter Services to support Members and Providers in this requirement.

Compliance with Federal Electronic Data Interchange Standards

Providers are required to transmit data to and receive data from BCBSIL, which information includes, but is not limited to, data relating to health care claims and equivalent encounter information, health care claims status, Member enrollment and eligibility, health care payment and remittance advice, premium payments, referral certification and authorization, coordination of benefits, first report of injury and health claims attachments using only the code sets and data transmission standards as issued, and in effect by, the United States Department of Health and Human Services as published in 45 Code of Federal Regulations Part 142; and comply and ensure compliance by its officers, employees and Physicians, with all electronic data security standards as issued and in effect by the United States Department of Health and Human Services as published in 45 Code of Federal Regulations Part 142; and accept electronic claims and encounter data that may be routed to the provider by BCBSIL, a physician or other health care provider or clearinghouse.

Protected Health Information (PHI)

Providers must follow all laws regarding privacy and confidentiality including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provisions for the use of PHI and the provisions identified below and must require any sub-delegates to follow those same provisions:

- Use PHI (any Member identifiers that can be linked to a Member) only to provide or arrange for the provision of medical and behavioral health benefits administration and services;

- Provide a description of appropriate safeguards to protect the information from inappropriate use or further disclosure;
- Ensure that sub-delegates have similar safeguards;
- Provide individuals with access to their PHI;
- Inform all affected parties, including the provider, if inappropriate use of the PHI occurs; and
- Ensure that PHI is returned, destroyed, or protected if the contract ends.

Medical Records

Providers are required to provide medical records requested by BCBSIL. Purposes for which medical records from Providers are used by BCBSIL include, but are not limited to:

- Advance benefit determinations
- Plan coverage
- Medical necessity
- Proper billing
- Quality reporting
- Fraud and abuse investigations

PCPs are required to maintain a permanent medical record for each Member and that medical record shall be available to the PCP, WHCP, and other Providers. Medical record reporting requirements shall be adequate to provide for acceptable Continuity of Care to Members and PCPs shall send copies of medical records, at no charge to the Member or Plan, to any new PCP that the Member transfers to.

The medical records must include Provider identification and all entries in the medical record must be legible, accurate, complete, and dated, and include the following where applicable:

- Member identification;
- Personal health, social history and family history, with updates as needed;
- Risk assessment;
- Obstetrical history and profile;
- Hospital admissions and discharges;
- Relevant history of current illness or injury and physical findings;
- Diagnostic and therapeutic orders;
- Clinical observations, including results of treatment;
- Reports of procedures, tests, and results;
- Diagnostic impressions;
- Member disposition and pertinent instructions to the Member for follow-up care;
- Immunization record;
- Allergy history;
- Periodic exam record;
- Weight and height information and, as appropriate, growth charts;
- Referral information;
- Health education and anticipatory guidance provided; and
- Family Planning and counseling.

PCP's shall only release copies of medical records to Authorized Persons upon request. Original medical records shall be released only in accordance with federal or State law, including court orders or subpoenas, or a valid records-release form executed by a Member. PCPs shall document efforts to obtain Member's consent when required by law.

Providers are required to maintain and share medical records, mental-health records, and any other information about Member for the Department upon request and in accordance with professional standards.

Initial Health Risk Screening

Members will complete a Health Risk Screening (HRS) within 60 days enrollment into the plan. BCCHP will call or text a Member after enrolling to complete their HRS. This screening will help determine Member's health habits, if they have any health risks, determine Care Coordination stratification level for purpose of engagement in the Care Coordination Program.

- Members can call Member Services at 1-877-860-2837 if they missed our call or text and would like to complete their HRS.
- Members can also log into the free Blue Access For Members (BAM) account to complete the HRS.

Quality Improvement

Quality improvement (QI) is an essential element in the delivery of care and services to Members. To help define and assist in monitoring quality improvement, the BCBSIL QI Program focuses on measurement of clinical care and service delivered by Providers against established goals.

Providers are required to cooperate with BCBSIL's quality improvement activities and participate in the BCBSIL QI Program. Providers' cooperation with the QI Program includes, but is not limited to:

1. Cooperate with the BCBSIL data collection process by reviewing medical and administrative records for identified Members and submitting requested documentation to BCBSIL.
2. Permit BCBSIL to publish results related to Provider's clinical performance
3. Permit BCBSIL Medical Director(s) and/or BCBSIL staff to inspect, at mutually agreed upon times, but no later than seven days after a request, the premises used by the Provider for Members, as well as to study all phases of the medical services provided by the Provider to Members. Study may include the inspection of medical records.
4. Facilitate access to Provider's medical records, including electronic medical records, for Quality Improvement Program (QIP) reporting and other BCBSIL quality improvement initiatives;
5. Submit an annual emergency preparedness plan and copies of CPR (cardiopulmonary resuscitation) cards to BCBSIL personnel upon request;
6. Should a site visit be requested by BCBSIL, Provider will maintain an ADA physical site review score of 90 percent or better, which includes accessibility and facility inspection.

Utilization Management (UM)

The BCBSIL Utilization Management (UM) program includes:

- Admission notification (emergency admissions)
- Prospective review (benefit preauthorization and pre-certification)
- Concurrent review
- Discharge planning
- Retrospective review

Providers are required to cooperate with BCBSIL's UM policies and procedures and participate in BCBSIL's UM Program concerning BCCHP Members as the policies and procedures are developed and implemented. Provider cooperation with the UM Program includes, but is not limited to:

1. Cooperate with the BCBSIL UM program for hospital, skilled nursing facility and other inpatient facility admissions, home health care, outpatient surgery and outpatient specialist services, home and community-based waiver services, supportive living facilities, mental health and substance abuse services;
2. Adhere to BCBSIL requirements for pre-admission certification, concurrent review, and case management activities;
3. Participate in BCBSIL disease and case management programs;
4. Designate a staff member employed by the Provider who will serve as the primary contact for BCBSIL and will be responsible for care coordination activities including, but not limited to, the following:
 - a. Facilitate physician involvement in the development and ongoing monitoring of the Member's individualized care plan;
 - b. Cooperate with the BCBSIL care coordination team, Member's designated integrated health home, and quality team in arranging or scheduling Provider services; and
 - c. Submit to BCBSIL all physician orders for BCCHP Members that require prior authorized services.
5. Communicate appropriate treatment alternatives, regardless of cost or benefit coverage.
6. Distribute within their group or facility BCBSIL information to all Providers, which includes, but is not limited to:
 - a. Designated UM reports;
 - b. Pharmacy reports;
 - c. Quality reports including reports identifying Members with gaps in care for targeted quality metrics;
 - d. *Blue Review* provider newsletter;
 - e. Any network survey results as requested by BCBSIL.

Health Benefits for Immigrant Adults and Seniors (HBIA/HBIS)

Starting in 2024, the State of Illinois is now offering medical coverage to immigrant adults aged 42-64 and immigrant seniors aged 65+, both regardless of their immigration status. The new medical program offers a full benefit package. The program may cover up to 3 months of health care services prior to the Member's enrollment. Additional information can be found at <https://www.bcbsil.com/bcchp/hbia-hbis/hbia-hbis>

Covered services include:

- Doctor and hospital care
- Lab tests
- Rehabilitative services such as physical and occupational therapy
- Home health, mental health and substance use disorder services
- Dental and vision services
- Prescription drugs
- 90- day nursing facility rehab stays

Are there unique processes for Appeals and Grievances or UM for this population?

- No. Requirements are the same as for other BCCHP Members.

What is Not Covered?

- Home and Community Based Waiver services are not covered services
- Transplant services are limited to kidney transplants and inpatient stem cell transplants
- Long Term Care facility services are not covered

Copayments for the Programs

- Nonemergency Inpatient Hospitalization: Up to \$250
- Nonemergency Hospital or Ambulatory Surgical Treatment Center Outpatient Services: Up to 10% of the Medicaid payment. The amount that can be charged will vary depending on the service.

Compliance, Fraud, Waste and Abuse Program and Reporting

Compliance Program

Providers are required to implement and maintain a compliance program that, at a minimum, meets the standards for an effective compliance program set forth in Laws, including, without limitation, the Federal Sentencing Guidelines, and that address the scope of services under BCCHP. The Provider's compliance program must require cooperation with BCBSIL's compliance plan and policies and include, at a minimum, the following:

1. A code of conduct specific to the Provider that reflects a commitment to preventing, detecting, and correcting fraud, waste and abuse in the administration or delivery of covered services to Members. BCBSIL's code of conduct is available at <http://www.hisccompliance.com>.
2. Compliance training for all employees, subcontractors, any affiliated party, or any downstream entity involved in the administration or delivery of covered services to Members or involved in the provision of delegated activities such as:
 - a. General compliance training to employees, subcontractors, any affiliated party, or any downstream entity involved in the administration or delivery of covered services to Members or involved in the provision of delegated activities at the time of initial hiring (or contracting) and annually thereafter. General compliance training must address matters related to the Provider's compliance responsibilities, including, without limitation, (a) Provider's code of conduct, applicable compliance policies and procedures, disciplinary and legal penalties for non-compliance and procedures for addressing compliance questions and issues; (b) Provider's obligations to comply with Laws; (c) common issues of non-compliance in connection with the provision of health care services to Members; and (d) common fraud, waste and abuse schemes and techniques in connection with the provision of health care services to Members.
 - b. Providers will also provide specialized compliance training to personnel whose job function directly relates to the administration or delivery of covered services to Members on issues particular to such personnel's job function. Such specialized training shall be provided (i) upon each individual's initial hire (or contracting); (ii) annually; (iii) upon any change in the individual's job function or job requirements; and (iv) upon the contracted Provider's determination that additional training is required because of issues of non-compliance.
 - c. Providers must maintain records of the date, time, attendance, topics, training materials and results of all training and related testing. Upon request, Providers will provide to BCBSIL annually a written attestation certifying that the Provider has provided compliance training in accordance with this section.
3. Policies and procedures that promote communication and disclosure of potential incidents of non-compliance or other questions or comments relating to compliance with Laws and the Provider's compliance, and anti-fraud, anti-waste, and anti-abuse initiatives. The program must include implementation and publication to Provider's directors, officers, employees, agents, and contractors of a compliance hotline, which provides for anonymous reporting of issues of non-compliance with Laws or other questions or comments relating to compliance with Laws and the Provider's anti-fraud, anti-waste, and anti-abuse initiatives.
4. Annual compliance risk assessments performed at the Provider's sole expense. Upon request, the Provider will share the results of the assessments with BCBSIL to the extent any part of the assessment directly, or indirectly, relates to BCBSIL.
5. Routine monitoring and auditing of the Provider's responsibilities and activities with respect to the administration or delivery of covered services to Members.
6. Upon request, provide to BCBSIL reports of the activities of the Provider's compliance program required by BCBSIL, including reports and investigations, if any, of alleged failures to comply with laws, regulations, the terms and conditions of the HFS Contract, or the BCBSIL Medical Service Agreement so that BCBSIL can fulfill its reporting obligations under Laws.
7. Upon request, provide to BCBSIL the results of any audits related to the administration or delivery of covered services to Members.
8. Make appropriate personnel available for interviews related to any audit or monitoring activity.

Incidents of Suspected Non-Compliance, Fraud, Waste or Abuse

Providers must promptly investigate any potential and/or suspected incidents of non-compliance with Laws, fraud, waste, or abuse in connection with the BCBSIL Medical Service Agreement and/or the administration or delivery of covered services to Members and report any incident to BCBSIL as soon as reasonably possible, but in no instance later than 30 calendar days after the Provider becomes aware of such incident. Notice to BCBSIL must include a statement regarding the Provider's efforts to conduct a timely, reasonable inquiry into the incident, proposed or implemented corrective actions in response to the incident and any other information that may be relevant to BCBSIL in making its decision regarding self-reporting of such incident.

Providers must cooperate with any investigation by BCBSIL, HFS, the Department of Health and Human Services (HHS) or their authorized designees relating to the incident. Failure to cooperate with any investigation may result in a referral to law enforcement and/or other implementation of corrective actions permitted under Laws.

The Provider must require its downstream entities to promptly report to the Provider, who shall report to BCBSIL, any incidents in accordance with this section.

Conflicts of Interest

The Provider shall require any manager, officer, director, or employee associated with the administration or delivery of covered services to Members to sign a conflict of interest statement, attestation, or certification at the time of hire, and annually thereafter, certifying that such individual is free from any conflict of interest in administering or delivering covered services to Members. The Provider shall supply the form of such statement, attestation, or certification to BCBSIL upon request.

Compliance Reviews

Providers must provide BCBSIL with access to Provider records, physical premises and facilities, equipment, and personnel in order for BCBSIL, in its sole discretion and at its sole cost and expense, to conduct compliance reviews in connection with the terms of the BCBSIL Medical Service Agreement.

Sanctions under Federal Health Programs and State Law

Providers are required to check the appropriate databases specified in the Provider Contract at least monthly to ensure that no management staff or other persons who have been convicted of criminal offenses related to their involvement with Medicaid, or other federal health care programs, are employed or subcontracted by the Provider.

Providers must disclose to BCBSIL whether the Provider or any staff member or subcontractor has any prior violation, fine, suspension, termination or other administrative action taken under Medicaid laws, the rules or regulations of the State of Illinois, any government sponsored program or any public insurer. Providers must notify BCBSIL immediately if any such sanction is imposed on a Provider, a staff member or subcontractor.

Membership Information

Primary Care Physician Selection

BCBSIL requires that all Members enrolled with BCCHP select a Primary Care Physician (PCP).

Assignment to PCP

Members are required to have a PCP. Members who have not selected a PCP within 30 days of their enrollment date will be assigned a PCP by BCBSIL. BCBSIL will consider the following in the assignment process:

1. Prior history with a PCP, if available
2. Ability of PCP to help meet the needs of the Member
3. Location of PCP to Member residence

Identification Cards

All eligible BCCHP Members are issued an identification card.

Identification cards are generated when:

- Member becomes eligible
- Member name changes
- Member changes PCP
- PCP phone number change
- Requested by contacting Member Services at 1-877-860-2837 (TTY/TDD: 711)
- Requested after login to Blue Access for Members (BAM) at www.bcbsil.com

Each identification card contains the following information:

- Product name – Blue Cross Community Health Plans
- Member name
- Effective date – The Member's most current effective date
- PCP name
- PCP phone number
- Prescription drug benefit information
- The 24-hour telephone number to confirm eligibility and for benefits and benefit preauthorization for services

Below are examples of typical BCCHP identification cards. Note: BCBSIL reserves the right to change the ID cards without advance notice.

BCCHP Member ID Card

 	
MEMBER INFORMATION	PROVIDER INFORMATION
MEMBER NAME: <Cardholder Name> MEDICAID ID: <Medicaid Recipient ID#> MEMBER ID: XOG<Cardholder ID#> GROUP NUMBER: <Group #> ENROLLMENT EFFECTIVE DATE: <01/01/2020>	PCP NAME: <PCP Name> PCP PHONE: <PCP Phone> <hr/> RxBIN: <RxBIN #> RxPCN: <RxPCN #> RxGRP: <RxGRP#>
Member Services: 1-877-860-2837 TTY/TDD: 711 Website: www.bcchpil.com	


BCCHP – MLTSS Member ID Card

 	
MEMBER INFORMATION	GROUP INFORMATION
MEMBER NAME: <Cardholder Name> MEDICAID ID: <Medicaid Recipient ID#> MEMBER ID: XOG<Cardholder ID#> ENROLLMENT EFFECTIVE DATE: <01/01/2020>	GROUP NUMBER: <Group #> BENEFIT GROUP: <Group Name>
Member Services: 1-877-860-2837 TTY/TDD: 711 Website: www.bcchpil.com	

	
MEMBER CONTACT INFO	PROVIDER CONTACT INFO
BENEFIT QUESTIONS: 1-877-860-2837 TRANSPORTATION: 1-877-860-2837 DENTAL: 1-888-291-3763 BEHAVIORAL HEALTH CRISIS LINE: 1-800-345-9049 24/7 NURSELINE: 1-888-343-2697	PROVIDER CLAIMS: 1-877-860-2837 Blue Cross Community Health Plans P.O. Box 3418 Scranton, PA 18505 PHARMACY CLAIMS: 1-855-457-0173
<small>Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association</small>	

	
MEMBER CONTACT INFO	PROVIDER CONTACT INFO
BENEFIT QUESTIONS: 1-877-860-2837 TRANSPORTATION: 1-877-860-2837 BEHAVIORAL HEALTH CRISIS LINE: 1-800-345-9049 24/7 NURSELINE: 1-888-343-2697	PROVIDER CLAIMS: 1-877-860-2837 Blue Cross Community Health Plans P.O. Box 3418 Scranton, PA 18505
<small>Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association</small>	

BCCHP – HBIA/HBIS Member ID Card

 Regulatory Agency – HealthCare and Family Services	
MEMBER INFORMATION	PROVIDER INFORMATION
MEMBER NAME: <Cardholder Name> MEDICAID ID: <Medicaid Recipient ID#> MEMBER ID: XOG<Cardholder ID#> GROUP NUMBER: <Group #> EFFECTIVE DATE: <01/01/2024>	PCP NAME: <PCP Name> PCP PHONE: <PCP Phone> <hr/> RxBIN: <RxBIN #> RxPCN: <RxPCN #> RxGRP: <RxGRP #>
NON - EMERGENCY CO-PAYS	HBIA/S
Inpatient Hospitalization: \$250 Ambulatory Surgical Centers and Outpatient Hospital Services: 10% of the Medicaid Rate	
MEMBER SERVICES: 1-877-860-2837 (TTY/TDD: 711) WEBSITE: www.bcchpil.com	

	
MEMBER CONTACT INFO	PROVIDER CONTACT INFO
TRANSPORTATION: 1-877-831-3148 DENTAL: 1-888-291-3763 BEHAVIORAL HEALTH CRISIS LINE: 1-800-345-9049 24/7 NURSELINE: 1-888-343-2697	PROVIDER CLAIMS: 1-877-860-2837 Blue Cross Community Health Plans P.O. Box 3418 Scranton, PA 18505 PHARMACY CLAIMS: 1-855-457-0173
<small>Blue Cross Community Health Plans is provided by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association.</small>	

Unassigned Members

There are occasions where a Member will be eligible with BCCHP but does not have a valid PCP assignment, for example:

- The Member does not indicate a PCP selection on the enrollment application
- If the Member is “asked out” of a PCP practice and fails to select a new PCP in the designated time frame
- BCCHP cannot determine the PCP selection on the enrollment application
- The Member chooses an invalid PCP selection

If any of the above circumstances occur, the Member will not receive an ID card. The Member will be contacted requesting that they choose a PCP. If a Member does not choose a PCP, BCBSIL will assign the Member to a PCP based on BCCHP established protocols.

If a Member wishes to change their PCP assignment, they can do so anytime via the Blue Access for Members (BAM) portal, or by calling Member Services at 877-860-2837 (TTY/TDD: 711)

Verifying Membership

Providers can check Member eligibility via Availity Essentials (www.availity.com) or by phone at 877-860-2837. Remember to always check the Member’s ID card before services are rendered.

Introduction and Guidelines for Benefits Interpretation

The Scope of Benefits is based, in part, on Medicaid State Plan benefits and services including but not limited to home and community-based waiver services. HFS has the right to make changes to BCCHP benefits.

Each BCCHP Member receives a BCCHP Member handbook upon enrollment. Information in the Member handbook is also available online via the secure Member portal (BAM: Blue Access for Members).

The Provider is responsible for providing or arranging for all covered physician services, provider-approved inpatient and outpatient hospital services, ancillary services, long-term care support services and non-hospital-based emergency services within the scope of benefits of the Member handbook.

All inpatient hospital admissions (except out-of-area admissions), skilled nursing facility (SNF) days and home health visits must be approved by the Provider to be covered by BCCHP.

Covered services to a Member will cease upon the effective date of disenrollment. Under special circumstances, the Provider can request an exception from the Customer Services Department before the service is rendered.

This section is intended to provide a quick reference of covered and non-covered services. It includes frequently asked benefit questions and clarification on some issues that may be misinterpreted based upon past experience. However, it is not possible to include everything. Eligibility and Benefit information may also be obtained via Availity Essentials (www.Availity.com). If you have additional questions regarding covered services, please contact the Customer Service Department.

Medicaid Covered Services

BCCHP must cover all services and benefits covered by Medicaid. Covered services eligible for benefits under BCCHP are in accordance with the terms of the Medicaid program. BCCHP may offer additional benefits and services. For complete details including benefits, limitations and exclusions, Members should refer to their Member handbook. Providers should refer to resources made available for Providers including, but not limited to, those on bcbsil.com and in Availity Essentials.

All services must meet the definition of Medically Necessary Services as defined in the Member handbook and in Provider resources. Some services may have coverage limits, need a doctor's order, and/or need prior approval.

In addition to the covered waiver services described in the table below, BCBSIL covers the following for eligible BCCHP Members:

- Long Term Care
- Long Term Care SLF Dementia Care
- Non-Emergency Transportation
- Non-Emergent Ambulance Transportation
- Mental Health Rehabilitation Services
- Alcohol and Substance Abuse Rehabilitation Services
- Dental

Home and Community Based Waiver Services

Home and Community Based Services (HCBS) waivers are granted under the authority of Section 1915c of the Social Security Act, enabling states to provide services (other than room and board) to individuals as an institutional alternative.

Individuals served by waivers are most commonly disabled and/or over age 65.

In order to be eligible for a waiver, persons usually must require a level of care that, in the absence of community services, would require placement in one or more of these institutional settings:

- Hospital,

- Nursing Facility, or
- Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID)

States can offer a combination of standard medical and non-medical community services to divert or move individuals from institutional settings into their homes and community. Illinois HCBS waivers may be granted in the following situations:

- **Aging Waiver** – For individuals 60 years and older that live in the community.
- **Individuals with Disabilities Waiver** – For individuals who have a physical disability and are between the ages of 19-59.
- **HIV/AIDS Waiver** – For individuals that have been diagnosed with HIV or AIDS.
- **Individuals with Brain Injury Waiver** – For individuals with an injury to the brain.
- **Supportive Living Facilities** – For individuals that need assistance with the activities of daily living but do not require the care of a nursing facility.

Medicaid Covered Home and Community Based Waiver Services:

Members may qualify for Home and Community-Based Services waiver (HCBS), Supportive Living Facility (SLF) or Long-Term Care (LTC) benefits. Eligibility for these benefits or waivers is determined solely by the State of Illinois. This is usually done through an assessment tool, the Determination of Need (DON). In this process, the Member will be asked a series of questions and given an overall score. Based on the Member’s DON score, the state will determine if the Member is eligible for a waiver service or benefits to reside in a SLF or LTC facility. The table below is an outline of services available under a HCBS waiver.

Service	Waiver			
	Elderly	Disability	HIV/AIDS	Brain Injury
Adult Day Service	√	√	√	√
Adult Day Service Transportation	√	√	√	√
Environmental Modification		√	√	√
Supported Employment				√
Home Health Aide		√	√	√
Nursing, Intermittent		√	√	√
Nursing, Skilled		√	√	√
Occupational Therapy		√	√	√
Personal Assistant		√	√	√
Physical Therapy		√	√	√
Speech Therapy		√	√	√
Prevocational Services				√
Day Habilitation				√
Homemaker	√	√	√	√
Home Delivered Meals		√	√	√
Emergency Home Response System	√	√	√	√
Respite		√	√	√
Adaptive Equipment		√	√	√
Behavioral Services				√

This table is provided for informational purposes only and is not a guarantee that an individual will receive a waiver. Waiver determinations are made by the State of Illinois.

Overview of Care Coordination

Care Coordination is designed to assist Members (and their families and caregivers) with multiple, complex, cognitive, physical, behavioral and special health care needs. Care Coordination seeks to integrate health care service providers involved in addressing all aspects of a Member's needs.

Care Coordination is designed to help identify the Member's medical, behavioral health and social needs and seeks to have necessary services provided and coordinated by:

- Providing a designated person who is primarily responsible for coordinating the Member's health care services;
- Assisting with access to Providers for Members with special needs;
- Assisting with coordination of medical and behavioral health services; and
- Interfacing and collaborating with outside entities or a Member's case manager, if applicable. The care coordinator may also refer the Member to case management as needed.

The Care Coordinator is not a substitute for the Member's doctor or health care provider. Members should discuss any questions or concerns about their health with their doctor/health care provider. Providers are required to exercise their independent medical judgment in providing services for their patients.

Members who meet criteria outlined by IL Medicaid for care coordination will be assigned a Care Coordinator. Members may also call in to request a Care Coordinator, in which case a Care Coordinator will be assigned to them. An Interdisciplinary Care Team (ICT) is developed with the Member's input which supports the Member in identifying and reaching their individualized goals. A care plan is developed by the Member and the ICT and progress is evaluated regularly to ensure there are no barriers or risks to meeting goals. This is accomplished through regularly scheduled ICT meetings. The Care Coordinator is also a point of contact for the Member when questions arise about benefits, services, and health concerns. Care Coordination must be notified by Providers **at least two (2) business days prior** to the disruption or discontinuance of a Member's services. This notification will allow the Care Coordination team to assess the situation and assist in the coordination of services for the impacted Member(s). This notification may be e-mailed to LTSS_SupportCtr@bcbsil.com.

The State of Illinois has a statewide program named the Family Case Management Program (FCM) that helps income eligible clients with a pregnant woman, infants, or young children to obtain the health care services and other assistance they may need to have a healthy pregnancy and to promote the child's healthy development.

The program serves pregnant women and infants in families that are below 200% of the federal poverty level. Local FCM programs develop close working relationships with physicians, hospitals, pharmacist, and other specialty medical providers. The FCM program also collaborates (and develops signed working agreements) with community agencies to address barriers in accessing medical services, childcare, transportation, housing, food, mental health needs and substance abuse services. Case management providers are extensions of the local Department of Human Service offices in that they serve as authorized agents for completing Medicaid Presumptive Eligibility (MPE) applications for pregnant women and assist families in completing All Kids applications for their children. These providers are not directly contracted with BCBSIL and the Blue Cross Community Health Plans. BCBSIL does work to collaborate with these entities to ensure our Members have continuous care and receive the care and/or referrals to programs that are needed. For additional information on the State of Illinois' Family Case Management Program please visit <https://www.dhs.state.il.us/page.aspx?item=143419> or contact the provider help line and request to speak with a Special Beginnings care manager.

Comprehensive Health Assessments

Based on the results of the health risk screening and other data sources, a comprehensive health risk assessment may be indicated. This may be completed telephonically or face-to-face. These assessments seek to identify the Member's unique needs. The goals of the assessment include the following:

- Identify possible Member health care needs;
- Assist with access to health care services;
- Assist with coordination of care;
- Provide telephonic educational or written materials via mail as needed; and
- Refer Members to appropriate case and condition management/disease management programs as may be needed.
 - Programs include Care Coordination, Complex Case Management, Disease Management, Pregnancy Support (Special Beginnings), Transition of Care, and Wellness Education.

Disease Management and Complex Case Management referrals

There are multiple ways in which a member interested in our disease management or complex case management programs can be referred. Those include:

1. Medical management referral
2. Discharger planner referral
3. Member or caregiver referral
4. Practitioner referral

BCCHP Utilization Management Program

The BCCHP Utilization Management (UM) Plan is developed by BCBSIL in accordance with the requirements prescribed by the Illinois Department of Healthcare and Family Services (HFS), the Illinois Department of Insurance and other regulatory and accrediting agencies. The UM plan is evaluated and may be revised annually by BCBSIL.

The BCCHP UM Plan incorporates standards related to the monitoring of care and services rendered to BCCHP Members. BCBSIL is responsible, unless delegated to another party, for the performance of UM and Case Management (CM), including complex and intensive case management, for Members receiving physical health care, Long-Term Supports and Services (LTSS) and behavioral health services.

Physician Responsibility for Care

Providers are solely responsible for the provision of all health care services to BCCHP Members and all decisions regarding Member treatment and care are the sole responsibility of the Provider. Such decisions are not directed or controlled by BCBSIL. BCBSIL's decisions about whether any medical service or supply is a covered benefit under the Member's BCCHP benefit plan are benefit decisions only and are not the provisions of medical care. It is the Provider'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. Providers and subcontractors are encouraged to cooperate and communicate with other service providers who serve Members. Providers are required to provide services to Members in the same manner and quality as those services that are provided to other patients who are not BCCHP Members.

Program Scope

The UM Program is applicable to all Members in BCCHP living in the service area. The UM Program is under the direction of the BCBSIL Medical Director. The goal of the UM process is to integrate the admission, ongoing prior authorization of benefits for inpatient hospital, residential treatment, skilled nursing facility care, long-term acute care (LTAC), Long Term Supports and Services (LTSS), outpatient care, office and home care and discharge planning functions and to assist Members with receiving benefits for continuity of service across the continuum. One goal of the UM program is to help in the assessment process that identifies specific health care needs and works with the Member, family, and physician in order to help meet the assessed needs.

Utilization Review

BCBSIL reviews and evaluates the following data, and such other information as BCBSIL deems appropriate, in order to identify any patterns of potentially inappropriate utilization:

- Inpatient admissions/1000 (including acute and Long-Term acute care);
- Inpatient days/1000;
- Average length of stay (LOS);
- Outpatient surgery/1000;
- ER visits;
- BH and CD days/1000; and
- Member satisfaction data from annual surveys

Also, claims payment data, denial files, customer service issues, quality of care issues, diagnosis, referrals, case detail, Member satisfaction and appeals are also utilized to identify potential problems. Data is collected at the Provider level. When deemed appropriate, an action plan is requested from the Provider. It may include any of the following components: further data collection, written requests for action, meeting with the network consultant and the Provider.

Benefit Preauthorization and Referral Process

- Prior benefit authorization is not required for emergency and urgent care services. Providers do not need to obtain benefit preauthorization from BCBSIL for referrals to in-network specialists.
- Obstetrical/Gynecological Services – Members can self-refer to in-network Providers for routine OB/GYN services.
- Prior benefit authorization is not required for substance abuse services when Provider notifies BCBSIL within 24 hours of initiation of treatment. All services are subject to establishment of medical necessity and may require a medical necessity review.
 - Applicable substance abuse services include the following: American Society of Addiction Medicine levels of treatment 2.1 (Intensive Outpatient), 2.5 (Partial Hospitalization), 3.5 (Clinically Managed High-Intensity Residential), and 3.7 (Medically Monitored Intensive Inpatient) and OMT (Opioid Maintenance Therapy) services
- Non-contracted providers must be registered with IMPACT to be eligible for claims payment.
- Additionally, benefit preauthorization is required from BCBSIL for services rendered by all non-contracted providers before the services are rendered.
- Services rendered to Members by non-contracted providers without appropriate medical referral, benefit preauthorization or IMPACT registration will not be considered for reimbursement.
- Approved referrals to non-contracted providers are valid for one visit within six months from the date the request is entered into the information system.

Unless otherwise prohibited by law, benefit preauthorizations, also referred to as prior benefit authorization, prior approval, or pre-certification, are required for certain services before they are rendered. Benefit preauthorizations are based on benefits, limitations and exclusions as well as meeting the definition of medical necessity, as defined in the Member handbook and supported through clinical information supplied by requesting physicians. Benefit preauthorizations can be obtained by calling the BCBSIL Utilization Management Department at 877-860-2837, or by faxing a completed [Medicaid Prior Authorization Request Form. \(https://www.bcbsil.com/provider/education/education-reference/forms\)](https://www.bcbsil.com/provider/education/education-reference/forms)

Prior Authorization Code List

The BCCHP Prior Authorization Requirements Summary and Prior Authorization Code List can be found on our website here: <https://www.bcbsil.com/provider/claims/claims-eligibility/utilization-management/government-support-materials>

The fact that a benefit preauthorization has been granted is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon the Member's coverage in effect on the date of service including, eligibility, exclusions, limitations, and terms of coverage.

BCBSIL has contracted with eviCore healthcare (eviCore) to manage benefit preauthorization requests for certain specialized clinical services for BCBSIL Medicaid Members. eviCore healthcare (eviCore) is an independent specialty medical benefits management company that provides utilization management services for BCBSIL.

Confidential and Proprietary

Medical Benefit Preauthorization Form

<https://www.bcbsil.com/docs/provider/il/network/27raumat/mmai-bcchp-preauth-form.pdf>



BlueCross BlueShield of Illinois

FOR INTERNAL US ONLY
UMC
(WORK ITEM TYPE)

Medicaid Prior Authorization Request Form

Please fax completed form to 312-233-4060

This information applies to Blue Cross Community Health PlansSM (BCCHPSM) and Blue Cross Community MMAI (Medicare-Medicaid Plan)SM members.

URGENT (If checked, please provide anticipated date of service below)

Please attach supporting documentation to facilitate your request (e.g., the history & physical, letter of medical necessity, original photographs, etc.) This form **must be placed on top** of the information you are submitting.

MEMBER / PATIENT DATA	
ID # (INCLUDE THREE-CHARACTER PREFIX)	GROUP #
MEMBER NAME	DATE OF SERVICE
PATIENT NAME	DATE OF BIRTH
PROCEDURE CODE(S)	
DIAGNOSIS CODE(S) (IF A MEDICAL SERVICE ONLY) (LIST PRIMARY FIRST)	CPT4/HCPC CODE(S) INCLUDE UNIT OF MEASURE/FREQUENCY FOR SUPPLIES & SERVICES
SERVICES RENDERED	PLEASE CHECK ONE: <input type="checkbox"/> PROVIDER OFFICE <input type="checkbox"/> OUTPATIENT FACILITY <input type="checkbox"/> INPATIENT FACILITY
	OFFICE OR FACILITY NAME
	ADDRESS/CITY/STATE/ZIP
	PHONE
	NPI(S)
PLEASE ATTACH OR INCLUDE ANY ADDITIONAL SUPPORTING CLINICAL INFORMATION IN THE SPACE BELOW.	
PROVIDER DATA	
NPI, IF APPLICABLE	DATE
PHYSICIAN/PROFESSIONAL PROVIDER NAME	
ADDRESS/CITY/STATE/ZIP	

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

242129.0121

Behavioral Health Benefit Preauthorization Form

For behavioral health outpatient service benefit preauthorizations, please visit https://www.bcbsil.com/provider/education/education-reference/forms#bh_medicaid

Prior Authorization List

Always check eligibility and benefits first through [Availity Essentials \(www.availity.com\)](http://www.availity.com) or your preferred web vendor portal to confirm coverage and other important details, including prior authorization requirements and vendors, if applicable. For some services/Members, prior authorization may be required through BCBSIL. For other services/Members, BCBSIL has contracted with eviCore healthcare (eviCore) for utilization management and related services.

Check the [Support Materials \(Government Programs\) page](#) for summary and procedure code lists to help you navigate prior authorization requirements for our Illinois Medicaid Members.

Timeliness of Decisions and Notifications

Routine or Standard Decisions	<p>Decision – Normally will be completed no later than 96 hours from receipt of request for benefits for services (or additional 96 hours when an extension is granted)</p> <p>Notification – Normally the Provider shall be orally notified within 96 hours of making the decision for benefit preauthorization or denial of non-urgent (routine) care</p> <p>Denial confirmation – For non-urgent (routine) care, the Member will be given written or oral confirmation for the decision within 96 hours of making the decision. For non-urgent (routine) care, the Provider will be given written or oral confirmation for the decision within 96 hours days of making the decision.</p>
Urgent or Expedited Decisions	<p>Decision – Coverage decisions for emergent situations will be completed and notification provided within 48 hours of receipt of request.</p> <p>Notification – Written notification will follow within 24 hours of the decision.</p> <p>Denial confirmation – The Member will be given written confirmation for the decision within 24 hours of making the decision. The Provider will be given written or oral confirmation for the decision within 24 hours of making the decision.</p>

Satisfaction with the UM Process

BCBSIL relies upon the CAHPS survey to identify areas of concern expressed by Members with accessing needed care. The results of the annual survey are used to identify potential areas of concern and outline action plans.

The BCBSIL QI Department conducts a Provider satisfaction survey annually. Results are monitored and the findings are reported to the QI Committee for review, discussion, and the development of an action plan, if deemed appropriate.

BCCHP Mental Health Mobile Crisis Response Program

Mobile Crisis Response (MCR) is a life span program that provides the screening and assessment of children, adolescents, and adults prior to any admission to a hospital for inpatient psychiatric care. MCR promotes the well-being of children by attempting to maintain them in the least restrictive of settings, working with families in their home(s) or other natural environments, providing culturally and linguistically competent services, normalizing routines and activities, and allowing for earlier interventions to address growing problems.

Access to a Dedicated Crisis Hotline

Access to a dedicated crisis line is provided in Illinois by the Crisis and Referral Entry Services (CARES) Hotline operated by Chrysalis. The (800) 345-9049 CARES Hotline is available 24 hours a day, every day of the year. Each CARES crisis line call will be answered by staff who are capable of addressing a Behavioral Health Crisis upon direct answer, knowledgeable and authorized to engage the Mobile Crisis Response system, and knowledgeable about BCBSIL's Disease Management Model for Children's Mental Health.

The CARES hotline links parents, caregivers, family members or other concerned parties seeking to refer a Member to Behavioral Health Crisis services. CARES follow strict guidelines to decide and issue eligibility for crisis services. They are the central intake hub for Illinois' Mobile Crisis Response (MCR) Program and its Screening, Assessment and Support Services (SASS) Program.

Admission Process into the MCR Program

The Crisis and Referral Entry Service (CARES) monitors the admission process into the MCR program and authorizes a MCR screening. CARES is available 24 hours a day, seven days a week. CARES will perform an acuity assessment for calls denoting a psychiatric crisis or asking for MCR services. If the acuity assessment determines a need for MCR services and the child/family meet the age and financial criteria, CARES will refer the call to a MCR provider for screening. MCR will complete a face-to-face screening within ninety (90) minutes of notification to all Members experiencing a Behavioral Health Crisis, or within twenty-four (24) hours of notification of a non-emergency referral. A non-emergency referral is when the Member is not at immediate risk of harm, but still requires an MCR screening (i.e., court-ordered screening, Members admitted to a psychiatric hospital prior to an MCR screening).

The MCR program has a 24/7 screening schedule with a backup schedule. MCR screening services are provided 365 days per year, 24 hours per day with acceptance of all referrals from CARES on a no-decline basis. The CARES line contact information is **800-345-9049**.

Mobile Crisis Response Services

MCR staff are required to ensure the screening and assessment of children and adolescents prior to any admission to a hospital for inpatient psychiatric care for all children eligible for Healthcare and Family Services (HFS) Medical Programs.

Mobile Crisis Response Services Provided

- Screening, assessment and treatment of any person who may be at risk for psychiatric hospitalization and who is eligible for public funding
- Crisis Intervention and Stabilization Services
- Access to coordinated community based mental health services whether hospitalized or deflected from hospitalization.
- Linkage of families and guardians to appropriate level of care to meet the mental health treatment needs
- Intensive Outpatient Services
- Linkages Discharge Coordination (if hospitalized)
- Psychiatric Follow-up (if needed)

The MCR screening documentation includes, at minimum

- Illinois Medicaid Crisis Assessment Tool (IM-CAT) or any state defined successor
- Crisis Safety Plan

All eligible Members potentially requiring psychiatric inpatient hospitalization, acute care, or subacute care are screened prior to admission for the viability of stabilization in the community as required by the Children's Mental Health Act of 2003.

The MCR staff responsible for providing the services must hold the following credentials: Mental Health Professional (MHP) with direct access to a Qualified Mental Health Professional (QMHP); or Licensed Practitioner of the Healing Arts. A thorough clinical assessment will be conducted when making a determination to utilize crisis stabilization and community resources or to facilitate a psychiatric hospitalization.

Inpatient Institutional Treatment

MCR staff responsible for providing Mobile Crisis Response Services will facilitate the member's admission to an appropriate inpatient institutional treatment setting when the member in crisis cannot be stabilized in the community.

- MCR staff will assist in ensuring that inpatient psychiatric Network Providers complete a physical examination of the Member within twenty-four (24) hours after admission when a Member requires admission to an appropriate inpatient institutional treatment setting.
- Network Providers responsible for providing Mobile Crisis Response Services are to inform the Member's parents, guardian, caregivers, natural supports, or residential staff, if applicable, about all of the available Network Providers and any pertinent policies needed to allow the involved parties to select an appropriate inpatient institutional treatment setting.
- The MCR staff shall arrange for the necessary transportation when a Member requires transportation assistance to be admitted to an appropriate inpatient institutional treatment setting and may contact BCBSIL for assistance with transportation if needed.

The MCR staff will participate in discharge and transitional planning consistent with the following:

- Planning shall begin upon admission;
- Community based Providers responsible for providing service upon the Member's discharge shall participate in all inpatient staffing by phone, video conference, or in person;
- The Provider will collaborate with the Member's BCBSIL Care Coordinator to notify the Member's family and caregiver of key dates and events related to the admission, staffing, discharge, and transition of the Member, and he or she shall make every effort to involve the Member and the Member's family and caregiver in decisions related to these processes;
- The Provider and BCBSIL Care Coordinator shall ensure there is direct communication with the Member and family at least once each week for 90 days following the initial mobile crisis intervention;
- The Member's Network Provider shall educate and train the member's family on how to use the Crisis Safety Plan while the Member is receiving inpatient institutional treatment; and
- The Network Provider shall collaborate with the Member's Care Coordinator for staffing, discharge, and transition processes, including necessary follow up appointments and referrals for the Member upon transition back to the community. Appointments shall be secured prior to discharge and scheduled within 7 days of discharge to ensure continuity across care providers.

Crisis Safety Plan Development

MCR staff responsible for providing Mobile Crisis Response services will:

- Create, or review and update a crisis safety plan for all Members that present in Behavioral Health Crisis, in collaboration with the Member and the Member's family.
 - Prior to the completion of crisis intervention and stabilization services necessary to stabilize a Member in the community following an MCR screening;
 - Prior to the Member's discharge from an inpatient psychiatric hospital setting for any Member admitted to such a facility.

- Provide Members and families of Members with physical copies of Crisis Safety Plans.
- Educate and orient the Member's family to the components of the Crisis Safety Plan, to ensure that the plan is reviewed with the family regularly, and to detail how the plan is updated as necessary; and
- Share the Crisis Safety Plan with all necessary medical professionals, including Care Coordinators consistent with the authorizations established by consent or release. Crisis Safety plans and IM+CANS must be sent via email to BCBSIL_SASSProviders@bcbsil.com or via fax to 312-233-6010 within 48 hours of the Crisis event
- If a Member experiences a Crisis event, the MCR staff shall participate in an Interdisciplinary Care Team meeting for the Member within fourteen (14) days after the event if the Member is community stabilized and within fourteen (14) days after discharge if the Member is hospitalized.
- Ensure that Members who have been community stabilized following a Crisis event is referred and immediately linked with an urgent appointment with a mental health provider within one (1) Business Day after the Crisis event, if deemed Medically Necessary.
- Ensure that Members have a scheduled appointment with a Behavioral Health Provider for follow-up within seven (7) days after the Member's discharge from hospitalization.
- Psychiatric Resources and Pharmacological Services:
 - Fourteen (14) days after a Member's discharge from an inpatient psychiatric hospital setting; or,
 - Within three (3) days after the Crisis event for a Member who is community stabilized.
- If the MCR staff receives notification from DCFS that the Member has been designated a Youth at Risk, the CCSO staff will collaborate with the Member's Care Coordinator to involve DCFS on the Member's Interdisciplinary Care Team.

Community Stabilization

If the Member is deflected from hospitalization, an MCR plan is implemented to help stabilize the Member in the community. The MCR plan may include emergency contact numbers and a Crisis Safety Plan unique to the Member and circumstances. The plan should include concrete interventions and techniques that will assist in alleviating the circumstances leading to the crisis situation which includes agreed upon instructions as to when to contact police or emergency medical service (EMS) if the need arises.

The MCR staff member will educate and orient the Member and family to the components of the Crisis Safety Plan. Within 48 hours from the time of the mobile crisis evaluation, the MCR staff will follow up with the Member and family either by phone or in person.

The MCR staff will ensure that Members who have been community stabilized following a Crisis event is referred and immediately linked with an urgent appointment with a mental health provider within one (1) Business Day after the Crisis event, if deemed Medically Necessary. Additionally, MCR staff will facilitate access to a psychiatric resource to provide consultation and medication management services as medically necessary within three (3) calendar days after the date of the Crisis event for a Member for whom community-based services were put in place in lieu of psychiatric hospitalization.

BCBSIL's Mobile Crisis Response Program will not require benefit prior authorization for community mental health services listed on the prior authorization list for 30 calendar days post crisis event and referral to the mobile crisis response system. MCR staff are required to provide notification of initiation of services to BCBS IL to ensure claims payment.

Discharge Planning and Transitional Services

- The Care Coordination and Support Organizations CCSO staff and BCBSIL Care Coordination staff will arrange for discharge planning and transitional services when being discharged from higher levels of care to lower levels or community-based services. CCSO staff shall collaborate with Care Coordination to work with involved parties to facilitate appropriate follow up services, including the scheduling of follow-up treatment appointments.
- The CCSO staff shall encourage the Member and the Member's family to contact the Member's Care Coordinator whenever a biological, psychological, or social intervention is required or requested. CCSO staff shall collaborate with the Member's Care Coordinator to ensure that entry and exit from any level of care is managed effectively, efficiently, and, when possible and appropriate, within BCBSIL's Provider Network.
- The CCSO staff shall work with BCBSIL to obtain access to non-Network Providers and to facilitate the timely provision of necessary and appropriate records to those non-Network providers.
- The CCSO staff and BCBSIL Care Coordination staff will initiate follow-up care within seven (7) days after discharge from higher levels of care (e.g., inpatient behavioral health treatment) and provide oversight that appropriate levels of services are being provided.
- Network Providers will notify BCBSIL or the CCSO team, as appropriate, at least twenty-four (24) hours in advance of any discharge from inpatient hospital stays, including psychiatric hospital stays.
- For Youth Members, the CCSO staff will complete a face-to-face visit within seven (7) days following discharge.

Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) Assessment

The IM+CANS is the approved IATP instrument in Illinois. The IM+CANS serves as the foundation of Illinois' efforts to transform its publicly funded behavioral health service delivery system. It was developed as the result of a collaborative effort between the Illinois Department of Healthcare and Family Services (HFS), Human Services-Division of Mental Health (DHS-DMH) and the Illinois Department of Children and Family Services (DCFS). The comprehensive IM+CANS assessment provides a standardized, modular framework for assessing the global needs and strengths of individuals who require mental health treatment in Illinois.

The IM+CANS is a formal process of information gathering and review that utilizes a standardized assessment and service planning tool in order to:

1. Identify a client's integrated healthcare needs and strengths across all domains;
2. Recommend services needed to improve a client's condition and well-being; and
3. Develop, review, and update an individualized treatment plan

Providers not utilizing the IM+CANS may not be reimbursed for the IATP services and will not be able to participate in nor assist HFS in identifying individuals eligible for the HFS 1115 waiver pilot program.

IATP services must:

1. Include the utilization of an HFS-approved instrument.
2. Be completed prior to the delivery of mental health Medicaid Rehabilitation Option (MRO) services.
3. Be reviewed, approved, and signed by a Licensed Practitioner of the Healing Arts (LPHA)
4. Be reviewed and updated once every 180 days.
5. Provide a copy of the completed IATP to the client or their parent/legal guardian.

Additional information regarding the IM+CANS and requirements can be found at:

<https://hfs.illinois.gov/medicalproviders/behavioral/communitymentalhealthcenter/imcansproviderportal.html>

MCR Case Closing

The closure of the Member's MCR episode of care will occur when one of the following applies:

- No clinical necessity: it is determined by the CCSO staff in consultation with the supervisor that there is no clinical need for MCR services
- Case is transferred; the case is transferred to another CCSO
- Member and/or family not willing or able to participate; the Member or family is no longer available to receive services or has refused services

The family will also be provided with any referral linkages that may be appropriate, and BCBSIL Behavioral Health Care Coordination staff will continue to provide care coordination.

Reporting Requirements for Contracted Mental Health Mobile Crisis Response Program Providers

BCCHP Mental Health Mobile Crisis Response Program Providers, including the contracted CARES program and contracted CCSOs, are required to provide to BCBSIL the standard, mandatory reporting, per agreed upon guidelines.

The CCSO staff shall ensure the completion of the IM+CANS on all Members who require mental health services within the timelines established by the Department.

The CCSO staff shall provide the Department with data related to the IM+CANS on an ongoing basis, in a manner established by the Department.

Pathways To Success

The Pathways Program is a free service which provides access to additional home and community-based services to improve family functioning and reduce caregiver stress, improve school attendance and performance, increase family and youth involvement, and reduce contacts with law enforcement and child welfare. Not every child qualifies; complex behavioral-health needs would need to be identified. The program is available to Medicaid-enrolled children under the age of 21 in Illinois who have significant and complex behavioral health needs, have a Serious Emotional Disturbance (SED) or Serious Mental Illness (SMI), or demonstrate a need for intensive services pursuant to the State's IM+CANS Decision Support Criteria.

Additional information can be accessed here:

<https://www2.illinois.gov/hfs/MedicalProviders/behavioral/pathways/Pages/resources.aspx>

Learn to Live, Inc.

Learn to Live is a no-cost online health program. It is offered to Members ages 13 and older and their caregivers. Learn to Live gives self-paced mental health solutions plus access to 24/7 Member coaches. It can help with common challenges like stress, anxiety, depression, insomnia, and substance abuse. To start, Members can register at www.learntolive.com/Welcome/BCBSILMedicaid (Access Code: **ILMED**).

Member Grievances and Appeals

A Member or their representative may file a grievance or an appeal, orally or in writing, through the BCCHP Customer Service Department at 877-860-2837, or mail to:

Blue Cross Community Health Plans
Attn: Appeals & Grievances
PO Box 660717
Dallas, TX 75266-0717

BCBSIL Grievances and Appeals Process

The BCCHP Customer Service Department will attempt to resolve all grievances during the phone call; however, if Customer Service cannot resolve the grievance, they will provide the Member appeal and/or grievance rights. If the Member wants to file an appeal and/or grievance over the phone, Customer Service will document all pertinent facts and route the issue to Government Programs Appeals and Grievances.

1. Grievance – A grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include the quality of care or services provided, and aspects of interpersonal relations such as rudeness of a Provider or employee, or failure to respect the Member's rights regardless of whether remedial action is requested. Grievance includes a Member's right to dispute an extension of time proposed by Contractor to make an authorization decision. The BCBSIL grievance process is as follows:
 - a) A grievance may be filed by the Member or Member's authorized representative (on behalf of the Member with the Member's written consent).
 - b) Grievances will be acknowledged in writing within forty-eight (48) hours;
 - c) A Member can file an expedited grievance if BCBSIL Appeals and Grievances extends the time frame to make a decision or refuses to grant a request for an expedited appeal. Appeals and Grievances will notify the Member of their right to file an expedited grievance;
 - d) Prompt and appropriate action as quickly as the case requires, including completion of a full investigation of the grievance, no later than 90 calendar days from the date the oral or written request is received; and
 - e) Notification of all concerned parties upon completion of the investigation.
2. Appeals – The Member may not agree with a decision or an action made by BCBSIL about a request for benefits for a service or an item requested (i.e., dissatisfaction with an adverse organization determination) in which case they may file an appeal. The BCBSIL appeals process is as follows:
 - a) An appeal may be filed either orally or in writing by a Member, Member's representative (on behalf of the Member with the Member's written consent) within 60 calendar days from the date of the Notice of Action;
 - b) Appeals will be acknowledged within 3 business days of receipt of the appeal with all information required to review the appeal;
 - c) Investigation of the appeal, including any clinical care involved;
 - d) The Member or representative will have an opportunity to submit written comments, documents or other information relating to the appeal;
 - e) Submit all relevant clinical information when you request an appeal. Insufficient clinical information may result in a delay in review or an inability to make a fully informed decision.
 - f) Appointment of a new person for review of the appeal who was not involved in the previous review;
 - g) For medical necessity appeals, the case must be reviewed by a practitioner with expertise in the field of medicine appropriate to the services under review;
 - h) The decision and notification, will be provided in writing to the Member or Member's authorized representative within 15 business days of receipt of appeal unless a 14- day extension is requested;

- i) Prompt notification to the Member, or their representative, regarding an organization's plan to take up to a 14-calendar-day extension, no later than two (2) days after the decision is made to extend the time frame;
- j) Documentation of the need for any extension taken (other than one requested by the Member) that explains how the extension is in the best interest of the Member;
- k) Notification about further appeal rights including the State fair hearing process and notification of the contact information;
- l) Providing the Member access and copies of all documents relevant to the appeal;
- m) Expedited pre-service appeals, which include the initiation, decision, and notification process;
- n) Member requests and receives appeal data from Medicaid health plans; and
- o) Providing notices of the appeals process to Members in a culturally and linguistically appropriate manner.

3. Expedited Reconsideration (Appeal)

An expedited appeal may occur 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.

BCBSIL has procedures for registering and responding to expedited appeals, which include:

- a) Allow oral or written initiation of an expedited appeal by the Member, a Member's representative or practitioner acting on behalf of the Member;
- b) If a request for an expedited appeal is approved, the Member will be notified within 24 hours of receipt of Member's request of all information necessary to evaluate the appeal;
- c) Request for necessary information from non-contracted providers;
- d) Decision and notification to the Member and practitioner, verbally and in writing as soon as reasonably possible, but no later than 24 hours after receiving all required information; and
- e) Notification of further appeal rights and the right to file an expedited grievance if the Member disagrees with the decision not to expedite the determination.

4. Additional Appeal Rights

Requests from the Provider(s) and/or Member for further information on an appeal should be directed to the BCCHP Customer Service Department at 877-860-2837.

5. Continued Coverage

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

6. Provider Authorization Disputes

- a) BCBSIL gives network and non-network providers sixty (60) days to dispute a BCCHP authorization denial based on potential administrative error.
- b) Providers may file a Provider Authorization by submitting the Form and supporting documentation by Fax number or by mail to:

Blue Cross Community Health Plan
Provider Authorization Disputes
PO Box 660906
Dallas, TX 75266
312-653-9443

- c) The Provider Authorization Dispute Request Form can be found on our website at <https://www.bcbsil.com/docs/provider/il/education/forms/medicaid-service-authorization-dispute-form.pdf>

**Please note, that claims disputes regarding payment and contractual issues should be filed using the form at https://www.bcbsil.com/pdf/network/medicaid_claims_inquiry_dispute_request_form.pdf*

Medical Policies, 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. BCBSIL evaluates emerging medical technologies as well as new applications of existing technologies through BCBSIL's corporate medical policy development process. The evaluation process is applied to new technologies, products, drugs, medical and surgical procedures, behavioral health procedures, medical devices and any other such services as may come under policy and claims review.

[Medical policy](#) guidelines are solely intended to exist to make benefit determinations. The final decision about any service of treatment, regardless of any benefit determinations, is between a Member and their health care provider.

Pharmaceutical Management

Pharmacy benefits are administered by Prime Therapeutics (Prime), BCBSIL's Pharmacy Benefit Manager. Prime is a third-party vendor pharmacy benefit manager (PBM) that administers certain core services on behalf of BCBSIL. Such services include claims processing, retail pharmacy network management and mail order services. Prime also has the capability to allow electronic prescribing, or e-prescribing.

The goal of the Pharmacy Benefit Management program is to help:

- Contain rapidly rising drug costs,
- Maintain and improve the quality of care delivered to BCCHP Members,
- Facilitate access, and
- Encourage appropriate use of cost-effective drug therapies.

To achieve this goal, BCBSIL employs a number of industry-standard management strategies in order to ensure appropriate utilization. These strategies include, but are not limited to, formulary management, benefit design modeling, specialty pharmacy benefits and clinical programs.

Opioid Prescription Guidelines

In collaboration with Prime Therapeutics, BCBSIL has implemented many standard opioid safety edits to limit the opioids available to the public to medically necessary purposes only and to prevent diversion and inappropriate use.

To further ensure proper utilization of opioids we recommend each opioid prescription have a valid and appropriate diagnosis (defined below) written on the hard copy or provided in the electronic prescription in order for BCBSIL to provide coverage for opioid prescription. The benefits of this include faster and improved care management and disease management engagement with our Members. This process will ensure that all opioid prescriptions covered for our Members are appropriate and that the dispensing pharmacists are aware of the patient's pain treatment needs. Excluded from this recommendation will be buprenorphine products used for treating opioid addiction.

- **Valid Code:** Current ICD10 diagnosis codes can be found in the CMS coding database <https://www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-CM>
- **Appropriate Code:** A Valid ICD10 Dx code that is an appropriate indication for the use of opioids. (i.e., G89.3 Neoplasm related pain)

As a reminder: if you are a Provider that is a Part 2 Program under the Substance Abuse and Mental Health Services Administration ("SAMHSA") 42 CFR Part 2 Rules (the "Rules") you may have obligations to obtain patient consent and provide notices related to the use or redisclosure of the diagnosis information to the dispensing pharmacy.

Prescription Drug Monitoring Program (PMP) Requirement

In accordance with Illinois Public Act 100-0564 720 ILCS 570 Sec (314.5) and Sec (316), and Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, prescribers and dispensers of controlled substances are required to document their attempt to access patient-controlled substance information in the PMP when providing an initial prescription for Schedule II narcotics such as opioids. The exception to this rule is for prescriptions for patients who are receiving oncology treatment or palliative care, or a 7-day or less supply provided by a hospital emergency department when treating for an acute, traumatic medical condition.

Providers are instructed to document attempted access and analysis of the results from the PMP in the Providers electronic health record system.

Notice to Prescribers of Clinical Review Activities by Medicaid Managed Care Organization (“MCO”) Pharmacists

Pursuant to section 720 ILCS 570/316(g) of the Prescription Monitoring Program, as amended by House Bill 4650 (Public Act 100-1005) and set forth in the Illinois Controlled Substances Act (the “Act”), prescribers are notified that Blue Cross Blue Shield of Illinois (“BCBSIL”) MCO pharmacists may conduct clinical review activities of services provided to persons covered by the MCO to determine compliance with section 720 ILCS 570/314.5 of the Act, titled “Medication shopping; pharmacy shopping.”

Confidential and Proprietary

Quality Improvement

BCBSIL is committed to pursuing opportunities for improvement of health, health outcomes and service through ongoing comprehensive assessment and quality improvement activities. BCBSIL establishes and maintains the Quality Improvement (QI) Program, which is designed to lead to improvements in the delivery of health care and services, inclusive of both physical and behavioral health, to its Members, as well as in all health plan functional areas. The quality improvement initiatives strive to achieve significant improvement over time in identified clinical care and non-clinical care / service areas that are expected to have a favorable effect on health outcomes, service received and Member and Provider satisfaction.

Oversight for the Quality Improvement Program

The Enterprise Quality Improvement Oversight Committee (EQIOC) of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), has the authority, responsibility, and overall accountability for the Illinois Medicaid QI Program. The EQIOC meets at least four times a year to review QI activities, provide feedback and recommendations and approves the QI Program, Annual Work Plan and Evaluation. Responsibility for ensuring development, implementation, monitoring, and evaluation of the QI Program is delegated to the Illinois Medicaid Quality Improvement Team. Quality oversight encompasses all functional units within Illinois Medicaid with individual subcommittees, teams and/or functional units providing reports to the Quality Improvement Team, and Executive Committee as applicable.

All aspects of the program are documented in the Quality Improvement Program description and the Quality Improvement Work Plan, in accordance with all relevant regulations and standards.

Clinical aspects of the QI program are reviewed by network physicians who sit on one or more of the Quality Committees. Operations are managed by a Director of QI and a Medical Director for QI. Close operational linkages are found between the QI Program and the programs for Utilization Management, Condition/Disease Management, Case Management, and Network Services.

Responsibilities of the Quality Committees include:

- Review and approval of the annual Quality Improvement Program Description
- Review and approval of the annual Quality Improvement Work Plan
- Monitoring and analysis of reports on QI activities from subcommittees
- Review and approval of annual Quality Improvement Program Evaluation
- Review and approval of Performance Improvement Projects
- Recommendation of policy decisions
- Analysis and evaluation of the results of QI activities
- Review of analysis of significant health care disparities in clinical areas
- Review of analysis of information, training and tools to staff and practitioners to support culturally competent communication
- Review and evaluation of ADA site visit results as a function of the Provider's ability to provide quality care to Members
- Review of analysis and evaluation of Member grievances and appeals
- Review of analysis and evaluation of populations with complex health needs
- Ensuring practitioner participation in the QI Program through project planning, design, implementation and/or review
- Institution of needed actions
- Ensuring follow-up, as appropriate

Quality Monitoring Activities

Ongoing monitoring of specific quality indicators is an important component of the BCBSIL Quality Improvement (QI) program. Indicators are selected based on important aspects of care for BCCHP Members including, but not limited to, utilizing medical/surgical, behavioral health and chemical dependency data. These indicators are relevant to the enrolled population; are designed to be reflective of high volume or high-risk services; encompass preventive, acute and chronic care and span a variety of delivery settings. Categories of indicators may include the following:

- Effectiveness of care and services for preventive health, BH, chronic, and complex conditions.
- Clinical QI Program effectiveness
- Service QI Program effectiveness including Appeals and Grievances
- Member and Provider experience of clinical and BH care and services
- UM, complex case management, and disease management program effectiveness
- Adult, child, and adolescent experience of and benefit from clinical and BH care coordination and services
- Patient safety and critical incidents
- Continuity and quality of care between medical practitioners and transitions and settings of care
- Continuity and quality of care between medical and behavioral health practitioners
- Practitioner and Provider contracting, credentialing, and re-credentialing
- Effectiveness of care and services to Members at-risk due to specific age, racial, cultural, ethnic, and linguistic needs
- Performance against clinical practice guidelines for acute, chronic, BH medical conditions, and adult and child preventive guidelines (EPSDT services).

Quality indicators are usually selected on the basis of their objectivity, measurability, and validity. Performance goals or benchmarks may exist or may be established after baseline measurements have been completed. Quality indicators are reported to the Quality Committee(s) for review and recommendations, including the development of corrective action and/or performance improvement plans.

Quality Improvement Program Documents

QI Program Description

The QI Program description is reviewed annually and may be updated as needed.

QI Work Plan

The QI Program Work Plan is initiated annually based upon the planned activities for the year and includes improvement plans for issues identified through the evaluation of the previous year's program. The scope of the BCCHP Work Plan includes aspects of the QI Program and the activities appropriately linked to the established goals and objectives. The work plan may include time frames for accomplishing each planned activity. The document may be updated throughout the year to reflect the progress on QI activities and new initiatives as they are identified.

QI Program Evaluation

The QI Program is evaluated annually and may be updated as needed. The evaluation process includes:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service rendered by network Providers.
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service rendered by network Providers.
- Analysis of the results of QI initiatives, including barrier analyses.
- Evaluation of the overall QI Program, including progress toward influencing network-wide safe clinical practices.

Disclosure of the QI Program Information

Information regarding the QI Program is made available to Providers and to Members, upon request.

Healthcare Effectiveness Data and Information Sets (HEDIS)

BCBSIL collects data to complete the annual HEDIS audit. Results from the annual HEDIS audit are used to guide various quality improvement efforts at BCBSIL. Many of the measures in HEDIS focus on preventive health care services and wellness care as well as monitoring health care of Members with specific acute illness (e.g., Upper Respiratory Infection) or chronic disease (e.g., diabetes, asthma). To determine if the recommended services reported in the annual HEDIS rates to the state were provided to our Members, BCBSIL looks first at its claims (or encounter) data. If BCBSIL is unable to identify that a particular service was provided from the claims (or encounter) data, BCBSIL conducts an annual medical record review to determine if the service was provided but for some reason not in the claims data (perhaps a bill was not submitted). If any of your Members are selected for medical review, representatives from BCBSIL will conduct a chart review to collect necessary information. As a participating BCCHP Provider, one or more of your patients may be randomly selected for review and BCBSIL asks for your cooperation in collecting this important information.

Converged Provider Enablement by Inovalon (formerly Indices)

The Provider Enablement platform is a secure online tool that allows Providers and HCSC stakeholders to monitor quality and risk metrics to help improve the quality of care for our Members by identifying gaps in care. Provider Enablement will also help identify Members with open HCCs and pinpoint disease severity. Using the detailed data available through this application, Providers can take action to proactively close identified gaps in care. Access to this tool requires a special provisioning step after which access becomes available through Availity Essentials Your PNC or your Clinical Practice Consultant (CPC) can submit the Provider Group Enrollment Form to get your group provisioned for use.

MXOTech / MXOCare

A secure portal providing access for BCCHP Providers to retrieve Quality Incentive Payment information. Providers can also use MXOTech to share Member Medical Record data with their CPC for Quality purposes. The access request form can be provided by your PNC upon request, then must be submitted on your behalf. <https://ipa.bcbsilezaccess.com/SitePages/Home.aspx>

National Committee for Quality Assurance (NCQA)

NCQA is the major accrediting body for health plans. NCQA publishes a set of standards developed by a national committee with representation from physicians, the business community, government, and consumers. Compliance with these standards is one way to measure a health plan's commitment to quality. Interested parties can learn about the standards and obtain other useful information directly from NCQA at its website: ncqa.org (link below). HEDIS data are collected from claims, encounters and may be supplemented with medical chart review. HEDIS Performance Measures results are evaluated on an annual basis to monitor improvement. The extent to which a Provider's practice cooperates with our ongoing efforts to meet NCQA standards may be reviewed at the time of recredentialing. HEDIS data submitted to National Committee for Quality Assurance (NCQA) and other entities are audited by an NCQA certified HEDIS auditor. Our current accreditation status may be found on ncqa.org.

BCBSIL Quality Improvement Program Data Submission and Calculation

Quality Improvement Program (QIP) Clinical Measures are based on BCCHP claims data, pharmacy data, and outcomes data. The PCP or the medical group, as appropriate, is required to submit complete and accurate data for each of the QIP Clinical Measures as requested by BCBSIL. The data must be submitted in a format acceptable to BCBSIL and within the time period established in the QIP instructions.

While BCBSIL does not intend on conducting any medical record review to validate QIP clinical measures, BCBSIL reserves the right to conduct an audit to confirm the results.

All documentation requested by BCBSIL to support any claims for payment must be received by BCBSIL within seven days of the request for documentation, unless the QIP instructions allow more time for the PCP to provide such documentation. BCBSIL may reduce or eliminate any payments that the PCP or the medical group may be eligible for if the PCP or the medical group either refuses or delays providing such documentation.

Various components of the BCBSIL QI Program incorporate elements of Member rights, which may include:

- Policies on inquiries and grievances
- Policies on appeals
- Policies on quality-of-care grievances
- Access and availability standards
- Member involvement in satisfaction surveys
- Member involvement in the development of their care plan and their Interdisciplinary Care Team

In addition, the policy on Member Rights and Responsibilities further defines the relationship between the Member, the practitioner, and BCBSIL.

Critical Incidents

A critical incident is an incident involving a Member that may include, but is not limited to, abuse, neglect or exploitation; any unexpected death including death due to substantiated cases of abuse, neglect or exploitation, or incidents that have the potential to place a Member or Member's services at risk but does not rise to the level of abuse, neglect or exploitation, such as restraint applications, seclusion or other restrictive interventions, environmental hazards; law enforcement intervention; or emergency services, and which encompasses the full range of physical and mental health and home and community-based services.

Critical Incidents of abuse, neglect and financial exploitation must be reported to the appropriate authorities as mandated by state law. In addition to reporting abuse, neglect, and exploitation to the appropriate agency, Providers are also required to report the critical incident to BCBSIL. Reporting an incident gives the victim the opportunity to receive the help they need to stop the abuse; this also may help reduce risk of abuse in the future.

Potential Quality of Care Issues

A potential quality of care issue can be reported to the Quality Improvement Department either through a Member grievance or by Providers, BCBSIL staff or other entities involved in quality of care. The Quality Improvement Program has a process that seeks to identify, research, and resolve quality of care issues. All Quality of Care (QOCs) issues are investigated and if there is validation of the QOC, specific actions may be taken to help address and/or avoid a recurrence. This may include referring the quality-of-care issue to peer review. QOCs are tracked and trended, and a summary report is presented to the Clinical Quality Committee quarterly. QOCs are also tracked for credentialing purposes.

All quality-of-care grievances filed with BCBSIL are investigated. Based on the investigation, if there is validation of quality concerns, the Provider may be requested to take specific actions to help address and/or avoid a recurrence.

Member and Provider Satisfaction

The monitoring, evaluation and improvement of Member satisfaction are important components of the BCBSIL QI Program. This is accomplished through the use of surveys, as well as through the aggregation, trending and analysis of Member grievance and appeal data including the following categories: quality of care, access, attitude and service, billing and financial issues and quality of the practitioner's office site. In addition to the administration of surveys, BCBSIL encourages Members to offer suggestions and express concerns utilizing customer service telephone lines and request for comments in survey instruments.

The following surveys are some of the tools utilized in the assessment of Member satisfaction:

- CAHPS Survey
- Quality of Life Survey
- Condition Management Surveys
- Behavioral Health Survey, if applicable

In addition to assessment of Member satisfaction, Providers are surveyed to assess their satisfaction with various aspects of the BCCHP program including Utilization Management and Case Management. In addition, BCCHP practitioner needs and expectations may be voiced at regular open meetings including BCCHP Administrative Forums and Managed Care Roundtables. BCBSIL uses information from practitioner surveys in ongoing program evaluation.

BCCHP Providers may be surveyed to assess their overall satisfaction. For example, they may be asked about their satisfaction with BCBSIL support staff (e.g., Provider Network Consultants, Nurse Liaisons) as well as other questions related to network support. Information obtained through surveys is utilized in network development and planning.

BCBSIL also solicits input from Providers and facilities by the following means:

- BCCHP Consumer Advisory Committee
- Telephonic encounters
- Ad hoc advisory groups
- Face-to-face meetings

Missed or Cancelled Appointments

Providers must:

- Document in the Member's medical record, and follow-up on missed or cancelled appointments.
- Conduct affirmative outreach to a Member who misses an appointment by performing the reasonable efforts to contact the Member.
- Not bill Members for missed appointments or refuse to provide services to Members who have missed appointments.

Continuity and Coordination of Care

Continuity and coordination of care are important elements of care and, as such are monitored through the BCBSIL QI Program. Opportunities for improvement in the continuity and coordination of medical care may be selected from across the delivery system, including settings, transitions in care and patient safety. In addition, coordination between medical and behavioral health care is also monitored.

Transition of Care

BCBSIL will help facilitate transition of care when a Member needs assistance in moving from one level of care to another or from one Provider to another. Transitions of care protocols are applicable when a Member is displaced by Provider de-participation or is displaced by termination of a Provider contract. The Care Coordinator will help facilitate location of new in-network Providers for the Member. New Members are assigned a Care Coordinator who will work with the Member to identify in-network Providers within 180 days of enrollment. BCCHP 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 time. Such Members should be directed to the BCCHP Customer Service Department at 877-860-2837 for help in this matter.

Practice Guidelines

Development and Updates

BCBSIL has developed and implemented evidence-based preventive and clinical practice guidelines and criteria to assist clinical decision-making by patients and practitioners, provide standards and measures to help assess and improve the quality of care and encourage uniformity and consistency in the provision of care. Clinical practice guidelines and clinical criteria are developed and derived from a variety of sources, including recommendations from specialty and professional societies, consensus panels and national task forces and agencies, reviews of medical literature and recommendations from ad hoc committees.

Clinical practice guidelines and clinical criteria are provided for informational purposes only and are not a substitute for the independent medical judgment of health care providers. Providers are required to exercise their own medical judgment in providing health care to Members.

The Enterprise Clinical Practice Guideline (ECPG) Work Group will review and, as necessary, update clinical criteria and clinical practice guidelines. These guidelines are updated annually and when new significant findings or major advancements in evidence-based best practices and standards of care are established. Questions and feedback about the guidelines can be directed to il_medicaid_qi@bcbsil.comail.

Service Quality Improvement

The ability to provide quality health care correlates strongly with services that support the managed care organization and health care delivery system. Further, satisfaction with BCBSIL is often derived from the quality of service Members receive. Service standards have been established to help prevent issues, whenever possible, and provide consistent, timely and accurate information and assistance to Members, physicians, Providers, and other customers. The standards are routinely monitored. Surveys and grievances are monitored to help ensure the standards established are appropriate and meet the needs of the organization and customers. Service indicators include:

- Inquiry and grievance rates
- Telephone access standards
- Results from Member and Provider appeals
- Compliance with Provider and practitioner access standards
- Results from Member and Provider surveys
- ADA compliance

Each of the standards allows Member satisfaction with key service indicators to be assessed and interventions implemented as necessary. The key areas of focus are likely to include, but are not limited to:

- Customer service
- Claims payment

Claim Submission

Effective Jan. 1, 2023, Blue Cross and Blue Shield of Illinois (BCBSIL) will require electronic submission of all claims which do not require attachments for services provided to BCCHP and MMAI Members. This change aligns with the Illinois Department of Healthcare and Family Services (HFS) transition toward paperless claim filing, as outlined in their provider notice from November 2021.

(<https://hfs.illinois.gov/medicalproviders/notice.prn211124c.html>)

Facility and Professional claims – **Payer ID: MCDIL**

Please note that the alpha prefix for BCCHP Members is **XOG**. The alpha prefix must be included as part of the Member ID number.

Paper claims requiring attachments should be sent to the following address:

Blue Cross Community Health Plans
c/o Provider Services
P.O. Box 3418
Scranton, PA 18505

Providers are required to prepare and submit to BCBSIL, according to the billing procedures established by BCBSIL, billing and encounter information for Members who have received covered services from a Provider. Providers are required to submit all claims eligible for reimbursement within 180 days from the date of service. BCBSIL may, at its sole discretion, deny payment for any such fee for service claim(s) received after 180 days from the date of service.

Claims must be submitted in a format that complies with the transaction and code set standards established by the Health Insurance Portability and Accountability Act of 1996 and the Act's implementing regulations (collectively "HIPAA"). Claims not submitted via the defined formats are subject to rejection.

Refer to our claim submission page for tips on how to get started with electronic claim filing.

<https://www.bcbsil.com/provider/claims/claims-eligibility/claim-submission>

Non-Contracted Providers (Nonpar)

Providers who are registered in IMPACT but not contracted with BCCHP may see Members and submit claims for reimbursement. All services may require preauthorization. If the Member belongs to a Blue Plan in a state other than your locally contracted Blue Plan, you must file the claim to your local Blue Plan. The two states will communicate through BlueCard to finalize the claim.

Dually Contracted Providers

Providers who are directly contracted with Blue Plans in multiple states, usually due to contiguous county contracting, are sometimes considered to have two "local" plans: one is their geographic local plan (Plan A), the other is a local plan due to contractual obligation (Plan B). In this circumstance, Providers must file Member claims from Plan B with that state, regardless of the state where services were rendered. Providers file all other Member claims to their geographic local / state where services were rendered (Plan A).

Transportation Claim Administration

To view detailed billing guidelines for transport services, view the IAMHP Comprehensive Billing Manual on their website at: <https://iamhp.org/providers>

To learn more about PCS form guidelines, go to:

<https://hfs.illinois.gov/medicalproviders/noninstitutional/physiciancertificationstatement.html>

Non-emergent transportation

BCCHP Members can receive non-emergent transportation services through ModivCare Inc. For routine appointments, transportation requests should be scheduled at least two (2) business days in advance.

Members can schedule/make a reservation for a ride directly with ModivCare at 1-877-917-4149 (TTY-711)

The Member should have the following information when calling to schedule transportation:

- Name of the doctor and doctor's office
- Address
- Telephone number
- Appointment date and time
- Type of transportation needed (ie, regular car, wheelchair-accessible van)

Non-Emergency Transportation Services

BCCHP is working with ModivCare to provide transport services. You can get a ride to a provider's appointment, pharmacy, or a BCCHP event. You can also get a ride to a Blue Door Neighborhood Center.

To Schedule a Ride



ModivCare App

Search "ModivCare" in your app store and use for all your ride needs



Call ModivCare

1-877-831-3148

Monday – Friday
8 a.m. – 6 p.m., CST



Confirm Your Ride

1-877-831-3148

Call or check your mobile app 3 days prior

The day of your appointment

- Be ready for your ride one hour beforehand
- When your driver comes, they will honk, knock, ring the bell, or call you. They must wait 5 minutes for you. After 5 minutes, they can leave and report a no-show
- Drivers can transport multiple members on the same ride. This should not add any more than 45 minutes to your travel time

Return Ride

- You may pre-schedule a return ride. The driver should come within 30 minutes
- If you do not have a pre-scheduled pick-up time, call ModivCare when you are done with your visit. The driver should come within an hour of the call

Emergency Transportation

If a Member has an emergency and has no way to get to a hospital, please have them call 911. Effective with dates of services beginning 04/01/2021, claims for emergency ground ambulance services are no longer handled by the MCO and must be billed directly to the Department.

Claim Payment

BCBSIL will pay Providers for covered services authorized by BCBSIL and provided to eligible Members. Providers agree to accept payment from BCBSIL as payment in full for the provision of covered services to Members, as per the Medical Service Agreement, less any applicable copayments, deductibles, coinsurance and/or cost-share amounts required directly from the Member, if any.

As a reminder, checking eligibility and benefits is an important first step, prior to rendering services and submitting claims, as some services may require benefit prior authorization by BCBSIL. Additional information on services requiring benefit prior authorization may be found in the Utilization Management section of this manual.

Claim Payment Adjustments.

BCBSIL will process accurate and complete Provider claims according to BCBSIL claims processing procedures and applicable Laws, rules, and regulations. Such claims processing procedures may include, but are not limited to, system applications which review compliance with standards for claims coding.

In addition, Providers should be aware that BCBSIL may make retroactive adjustments to the payment arrangements outlined in the Medical Service Agreement for reasons including, but not limited to, changes to Member enrollment status and claims payment errors.

Confidential and Proprietary

Provider Claim Disputes

BCBSIL gives network and non-network providers at least sixty (60) days to dispute a BCCHP claim after BCBSIL has partially paid or denied it. You may also dispute recovery requests initiated by BCBSIL via this process if you believe the associated claim adjustment was incorrect.

Providers may file a dispute by contacting BCBSIL at 877-860-2837 or by completing the Medicaid Claims Inquiry and Dispute Form and submitting it along with supporting documentation by fax to 855-322-0717 or by mail to:

Blue Cross Community Health Plans
C/O Provider Services
PO Box 4168
Scranton, PA 18505

The Provider Claims Inquiry or Dispute Request Form can be found on our website at https://www.bcbsil.com/pdf/network/medicaid_claims_inquiry_dispute_request_form.pdf

Providers who call Customer Service to file a Provider Dispute are assigned a 12-digit unique tracking ID number. The Tracking ID Number will appear in the following format: 193450004656

- The first two digits represent the year of receipt: 19
- Digits 3-6 are the date within the year, for instance 345= December 11th
- The remaining digits uniquely identify the dispute in our system

Written notification of payment dispute must include, at a minimum, the following information: Member name and identification number, date of service, claim number, name of the provider of service, charge amount, payment amount and an explanation of the basis for the contestation. BCBSIL will review such contestation(s) and usually will respond to Providers within 30 days of the date of receipt by BCBSIL of such contestation. BCBSIL's decision on the matter will be final. Failure to contest the amount of any claim hereunder within the time specified above will result in a waiver of the service provider's right to contest such claims payment.

Response to a Submitted Claims Dispute:

Upon completion of its review, BCBSIL will send a response letter to the submitter detailing the results of the review. The letter will include whether the claim outcome was upheld or overturned along with a reason for this outcome and a reference number which will be a 12-digit unique tracking ID number or EAA tracking ID.

Your dispute may be rejected if it:

- Does not contain a valid reference number
- Is a duplicate to an existing claim dispute
- Was not submitted within the allowable timeframe (60 days) to submit a dispute

Appeals

- Providers do not have separate appeal rights. Members can file an Appeal or can appoint a representative to file on their behalf.
- The BCBSIL Member Appeal process is used for services that require an authorization and the authorization request has been denied. Appeals are not to be used to contest claim payment and/or claim denials.
- Providers may file an Appeal on behalf of a Member to have a physician review the determination of a denied authorization with an Authorized Representative Designation Form (AOR).
- Providers may not file an Appeal on behalf of a Member for lack of authorization.
- Providers may file a Provider Authorization Dispute if they believe it has been a potential administrative error. The Provider Authorization Dispute Request Form can be found on our website at <https://www.bcbsil.com/docs/provider/il/education/forms/medicaid-service-authorization-dispute-form.pdf>

More information on appeals can be found by referencing the Member Appeals section.

Claims to State or Federal Government Prohibited

Providers cannot request payment for covered services provided in any form from HFS, HHS or any other agency of the State of Illinois or the United States of America or their designees for items and services furnished in accordance with the Medical Service Agreement, unless approved in advanced by BCBSIL and HFS, or ordered by court of law.

Coding Related Updates

Provider acknowledges and agrees that BCBSIL may apply claim editing rules or processes, in accordance with correct coding guidelines and other industry-standard methodologies, including, but not limited to, CMS, CPT, McKesson and Cotiviti coding process edits and rules.

Recovery of Overpayments

Providers are required to provide notice to BCBSIL of any overpayment(s) identified by the Providers, including duplicate payments, within 10 calendar days of identifying such overpayment and, unless otherwise instructed by BCBSIL in writing, Providers are required to refund any amounts due to BCBSIL within 30 calendar days of identifying such overpayment. In the event of any overpayment, duplicate payment, or other payment in excess of that to which the Provider is entitled for covered services furnished to a Member, BCBSIL may recover the amounts owed by way of offset or recoupment from current or future amounts due from BCBSIL to the Provider.

Balance Billing

An important protection for BCCHP Members when they obtain plan-covered services is that they do not pay more than the BCBSIL-allowed amount.

Payment will not be made by BCBSIL for services rendered to Members that are determined by BCBSIL not to be medically necessary, as defined in the Member handbook. In the event of a denial of payment for services provided to Members that are determined by BCBSIL not to be medically necessary, Providers shall not bill, charge, seek payment or have any recourse against a Member for such services. Providers may bill the Member for services that are determined not to be medically necessary if the Provider provides the Member with advance written notice that informs the Member that such services may be deemed by BCBSIL to be not medically necessary and provides Member with an estimate of the cost to the Member for such services and the Member agrees, in writing that is signed and dated, to assume financial responsibility in advance of receiving such services.

Treating Family Members

Participating Providers may not bill BCBSIL for health care services rendered to themselves or their immediate family members, or designate themselves as a primary care physician, for any purpose, for themselves or their immediate family members. An "immediate family member" is defined as: (i) current spouse; (ii) eligible domestic partner; (iii) parents and step-parents of themselves or their spouse or domestic partner; (iv) children and grandchildren (biological, adopted or other legally placed children) of themselves or their spouse or domestic partner; and (v) siblings (including biological, adopted, step, half or other legally placed children) of themselves or their spouse or domestic partner. BCBSIL will not process any claims for services, nor make payment for any claims for services, rendered by a participating Provider to the Provider's self, or to the Provider's immediate family members. In the event that BCBSIL determines that a benefit was paid in error, BCBSIL has the right to request and receive a refund of the payment from the participating Provider.

Coordination of Benefits

If a Member has coverage with another plan that is primary to Medicaid, please submit a claim for payment to that plan first. The amount payable by BCBSIL will be governed by the amount paid by the primary plan and Medicaid Secondary Payer law, regulations, and policies.

If BCBSIL is not the primary payer, the Provider must bill payer(s) with the primary liability prior to submitting bills for the same services to BCBSIL. The Provider must also provide BCBSIL with relevant information it has collected from Members regarding coordination of benefits. If BCBSIL is not Member's primary payer, the Provider's compensation by BCBSIL shall be no more than the difference between the amount paid by the primary payer(s) and the applicable rate under the medical service agreement.

Worker's Compensation

The Illinois Workers' Compensation Act provides that an insured employee has the right to obtain medical care for treatment of a work-related injury. If the employee chooses to use the services of the chosen Provider, the charges or equivalents for these services should be recouped through the employer's Workers' Compensation carrier. The Provider must not bill the Member. A Member can be questioned to determine whether the injury a) occurred at work or b) during the course of their work duties.

Regular follow up by the Provider, via certified mail, is recommended to ensure reimbursement. Liens should not be issued for Workers' Compensation claims.

Illinois Association of Medicaid Health Plans (IAMHP) Comprehensive Billing Guide

In collaboration with all of the MCO's, IAMHP has developed a "Comprehensive Billing Guide" that is regularly updated with information related to specific provider types. This guide includes general billing information as well as billing information specific to each MCO. IAMHP's "Comprehensive Billing Guide" is located on their website which is accessible at <https://iamhp.org/providers>.

BCCHP Medical Home Program (MHP)

BCCHP supports the concept of medical home by offering PCPs an opportunity to participate in the BCCHP Medical Home Program (MHP). PCPs meeting the MHP practice standard requirements may be eligible to receive a monthly Care Coordination Fee for each Member assigned to the PCP. Please reference Medical Service Agreement for more details on Care Coordination Fees, including eligibility requirements.

A Medical Home Model is central to helping develop a culture of health between medical Providers and Members. Enrollment in the Medical Home Program by IPA PCPs is voluntary. BCCHP will strive to identify and support Medical Home IPA PCP Practices that are able to better serve the health care needs of HMO Members. BCCHP will assist identified IPA PCP Practices in converting to and maintaining a Medical Home Model by assessing their progress in the categories referenced below:

- BCCHP Policies and Procedures
- Performance Standards and Compliance
- Patient Care Plan Participation
- Quality Improvement Program
- Patient-Centered Access and Continuity
- Team-Based Care and Practice Organization
- Knowing and Managing Your Patients
- Care Management and Support
- Care Coordination and Care Transitions

Patient Care Plan Payment

Members enrolled in BCCHP will receive an Individual Patient Care Plan. BCBSIL Care Managers will be responsible for the developing the Patient Care Plan in conjunction with the Member's PCP. BCBSIL agrees to reimburse PCPs participation in interdisciplinary team meetings once per year, per Member.

The PCP must clearly document the interdisciplinary team meeting in the Member's chart, including all the particulars relating to the meeting including, but not limited to, all the particulars discussed, the attendees to the meeting, the Member's medical history, all progress and regression with respect to any key diseases, and treatment plans and steps that the Member must take to address such conditions.

Providers may submit for reimbursement via the normal claims process utilizing CPT code 99339.

Quality Improvement Program Payment

The BCBSIL Quality Improvement Program (QIP) is intended to recognize the PCP for maintaining quality and patient satisfaction standards in the delivery of covered services.

QIP Clinical Measures and performance thresholds will be established by BCBSIL on annual basis. QIP Clinical Measures and performance thresholds may be modified by BCBSIL to comply with the contractual requirements from HFS.

If applicable, BCBSIL shall reimburse the PCP for each eligible BCCHP Member enrolled with the PCP who received either a targeted Clinical Measure service or achieved the targeted outcome according to the payment terms of the Provider's MSA.

A completion for the Medical Group occurs only if a Designated BCCHP Member who is attributed to the Medical Group at the end of the Performance Period closed a Care Gap during the Performance Period. If a Designated BCCHP Member closes a Care Gap during the Performance Period while attributed to the Medical Group but is not attributed to the Medical Group at the end of the Performance Period, then the completion does not apply to the Medical Group. If a Designated BCCHP Member closes a Care Gap during the Performance Period at a time the Designated BCCHP Member is not attributed to the Medical Group but the Designated BCCHP Member is attributed to the Medical Group at the end of the Performance Period, then the completion does apply to the Medical Group. For sake of clarity, the completion for the Medical Group occurs irrespective who provides the Health Care Services to the Designated BCCHP Member that closes a Care Gap.

Table A: QIP Clinical Measures and Performance Incentives

Payment Amount and Payment Criteria	Measures and Measure Criteria	Benchmark
For each completion above the HEDIS Percentile, BCBSIL will pay the participating Medical Group \$56 for exceeding the Pass Threshold	BCS – Breast Cancer Screening Assesses women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years	≥51%
For each completion above the HEDIS Percentile, BCBSIL will pay the participating Medical Group \$44 for exceeding the Pass Threshold	GSD – Glycemic Status Assessment for Patients with Diabetes Assesses the percentage of adults 18–75 years of age with diabetes (type 1 and type 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year: <ul style="list-style-type: none"> • Glycemic status <8.0% • Glycemic status >9.0% 	≥50%
For each completion above the HEDIS Percentile, BCBSIL will pay the participating Medical Group \$90 for exceeding the Pass Threshold	FUH – Follow-Up After Hospitalization for Mental Illness Within 7 Days Assesses the percentage of inpatient discharges for a diagnosis of mental illness or intentional self-harm among patients age 6 years and older that resulted in follow-up care with a mental health provider within 7 days.	≥38%
For each completion above the HEDIS Percentile, BCBSIL will pay the participating Medical Group \$90 for exceeding the Pass Threshold	FUH – Follow-Up After Hospitalization for Mental Illness Within 30 Days Assesses the percentage of inpatient discharges for a diagnosis of mental illness or intentional self-harm among patients age 6 years and older that resulted in follow-up care with a mental health provider within 30 days.	≥59%
For each completion above the HEDIS Percentile, BCBSIL will pay the participating Medical Group \$9 for exceeding the Pass Threshold	CCS – Cervical Cancer Screening Assesses women who were screened for cervical cancer using any of the following criteria: <ul style="list-style-type: none"> • Women 21–64 years of age who had cervical cytology performed within the last 3 years. • Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. • Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last 5 years. 	≥58%
For each completion above the HEDIS Percentile, BCBSIL will pay the participating Medical Group \$149 for exceeding the Pass Threshold	CIS - Childhood Immunization Status (Combo 3) Percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	≥63%
For each completion above the HEDIS Percentile, BCBSIL will pay the participating Medical Group \$34 for exceeding the Pass Threshold	CBP – Controlling High Blood Pressure Assesses adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg)	≥60%

Payment Amount and Payment Criteria	Measures and Measure Criteria	Benchmark
Payment Amount is equal to whatever is greater: (1) Zero dollars (\$0); or (2) The lesser of: (i) The Average Membership* divided by 1,000 <i>then</i> that quotient multiplied by the Custom Benchmark and <i>then</i> that product subtracting the actual number of Emergency Department (ED) Admissions and <i>then</i> that total difference multiplied by the incentive multiplier of \$5**; or (ii) ED Admission Payment Amount Cap***.	ED Admissions (All-cause) ***** Describes ED utilization among BCCHP Members	<= 651 ED Admissions/1000 BCCHP Members
Payment Amount is equal to whatever is greater: (1) Zero dollars (\$0); or (2) The lesser of: (i) The Average Membership* divided by 1,000 <i>then</i> that quotient multiplied by the Custom Benchmark and <i>then</i> that product subtracting the actual number of Inpatient (IP) Admissions and <i>then</i> that total difference multiplied by the incentive multiplier of \$5**; or (ii) IP Admission Payment Amount Cap****.	IP Admissions (All-cause) ***** Assesses acute care hospital inpatient utilization among BCCHP Members.	<= 62 IP Admissions/1000 BCCHP Members

*Average Membership: for purposes of this ED Admission and IP Admission criteria, is defined as the total BCCHP Medical Group Member months over the Performance Period divided by 12.

** See below for further illustrative calculations.

***** ED Admission Payment Amount Cap**

\$1,000 for Medical Groups with a May 2023 Membership of the applicable Performance Year between 1-4,999 BCCHP Members.
 \$2,500 for Medical Groups with a May 2023 Membership of the applicable Performance Year between 5,000-14,999 BCCHP Members.
 \$5,000 for Medical Groups with a May 2023 Membership of the applicable Performance Year of 15,000 or more BCCHP Members.

****** IP Admission Payment Amount Cap:**

\$750 for Medical Groups with a May 2023 Membership of the applicable Performance Year between 1-4,999 BCCHP Members.
 \$1250 for Medical Groups with a May 2023 Membership of the applicable Performance Year between 5,000-14,999 BCCHP Members.
 \$2500 for Medical Groups with a May 2023 Membership of the applicable Performance Year of 15,000 or more BCCHP Members.

***** Measure only applies to Medical Groups with Membership in May 2023 of 1,000 or more BCCHP Members.

ILLUSTRATIVE BONUS CALCULATIONS

Measure: Well-child Visits 3-11

Illustrative Benchmark: $\geq 50\%$ completion

Provider X: Has 100 Members in total eligible for well child visits. The target well child visit rate is 50%.

Provider X completes 60 visits.

Increased marginal well child visits have a \$4 PMPY bonus.

Provider X Incentive Bonus: Target well child visits = $100 \times 50\% = 50$ well child visits
 $(60 - 50) = 10$ increased visits \times \$4/marginal visit = **\$40**

Measure: ED Admission Payment Amount Calculation:

Assume Medical Group XYZ has an Average Membership of 1,100 BCCHP Members, who incurred 525 ED Admissions over the Performance Year. Further, assume that the Custom Benchmark equals 500 ED Admissions/1,000 BCCHP Members and that the incentive multiplier equals \$100. Assume the ED Admission Payment Cap for Medical Groups with Membership between 1,000-4,999 BCCHP Members equals \$2,000.

To calculate Medical Group XYZ's Payment Amount for ED Admissions, perform the following steps:

Equation: $\text{Min} [\text{Payment Amount Cap}, (\text{Max}\{0, [(\text{Custom Benchmark} * (\text{Average Membership}/1,000)) - \text{Incurred ED Admissions}] * \text{incentive multiplier})]$

Steps:

1. Calculate initial Payment Amount: $[(500 * (1,100/1,000)) - 525] * 100 = \$2,500$
 - a. Note: If this would have resulted in a negative number, the Payment Amount would be zero.
2. Compare initial Payment Amount to ED Admissions Payment Amount Cap: $\$2,500 > \$2,000$. Since the Initial Payment Amount is greater than the ED Admissions Payment Amount Cap, then the Payment Amount will equal \$2,000.

Measure: IP Admission Payment Amount Calculation:

Assume Medical Group XYZ has an Average Membership of 1,100 BCCHP Members, who incurred 600 IP Admissions over the Performance Year. Further, assume that the Custom Benchmark equals 700 IP Admissions/1,000 BCCHP Members and that the incentive multiplier equals \$100. Assume the IP Admission Payment Amount Cap for Medical Groups with Membership between 1,000-4,999 BCCHP Members equals \$2,000.

To calculate Medical Group XYZ's Payment Amount for IP Admission, perform the following steps:

Equation: $\text{Min} [\text{Payment Amount Cap}, (\text{Max}\{0, [(\text{Custom Benchmark} * (\text{Average Membership}/1,000)) - \text{Incurred IP Admissions}] * \text{incentive multiplier})]$

Steps:

1. Calculate initial Payment Amount: $[(700 * (1,100/1,000)) - 600] * 100 = \$17,000$
 - a. Note: If this would have resulted in a negative number, the Payment Amount would be zero.
2. Compare initial Payment Amount to IP Admissions Payment Cap: $\$17,000 > \$2,000$. Since the Initial Payment Amount is greater than the IP Admissions Payment Cap, then the Payment Amount will equal \$2,000.

***** Measure only applies to Medical Groups with Membership in May 2023 of 1,000 or more BCCHP Members.

Data Submission and Calculation

- A. QIP Clinical Measures shall be based on BCCHP claims data or encounter data and will be paid for Members who are HEDIS eligible. All claims or encounters should be submitted within 30 days from the date of service and include the appropriate HEDIS eligible codes for each measure. BCCHP reserves the right to conduct a medical record review audit to confirm the results. Practice Providers are required to submit complete and accurate data for each of the QIP Clinical Measures as requested by BCCHP. The data must be submitted in a format acceptable to BCCHP and within the time period established in the annual QIP instructions.
- B. The Practice agrees to submit all documentation requested by BCCHP to support any data for payment under this Agreement within seven (7) days of such request for documentation, unless the QIP instructions allow more time for the Practice to provide such documentation. BCCHP may, in its sole discretion, reduce or eliminate any payments that the Practice may be eligible for if the Practice either refuses or delays providing such documentation to BCCHP.

Calendar Year 2021 and beyond Quality Reimbursement

- A. For Calendar Year 2021 and beyond, certain measures may be reimbursed on a quarterly basis and certain measures may be reimbursed on an annual basis as determined by BCCHP. BCCHP agrees to reimburse the Practice for each HEDIS eligible BCCHP Member enrolled with the Practice who received a targeted Clinical Measure service as outlined in Table A.

BCCHP will calculate compliance rates for the Calendar Year and payment to the Practice will occur based on or before the timeline outlined in Table B.

Table B: Payment Schedule for CY2021 and Beyond

For Measures That Will Be Reimbursed On A QUARTERLY Basis	
Date of Reimbursement	Reimbursement for Dates of Services
June 30	January – March
September 30	April – June
December 31	July – September
April 30	October – December
For Measures That Will Be Reimbursed On An ANNUAL Basis	
Date of Reimbursement	Reimbursement for Dates of Services
By the 15 th of October	January – December

BCCHP reserves the right to calculate compliance rates for applicable measures that are not reimbursable on a quarterly schedule, on an annual basis with reimbursement to occur by the 15th of October of each calendar year.

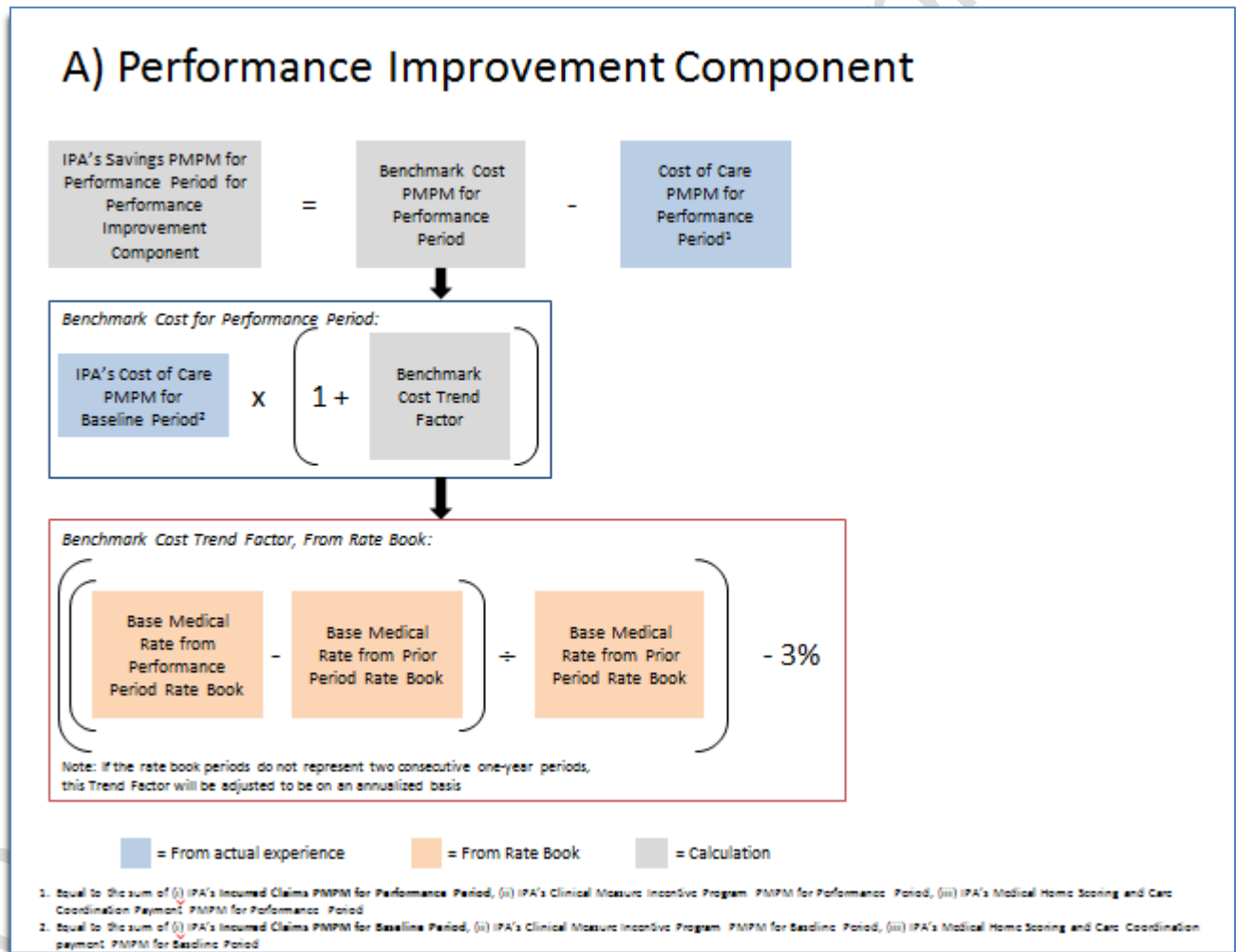
Upon termination of this Agreement, BCCHP may retain an amount equivalent to outstanding bills of the Practice.

Illinois Medicaid Shared Savings Program

This section only applies to Providers that are participating in a Value Based Program, as specified in their Provider Agreement.

The Illinois Medicaid Shared Savings Program is designed to recognize eligible IPAs for the delivery of quality care that is economical and efficient. The savings generated will be shared with eligible IPAs based on IPA's cost of care relative to both its own historical cost of care for Members assigned to IPA and historical BCCHP averages for the similar BCCHP Member population as a whole. This recognizes eligible IPAs for providing efficient care and managing cost growth. All care coordination and value-based care program dollars are included in calculation of shared savings. Please see the illustration below for calculations.

Illustrative Calculation for January 1, 2018



B) Absolute Performance Component¹

$$\text{IPA's Savings PMPM for Performance Period for Absolute Performance} = \text{Absolute Cost Threshold PMPM for Performance Period} - \text{Cost of Care PMPM for the Performance Period}$$

Absolute Cost Threshold for Performance Period:

$$\text{Average Per Member Premium for the Members assigned to the IPA during Performance Period} \times \text{Medical Cost Percent of Premium}$$

Medical Cost Percent of Premium, from Rate Book:

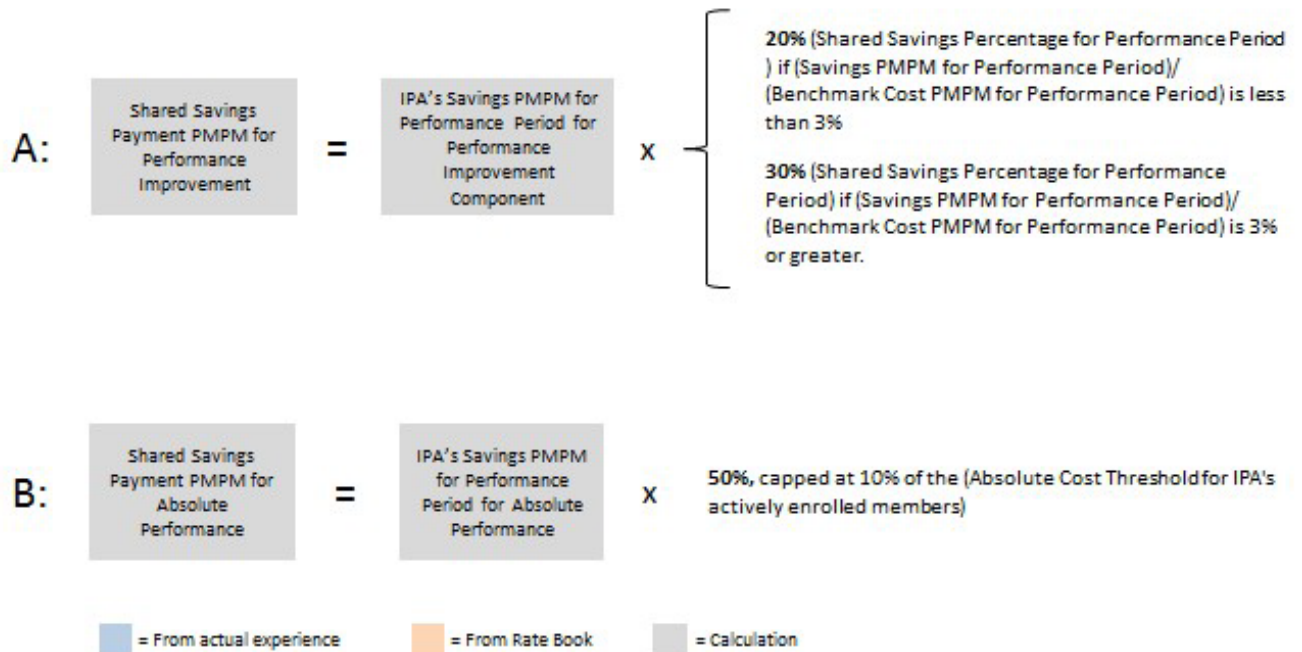
$$\frac{\text{Base Medical Rate component PMPM, from the Data Book for the Performance Period}}{\text{total MCO Effective Rate PMPM, from the Data Book for the Performance Period}}$$

= From actual experience
 = From Rate Book
 = Calculation

1. Shared Savings Only (Cost of Care PMPM for the Performance Period must be greater than the Absolute Cost Threshold PMPM for Performance Period)

Share of Savings as Payment

The IPA will be eligible for a payment which is the greater of A or B



Glossary

Absolute Cost Threshold PMPM for Performance Period

The Absolute Cost Threshold PMPM for Performance Period will be calculated in each year as [Medical Cost Percent of Premium] multiplied by [the Average Per Member Premium]. The Absolute Cost Threshold PMPM for Performance Period is the threshold that the Cost of Care PMPM for the Performance Period will be compared to, in order to determine if the IPA is eligible for the Shared Savings Payment PMPM for Absolute Performance. If the IPA's Cost of Care PMPM for Performance Period falls below the Absolute Cost Threshold PMPM for Performance Period, the IPA will be eligible for Shared Savings Payment PMPM for Absolute Performance. Average Per Member Premium means the Average Per Member Premium for the Members assigned to the IPA during Performance Period. The average will be calculated for Members assigned to the IPA based on individual premium data taken from Member enrollment data that is provided by the State for each given month.

Americans with Disabilities Act (ADA)

A federal law that prohibits discrimination against individuals with disabilities in everyday activities, including medical services.

ADA Accessible

A term defined under the ADA that generally requires that any site, facility, work environment, service or program be easy to approach, enter, operate, participate in and/or use safely and with dignity by a person with a disability.

Adults with Disabilities

An individual who is 19 years of age or older, who meets the definition of blind or disabled under Section 1614(a) of the Social Security Act (42 U.S.C.1382) and who is eligible for Medicaid.

Advance Directive

An individual's written directive or instruction, such as a power of attorney for health care, a living will or a mental health treatment preference declaration, for the provision of that individual's health care if the individual is unable to make his or her health care wishes known.

Appeal

A request by or on behalf of a Member for review of an organization determination.

Adverse Action

The denial or limitation of authorization of a requested service; reduction, suspension, or termination of a previously authorized service; denial of payment for a service; failure to provide services in a timely manner; failure to respond to an appeal in a timely manner, or solely with respect to an MCO that is the only contractor serving a rural area, the denial of a Member's request to obtain services outside of the contracting area.

Affordable Care Act (ACA) Adult (ACA Adult)

Participant eligible for HFS Medical Programs through the ACA as of January 1, 2014, and pursuant to 305 ILCS 5/5-2(18).

Average Per Member Premium

The Average Per Member Premium for the Members assigned to the IPA during Performance Period. The average will be calculated for Members assigned to the IPA based on individual premium data taken from Member enrollment data that is provided by the State for each given month.

Base Medical Rate

The component of revenue PMPM attributable to medical costs as specified in the Data Book.

Baseline Period

Defined as the twelve (12) months immediately preceding the Performance Period. The IPA must have participated in an HMO Medicaid Plan for at least one full calendar year in order to have an established baseline year with the HMO.

Basic Benefits

All health care services covered under Medicaid. All Members of BCCHP are eligible to receive all basic benefits.

Benchmark Cost PMPM for Performance Period

Equal to the IPA's Cost of Care PMPM for Baseline Period, multiplied by (1 plus Benchmark Cost Trend Factor).

Benchmark Cost Trend Factor

Defined as the increase in the medical cost component of revenue PMPM, called Base Medical Rate in the most recent Data Book, reduced by three (3) percentage points. The increase will be calculated as the percentage increase in the Base Medical Rate between the Performance Period and the period defined in the most recent Data Book for the period immediately preceding the Performance Period, and annualized. The increase in Base Medical Rate will be based on the IPA's Members enrolled in both the Performance Period and the previous year for the calculation of the Benchmark Cost PMPM for Performance Period. If the Data Book periods do not represent two consecutive one-year periods, the Benchmark Cost Trend Factor will be adjusted to be on an annualized basis by the HMO.

CAHPS

Consumer Assessment of Healthcare Providers and Systems (CAHPS) are a set of standardized surveys that assess Member satisfaction with the experience of care. Blue Cross Community contracts with an NCQA-certified vendor to administer the survey. This survey is administered annually and is based on randomly selected Members. The NCQA-certified vendor reports the data to the Quality Improvement Department who analyzes and evaluates the results of the survey to identify areas of Member dissatisfaction for corrective action as well as areas of Member satisfaction in order to continue improvement. The results of the survey are reported to Healthcare and Family Services.

Care Coordinator

Care Coordinator provides Care Management and working with a Member and care team, establishes a Care Plan for the Member.

Care Management

Care Management is a program designed to assist Members in gaining access to services, including medical, social, educational, and other services, regardless of the funding source for the services. Care Management is a collaborative process that is designed to assist Members and their providers to assess, plan, implement, coordinate, monitor and evaluate the options and services required to meet the Member's needs across the continuum of care.

Care Plan

A care plan is a Member-centered, goal-oriented, culturally relevant, and logical written plan of care with a service plan component, if necessary, that is designed to assist the Member to obtain access, to the extent applicable, medical, medically related, social, behavioral, and necessary covered services, including long-term services and supports, in a supportive, effective, efficient, timely manner that emphasizes prevention and continuity of care.

CCSO (Care Coordination and Support Organization)

CCSOs serve as hubs of accountability for a Designated Service Area (DSA), responsible for delivering high-quality care coordination, Mobile Crisis Response services, and for facilitating access to other support services to customers with significant behavioral health needs and their families across a range of HFS-administered programs

Center for Health Dispute Resolution (CHDR)

An independent Centers for Medicare & Medicaid Services (CMS) contractor that reviews appeals by Members of managed care plans, including BCCHP.

Chronic Health Condition

A health condition with an anticipated duration of at least 12 months.

Clinical Practice Consultant (CPC)

A BCBSIL representative engaged to work with Quality information within a territory of assigned Providers. The CPC will educate Providers regarding use of the Provider Enablement tool (formerly Indices), help Providers learn to proactively identify and resolve gaps in care, identify, monitor and evaluate clinical and service improvement opportunities, and provide wide ranging education and support both internally and for Providers across various Quality measures and programs.

Contracted Facility / Facility

Any independently contracted health facility, hospital, laboratory, or other institution licensed and/or certified by the State of Illinois and Medicaid to deliver or furnish health care services and which has a written agreement to provide services directly or indirectly to BCCHP Members pursuant to the terms of the Agreement for facility services.

Contracted Pharmacy / Pharmacy

Any independently contracted pharmacy that has an agreement to provide BCCHP Members with medication(s) prescribed by each Member's contracted Provider in accordance with BCCHP.

Contracted Provider / Provider

Any independently contracted physician or practitioner, to include, but not limited to, a physician, physical therapist, psychologist, and any other Provider of medical services, licensed and/or certified by the State of Illinois and Medicaid to deliver or furnish health care services and who has a written agreement to provide services directly or indirectly to BCCHP Members pursuant to the terms of the Medical Service Agreement.

Converged Provider Enablement (formerly Indices)

A secure online tool developed by Inovalon that allows Providers and HCSC stakeholders to monitor quality and risk metrics by identifying gaps in care. After provisioning, Provider access to this tool is through Availity Essentials.

Cost of Care PMPM for Baseline Period

Equal to the sum of (i) IPA's Incurred Claims PMPM for Baseline Period, (ii) IPA's Clinical Measure Incentive Program (CMIP) payment PMPM for Baseline Period, (iii) IPA's Medical Home Scoring and Care Coordination payment PMPM for Baseline Period, in aggregate divided by the number of Member months.

Cost of Care PMPM for Performance Period

Equal to the sum of (i) IPA's Incurred Claims PMPM for Performance Period, (ii) IPA's CMIP PMPM for Performance Period, (iii) IPA's Medical Home Scoring and Care Coordination Payment PMPM for Performance Period, in aggregate divided by the number of Member months. In the calculation of the Savings PMPM for Performance Improvement, the Cost of Care PMPM for Performance Period will be compared to the Benchmark Cost PMPM for Performance Period to determine shared savings.

Covered Services

Those benefits, services or supplies that are covered under BCCHP and approved for a Member by BCCHP as more fully set forth in the BCCHP plan document.

Critical Incident

A reportable incident involving an eligible recipient that may include, but is not limited to, abuse, neglect or exploitation; any unexpected death including death due to substantiated cases of abuse, neglect or exploitation; additional critical incidents that has the potential to place a Member or Member's services, at risk but does not rise to the level of abuse, neglect or exploitation, such as restraint applications, seclusion or other restrictive interventions, environmental hazards; law enforcement intervention; or emergency services, and which encompasses the full range of physical and mental health and home and community-based services.

Cultural Competence

Generally considered to be the understanding of those values, beliefs and needs that are associated with age, gender identity, sexual orientation, and/or racial, ethnic, or religious backgrounds of Members receiving health care services. Cultural competence also includes a set of competencies, which are required to ensure appropriate, culturally sensitive health care to persons with congenital or acquired disabilities.

Data Book

The document most recently entitled Medicaid Managed Care Data Book, issued by the State of Illinois Medicaid actuary.

DHS-SUPR

The Division of Substance Use Prevention and Recovery (SUPR), or its successor, within Illinois Department of Human Services (DHS) that operates treatment services for alcoholism & addiction through an extensive treatment Provider network throughout the State of Illinois.

<http://www.dhs.state.il.us/page.aspx?item=29725>

DCFS

The Illinois Department of Children and Family Services and any successor agency.

<http://www.state.il.us/dcfs/index.shtml.1.17.40>

DCMS

The Illinois Department of Central Management Services and any successor agency.

Delegated Activities

Delegation occurs when an organization gives another entity the authority to carry out a function that it would otherwise perform. Delegation or Subcontracting is the process by which an organization contracts with or otherwise arranges for another entity to perform functions and to assume responsibilities on behalf of the health plan, while the health plan retains final authority to provide oversight to the delegate.

Determination of Need (DON)

The tool used by the State of Illinois or the Department's authorized representative to determine eligibility (level of care) for nursing facility and home and community-based services (HCBS) waivers for persons with disabilities, HIV/AIDS, brain injury, supportive living, and the elderly.

DHS

The Illinois Department of Human Services and any successor agency.

DHHS

The United States Department of Health and Human Services and any successor agency.

DHS-DDD

The Division of Developmental Disabilities within Illinois Department of Human Services that operates programs for persons with developmental disabilities.

DHS-DMH

The Division of Mental Health, and any successor agency, within Illinois Department of Human Services that is the state mental health authority.

DHS-DRS

The Division of Rehabilitation Services, and any successor agency, within Illinois Department of Human Services that operates the home services programs for persons with physical disabilities, brain injury and HIV/AIDS.

DHS-OIG

The Department of Human Service Office of Inspector General, and any successor agency, is the entity generally responsible to investigate allegations of abuse and neglect of people who receive mental health or developmental disability services in Illinois and to seek ways to prevent it.

Disenrollment

The process by which a Member's participation in BCCHP is terminated. Reasons for disenrollment include, but are not limited to, death, loss of eligibility for BCCHP or choice not to participate in BCCHP. Disenrollment at the direction of the Member may also be referred to as "opt-out."

DoA

The Illinois Department on Aging, and any successor agency.

DPH

The Illinois Department of Public Health, and any successor agency, the State Survey Agency responsible for promoting the health of the people of Illinois through various means, including, but not limited to, the prevention and control of disease, injury, licensure, and certification of nursing facilities (NFs) and Intermediate Care Facility Services for the Developmentally Disabled (ICF/DD) facilities.

Downstream Entity

Downstream Entity has the same definition that is found in 42 C.F.R. §§ 422.2 and 423.4, which, at the time of execution of this Agreement, means any person or entity that enters into a written arrangement with persons or entities involved in the MMAI, MA and/or Medicare Part D Programs, below the level of the arrangement between HMO and a First-Tier Entity, such as IPA.

Eligible Member Months

Means the sum of all number of eligible Members assigned to the IPA in each month of the Performance Period.

Effectuation

Compliance with a reversal of BCBSIL's original adverse organization determination. Compliance may entail payment of a claim, authorization for a service or provision of services.

Emergency Medical Condition

Medical conditions of a recent onset and severity, including, but not limited to, severe pain that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness or injury is of such a nature that failure to receive immediate medical care could result in:

- Serious jeopardy of the patient's health;
- Serious impairment of bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement; or
- Serious jeopardy to the health of the fetus, in the case of a pregnant patient.

Emergency Services

Covered inpatient or outpatient services that are:

- Furnished by a Provider qualified and appropriately licensed to furnish emergency services; and
- Needed to evaluate or stabilize an emergency medical condition.

Enrollee

See “Member”

Enrollment

The processes by which an individual who is eligible for BCCHP is enrolled in BCCHP, including transfers from one participating BCBSIL plan to another.

eviCore

BCBSIL has contracted with eviCore Healthcare (eviCore) to manage benefit preauthorization requests for certain specialized clinical services for BCBSIL Members. eviCore is an independent specialty medical benefits management company that provides utilization management services for BCBSIL.

Explanation of Payment (EOP)

The statement provided to the provider when payment is made that informs the provider which procedures are being paid.

Facility

Hospital and ancillary providers, which include, but are not limited to: Durable Medical Equipment (DME) suppliers and Skilled Nursing Facilities (SNFs).

Grievance

Expression of dissatisfaction by a Member, including grievances regarding healthcare services and about any matter other than an organization determination.

Habilitation

An effort directed toward the alleviation of a disability or toward increasing a person's level of physical, mental, social, or economic functioning. Habilitation may include, but is not limited to, diagnosis, evaluation, medical services, residential care, day care, special living arrangements, training, education, sheltered employment, protective services, counseling, and other services.

HEDIS (Healthcare Effectiveness Data and Information Set)

A tool developed and maintained by the National Committee for Quality Assurance and its successor organization that is used by health plans to measure performance on dimensions of care and service in order to maintain and/or improve quality. Ensures that Members will receive optimal preventive and quality care. Annually, the Quality Improvement Department collects, analyzes, and evaluates performance measures. The results are used to evaluate our adherence to practice guidelines and improve Member outcomes. The results are reported to Healthcare and Family Services in June.

Hospital-Acquired Conditions

Conditions that are generally considered by CMS: (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG (Diagnosis Related Group) that has a higher payment when present as a secondary diagnosis and (c) could reasonably have been prevented through the application of evidence-based guidelines. These criteria are subject to change by CMS.

Home and Community Based Services (HCBS)

A combination of standard medical services and non-medical services that allow individuals to remain in their own home or live in a community setting including but not limited to case management (i.e., supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential) and respite care.

Home and Community Based Waiver

Waivers issued under Section 1915(c) of the Social Security Act that allow Illinois to cover home and community services and provide programs that are designed to meet the unique needs of individuals with disabilities who qualify for the level of care provided in an institution but who, with special services, may remain in their homes and communities.

Home Health Agency (HHA)

A Medicaid-certified agency which provides intermittent skilled nursing care and other therapeutic services in the Member's home when medically necessary, when Members are confined to their home and when authorized by their Provider.

Homemaker Service

General non-medical support by supervised and trained homemakers. Homemakers are trained to assist Members with their activities of daily living, including personal care, as well as other tasks such as laundry, shopping, and cleaning.

Hospice

An organization or agency, certified by Medicaid, which is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

Hospital

A Medicaid -certified institution licensed in the State of Illinois, which provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term "hospital" does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily custodial care, including training in routines of daily living.

Illinois Client Enrollment Services (ICES)

The entity independently contracted by the Illinois Department of Healthcare and Family Services (HFS) to conduct enrollment activities for potential Members, including providing impartial education on health care delivery choices, providing enrollment materials, assisting with the selection of a health plan and PCP and processing requests to change health plans. ICES is also responsible for disenrollment of Members.

Indices (by Inovalon)

See "Converged Provider Enablement"

HFS

Illinois Department of Healthcare and Family Services and its successor agency.

HFS Contract

HFS Contract means all the contracts between BCBSIL and HFS pursuant to which BCBSIL and Dual Plans as applicable.

Incurred Claims PMPM for Baseline Period

Equal to all the fee for service claims incurred during the Baseline Period by Members assigned to the IPA during the Baseline Period, provided that the fee for service claims incurred by any individual Member shall be reduced to the Member Cap if they otherwise exceed the Member Cap, in aggregate, divided by the number of Member months.

Incurred Claims PMPM for Performance Period

Equal to all the fee for service claims incurred during Performance Period by Members assigned to the IPA during Performance Period, provided that the fee for service claims incurred by any individual Member shall be reduced to the Member Cap if they otherwise exceed the Member Cap, in aggregate, divided by the number of Member months.

Independent Physicians Association (IPA)

IPA means 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.

Institutionalized

Residency in a nursing facility, Intermediate Care Facility Services for the Developmentally Disabled (ICF/DD) or state operated facility, but not including admission in an acute care or rehabilitation hospital setting.

Laws

Any and all applicable laws, rules, regulations, statutes, orders, and standards of the United States of America, the states or any department or agency thereof with jurisdiction over any or all of the Parties, as such laws, rules, regulations, statutes, orders, and standards are adopted, amended, or issued from time to time. Laws include, without limitation, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations, including the HIPAA Privacy Rule and HIPAA Security Rule; all CMS guidance and instructions relating to the Medicaid Programs; Title VI of the Civil Rights Act of 1964; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act; the requirements applicable to individuals and entities receiving federal funds; the federal False Claims Act; any applicable state false claims statute, the federal anti-kickback statute; and the federal regulations prohibiting the offering of beneficiary inducements.

Long-Term Care (LTC) Facility or Nursing Facility (NF)

A facility that provides skilled nursing or intermediate long-term care services, whether public or private and whether organized for profit or not-for-profit, that is subject to licensure by the State of Illinois, including a county nursing home directed and maintained under Section 5-1005 of the Counties Code; and a part of a hospital in which skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act are provided.

Long-Term Services and Support (LTSS)

See Home and Community Based Services (HCBS)

MCO Effective Rate

The total rate PMPM as specified in the Data Book. It will be taken from the Data Book for the Performance Period to calculate the Medical Cost Percent of Premium.

Medicaid

The program of medical assistance benefits under Title XIX of the Social Security Act and various demonstrations and waivers thereof.

Medical Cost Percent of Premium

Equal to the Base Medical Rate, from the Data Book for the Performance Period, divided by the total MCO Effective Rate as such term is defined in the Data Book, for the Performance Period. The Medical Cost Percent of Premium will be calculated separately for each Rate Cell, and these separate Medical Cost Percent of Premium amounts will be averaged based on the Members assigned to the IPA during the Performance Period. The Medical Cost Percent of Premium will be used to calculate the Absolute Cost Threshold PMPM for Performance Period.

Medically Necessary Services

A service, supply or medicine that is reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member, for the prevention of future disease, to assist in the Member's ability to attain, maintain, or regain functional capacity or to achieve age-appropriate growth, or otherwise medically necessary and meets the standards of good medical practice in the medical community, as determined by the Provider in accordance with BCBSIL guidelines, policies or procedures.

Member / Enrollee

The Medicaid beneficiary, entitled to receive covered services, who has voluntarily elected to enroll in BCCHP and whose enrollment has been confirmed by HFS.

Member shall include the guardian where the Member is an adult for whom a guardian has been named; provided, however, that BCCHP is not obligated to cover services for a guardian who is not otherwise eligible as a Member.

Member Cap

The maximum claims amount used in calculations under this Medicaid Agreement in connection with a single Member during a Performance Period For purposes of this agreement, the Member Cap equals \$150,000.00 during the Baseline Period and the Performance Period.

Member Communications

Materials designed to educate Members on covered services and flexible benefits, policies, processes and/or Member rights. This includes pre-enrollment, post-enrollment, and operational materials.

Member Centered

A BCCHP requirement that services and care are built on the Member's specific preferences and needs, delivering services with transparency, individualization, respect, linguistic and cultural competence, and dignity.

MXOTech / MXOCare

A secure portal providing access for BCCHP Providers to retrieve Quality Incentive Payment information. Providers can also use MXOTech to share Member Medical Record data with their CPC for Quality purposes.

Non-Contracted Provider or Facility

Any professional person, organization, health facility, hospital or other person or institution licensed and/or certified by the State of Illinois or Medicaid to deliver or furnish health care services and also being neither employed, owned, operated by, nor under contract with BCBSIL to deliver covered services to BCCHP Members.

Older Adult

An individual who is 65 years of age or older and who is eligible for Medicaid.

Organization Determination

Any determination made by BCBSIL with respect to any treatment or services that may be covered by BCCHP, including, but not limited to:

- Payment for temporarily out-of-area renal dialysis services, emergency services, post-stabilization care or urgently needed services;
- Payment for any other health services furnished by a Provider that the Member believes are covered under Medicaid, or, if not covered under Medicaid, should have been furnished, arranged for, or reimbursed by BCBSIL;
- BCBSIL's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by BCBSIL;
- Reduction, or early discontinuation of a previously authorized ongoing course of treatment; and/or
- Failure of BCBSIL to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination, such that a delay would adversely affect the health of the Member.

Performance Period

Defined as the twelve (12) month period beginning on the Effective Date, or any consecutive twelve (12) month period thereafter during which this Agreement is in effect.

Personal Assistant

Individuals who provide personal care to a Member when it has been determined by the case manager that the Member has the ability to supervise the personal care provider.

Personal Care

Assistance with meals, dressing, movement, bathing or other personal needs or maintenance or general supervision and oversight of the physical and mental well-being of a Member.

Personal Emergency Response System (PERS)

An electronic device that enables a Member at high risk of institutionalization to secure help in an emergency.

Post-stabilization Care Services

Post-stabilization care services are covered services defined under the BCCHP plan that generally are:

- Related to an emergency medical condition;
- Provided after a Member is stabilized; and
- Provided to maintain the stabilized condition or under certain circumstances to improve or resolve the Member's condition.

Primary Care Physician (PCP)

Any physician, including a WHCP who, within his or her scope of practice and in accordance with State certification requirements or State licensure requirements, is responsible for providing all preventive and primary care services to his or her assigned Members.

Provider

Any contracted physician or practitioner, to include, but not limited to, a physician, physical therapist, psychologist, hospital facility, health care facility, laboratory, and any other provider of medical services, licensed in accordance with all applicable Laws.

Quality Improvement Organization (QIO)

Organizations comprising practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicaid Members. QIOs review grievances raised by Members about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, SNFs, HHAs, Medicaid health plans and ambulatory surgical centers. The QIOs also review continued stay denials for Members receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs and Comprehensive Outpatient Rehabilitation Facilities (CORFs).

Quality of Care Issue

A quality-of-care grievance may be filed through the BCCHP grievance process and/or a Quality Improvement Organization (QIO). A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

Rate Cell

(Defined in the Data Book) Refers to rate cells for different populations set by the State Actuary. Each rate cell contains rates paid to the MCO by the state based on the demographics of the Members in the population managed by the MCO.

Reconsideration

A BCCHP Member's first step in the appeal process after an adverse organization determination. BCBSIL or an independent review entity may re-evaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.

Representative

An individual appointed by a BCCHP Member or other party, or authorized under state or other applicable law, to act on behalf of the Member or other party involved in an appeal or grievance. Unless otherwise stated, the representative will have all of the rights and responsibilities of the Member or party in obtaining an organization determination, filing a grievance or in dealing with any of the levels of the appeal process, subject to the applicable rules described at 42 CFR Part 405.

Savings PMPM for Absolute Performance

The savings that the IPA may be eligible for due to absolute performance. It is calculated as follows: ([Absolute Cost Threshold PMPM for Performance Period] minus [Cost of Care PMPM for Performance Period]).

Savings PMPM for Performance Improvement

The savings that the IPA may be eligible for due to performance improvement. It is calculated as Benchmark Cost PMPM for Performance Period minus the Cost of Care PMPM for Performance Period. The Savings PMPM for Performance Period will be multiplied by the Shared Savings Percentage for Performance Period to determine the Shared Savings Payment PMPM for Performance Improvement.

Serious Reportable Adverse Events (SRAEs)

BCBSIL will not cover a particular surgical or other invasive procedure to treat a particular medical condition when the provider erroneously performs: 1) a different procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient. BCBSIL will also not cover hospitalizations and other services related to these non-covered procedures.

Service Area

A geographic area approved by HFS within which an eligible individual may enroll in a participating BCBSIL plan.

Shared Savings Payment PMPM for Absolute Performance

Refers to the savings the IPA may be eligible for if the IPA's Cost of Care PMPM for Performance Period falls below the Absolute Cost Threshold PMPM for Performance Period. It will be calculated as Savings PMPM for Absolute Performance multiplied by [50%].

Shared Savings Payment PMPM for Performance Improvement

Is calculated as follows: [Savings PMPM for Performance Period] multiplied by [IPA's Shared Savings Percentage for Performance Period]. The Shared Savings Payment PMPM for Performance Improvement will then be multiplied by the number of eligible months to calculate the Total Shared Savings Payment for Performance Improvement.

Shared Savings Percentage for Performance Period

The percentage of achieved savings for performance improvement that BCBSIL will share with the IPA. If the IPA's Savings PMPM for Performance Period, divided by the Benchmark Cost PMPM for Performance Period, is greater than zero percent but is less than 3%, the Shared Savings / Loss Percentage for Performance Period is 20%. If the IPA's Savings PMPM for Performance Period, divided by the Benchmark Cost PMPM for Performance Period, is 3.00% or greater, the Shared Savings Percentage for Performance Period is 30%.

Skilled Nursing Facility (SNF)

A nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health services. Temporary residence for patients undergoing medically necessary rehabilitative treatment outside of a hospital. Skilled nursing care is provided 24/7 by trained registered nurses in a medical setting under a doctor's supervision.

Subcontractor

See Downstream Entity

Supportive Living Facility (SLF)

Residential apartment-style housing (assisted living) setting in Illinois that is certified by the Department of Healthcare and Family Services that provides or coordinates flexible personal care services, twenty-four (24) hour supervision and assistance (scheduled and unscheduled), activities and health related services with a service program and physical environment designed to minimize the need for residents to move within or from the setting to accommodate changing needs; has an organizational mission, service programs and physical environment designed to maximize residents' dignity, autonomy, privacy and independence; and encourages family and community involvement. Services include: temporary nursing care, social/recreational programming, health promotion and exercise, medication oversight, ancillary services, 24-hour response/security, personal care, laundry, housekeeping and maintenance.

Timely Filing

For BCCHP, timely filing for first file is 180 days from the date of service. If there is a date range on the claim, then timely filing starts from the last date of service on the claim. The timeframe for submitting corrected/replacement claims is 180 days from date of service or date of discharge on the claim, whichever is later. The timeframe for submitting a dispute is 60 days from the date of claim denial or payment. After that time, prior payment of the disputed claim(s) will be considered final payment in full and will not be further reviewed by BCBSIL.

Total Shared Savings Payment for Absolute Performance

Calculated as the Shared Savings Payment PMPM for Absolute Performance, multiplied by the number of eligible Member months.

Total Shared Savings Payment for Performance Improvement

Calculated as the Shared Savings Payment PMPM for Performance Improvement, multiplied by the number of eligible Member months.

Urgently Needed Services

Covered services provided that are not emergency services, as defined above, but that are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition.

Women's Health Care Provider (WHCP)

Any physician specializing by certification or training in obstetrics, gynecology, or family practice.

Checking eligibility and/or benefit information and/or obtaining prior authorization is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage, including, but not limited to, exclusions and limitations applicable on the date services were rendered. If you have any questions, call the number on the member's ID card.

Availity is a trademark of Availity, LLC., a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSIL. eviCore healthcare (eviCore) is an independent company that has contracted with BCBSIL to provide prior authorization for expanded outpatient and specialty utilization management for members with coverage through BCBSIL. Prime Therapeutics LLC (Prime) is a pharmacy benefit management company. BCBSIL contracts with Prime to provide pharmacy benefit management and other related services. BCBSIL, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime. Heritage Vision is an independent company that has contracted with BCBSIL to provide vision network/administration for members with coverage through BCBSIL. ModivCare is an independent company that provides transportation services to BCBSIL through a contractual agreement between BCBSIL and ModivCare. BCBSIL makes no endorsement, representations or warranties regarding third party vendors and the products or services they offer.