BCBSIL Commercial and IFM HMO
Utilization Management and Population Health Management Plan
2024

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

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation,
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Definitions

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

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

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

Case Management (CM) - Case Management is the collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost effective outcomes.

Complaint/Grievance - A complaint is an expression of dissatisfaction, either verbal or written. Complaints can be related to but are not limited to the following:

- Claim related issues
- Accessibility/availability of services
- Membership issues
- Group and member billing
- Benefit related issues
- Medical Group/Individual Practice Association or Physician Hospital Organization, Primary Care Physicians (PCPs), other providers
- Quality of Care, and
- HMO employees (service related)

A Grievance is a potential wrong that is considered grounds for a complaint or dispute that is related to benefits, policies and/or guidelines.

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

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

Cotiviti - Data analytics tool made available to IPAs by the HMO, which allows the IPAs to review member utilization patterns and gaps in care. (https://https://login.cotiviti.com

Custodial Care - Nonskilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving round, and using the bathroom. It may also include care that most people do themselves, like using eye drops. In most cases, Medicare doesn't pay for custodial care. (cms.gov)

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

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

Enrollee Experience Survey (EES): The qualified Health Plan Enrollee Experience Survey was designed to collect accurate and reliable information from consumers about their experience with the health care they received through Health Insurance Marketplace Qualified Health Plans (QHPs).

Exhaustion of Limited Benefits: Some benefit plans limit the number of treatments for select services (i.e., Physical Therapy, Speech Therapy, Occupational Therapy, Chiropractor, Infertility, and Behavioral Health). It is the IPAs responsibility to confirm the benefit limits at the start of treatment.

Glucose Management Indicator (GMI) - A measurement based on average glucose obtained from continuous glucose monitoring (CGM).

Glycemic Status Assessment for Individuals with Diabetes (GSD) – Evaluation of an individual's blood glucose level via HbA1c or the glucose management indicator (GMI.)

Health Equity - When all people have "the opportunity to 'attain their full health potential' and no one is 'disadvantaged from achieving this potential because of their social position or other socially determined circumstance.'" (Source: CDC; Health Equity Institute of San Francisco University)

Health Plan (HP) – An entity that assumes the risk of paying for medical treatments, i.e., uninsured patient, self-insured employer, payer, or HMO. (cms.gov)

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

HMO Administered Complaint - A written notice to the IPA from the HMO regarding IPA's failure to adhere to any of the terms, obligations, or conditions set forth in this Agreement. Complaints may include, but are not limited to, IPA's failure to pay bills, service, quality of care or access issues, or administrative problems such as failure to provide information.

HMO - Health Maintenance Organization - Five (5) Health Maintenance Organizations exist within the managed care structure of Blue Cross and Blue Shield of Illinois (BCBSIL). They are HMO Illinois®, (HMOI), Blue Advantage HMO℠ (BA HMO), Blue Precision HMO℠, BlueCare Direct℠ HMO, and Blue FocusCare℠. Except where distinctions are made, the five (5) programs will be referred to as the HMO**.**

Illinois Department of Insurance (IDOI)- The Department of Insurance works to ensure all insurance companies, HMOs, producers selling insurance in Illinois and other regulated entities obey state insurance laws. The Department provides consumer information and investigates Complaints about companies and producers.

Initial Assessment (IA) - The documented contact with a member that is completed after determination of the member's eligibility for Complex Case Management. The assessment is comprehensive and includes, but is not limited to: medical history, social history, mental health status, functional capacity, and caregiver resources. The Initial Assessment must be ***initiated*** within 30 calendar days of eligibility/identification for Complex Case Management. The initial assessment must be ***completed*** within 60 calendar days of identification for Complex Case Management. If a member cannot be reached within 30 calendar days, it must be documented that either the member was hospitalized, **OR** that the member was unable to be reached after (3) three or more attempts within a (2) two-week period within those first 30 calendar days of eligibility/identification. If a member is confined to a facility (hospital, acute rehab., skilled nursing facility, etc.) for greater than 30 calendar days, and unavailable for bi-directional communication with their case manager, their complex case management case should be closed. Once complex case management services are again appropriate, a new case should be initiatied with a new IA performed.

Inquiry - An inquiry is a general request for information regarding a claim, enrollment/eligibility, benefits, or billing matters. Inquiries are received via phone call, or written inquiry from various sources such as members and providers.

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

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

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

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

National Committee for Quality Assurance (NCQA)- A private, 501(c)(3) not-for-profit organization dedicated to improving health care quality. Since its founding in 1990, NCQA has been a central figure in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda.

No Surprises Act (NSA)- The 2021 Consolidated Appropriations Act includes the No Surprises Act (NSA). The NSA is effective on or after January 1, 2022, based on plan renewal date. The NSA includes, among other things, balance billing protections for in-network and out-of-network emergency services. For purposes of the NSA, emergency services include all emergency services provided in any department of the hospital and also includes out-of-network post-stabilization services where the member/patient is admitted after receiving emergency services.

Notice and Consent- There are some instances in which a patient may be aware they are receiving services from a nonparticipating provider and the financial consequences of doing so, in such cases, the NSA allows the provider to have the patient sign a Notice and Consent.
The Notice and Consent process does not apply to all scenarios where a member is protected from balance billing. Specifically:

- A Notice and Consent may not be obtained prior to emergency services.
- A Notice and Consent may not be used for "ancillary services" provided by a nonparticipating provider in a participating facility. The NSA defines "ancillary services" as items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether or not provided by a physician or non-physician practitioner, and items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services (including radiology and laboratory services); and items and services provided by such other specialty practitioners specified through rulemaking.
- A Notice and Consent obtained by a nonparticipating provider may not apply to any item or service that is furnished as a result of unforeseen, urgent medical needs that arise at the time such covered item or service is furnished.
- Notice and Consent has limited use in a non-participating facility for post-stabilization emergency services. For post-stabilization services by a non-participating facility, prior to discharge, the post-stabilization services continue until the provider determines that the patient is stable for transfer, the patient is competent to provide consent, and the patient signs the written Notice and Consent.

If a nonparticipating provider has obtained Notice and Consent, the provider must timely notify the plan or issuer that the item or service was furnished during a visit at a participating health care facility and provide to the plan or issuer a copy of the signed written notice and consent.

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

Private Duty Nursing (PDN) - Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse or licensed practical nurse. Private Duty Nursing Service does not include Custodial Care Services. Skilled Nursing Service means those services provided by a registered nurse (RN) or licensed practical nurse (LPN) which require the clinical skills and professional training of an RN or LPN and which cannot reasonably be taught to a person who does not have specialized skill and professional training.

Quality Improvement Committee (QIC) – A group of individuals, with qualifications as specified in the 2024 HMO Utilization Management and Population Health Management Plan, established by the IPA and responsible for implementing and enforcing the IPA's quality policies and measures as well as addressing quality concerns. The IPA's Quality Improvement Committee may also serve as the Utilization Management Committee. If the QI committee also serves as the UM Committee, oversight of both QI and UM functions, as specified in the 2024 HMO Utilization Management and Population Health Management Plan, must be evident in all meeting minutes.

Risk Stratification - The process of identifying the potential risk or risk status of members to assign them to tiers or subsets. Members in specific subsets may be eligible for programs or receive specific services.

Shared Decision Making-Aid: Shared decision-making occurs when a health care provider and a member work together to make a health care decision that is best for the member. The optimal decision considers evidence-based information about available options, the provider's knowledge and experience, and the members, values, and preferences.

SMART Goals - Specific, Measurable, Achievable, Results-focused, and Time-bound goals.

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

Utilization Management (UM) Committee - A group of individuals, with qualifications as specified in the 2024 HMO Utilization Management and Population Health Management Plan, responsible for implementing and enforcing UM policies as well as providing oversight of delegated IPA components and addressing UM concerns.

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

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

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

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

Introduction

HMO Illinois®, Blue Advantage HMO℠, Blue Precision HMO℠ BlueCare Direct HMO℠, and Blue Focus Care HMO℠ (hereinafter the "HMO") of Blue Cross and Blue Shield of Illinois (BCBSIL), a Division of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, grants full delegation of the Utilization Management Program (UM) and partial delegation of the Population Health Management Program to the IPA.

Through this delegation arrangement, the HMO (a.k.a. the Health Plan) partners with the IPAs (a.k.a. the Delegate) for the establishment and implementation of Utilization Management and Population Health Management processes to ensure the quality, appropriateness, and the efficiency of care and resources furnished by the IPA providers for HMO members.

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

Appointment of a new IPA to the network or appointment of an existing IPA into new HMO products is contingent upon a number of factors, including IPA adherence to the following 2024 HMO Utilization Management and Population Health Management Plan pre-delegation criteria:

a) Valid Utilization Review Organization (URO) license with the state of Illinois;
b) Demonstration of ability to effectively manage utilization within the other HMO products in which it participates;
c) Demonstration of successful implementation of the IPA UM and Population Health Management Plan while striving for improvement in member and practitioner experience; as demonstrated in member surveys, with identified areas for improvement addressed by the IPA;
d) Demonstration of satisfactory performance on Quality, UM and Population Health Management Delegation Oversight Adherence Audits;
e) Demonstration of compliance with all other HMO UM requirements;
f) Demonstration of an effective Population Health Management Program;
g) Demonstration of the functional ability and process of the IPA's to carry out the mandates of the UM and Population Health Management Plan; and
h) Demonstrated ability to meet all regulatory and accreditation requirements of the HMO.

HMO Delegation Oversight

The HMO delegates performance of Utilization Management and Population Health Management Plan responsibilities to the IPAs in the HMO network. The HMO MSA and HMO UM and Population Health Management Plan delineate the responsibilities of the IPAs, as well as the HMO's responsibility and mechanisms for oversight. With oversight of the Utilization Management and Population Health Management Plan responsibilities, the objective of the HMO is to monitor the IPA UM decision-making processes and to ensure compliance with the standards as set forth in the 2024 HMO Utilization Management and Population Health Management Plan. An ongoing assessment of the IPA's performance and ability to implement the 2024 HMO Utilization Management and Population Health Management Plan mandates will continually be assessed.

Delegated Utilization Management and Population Health Management Plan responsibilities must be consistently performed within the parameters set forth in theHMO MSA and the 2024 HMO Utilization Management and Population Health Management Plan. Within this structure and its own process capabilities, the IPA has the opportunity to design a Utilization Management and Population Health Management Plan that is suited to its unique practice environment as long as all HMO minimum requirements, as outlined in the 2024 HMO Utilization Management and Population Health Management Plan, are met.

The HMO delegates Utilization Management and Population Health Management functions, which include the management of Behavioral Health (BH) and Substance Use Disorders (SUD). IPAs may coordinate BH services through the Primary Care Physician (PCP), a BH practitioner (defined as any licensed BH professional, i.e., PhD, LPC, MSW, PsyD and LCSW), or sub- delegated BH vendor.

The HMO delegates the selection of nationally recognized clinical criteria to the IPA and specifies procedures for selection, annual review, application, and dissemination of the criteria. Clinical practice guidelines are designed to assist IPA physicians. The guidelines are not a substitute for the sound medical judgment of the physician. The physician must make the final determination about what treatment or services are appropriate for the member based upon the specific medical condition of the member. HMO Member Medical Guidelines (f ormerly referred to as the "HMO Scope of Benefits") may be cited in prospective denials and adverse determinations. HMO Member Medical Guidelines are found within the HMO Provider Manual. A ***member version*** of the HMO Member Medical Guidelines is available to the member*, upon request*, by calling the HMO Customer Assistance Unit (CAU) at (312)-653-6600. (This is similar to when a member ocassionally requests a copy of MCG guidelines or Medical Group Guidelines) All proprietary information, such as payment and division of financial responsibility, has been removed from the member version. The member will only receive a copy of the guideline specific to their inquiry. **The IPA may NOT share a copy of the HMO Member Medical Guidelines with the member. Instead, members must be referred to the HMO CAU at (312) 653-6600**, because the HMO Member Medical Guidelines is an evergreen and continuously updated document; and the correct applicable version of the criteria on the date of their denial determination will be sent to the member.

The HMO provides oversight and conducts ongoing review by conducting, at minimum, semi-annual Adherence Audits to ensure that delegated processes and procedures are compliant with HMO, regulatory and accreditation standards.

BCBSIL monitors the performance of each contracted HMO Individual Physician Association (IPA). An IPA who does not meet the acceptable performance threshold, as determined by the HMO is required to submit a written Corrective Action Requirement (CAR).

Non-compliance with the Utilization Management and Population Health Management Plan requirements will result in a corrective action until compliance is achieved. Any failure of the HMO Adherence Audit requires a written Corrective Action Requirement (CAR) and immediate remediation of the failing components of the Audit. Non-compliance with completion of a CAR may result in an HMO Administered Complaint.

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

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

The IPA must submit the CAR to the HMO by the due date specified in the notification letter. If the CAR is not received by the letter's due date, then an HMO Administered Complaint may be issued. IPA submitted CARs will be reviewed by the BCBSIL staff for completeness and compliance with HMO requirements. The HMO Clinical Delegation Coordinator (CDC) may request follow-up communication related to incomplete and/or insufficient CAR components. An amended CAR must be submitted by the due date specified in this follow-up communication. Amended CARs not received by the due date will also be subject to an HMO Administered Complaint.

Once the IPA's CAR has been approved by the HMO, a letter of acceptance is sent to the IPA by the CDC and copied to the HMO Medical Director, Director, Delegation Oversight, HMO Manager, Clinical Operations, and the HMO Provider Network Consultant. The IPA is required to document acceptance of the CAR in their UM/QI Committee meeting minutes the following month.

A monthly audit will be performed for a period, determined by the HMO, after the date of the initial audit, based on the extent of the deficiences and progress toward remediation.

Non-compliance with the Utilization Management and Population Health Plan requirements may additionally result in the IPA's ineligibility to earn certain incentive payments as outlined in the HMO MSA. The HMO may terminate the delegation agreement with the IPA for non-compliance with the Utilization Management and Population Health Management Plan depending on the severity of the infraction, or continued non-compliance with the Plan.

Review of Delegated PHM Programs

The HMO will oversee delegated PHM programs. For contracts in effect for 12 months or longer, the HMO will:

a) Annually review the delegated PHM program description;
b) Annually audit CCM files against NCQA standards;
c) Annually evaluates delegate performance against NCQA standards for all delegated activities; and
d) Semi-Annually evaluates reporting.

All new agreements with delegates will require evaluation of the delegate's capacity to meet HMO, regulatory and accreditation requirements prior to delegation taking place.

IPA Delegation Requirements and Responsibilities

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

IPA Utilization Management and Population Health Management Plan

The plan must:

a) Be reviewed and approved annually with approval documented in the IPA UM Committee minutes;
b) Describe the BH (including SUD) and non-BH aspects of the Utilization Management and Population Health Management Plan;
c) If at any point during 2024 the IPA experiences operational changes from what was previously approved, the IPA must provide an updated UM/PHM Plan to the CDC within 30 days of the change; &
d) All IPA PCPs must be notified about how to obtain the IPA Utilization Management and Population Health Management Plan and the process for notification must be stated in the IPA Utilization and Population Health Management Plan.

IPA Sub-Delegation Requirements and Responsibilities

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

It is the responsibility of the IPA to review and approve any sub-delegates program components prior to submitting the IPA Utilization and Population Health Management Plan, Policies and Procedures, and the completed compliance tool to the BCBSIL IPA Access Portal by February 15, 2024. Only one (1) IPA UM and Population Health Management Plan and one (1) compliance tool which documents all IPA (physical and behavioral health) delegated or non-delegated UM and Population Health Management Plan components will be accepted by the HMO. The HMO CDC reviewing the IPA Utilization Management and Population Health Management Plan will notify the IPA of the need for any revisions to the IPA Utilization and Population Health Management Plan, Policies and Procedures and/or compliance tool with an assigned due date for submission of revision(s). Failure to meet the revision due date may result in an HMO Administered Complaint, or de-delegation of UM services.

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

Sub-Delegation Agreement Requirements

The IPA Utilization Management and Population Health Management Plan must describe any sub-delegated responsibilities of their Utilization Management and Population Health Management Plan. There must be a contract that defines accountability of the IPA and the sub-delegate, as well as the mechanisms for oversight by the IPA. At minimum, the sub-delegation contract must:

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

The sub-delegated entity is responsible for performing all IPA UM activity for which it is contracted with the IPA. Sub-delegates must meet the HMO UM standards set forth in the 2024 HMO Utilization Management and Population Health Management Plan and be clearly documented within the IPAs Utilization Management and Population Health Management Plan.

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

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

Any delegated and/or sub-delegated Contract Management Firm (CMF), Management Service Organization (MSO) or Behavioral Health Organization must also be licensed with the state of Illinois as a Utilization Review Organization (URO). A current URO license must be always in effect and evidence of renewals must be submitted in a timely manner to the HMO. Proof of current URO licensure must also be submitted to the HMO Delegation Oversight Team with the IPA UM and Population Health Management Plan documents on an annual basis.

HMO Structure, Resources and Goals

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

The 2024 HMO Utilization Management and Population Health Management Plan is evaluated and revised annually by the HMO UM Workgroup and approved annually by the HMO QIC.

HMO is contracted with multiple IPAs and ***fully delegates*** the functions of the Utilization Management Program. This delegation includes BH and SUD management. The delegated BH UM Program includes specifics related to triage and referral processes and includes all levels of BH services, as applicable. The HMO ***partially delegates*** its Population Health Management Programs: Wellness and Prevention, Condition Management (Asthma and Diabetes), Case Management and Complex Case Management. **(See Appendix C: HMO and Delegate Responsibility Matrix -UM & Population Health Management)**

HMO Quality Improvement Committee (QIC)

The HMO QIC is chaired by a BCBSIL Medical Director. The HMO QIC has representation from across the BCBSIL organization. Physical and behavioral health physicians are present at all QIC meetings. The HMO QIC is accountable for the oversight of all UM and QI activities managed by the BCBSIL Plan. All Utilization Management and Population Health Management Plan reports are presented to this committee. The identified Utilization Management trends shape future Quality Improvement activities and interventions. Approval of the 2024 HMO Utilization Management and Population Health Management Plan is made by the QIC.

HMO UM Workgroup

The HMO Medical Director chairs the HMO UM Workgroup. A BH Medical Director is in attendance along with other members which include the Executive Director Clinical Programs Strategy & Oversight, Manager, Clinical Operations, HMO CDCs, and an HMO Provider Network Consultant.

The UM Workgroup's responsibilities include, but are not limited to, the following:

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

b) Oversight of HMO UM and PHM Program policies and procedures to ensure compliance with HMO, Regulatory and Accreditation Standards;
c) Oversight and monitoring of all UM and Population Health Management functions delegated to the IPAs, which include but are not limited to IPA UM and Population Health Management Plan compliance, IPA UM and Population Health Management Plan Adherence Audit results, UM, Population Health Management and CCM Program case file reviews, IPA submissions and corrective action as applicable;
d) Oversight of IPA monthly Complaints submission and Denials processing;
e) Oversight of the IPA Population Health Management Program requirements with specific reference to the program structure, resources, and compliance with HMO requirements;
f) Review of HMO's Quarterly Population Health and CCM Program Surveys;
g) Review of IPA UM data to identify potential over or underutilization patterns;
h) Review and analysis of UM information collected for QI purposes; and
i) Reporting HMO UM and PHM Program trends and outcomes to the QIC for review and approval.

HMO 2024 UM and Population Health Management Plan Goals

a) Receive Utilization Management and Population Health Management Plans from all contracted IPAs via the BCBSIL IPA Access Portal by February 15, 2024;
b) Ensure all IPA UM and Population Health Management Plans meet or exceed the HMO requirements by April 30, 2024;
c) Ensure all IPA UM and Population Health Management Plans meet legislative, regulatory and accreditation requirements;
d) Provide effective educational programs related to perceived and documented needs of the IPAs;
e) Improve member and provider satisfaction;
f) Improve IPA physicians awareness of the IPA Population Health Management Programs (Wellness and Prevention, Condition Management, Case Management and Complex Case Management);
g) Improve HMO Network Inpatient Utilization; 2024 Targets: Days 222.52, Admits 52.19, LOS 4.26;
h) Evaluate utilization through IPA monitoring of avoidable inpatient days;
i) Ensure compliance with BH triage, including substance use disorder and referral requirements;
j) Improve HMO Network Behavioral Health Utilization; 2024 Targets: Days 26, Admits 4.2, LOS 7.59;
k) Improve HMO Network Substance Use Disorder Utilization; 2024 Targets: Days 14.4, Admits 1.8, LOS 8.0; and
l) Meet Accreditation Standards (NCQA, URAC) and pertinent federal and state legislative and regulatory requirements (CMS, Illinois Department of Public Health, Illinois Department of Insurance).

HMO Staff

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

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

HMO Monitoring and Oversight of IPA

The HMO Staff will review required IPA submissions monthly, quarterly, semi-annually, and annually as outlined in the HMO MSA and the 2024 HMO Utilization Management and Population Health Management Plan.

a) The HMO provides regular feedback to the IPAs with monthly paid claims and quarterly utilization reports. HMO Staff review specific utilization trends including medical, surgical, outpatient surgery, home health, BH, and SUD with IPA Staff. Individual IPA performance is compared to its previous performance and to the performance of other IPAs within the network;
b) For selected IPAs, the HMO will voluntarily provide educational interventions to assist their progress. These interventions may include comprehensive and detailed UM or Population Health Management in-services, focused educational activities targeted to specific problem areas, document review and/or on- site UM or CM assessment;
c) The HMO provides an opportunity for discussion of important utilization issues during practitioner conferences. In this forum, best practices are discussed, and IPA input is obtained. The HMO may conduct focus groups with the IPAs;
d) Through selected QI indicators and studies, the HMO monitors the network for issues relating to over-utilization and/or under-utilization of services. This review, discussion and monitoring includes utilization data across practices and practitioner sites. This monitoring information is used to evaluate effectiveness of the processes used to achieve appropriate utilization.
   Where specific outcomes are relevant to a single IPA, this is communicated to the IPA Medical Director and considered in the re-credentialing and reappointment process;
e) IPAs are identified for face-to-face visits based on various factors considered by the HMO, including the following: potentially avoidable days, admits/1,000 members, days/1,000 members, average length of stay, Population Health Program performance or any other identified potential issue. In addition, CAHPS®/EES survey results, member and provider complaints, and appeals data are reviewed to evaluate member and PCP satisfaction with the utilization management process.
f) IPA is required to hold at least eleven (11) monthly UM/QI Committee meetings per year. By contract, the HMO reserves the right to have HMO staff attend these required UM/QI Committee meetings to observe and assess the IPA's internal processes and activities, and then to provide feedback to the IPA about these processes and activities. The HMO reserves the right to monitor and assess whether the delegated UM activity is performed according to the HMO's Plan requirements and the HMO MSA, however, such oversight shall not relieve the IPA of its obligations to perform the UM functions in accordance with all applicable HMO policies, procedures, and agreements;

g) The HMO UM Workgroup reviews reports and identifies potential issues. Also, claims payment data, Denial files, customer service issues, quality of care issues, diagnosis, referrals, case detail, assessment of member and Provider experience, and appeals are utilized to identify potential problems. Any significant substandard performance from the HMO requirements will be reported to HMO management; and
h) When deemed appropriate, a CAR will be requested from the IPA. It may include any of the following components: additional data collection, written requests for action, meeting with the network consultant and the IPA, and/or a meeting with the HMO Medical Director and IPA Medical Director and/or Administrator.

Under the supervision of the HMO Medical Director, the HMO CDC provides oversight of UM and Population Health Management Program delegated functions on an ongoing basis. Oversight includes but is not limited to:

a) Annual review and approval of IPA Utilization Management and Population Health Management Plan and required Policies and Procedures;
b) Review of random sample of Condition Management, Case Management and Complex Case Management files;
c) Monthly review of Condition Management, Case Management and Complex Case Management Forms;
d) Monthly review of IPA Complaint submissions which may have been misrouted to the IPA rather than the Health Plan;
e) Monthly review of **All** Denials (inpatient and outpatient); including Medical Necessity and Non-Covered Benefits
f) Monthly review of CCM referral source IPA submissions;
g) Quarterly review of **ALL HMO** OON referral logs;
h) Oversight of the Exhaustion of Benefit (EOB) processes;
i) Quarterly review of UM statistical reports;
j) Performing Semi-Annual and Annual IPA UM Adherence Audits.

Adherence Audits

The CDC performs a semi-annual audit of the IPA Utilization Management and Population Health Management Programs and meets with the IPA UM and CM staff, including the IPA Medical Director and/or Physician Champion, if indicated. The Adherence Audit Site Visit Tool is used to measure compliance with the 2024 HMO Utilization Management and Population Health Management Plan requirements. The IPA must score at least 90% to achieve a passing score.

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

The following elements will be addressed at the Utilization Management and Population Health Management Plan Semi-Annual Adherence Audit:

a) Review of UM Committee meeting minutes;
b) Utilization Management Case File Review including emergent and concurrent cases for both medical and BH/SUD, skilled nursing, home health, long stay, and cases not meeting criteria that have been referred to the Physician Advisor;
c) UM Case File Review includes but is not limited to the review of referral timeliness standards (receipt date, decision date, notification date)
d) Interview of the IPA's UM and Population Health Management staff to discuss the Population Health Management processes;
e) Discussion of audit results and any pertinent data reflecting the IPA performance; and
f) PHM Case File Review (Discussion of Condition Management, CM, CCM, any as needed, PHM case file review occurs throughout the year).

Note: Case File scores and resulting audit scores are final and not eligible for appeal once the CDC has completed the audit. Please work with the CDC to demonstrate compliance prior to completion of the audit. The administrator's designee from the IPA and the HMO CDC will sign a confirmation letter that they agree that all items have been reviewed and discussed.

HMO Utilization Management Program Oversight

Overview

The HMO UM Program is designed to ensure that physical and behavioral health services are medically necessary and appropriate, as well as in conformance with the benefits of the plan and state and regulatory requirements. The HMO UM program encompasses services rendered in ambulatory, inpatient and transitional settings. The program is monitored and evaluated to identify trends and opportunities to improve health care services and member experience. The core components of the HMO UM program include but are not limited to structure, goals, and processes to ensure appropriate utilization, measurement, and assessment of member experience.

Ensuring Appropriate Utilization

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

a) Inpatient admissions/1,000 member;
b) Inpatient days/1,000 member;
c) Average length of stay (LOS);
d) Outpatient surgery/1,000 member;
e) Emergency Department (ED) visits/1,000 member;
f) Primary Care Emergency Department (PCED) visits/1,000 member;
g) Behavioral Health days/1,000 member;
h) Substance Use Disorder days/1,000 member;
i) Assessment of CAHPS®/EES survey, member and provider complaints and appeals data.
j) IPA 30-day re-admission rate (HEDIS methodology);
k) Avoidable days; and
l) Home Health Utilization.

Data is collected at the network and individual IPA levels. Thresholds for intensified review by the HMO UM Workgroup are established based on a statistical analysis of an IPA's performance in relation to overall network performance.

The HMO UM Program contains utilization goal benchmarks that are set based on all BCBSIL products. In addition, MCG benchmark performance data (for moderately managed health plans) are used as a guide.

The HMO additionally collects a variety of member and practitioner data including, but not limited to, CAHPS/EES Surveys, member and practitioner Complaints, and appeals data.

Appeals

The HMO does NOT delegate any appeals to the IPA. The HMO will facilitate the appeal process according to legislative requirements (IDOI, CMS) and National Committee of Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC). The IPA is responsible for explaining all levels of appeal (pre-service, post-service, expedited and external) and the appeal process to the HMO member. IPA instructions and procedures for member-initiated appeals with the HMO must be listed within the new member welcome letter.

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

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

The Appeals attachment is based on the Member Plan:

a) Group Policies: HMOI® (H), Blue Advantage HMO℠ (B), Blue Precision HMO℠ (R) and Blue Care Direct HMO℠ (A)
b) Individual Policies: All start with the letter (I) Blue Precision HMO℠ BlueCare Direct HMO ℠, Blue Focus Care HMO ℠

Please note that the current and correct appeals attachment must be used for all Denials including Urgent Concurrent Denial letters. If an incorrect appeals attachment is used in error, it will result in an IPA CAR.

Continued coverage must be provided to the member pending the outcome of an internal appeal for covered services. The HMO reserves the right to modify or amend the Denial and Appeals policies or procedures in order to meet any legislative or regulatory requirements, as determined by the HMO.

Standard Appeals (Pre-Service and Post-Service)

The IPA denial letter states that the HMO has written policies and procedures regarding appeals that address the following:

a) Allowing at least 180 calendar days after receipt of notification of the Denial for the members to file an appeal;
b) Documentation of the substance of the appeal and action taken;
c) Full investigation of the appeal, including aspects of any clinical care involved;
d) The opportunity for the member to submit written comments, documents or other information relating to the appeal;
e) Appointment of a new person for review of the appeal who was not involved in, or a subordinate to anyone involved in the previous review;
f) For medical necessity appeals, the case must be reviewed by a practitioner of the same or similar specialty as the managing practitioner;
g) The decision and notification to the member or provider must be made within 15 business days of receipt of the request for standard appeals;

h) There must be notification about further appeal rights including the appeal process and notification of the contact information for the Department of Insurance;
i) There must be procedures for providing the member access and copies of all documents relevant to the appeal, free of charge and upon request;
j) An authorized representative, or attorney must be able to act on the member's behalf;
k) Procedures for expedited pre-service appeals, which include the initiation, decision, and notification process; and
l) Policies for providing notices of the appeals process to member in a culturally and linguistically appropriate manner.

Expedited Appeals

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

The HMO has procedures for registering and responding to expedited appeals which include:

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

External Appeals

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

New and Existing Medical Technology

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

Pharmaceutical Management

Pharmacy benefits are administered by Prime Therapeutics, BCBSIL's Pharmacy Benefit Manager, for members having this benefit.

HMO Population Health Management Program Oversight

Overview

The HMO Population Health Management Program seeks to provide a cohesive plan of action for addressing member needs across the continuum of care.
The HMO Population Health Management Program is designed to assist members in navigating the health care continuum from wellness through end-of-life care. Objectives match those of The Triple Aim: Improving Quality, Improving Member Experience and Decreasing Costs. The HMO Population Health Management Program places the member at the center of the health care system. The HMO Population Health Management Program employs a population health approach striving to accurately identify and stratify members to ensure appropriate interventions for the right patient, in the right setting, at the right time. The HMO Population Health Management Program includes Wellness and Prevention, Condition Management, Case Management and Complex Case Management.

The HMO Population Health Program is partially delegated to each of its participating IPAs. The health plan aids in achievement of delegated activities by providing integrated data reporting to the IPAs monthly.

The HMO monitors member satisfaction with the Condition Management Program (annually) and Complex Case Management Program (quarterly) by mailing surveys to all members enrolled in the programs. This portion of the Population Health Management Programs is not delegated to the IPA.

Lastly, the HMO monitors the effectiveness of the Population Health Management Program on an annual basis. Analyses of the effectiveness of these programs shape the structure of the programs in subsequent years. (See Appendix C: HMO and IPA Delegation Responsibility Matrix)

Further references and description of HMO Population Health Management Program oversight and a description of the collaborative partial-delegation roles and responsibilities shared by the HMO and delegated IPA can be found in the following:

a) IPA Population Health Management (PHM) Program Structure and Resources
b) Appendix D: 2024 Population Health Management Program Strategy

IPA Utilization Management and Population Health Program Structure and Resources

IPA Physician, UM, and Population Health Management Program Staff Requirements

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

IPAs must have appropriate staff to perform UM and Case Management functions. A roster of the IPA staff documenting name, title and credentials, and license number is required with the annual submission of the UM and Population Health Management Plan. Any change in the IPA staff needs to be reported, in writing, to the HMOs within 30 calendar days of the change.

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

1. **IPA Medical Director**

   The IPA Medical Director is a board certified, Illinois licensed physician who:

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

2. **IPA Behavioral Health Medical Director**

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

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

3. **Physician Champion**

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

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

5. **Specialist**
   A board-certified specialist (both physical and BH medicine) must be an Illinois licensed practitioner and must be available as needed to assist in making determinations of medical necessity. The IPA must maintain and annually update a list of available board-certified specialists utilized for this purpose. The IPA will have a policy and procedure for the use of a board-certified specialist. Upon request, the IPA will be required to provide member case files demonstrating the use of board-certified specialists. The list of board-certified specialists, which must include contact information (e.g., names, specialties), must be submitted to the HMO CDC with the annual submission of the UM and Population Health Management Plan. The IPA will also make the list of specialists available to UM staff as a reference for contacting those specialists.

   For BH UM case review, there must be a board-certified Psychiatrist or licensed clinical Psychologist available as needed. In addition, the IPA may utilize a certified addiction medicine specialist for SUD. Note: Pediatricians are considered primary care providers. Pediatric Sub-specialists are required to be available, as needed, for pediatric medical necessity determinations.

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

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

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

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

Job descriptions and Staff Training

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

IPA Utilization Management Program

IPA UM/QI Committee Requirements

The IPA is required to have a minimum of eleven (11) monthly UM and/or QI Committee meetings including BH and Medical Specialists (with MD/DO licensure) representation, Medicine, General Practice, Internal Medicine, Obstetrician/Gynecologists, and Pediatricians are not considered specialists for this purpose. The purpose of the IPA UM Committee includes, but is not limited to, the review and approval of the annual IPA Utilization Management and Population Health Management Plan, review of ambulatory and inpatient services, behavioral health services, and Population Health Program services provided to the HMO members. The minutes of the committee meeting must document the following:

a) Date of the meeting;
b) Medical Director/Chairman, BH Medical Director (at minimum quarterly) and members present, including at least one specialist and one BH Practitioner (monthly);
c) Minutes signed by the IPA Medical Director/Chair within five weeks of the date of the last meeting and uploaded to the BCBSIL IPA Access Portal within one week of receiving the IPA Medical Director/Chair signature. (Meeting Minutes may not be stamped).

The IPA's QI Committee may also serve as the UM Committee. If the QI Committee also serves as the UM Committee, oversight of both QI and UM functions, as specified in the 2024 HMO Utilization Management and Population Health Management Plan, must be evident in all meeting minutes. Only one set of meeting minutes will be audited for HMO compliance purposes.

The IPA Utilization Management and Population Health Management Plan must identify the UM Committee chairperson, its membership, the committee structure, and meeting schedule. The UM Committee must include broad physician representation, including the following: IPA Medical Director, IPA BH Medical Director, actively practicing primary care physicians, and at least one board-certified specialist (MD or DO). A roster of the UM Committee members must include each Committee member's professional degree, license number and specialty, and be submitted with the IPA UM and Population Health Management Plan. Any revisions to the UM Committee membership must be submitted to the HMO within 30 calendar days of change. The UM and Population Health Management Plan must include a description of the process for its development (i.e., which persons or Committees are responsible for the UM and Population Health Management Plan review, revision, and the final approval). Any revisions to the IPA UM and Population Health Management Plan must be submitted to the HMO within 30 calendar days of change. A designated BH physician or doctoral-level behavioral health practitioner must be involved in the implementation of the behavioral health aspects of the IPA UM and Population Health Management Plan and is responsible for reporting behavioral health activities to the IPA UM Committee. The scope of the 2024 HMO Utilization Management and Population Health

Management Plan includes, but is not limited to, oversight of Utilization Management and Population Health Management Plan requirements, including delegated inpatient and outpatient services as follows:

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

IPA UM Targets

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

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

Complaints/Grievances

Complaints and Grievances are **not** delegated to the IPA. Members are instructed by their certificate of coverage to contact the HMO directly with any Complaints/Grievances. At times, Complaints and Grievances are received directly by the IPA from a member. If the IPA should receive a Complaint or Grievance from a member, the following process must be implemented:

a) Complaints must be submitted to the BCBSIL IPA Access Portal with reference to specific complaint categories within one (1) business day of receiving the complaint. The HMO Customer Assistance Unit (CAU) will send the acknowledgement letter to the member within one (1) business day of the complaint submission to the BCBSIL IPA Access Portal.
b) The IPA will e-mail or fax the IPA Complaints/Grievances Check List, along with all supporting documentation and Medical Director/Administrator recommendations to the (CAU) within fourteen (14) calendar days.
c) If all Complaints/Grievances related documents have not been received by the fifteenth (15th) calendar day, the CAU may issue an HMO Administered Complaint.
d) The final complaint resolution will be determined by the HMO. Quarterly review and discussion at the IPA UM Committee meeting of all complaints must be in summary format using categories of complaints. The report must reflect quarterly and year to date findings, and whether any trends have been identified.

Inter-Rater Reliability (IRR)

The purpose of IRR testing is to evaluate consistency and accuracy in the application of nationally recognized medical criteria.

Semi-annually, the IPA UM Committee must review inter-rater reliability results and document its findings in the UM Committee meeting minutes. All Physicians and Practitioners (including BH licensed practitioners, i.e., PhD, LPC, MSW, PsyD and LCSW), Physician Advisors, IPA Medical Directors, and UM Staff (licensed and non-licensed) who are involved in the UM process must be included in this assessment.

Inter-rater reliability testing must be performed by a licensed professional peer of the individual being reviewed. Every physician and UM staff member involved in UM decision making must be evaluated for inter-rater reliability compliance.

The IRR report must include a summary of findings and corrective actions (if applicable) in addition to detail on each staff member's results.

The UM Committee Minutes must address:

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

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

Inter-Rater Methodology

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

a) Initially, a random sample of eight files for each physician and staff member must be reviewed;
b) If each physician and UM staff member passes all eight files, the process is complete;
c) If a physician or staff member does not pass all eight files with 100% accuracy, an additional 22 files must be reviewed for this staff member(s) for a total of 30 files and must achieve a passing score of ≥ 90%. If the 90% threshold is not achieved, the Corrective Action Process will be initiated.
d) Inter Rater Reliability files must be redacted for protected health information (PHI). Both redacted and unredacted versions of the files are to be uploaded to the BCBSIL IPA Access Portal semi-annually (March and September)
e) Using the template below, please report the number of staff who passed the inter-rater (numerator) and the number of staff who took the interrater (denominator) and percentage of staff who passed on first attempt vs. required re-education and 2nd attempt. Also, report the staff breakdown for BH/SUD and Non-BH/SUD, and Physician vs. Non-Physician and Clinical vs. Non-Clinical UM staff members.
f) Acute Care Hospital (including BH), Acute Rehab, Long-Term Acute LTACH, Residential and Skilled Nursing Facility admissions are to be considered inpatient for this purpose;
g) BH/SUD Intensive Outpatient Program (IOP) and Partial Hospital Program (PHP) authorizations are to be considered outpatient for this purpose.

Consistency in the Application of Nationally Recognized Medical Criteria Review

Whether the application of criteria is consistent *or* not consistent across staff, there must be discussion regarding the IPA's results in the IPA UM Committee meeting minutes and the minutes must reflect any inconsistent application(s) of criteria, along with evidence of corrective action, if applicable.

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

Time Frames Adherence Review

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

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

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

UM Timeliness Report

The Timeliness Report applies to all prospective UM determinations, regardless of whether the determinations result in approval, denial, or case closure. Timeliness reports are to be submitted semi-annually to the BCBSIL IPA Access Portal (March and September.)

UM Timeliness Report Calculation Methodology

The IPA calculates the percentage of decisions that adhere to time frames specified using at least six months of data. If a physician or staff member does not pass all eight files with 100% accuracy, an additional 22 files must be reviewed for this staff member(s) for a total of 30 files and must achieve a passing score of ≥ 90%. If the 90% threshold is not achieved, the Corrective Action Process will be initiated. At a minimum, the Timeliness Report calculates rates of adherence to time frames for each category of request: Urgent concurrent, Urgent pre-service, Non-urgent pre-service. (Note: Post-service requests are considered claim determinations rather than pre-service determinations. A separate report must be run for each line of business: Commercial and IFM-HMO).

The IPA monitors and submits a report for timeliness of:

a) Non-behavioral UM decision making;
b) Notification of non-behavioral UM decisions;
c) Behavioral UM decision making;
d) Notification of behavioral UM decisions

Ensuring Appropriate Utilization

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

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

PCP Site Audits

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

Assessing Member and Practitioner Experience with the UM and PHM Programs

The HMO distributes Complex Case Management and Population Health Management satisfaction surveys to a statistically significant number of members in order to evaluate their experience with the IPA Complex Case Management and Population Health Management Programs. In addition, CAHPS®/EES survey results, member and provider Complaints, and appeals data are reviewed to evaluate member and PCP satisfaction with the utilization management process. The IPAs are not delegated to perform their own surveys. In addition, IPAs are required to implement and document in the IPA UM Committee minutes, intervention plans when they are non-compliant with the network goals for the Complex Case Management and Population Health Management Program surveys. Program goals are:

a) Member satisfaction with the IPA CCM Program (90% and above);
b) Member satisfaction with the Population Health Programs (90% and above);

IPA UM and PHM Plan: Supporting Documentation Requirements

URO Registration: Illinois Department of Insurance

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

Policies and Procedures

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

Annually, the HMO CDCs review and approve all of the required delegates' policies and procedures to ensure that the language and intent is consistent with HMO accreditation and regulatory requirements. After the CDC review and approval, the HMO develops a matrix of policies and procedures that support structural requirements, which is then reviewed and approved by the HMO UM Workgroup committee.

Required Policies Include:

1. **UM staff hospital On-Site Concurrent Review** at facility, (if applicable). If the IPA UM Coordinator performs on-site concurrent review at facilities, the IPA must have a documented process that includes the following elements:
    a) Guidelines for identification of IPA staff at the facility (in accordance with facility policy);
    b) A process for scheduling the on-site review in advance (unless otherwise agreed upon);
    c) A process for ensuring that IPA staff follows facility rules;
    d) If no on-site review is performed, this must be documented in the UM and Population Health Management Plan.
2. **Access to UM Staff** (see requirements on page 34 of this plan)
3. **Staff orientation/ training/ performance review** The IPA must have a written policy and procedure for training, orientation, and ongoing performance monitoring of clinical and non-clinical utilization review staff. The policy must be submitted to the HMO CDC annually, at the time of submission of the UM and Population Health Management Plan.
4. **Diagnoses, procedures, physicians not requiring pre-certification and/or concurrent** review, if applicable. (Ambulatory, Inpatient)
5. **Criteria for UM Decision-Making.** The IPA must have a written policy and procedure documenting:
    a) IPA uses written UM decision-making criteria that are objective and based on medical evidence;
    b) The consideration of individual needs when applying UM criteria;
    c) The assessment of the local delivery system when applying UM criteria;
    d) The involvement of appropriate practitioners in developing, adopting, and reviewing criteria; and
    e) The annual review of UM criteria and the procedures for applying them and updating the criteria when appropriate.
6. **Additional Clinical Decision-Making Criteria**, clinical pathways, guidelines used for UM decision-making and the process for development and approval, if applicable.
7. **Inter-Rater Reliability (IRR)-** The IPA will have a written policy stating the frequency (semi-annual) of the IRR to be conducted for all staff making UM decisions, the tool being used to audit, the methodology of audit, and plan of action if results fall below required standards. The results and any plans of action must be discussed in the UM/QI Committee meeting semi-annually (March and September)
8. **UM Case Closure** due to insufficient clinical information for UM decision-making. The closure of the case must meet the time frames identified for the type of case being considered.
9. **IPA Referral and Denial Process-** The IPA must have a policy describing their process for approving and denying pre-service and concurrent referral requests. The denial process must describe the distinction and management of both medical necessity versus non-covered benefit denials.
10. **Standing Referrals**- A listing of referral diagnoses/ procedures/ services/ physicians that do not require review based on historical UM data. A member diagnosed with a disease or condition requiring an ongoing course of treatment from a specialist or other health care provider may request a standing referral from his/her PCP. This is a single referral, provided at the discretion of the PCP, specifying duration, type, and frequency of specialist services to complete an ongoing course of treatment.
11. **Appeals** (not delegated, referred to the HMO Customer Service Department)

12. **Protected Health Information.** The HMO adheres to the Health Insurance Portability and Accountability Act (HIPAA) provisions for the use of Protected Health Information (PHI) and requires the IPA and any sub-delegates, in turn, to follow these provisions. The IPA must:
    a. Use PHI (any member identifiers that can be linked to a member) only to provide or arrange for the provision of medical and BH (which includes Behavioral Health or Substance Use Disorder) benefits administration and services;
    b. Provide a description of appropriate safeguards to protect the information from inappropriate use or further disclosure;
    c. Ensure that sub-delegates have similar safeguards;
    d. Provide individual members with access to their PHI;
    e. Inform the HMO if inappropriate uses or disclosures of the PHI occur;
    f. Ensure that PHI is returned, destroyed, or protected upon termination of the HMO MSA.
13. **Confidentiality** of all medical information maintained by the IPA or sub-delegated providers is protected from unauthorized use and disclosure.
14. **Tracking avoidable days** for IPA physicians and method for corrective action and non-compliance.
15. **PCP notification to member** of approved certification decisions, if applicable.
16. **Hospital Transition of Care Policy.** IPAs are required to provide a policy that identifies the IPA process of meeting or exceeding the following minimal requirements: Review of hospital Admission, Discharge and Transfer (A/D/T) data, and/or inpatient logs (and Emergency Department logs, if available) every business day, for potential high-risk transition cases. Contact Hospital Discharge Planner as appropriate. Case Manager bi-directional contact with consenting members, who are determined by the IPA to be at high-risk and those who are enrolled in a Condition Management, CM and CCM program, within 48 hours* of discharge. The transition of care call must include a medication reconciliation assessment.
17. **Transition to Other Care** describing the IPA process for notifying member of an exhausted benefit, transition of care and/or transition of care from Pediatric to Adult Care.
18. **Population Health Management Program Policy** describing the IPA Wellness and Prevention, Condition Management, Case Management and Complex Case Management programs.
19. **Wellness and Prevention Program Policy** describing the process for IPA practitioners and office staff to educate members regarding preventive health screenings, tracking gaps in care and outreaching to members in order to close gaps in care on an annual basis.
20. **Complex Case Management System-** The IPA must have a policy describing their electronic Complex Case Management software system.
21. **Out-of-Network Referral Policy**- Describing the process for ensuring that medical criteria is reviewed by the Medical Director to ensure the member can indeed be treated for their condition at the in-network provider office prior to issuing a denial re-directing the member back in network.
22. **Denial Controls**- The IPA has a documented policy and procedure describing internal system controls specific to UM denial notification and receipt dates. The policy must describe how the system controls are established, monitored, and what actions are taken should an instance of system over-ride is found. HMO will maintain an internal policy and will review delegate policies for compliance.

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

IPA Utilization Management Requirements

Requirements for HMO Commercial UM Decisions

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

a) UM decisions are made within the time frames established by the HMO using clinical information; **(See Appendix B: 2024 UM Timeframes and Requirements)**
b) A process is identified for UM concurrent reviews performed on-site at facilities, such as hospitals and skilled nursing facilities;
c) Transition of care is provided when benefits end (See Transition of Care Section of this document).

Accreditation UM Criteria for Decision Making

Annually, the IPA UM Committee must review, select, and approve, the current version, of a nationally recognized and evidence based medical criteria used for medical necessity and LOS determinations and document this in the UM Committee meeting minutes. The clinical criteria **(*medical and BH/SUD*)** must be the current version of the selected nationally recognized criteria.
The selection process must include credentialed or licensed (MD/DO) actively practicing physicians from at least one specialty in each of the IPA high volume specialty areas. (Examples of nationally recognized criteria include: MCG, InterQual, Apollo, ASAM).

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

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

a) Medical;
b) Surgical;
c) Outpatient surgery;
d) BH which includes behavioral health and ASAM criteria for SUD;
e) Rehabilitation;
f) Home health care (HHC); and
g) Skilled nursing facility (SNF).

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

In situations where nationally recognized criteria are not available, the IPA may utilize additional evidence-based guidelines created by the IPA, provided that the guidelines are subsequently reviewed and approved, annually, including any procedures for their use. Guidelines from appropriate medical specialty societies such as the American College of Cardiology, or the American Diabetes Association of Clinical Guidelines should be referenced when citing the evidence utilized in the creation of the IPA specific guidelines.

The development process of the criteria must include appropriate specialists. Every year, the criteria and procedure(s) must be submitted to the HMO CDC with the IPA Utilization Management and Population Health

Management Plan. Documentation of review and approval must be in the IPA UM Committee meeting minutes. The IPA may adopt additional objective criteria, clinical pathways, and/ or guidelines that must be reviewed by the UM Committee and chosen based on scientific medical evidence.
Discussion of how the additional criteria, clinical pathways, and/ or guidelines were chosen must be identified in the IPA Utilization Management and Population Health Management Plan as part of the criteria approval process.

Notification of Availability of Clinical Criteria

On an annual basis, a written statement must be distributed to all IPA practitioners notifying them of the availability of the IPAs nationally recognized criteria and any additional guidelines, the method for requesting the criteria, and the format in which the criteria will be provided. A sample of this annual written statement is to be attached to the annual Utilization Management and Population Health Management Plan for submission to the HMO CDC. IPAs will maintain a log of all requests for criteria. If no requests are made, that must be documented on the log.

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

Services not Meeting Medical Criteria

For cases that do not meet the nationally recognized medical criteria or for which criteria are unavailable, the IPA Medical Director and/or PA must decide considering the individual patient's circumstances including age, co-morbidities, and psychosocial considerations.

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

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

The IPA must provide the number of PA referrals per month in aggregate, and the number of PA referrals resulting in denial in aggregate. This must be reported at the UM Committee meetings. Upon request, the IPA must have a mechanism for calculating their denial rates for a requested time period. The number of IPA denials (ambulatory and inpatient) serve as the numerator. The number of IPA authorizations (ambulatory and inpatient) will serve as the denominator. Results will need to be reported with break out for BH/SUD and Non-BH/SUD. Additionally, results will need to be reported for in-network and out-of-network services. (See definitions for in and out-of-network services on previous page in the section entitled Referral Inquiry Logs). The following is a table that should be utilized for data submission to the HMO:

	Inpatient				Outpatient			
	In-Network		Out-of-Network		In-Network		Out-of-Network	
	Med/Surg	MH/SUD	Med/Surg	MH/SUD	Med/Surg	MH/SUD	Med/Surg	MH/SUD
Authorization Totals:								
Denial Totals:								
Denial Rate:								

Relevant Clinical Information

To support UM decision-making, the UM Coordinator and/or Physician Advisor must gather and document relevant clinical information including information from the attending physician. The HMO Clinical/Pre-Certification/Pre-Service/Initial Review Form must be utilized, or an equivalent IPA form that includes all required documentation which must be submitted with the UM and Population Health Management Plan. Relevant clinical information may include, but is not limited to, lab tests, physician's progress notes, x-ray reports, and individual patient circumstances as listed below:

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

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

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

Medical Necessity and Benefit Determinations

The IPA Utilization Management and Population Health Management Plan must describe the process of making medical necessity (including out-of-network) determinations and benefit determinations and the information utilized in making determinations, including the process for using board-certified specialists, if needed, to assist in medical necessity decisions. Prior to re-directing members back in network, the delegates' Medical Director must review clinical information in order to determine that required conditions/services are available to be provided in-network. Non-covered benefit determinations may only be issued when the service requested is never approved for any member, regardless of diagnosis or medical necessity.

UM Affirmation Statement

Annually, all IPAs are required to distribute an affirmation statement to all members, practitioners, providers, and employees who make UM decisions affirming that:

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

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

Access to UM Staff

The IPA must provide the following communication services for practitioners and members:

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

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

Prospective/Pre-Certification/Pre-Service Process

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

The IPA policy may include diagnoses, procedures, and/or physicians that do not require IPA prior authorization and/ or concurrent review. A member non-discrimination notice should be provided with all medical group approvals and denials pursuant to Section 1557 of the Affordable Care Act. The notice is available on the BCBSIL IPA Access Portal. This member notice is subject to change is the sole discretion of the HMO. In the event of a change to the notice, medical groups can expect the HMO to provide an updated notice for use.

Accreditation Pre-Certification and Pre-Service includes documentation of the following:

a) Sources of relevant clinical information utilized (medical record, physician information, labs/test results/x-rays, other);
b) Estimated length of stay (LOS) for inpatient admission;
c) Medical criteria met including criteria code for inpatient admission;

d) Non-urgent pre-service determination (approval or denial) within five calendar days of receipt of request, including the collection of all necessary information (no additional time is allowed for obtaining information);
e) Non-urgent pre-service member notification within five calendar days of the receipt of request;
f) Non-urgent pre-service Practitioner notification within five calendar days of the receipt of request;
g) Urgent pre-service determination (approval and denial) within 72 hours of receipt of request, including the collection of all necessary information (no additional time is allowed for obtaining information);
h) For urgent cases, member notification within 72 hours of receipt of request (IPA policy must state the process for member notification); and
i) For urgent cases, practitioner notification within 72 hours of receipt of request.

Initial Review: Emergent/Urgent Certification

For emergency admissions and out-of-network post-stabilization services following an emergency admission, prior-authorization is not required. Notification of inpatient admissions which may result in a review is encouraged.

Certification and Initial Review Process for emergent/urgent admissions, if notification is received, is to be completed within 24 hours of admission or notification of admission and includes documentation of the following:

a) UM decision (approval or denial) made within 24 hours of receipt of the request;
b) Nationally recognized medical criteria being met (code documented) in justification of medical necessity issues;
c) Assigned length of stay (LOS);
d) Notification of member within 24 hours of receipt of request (IPA policy must state the process for member notification);
e) Notification of practitioner(s) within 24 hours of the receipt of request;
f) Discharge planning needs to be documented within 24-48 hours of admission; and
g) Home, family, environmental assessment within 24-48 hours of admission.

For practitioner notification, if initial notification is made by telephone, IPA must record time and date of call, and document name of IPA employee who made the call. For all denials, confirmation of the decision must be provided by mail, fax, or e-mail to both the admitting provider and the member.

Initial Review-Non-Urgent Precertification

Initial Review for pre-certified / pre-service non-urgent (elective) admissions may be deferred until assigned length of stay for that approved admission has reached its limit.

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

a) Name of patient and patient identifier;
b) Date of review, Admit Date;
c) Name of Physician – PCP (or admitting physician) and/or Specialists;
d) Diagnosis and Procedure – date of procedure;
e) Facility/Agency Name;
f) Relevant clinical Information – supporting the admission and clinical information source;
g) Medical Criteria (nationally recognized) met and Code;
h) Anticipated Length of Stay (LOS);
i) Physician Notification Date;
j) Member Notification Date;

k) Social, family, caregiver support and home assessment for discharge planning;
l) Potential Discharge Plan, discharge needs, identification of any barriers (e.g., has no family support, is unable to pay for prescription drugs, discharged to home, but is unable to ambulate and lives on the 2nd floor); and
m) Case Management Referral, if applicable.

Admissions must be on the admission log semi-annually with the patient's name, facility, date of admit, diagnosis/ procedures performed, PCP or admitting physician and discharge date. The same log may be used for all admissions (including Hospital, Skilled Nursing Facility, Home Health Care, and Rehabilitation Facility). A sample admission log must be submitted with the annual IPA UM/PHM Plan and required documents.

Concurrent Review

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

a) UM decision (approval or denial) made within 24 hours of receipt of request;
b) Sources of relevant clinical information utilized (medical record, physician information, labs/test results/x-rays, other);
c) Nationally recognized medical criteria being met (code documented);
d) Additional criteria used in decision-making;
e) Additional assigned length of stay that is consistent with criteria;
f) Notification of member and Practitioner(s) within 24-hour time frame (If the IPA states in their UM and Population Health Management Plan that the practitioner assumes approval of continued stay, then the practitioner does not need to be notified of continued stay approval.);
g) Discharge planning needs to be documented within 24-48 hours of admission and confirmed at discharge;
h) Case review on the 7th calendar day after admission (for patients remaining admitted) to determine need for continued stay or change in discharge plan. If the 7th day occurs on a weekend, the concurrent review is required to be performed on the Friday preceding the weekend. Each additional 7 calendar day period that a member remains inpatient requires additional Medical Director review (Acute hospital, Acute behavioral health hospital, Acute Rehabilitation hospital, Long Term Acute Care (LTAC) hospital and Skilled Nursing Facility (SNF); and
i) All reviews for members who remain in an OON hospital for greater than two (2) midnights must be reviewed with the IPA Medical Director to discuss if transfer back in-network should be initiated, or continued stay is required.

For cases not requiring review as documented in the IPA's policies, after the assigned length of stay is determined and a discharge date is determined, the IPA must check for discharge on the designated discharge date. If the member has not been discharged and the case reaches the seventh day, concurrent review must begin with brief documentation of the events since admission. The case should be referred to the PA for a long stay review. Each additional 7 calendar day period that a member remains inpatient requires additional Medical Director review. An initial review form does not need to be completed.

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

Discharge Planning

A UM Coordinator or Case Manager at the IPA is responsible for assisting with identifying the member needs and implementing a discharge plan.

Each IPA must have written guidelines or protocols showing effective and timely discharge planning/Case Management with documentation as part of the concurrent review process, which include the following:

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

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

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

IPA Referral Process

Initiation of the Referral Process requires a written request for all services (as required by the IPA). The HMO requires the member and practitioner(s) be notified of the referral decision, within five calendar days of receipt of the request, (including time necessary for any requests for additional information). If the referral is denied, the member and practitioner(s) must be notified in writing or electronically within the five calendar days.

Required Elements in the Referral

All written referrals must include the following elements:

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

Referral Receipt Date is the date when the IPAs UM Department receives the referral request.
Referral Response/Notification Date is the date when the IPAs UM Department provides notification of the decision to the practitioner (and member, if applicable).

Additional Referral Requirements:

a) Maintenance of a Referral Inquiry Log by the IPA;
b) Providing the member with a copy of the referral (the IPA or PCP must mail, or fax copy to member, if requested by the member);
c) Documentation of communication with PCP if referral is denied (including member requested referrals). It must be documented that the PCP agrees with the denial decision. If the PCP does not

agree with the denial, a denial cannot be issued. A written denial letter is not required if the member does NOT receive a written referral;

d) The number of inpatient referrals to the Physician Advisor or IPA Medical Director and the number resulting in denial, must be documented in the UM Committee meeting minutes on a monthly basis; and
e) The UM Committee must discuss referral trends and interventions, if indicated, semi-annually and documented in the minutes. Referral data must be tracked and trended by specialty (including BH), with a two-quarter comparison for six months of data. This must be documented in the UM Committee minutes semi-annually.

Referrals, including but not limited to therapies, physical therapy, diagnostics, durable medical equipment (DME), and specialists, must be monitored by the IPA for quality of care, appropriate utilization, and compliance with UM decision-making timeframes (See Appendix B: 2024 Utilization Management Timeframe Requirements).

Referral Inquiry Logs:

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

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

Standing Referrals

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

IPA Denial Process for Medical and BH Services

The IPA must have a plan that describes the method for processing all IPA Denials (including medical necessity and non-covered benefit). This process applies to all services included in the Utilization Management and Population Health Management Plan and must meet the following requirements:

a) All cases that do not meet nationally recognized medical criteria must be reviewed by the IPA Medical Director and/or PA with the decision rendered and documented within the appropriate UM time frame (non-urgent pre-service – within five calendar days of the receipt of request, urgent pre- service – within 72 hours of the receipt of request, and concurrent – within 24 hours of the receipt of request). The IPA Medical Director or PA must determine whether the care should be approved or denied in medical necessity, non-BH care situations. This Denial decision can be made only with agreement from the member’s PCP, following bi-directional discussion with the IPA Medical Director;
b) A psychiatrist, doctoral level clinical psychologist, or certified addiction medicine specialist must be responsible for Denial of BH (which includes Behavioral Health and Substance Use Disorder) care that is based on lack of medical necessity. Please note: A psychiatrist or psychologist may deny both Behavioral Health and Substance Use Disorder cases. However, if the Addictions Specialist is not a

psychiatrist or psychologist, they cannot deny Behavioral Health cases but may deny Substance Use Disorder cases; and

c) The IPA must use the most recent HMO approved Denial letter, which includes the reason for the Denial based on specific guideline source, specific benefit provisions within the guideline and reference to the member's condition. Clinical information (in addition to the diagnosis) utilized in order to make the Denial decision must be included in the Denial file. Communication with the PCP regarding the decision must be documented (including member requested referrals). It must be documented that the PCP agrees with the Denial decision. An alternative to the denied service must be provided to the member. The written Denial notification must include an explanation of the HMO's appeal process in the body of the Denial letter, including the member's right to attorney representation and must include the correct Appeals Attachment based on the member's Group number:
    a) Group policies: HMO Illinois (H), Blue Advantage HMO (B), Blue Precision® HMO I (R), Blue Care Direct (A) (Appeals Footer: IL05.G.FI)
    b) Individual policies: All start with the letter (I) (Blue Precision HMO℠,BlueCare Direct HMO℠, Blue Focus Care HMO℠) (Appeals Footer: IL04.R)

d) For all denied cases, including concurrent review, Practitioner(s) and member must be informed of the expedited appeals process and this must be noted by the IPA staff member making the call if the initial notification was made by telephone. The member and practitioner(s) must be sent confirmation by mail, fax, or e-mail of the original notification within the appropriate time frame with inclusion of information on the expedited appeal process. For urgent pre-service or Urgent Concurrent Denials, the member must be informed that an expedited external review can occur concurrently with the internal appeal process for urgent care and ongoing treatment. All appeals must be forwarded to the HMO Customer Service Department upon appeal request;

e) If more clinical information is requested in order to make a referral determination, information should be requested. If it is not received by the last day of the required referral turnaround timeframe (5 calendar days standard referral, 72 hours urgent referral), the referral should be case closed. Case closure letters (See BCBSIL letter template) will be sent to both the member and the practitioner explaining that not enough clinical information was received in order for the Medical Director to make a determination. The provider should initiate a new referral request with the required information once it is available. (Example- The PCP is awaiting a consult note from the specialist which has not yet been dictated).

f) Denial decision must be agreeable to the PCP with agreement documented in the Denial file. For BH Denials, the title/specialty of the BH practitioner making the decision must be included with the signature. In addition, all Denial letters sent to the member require IPA Medical Director signature;

g) The IPA Medical Director must be available by telephone for the practitioner(s) to discuss Denial decisions for both BH (which includes behavioral health and SUD) and non-BH Denials. The IPA must notify Practitioners of its policy for making a reviewer available to discuss any UM Denial decisions in a newsletter, direct mailing, or Provider orientation;

h) The IPA should not send a Denial letter for non-group-approved services to the member where the IPA received notification after the service had already been provided. Claims received for services previously rendered that are non-group-approved should be forwarded to the HMO claims department for claims review;

i) The IPA UM Committee must review and discuss Denials to ensure Denials have been appropriately managed according to IPA's established procedures and HMO policies and this must be documented in the Committee minutes monthly;

j) Denial discussion must include a summary of the category of Denial;

k) For BH: document BH and SUD;

l) For non-BH: medical necessity, out-of-network, and benefit, number in each category, timeframe compliance and resolution, number of PA referrals and number resulting in a Denial; and
m) A member non-discrimination notice should be provided with all medical group approvals and Denials pursuant to Section 1557 of the Affordable Care Act. The notice is available on the BCBSIL IPA Access Portal. This member notice is subject to change. In the event of a change HMO shall notify the IPAs.

UM Denial System Controls

IPAs must have UM system controls in place to protect referral receipt and notification dates from being altered outside of the IPA's prescribed policy and procedure. The IPA will have a UM Denial system controls policy and procedure describing the protocols utilized to monitor compliance of system controls specific to UM referral receipt and notification dates and the compliance audit process. Refer to the IPA policy writing guide provided by the HMO for policy requirements.

UM Denial System Controls Compliance Audit

The IPA must have a process for monitoring compliance with its UM Denial System Controls policy. The IPA must audit compliance semi-annually. Audit reports will include:

1. Identification of all modifications to receipt and decision notification dates that did not meet the IPA's policies and procedure requirements for date modifications.
2. Explanation of the methodology used to identify date modifications.
3. A referral request may only be cancelled for the reasons listed below:
   a. The PCP or ordering provider states that he/she entered the referral in error
   b. The PCP or ordering provider states that he/she is retracting the order/request
4. A qualitative and quantitative analysis of all instances of date modifications that did not meet the IPA's policies and procedures for date modifications.
5. Follow-up action on all findings and implementation of a quarterly monitoring process until the IPA demonstrates improvement for one finding over three consecutive quarters. The IPA must continue to monitor until it demonstrates improvement of at least one finding over three consecutive quarters.
6. If the IPA did not identify any date modifications or if all identified date modifications met the organization's policies and procedures, requirement 4 does not apply.
7. Semiannual audit results will be discussed at the IPA's UM/QI Committee, documented in the meeting minutes, and uploaded to the BCBSIL IPA Access Portal.

Monthly Denial File Audit

Denial forms and denial files (medical and BH), including Benefit Denials, are reviewed monthly after submission to the HMO. Denial forms and files must be submitted to the BCBSIL IPA Access Portal by the 5th of each month (or the next business day if the date falls on a weekend or legal holiday). If the IPA does not have any denials for the month, this must be noted and submitted on the no denial form. Monthly submissions must include the following information for each denial: Authorization Request, , Denial Letter, Relevant Clinical Information utilized when making the determination, and a Copy of the Criteria utilized to support the denial determination.

Quarterly Denial File Audit

The HMO audits the IPAs denial files monthly and reports any deficiencies to the IPA. A Quarterly denial file audit findings letter is sent to the IPA Medical Director detailing the results of the audit. The IPA must discuss the findings and document the findings in the UM Committee Meeting minutes, including any corrective action requirements, if applicable. If the IPA fails the quarterly denial file review, the IPA is required to submit a written corrective action requirement. This corrective action must include a detailed description of how the

IPA will correct the identified deficiencies in the denial process. The Corrective Action Requirement (CAR) must be received within 5 business days from the date of the request. If the IPA does not meet or exceed an average 90% overall compliance with denial files by the end of the year (Q1-Q4), financial incentives will be impacted as outlined in the Master Service Agreement.

IPA Behavioral Health/Substance Use Disorder Requirements

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

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

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

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

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

IPAs (with delegated triage) who do not consistently meet the BH triage and referral requirements will be required to submit a Corrective Action Requirement (CAR) to the HMO.

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

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

Any delegated BH Organization or IPA providing BH services with a centralized triage and referral process, must submit telephone reports quarterly to the HMO QI Department. The reports must include the average speed of answer and the call abandonment rate. BH calls include BH or SUD related calls. Combined BH or SUD telephone stats are acceptable.

Quarterly review and discussion of any sub-delegate, CMF, or BH delegate including review of any submissions, or reports from the sub-delegates, if applicable, must be documented and approved in the IPA UM Committee meeting minutes. CMF quarterly reporting must include reference to telephone statistics and compliance with HMO standards.

Urgent Concurrent Denials

An IPA may not deny concurrent inpatient benefits of any type without the concurrent administrative review by the HMO Medical Director. This applies to medical as well as behavioral health and substance use disorder admissions.

There are two (2) types of Urgent Concurrent Denials:

1. Services provided at an in-network/par facility that are NOT Medically Necessary; and
2. Services provided at an out-of-network/non-par facility, where the PCP has recommended the member is stable for transfer to an in-network/par facility but the member refuses transfer.
   Note: A concurrent denial cannot be issued for emergent admissions or post-stabilization care post emergency admission.

Non-Emergent Admissions (In or Out of Network)-

When an IPA PCP is notified of a member's admission to a group-approved facility or to a non-group approved facility, the PCP must contact the attending physician within one business day of the notification of the admission to determine medical necessity. Once the IPA (PCP, Specialist, IPA UM Coordinator, IPA Medical Director, or anyone else affiliated with the IPA) is notified of the admission, it is the responsibility of the IPA to manage and oversee the care of the member. If after discussion with the attending physician, the PCP determined that services no longer meet medically necessary guidelines at the group approved facility, and the member refuses to discharge, or if the member refuses to transfer from the out of network facility to an in-network facility despite being stable to transfer, the Urgent Concurrent Denial process is initiated:

a) The PCP communicates the member's discharge needs or refusal to transfer to the IPA UM Coordinator and/or IPA Medical Director. A written statement from the PCP must indicate that the PCP discussed member's care with the attending and continued services for the member are no longer medically necessary or that the member is stable for transfer. The statement must include the alternative plan of treatment recommended by the PCP. In the event a member has not selected a PCP at the time of treatment, the IPA Medical Director may assume the role of the PCP.

b) The IPA notifies the CDC of a pending Urgent Concurrent Review Denial and submits a denial letter, on IPA letterhead, with the appropriate appeals attachment and non-discrimination notice prior to acting on the denial;

c) The PCP written statement must include signature, diagnosis, clinical summary, and patient's current medical condition/status, including recommendation(s) for transfer or discharge and recommendation alternatives;

d) The HMO Medical Director will review the submitted documentation to agree that all required elements are present so that the IPA may issue the Urgent Concurrent Denial Letter to the member;

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

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

g) For BH Urgent Concurrent Denials:

i. The PCP may agree to defer the denial decision and Urgent Concurrent Denial to the BH specialist. A written PCP statement of agreement must be provided to the IPA for the Urgent Concurrent Denials decision to be completed.
ii. The BH specialist would like to communicate with the PCP, but the member will not allow communication with their PCP: A statement from the member must be obtained stating they will not allow communication with their PCP.

h) In the event the IPA's Medical Director is the members PCP, the IPA's Co-Medical or Assistant Medical Director must draft the Urgent Concurrent Denial letter.
i) For medical Urgent Concurrent Denials, the PCP may defer the Urgent Concurrent Denial determination to the attending physician at the treating facility. However, a letter from the PCP stating they are deferring the Urgent Concurrent Denial determination to the attending physician at the treating facility must be provided for the Urgent Concurrent Denial to occur.
j) For BH and SUD admissions Urgent Concurrent Denials, the PCP may defer the Urgent Concurrent Denial decision to the BH specialist at the facility. However, a letter from the PCP stating they are deferring the Urgent Concurrent Denial determination to the BH specialist treating the member must be provided for the Urgent Concurrent Denial to occur.

Emergent Admissions (***Out of Network only***)
If the delegated IPA or provider within the IPA is notified of an OON emergent admission, the member may remain at the OON facility and is not subject to balance billing unless the provider follows the requirements related to the notice and consent. The OON facility may choose to transfer the member to an INN facility. In those situations, a notice of consent form as required by the NSA is not needed.

Transition of Care

1. **Transition to Other Care**
Transition of care is applicable when a member is new to the HMO, is displaced by physician de-participation, or is displaced by termination of an IPA contract. New members must request transition of care services within 15 calendar days of eligibility and existing members must request transition of care services within 30 business days after receiving notification of displacement. Members in one of these situations who are receiving frequent or ongoing care for a medical condition or pregnancy may request assistance to continue with established specialists for a defined timeframe. The continuity of care period for 2nd and 3rd trimester pregnancy should extend through six week's post-partum and the continuity of care period for 1st trimester pregnancy should be up to 90 calendar days post-notice of provider termination. Such members should be directed to the HMO Customer Assistance Unit (CAU) at (312) 653-6600 for help with this matter.

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

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

Emergency Services

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

High-Risk Pregnancy and Post-Partum Care

The HMO requires that each IPA develop and adhere to a High-Risk Pregnancy and Post-Partum Care program in order to help manage the care of members with pregnancy and/or post-partum needs.

Members identified by their treating provider as experiencing a high-risk pregnancy must have access to Case Management services. "High-risk pregnancy" means a pregnancy in which the pregnant or postpartum member or baby is at an increased risk for poor health or complications during pregnancy or childbirth - including but not limited to - hypertension disorders, gestational diabetes, and hemorrhage.

Pregnant and post-partum members must have access to medically necessary treatments for mental, emotional, nervous, or substance use disorders or conditions related to pregnancy or postpartum complications.

Medical necessity for the first 48 hours of service for any treatments for mental, emotional, nervous, or substance use disorders or conditions related to pregnancy or post-partum complications must be provided without concurrent review of medical necessity. Medical necessity for the first 48 hours of such treatments is determined solely by the member's provider.

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

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

Organ Transplants

IPAs are responsible for monitoring all aspects of clinical care including referral, pre-certification, and concurrent review related to organ transplants. The IPA should notify the HMO Customer Assistance Unit (CAU) prior to the member's evaluation at a BCBS transplant network facility by calling (312)653-6600, sending an email to **ILTransplantCoordinator@bcbsil.com**, or faxing the required clinical information to (312)233-6018. The HMO CAU will confirm that the facility is currently in the HMO transplant network for the relevant organ. If the member is accepted as a transplant candidate, the IPA forwards required documents to the HMO CAU for HMO Medical Director administrative review. These documents include a copy of the referral, the member's history, the reason for transplant, a letter from the PCP indicating his/her approval, and a letter from the transplant facility confirming the member's transplant candidate status. Following the HMO Medical Director review, the HMO CAU will provide the IPA with a letter indicating that services are in benefit for the requested facility, as applicable (Note: Organ and tissue transplants are a covered benefit when determined to be medically necessary and ordered by the Primary Care Physician or Woman's Principal Health Care Provider and when performed at a BCBSIL HMO Plan approved center for human organ transplants).

Members that are referred for, or that receive, organ transplants must be evaluated for inclusion in the IPA's Complex Case Management Program.

If the member is receiving active Case Management services from the Transplant Facility, documentation that the IPA is collaborating directly with the Transplant Care Team is an acceptable substitution so that the member is not receiving calls from multiple Case Managers.

Out of Area / Out of Network Admissions

Out of Area Admissions

The HMO is financially responsible for out-of-area admissions where member is admitted for an emergency condition or life-threatening situation more than a 30-mile radius from the IPA physician or IPA affiliated hospital in which the member is enrolled. The IPA retains responsibility for monitoring clinical aspects of care and for arranging the transfer of the member back into an in-network facility once clinically appropriate. The attending provider determines when a member is stable for transfer. Post-stabilization emergency services end once the member has been discharged home or to a lower level of care. If the member has signed a notice and consent, they have agreed to remain at the out-of-area facility and should not be transferred back in-network. When the treating physician determines that the member is medically stable for transfer, the IPA notifies the PCP that the member can be brought back into an in-network/participating facility within one business day of IPA notification. Refer to Urgent Concurrent Denials section for protocol of issuing an Urgent Concurrent Denial if the member refuses to transfer in-plan.

Non-Emergent Out of Network Admissions

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

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

Infertility

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

Record Retention

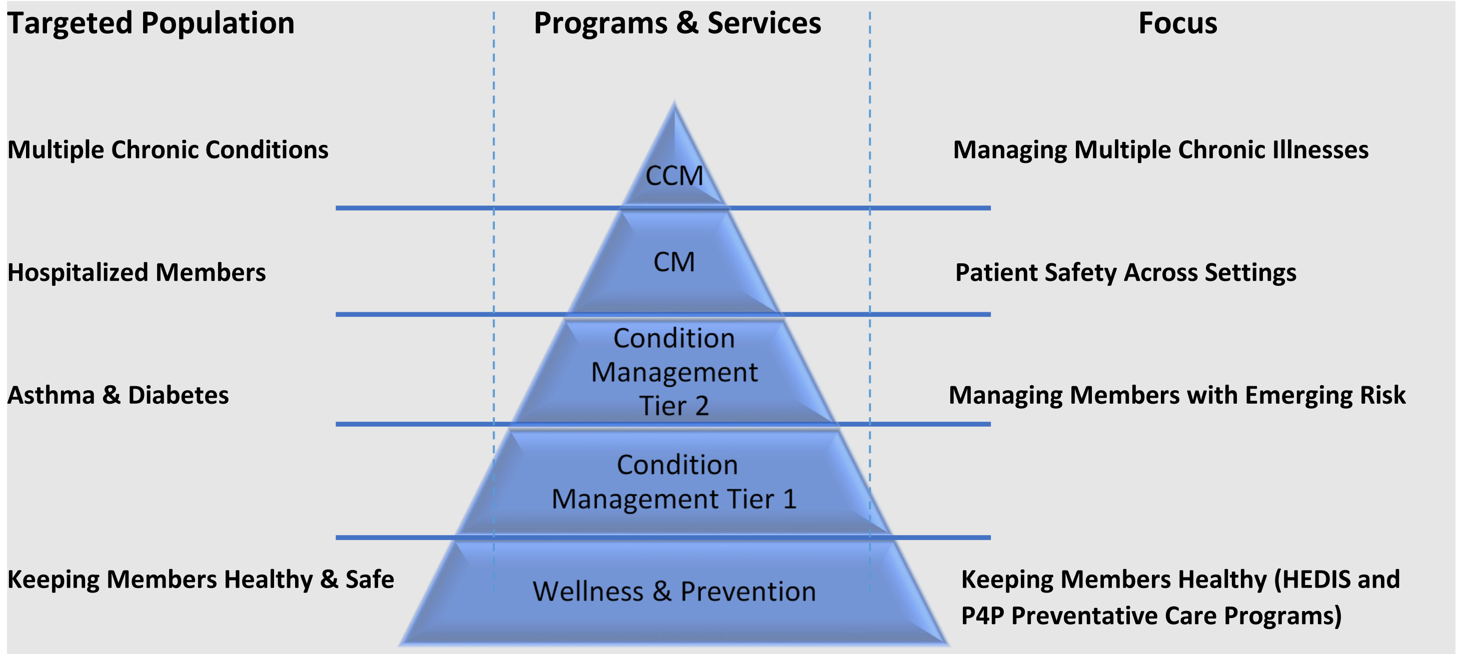
The IPA shall maintain all records necessary to allow HMO to audit and review IPA's performance and compliance with the terms of the HMO MSA Agreement. IPA shall require all subcontractors, agents or delegates working for, or on behalf of, IPA to comply with the terms of this provision. For purposes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

HMO Population Health Management (PHM) Program Strategy, Structure and Resources

The Population Health Management Program seeks to provide a cohesive plan of action for addressing member needs across the continuum of care.

(See Appendix D: 2024 Population Health Management Program Strategy)

Population Health Management Strategy at a Glance:



The HMO Population Health Management Strategy includes:

A. Goals and specific populations targeted;
B. Programs and Services offered to members;
C. Activities that are not direct member interventions;
D. How member programs are coordinated; and
E. How members are informed about available PHM programs.

A. Areas of Focus and Programs offered to members:

<u>Keeping Members Healthy: Wellness and Prevention</u> – The wellness and prevention programs focus on keeping members healthy and safe. The organization offers wellness services focused on preventing illness and injury, promoting health and productivity, and reducing risk. Currently, the program includes:

- **Influenza Vaccines** which include: Vaccine outreach for all members ages 18-64 years of age

- **Cancer Screening Program** which includes: Breast Cancer Screening, Cervical Cancer Screening, and Colorectal Cancer Screening goals

- **Well Child Care Screening Program** which includes:
  - Childhood Immunization Combo 10
  - Adolescents Immunization Combo 1
  - Adolescents Immunization HPV
  - Child and Adolescent Well-Care Visits

- **Depression Screening Program** (Adolescent and Young Adult Depression Screening & Adult Depression Screening) which includes: Screening for all members $\geq$ 12 years of age who have not already been diagnosed with depression or dysthymia within the prior 12 months. (And who had at least one face-to-face visit with their PCP in the past year). The depression screen is completed during the face-to-face visit with the primary care provider (Family Practice, Internal Medicine, Obstetrics and Gynecology, and Pediatric Providers are considered Primary Care Physicians.)

- **Chronic Opioid Use Initiative** which includes: The rate of current members (†)18 years and over who, during the 12-month window from November 1 prior to measurement year to October 31 of the measurement year have a new episode of opioid use, as defined by no prior opioid prescriptions for 180 calendar days prior to the new index prescription, for which the new episode lasts at least 15 calendar days of a 30-day period following the dispensing of the index prescription. (See Population Health Program Management Strategy Appendix for additional details related to the above programs)

The HMO contracts with an NCQA accredited third party vendor who offers our members health appraisals which meet all accreditation requirements. Health appraisal language is in easy-to-understand language. The HMO reviews and updates the health appraisal at least every two years but has the capability to administer the health appraisal annually. The HMO offers its members evidence based self-management tools.

Managing Members with Emerging Risk: Condition Management Programs – Currently, HMO requires two separate and distinct Condition Management Programs: Diabetes Mellitus and Asthma. Criteria for inclusion in each of the programs is described later in this document. Each Condition Management Program includes two levels of risk stratification: Tier 1 and Tier 2. Tier 1 represents members with better control, and tier 2 represents members with poor control. Tier 2 members receive bi-directional communication from a care manager on a monthly basis.

Managing Safety and Outcomes Across Settings: Acute Care Transitions Case Management Program – Case Management addresses the needs of members who require education related to management of their health care, behavioral health and/or social needs. Case Management focuses on members needing assistance during transitions in care, particularly from the emergency room or acute hospital setting. This Case Management Program, Managing Safety and Outcomes Across Settings, is designed to help members manage the transition in care from the emergency room and acute hospital settings.

Emergency Room Follow-up
In general, members should be scheduled to receive a follow-up visit with their PCP or Specialist within seven (7) calendar days of discharge from an emergency room visit.

In order to assist in meeting this goal of emergency room follow-up, the IPA will review daily ER logs and/or transmissions received from the affiliated hospitals in order to identify potential opportunities for real-time education related to PCED utilization, transition of care needs, or potential CCM needs. Semi-annually, the HMO will randomly audit that the IPA is monitoring, reviewing, and acting upon daily ER data as they are received. Auditing includes review that ER logs are discussed semi-annually in the IPA UM Committee minutes.

Acute Hospitalization Follow-up
In general, members should be scheduled to receive a follow-up appointment with their PCP or Specialist within seven (7) calendar days following discharge from an acute care setting (excluding maternity, newborn, BH/SUD, rehabilitation, skilled nursing (SNF) and residential treatment stays).

> *Note:* Behavioral Health and Substance Use Disorder is excluded because it is included and reported separately in the PHMQI measure Follow-up After Hospitalization for Mental Illness, 7-day rate and 30-day rate.

Transition of Care calls are no longer required but encouraged for all members. Calls should be received within 48 hours* of discharge from the hospital (when discharged to home.)

Managing Multiple Conditions: Complex Case Management Program – Complex Case Management addresses the needs of members with multiple, complex and/or high-cost conditions requiring assistance with coordination of multiple services and/or health needs with significant barriers to self-care. The organization coordinates services for its highest risk members with complex conditions and helps them access needed resources. A comprehensive assessment should also be performed for members with a BH and/or SUD diagnosis in order to determine the potential need for complex case management services. All members should also receive a comprehensive assessment and screening of SDOH factors that may impact the member's health outcomes and their ability to access care which may make them good candidates for participation in the complex case management program.

B. Non-Direct Member Interventions:
The HMO provides its practitioners with integrated data which serves as a predictive modeling report informing practitioners of their at-risk members that may benefit from population health management programs. The HMO also provides technology to help support the Condition Management, and Complex Case Management programs. Lastly, the HMO offers value-based payment arrangements including quality pay-for-performance programs.

C. Member Coordination:
The IPA coordinates member movement between Population Health Management programs. The objective is to coordinate programs across settings, providers, and levels of care to minimize confusion for members. Members may be included in a Wellness and Prevention intervention while also actively managed in other Population Health Management programs. If a member receiving care in a Condition Management Program requires a higher level of service, the Condition Management case will be closed, and the member will be transitioned to Complex Case Management. This is done in order to streamline care coordination activities and allow for a comprehensive and integrated focus, reducing the number of providers contacting the member in order to manage their care. The IPA care manager will call the member to inform them why they are closing a case and will explain how, if needed, the member's care will be managed and transitioned to a new program.

D. Informing Members about Interactive Population Health Programs
IPAs are delegated to inform members about PHM programs with interactive contact. Members must be aware of the IPA's Population Health Management Programs. Member notification methods may include, but are not limited to, the member welcome letter, and/or phone calls.

- Member notification must address how the member will use services provided by the IPA's interactive Population Health Management Programs, how to become eligible to participate as well as how to opt-out of the programs.

The HMO also sends an annual notice, the HMO regulatory letter, in the fourth quarter of each year, via U.S. mail to all members informing them of Population Health Management Programs with interactive contact.

E. Informing Members of All Available Population Health Programs

IPAs are delegated to inform members of all the available Population Health Management Programs and services, including those with interactive contact. Notification is made via the IPA member welcome letter. HMO provides a template with all of the required elements. IPAs are required to use the HMO template. IPAs are required to include information related to how the IPA member and physicians are notified of the IPA's Population Health Programs in the IPA's Utilization and Population Health Management Plan.

The HMO also sends an annual notice, the HMO regulatory letter, in the fourth quarter of each year, via U.S. mail to all members informing them of all available Population Health Management Programs.

F. Informing Members and Practitioners of Access to Case Management

IPAs are delegated to inform members and practitioners of access to case management. Communication of access to case management to members is partially delegated to the IPAs. Communication of access to case management to practitioners is fully delegated to IPAs. IPAs will notify new members of access to case management via their member welcome letter. At least annually, IPAs must notify their practitioners of access to case management and provide evidence of that notification.

The HMO also sends an annual notice, the HMO regulatory letter, in the fourth quarter of each year, via U.S. mail to inform members of access to case management.

Population Identification

The Health Plan systematically collects, integrates, and assesses member data to inform its population health management programs. The Health Plan integrates data to use for population identification and risk stratification purposes:

a) Medical and behavioral claims and encounters;
b) Pharmacy claims;
c) Laboratory results and/or EHR records;
d) Health appraisal results; and
e) Data from other health service programs: UM Program.

The IPA will identify members on a monthly basis utilizing the following the referral sources:

a) Medical management program referral (UM/CCM/Condition Mgmt./Health Info. Line referral);
b) Discharge planner referral;
c) Member of caregiver referral; and
d) Practitioner referral.

Assessing the Needs of the Member Population

Annually, the HMO uses available data sources to assess the needs of the member population and sub-populations and updates the HMO and IPA PHM Programs accordingly. This includes but is not limited to assessing characteristics and needs, Social Determinants of Health, of its member population, relevant member subpopulations, the needs of children and adolescents, individuals with disabilities and individuals with serious and persistent mental illness.

a) The HMO UM Workgroup evaluates the data, which includes, but is not limited to US Census Data, Enterprise Data Warehouse (EDW) data, Provider Cost and Utilization reports from Actuarial data, Cotiviti Analytics data, and prior years Population Health data.

b) Annually, HMO uses the population assessment to:
   i. Review and update its PHM activities to address member needs, including behavioral health (BH), substance use disorder (SUD), community resources and SDoH factors. Population assessment analysis includes but is not limited to:
      a. SDoH (income and ZIP code data).
      b. Needs of members with disabilities.
      c. Needs of members of racial or ethnic groups.
      d. Needs of children and adolescents.
      e. Needs of relevant member subpopulations.
      f. Needs of members with severe and persistent mental illness (SPMI) (Serious Mental Illness or Serious Emotional Disturbance).
      g. Needs of members with limited English proficiency.
   ii. Review and update its PHM resources and activities to address program needs;
   iii. Review and update activities or resources to address health care disparities for at least one identified population;
   iv. Review community resources including SDOH factors for integration into program offerings to address member needs (**delegated to the IPA**)

c) The HMO will annually risk stratify or segment its population specifying the number of members *eligible* for each category and the PHM programs or services for which they are eligible. The risk stratification or segmentation methodology will include an assessment for racial bias. (Reports will include raw numbers and percentage of overall population).

d) The method for stratifying or segmenting the population is described in Appendix D: PHM Strategy;

The Population Health Management Programs are opt-out programs, members are automatically enrolled unless they request to opt-out of the program.

Measurement and Reporting of PHM Program Effectiveness

The HMO will measure the effectiveness of its Population Health Management Program annually. Measurement will include:

a) Quantitative results for relevant clinical, cost/utilization and experience measures;
   i. Clinical measures: HEDIS Measures
   ii. Cost/Utilization measures: Admits/1,000 and ED/1,000
   iii. Experience measures: Population Health and CCM Member Satisfaction Surveys
b) Comparison of results with a benchmark or goal; and
c) Interpretation of results.

Annually, the results of the PHM program effectiveness will be utilized to identify opportunities for improvement. The HMO will act on at least one opportunity for improvement annually.

PHM Delivery System Supports

The HMO will work with its IPA providers to achieve population health management goals by:

a) Sharing data (Utilization Management: Admits/Days/LOS, PCED);
b) Providing training on equity, cultural competency, bias, diversity, and inclusion; and
c) Offering certified shared decision-making aids for IPAs to directly push out to their practitioners.

Value-Based Payment Arrangements

100% of HMO providers participate in pay-for-performance opportunities and receive either full or partial capitation payments for management of their member populations.

IPA Population Health Management Program Structure and Resources

The delegated IPA is required to establish Population Health Management Programs designed to provide support and coordination for a member's care in collaboration with the Member's PCP and interdisciplinary care team. All Complex Case Management services integrate with other IPA programs (UM, Wellness and Prevention, Condition Management and CM) as well as other services available to the member within the community.

Assessing & Managing SDoH

The IPA providers will screen and manage, as clinically appropriate, members for SDoH utilizing a published screening tool, with or without modification, and document members identified with ICD-10 Social Determinant of Health Z codes. Clinical management is defined as assisting the member to enroll in a population health management program, as necessary, and continued management of the member by his/her primary care physician.

The IPA is required to submit documentation of the IPA Population Management Program staff utilized to support the IPA Wellness and Prevention, Condition Management, CM and CCM services. Documentation may include a flow diagram and a roster of staff names, titles, certification, or licensure, if applicable and the role and responsibility of the staff in supporting the IPA Population Health Management Programs. Any revisions to the IPA staff or process must be provided to the CDC within 30 days of the change. The IPA will identify the "Evidenced Based Sources" used for their Population Health Management Program and include this information in their Utilization Management and Population Health Management Plan program description.

Members are identified as being eligible for the Population Health Management Programs on a monthly basis.

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

Population Health Documentation Requirements

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

Population Health Management Program Requirements

IPAs are required, on a monthly basis, to upload to the BCBSIL IPA Access Portal Case Management and Condition Management forms. These forms identify members enrolled in the IPA Population Health Management Program. (Please note, for Complex Case Management, forms are not required as the care plans for members in CCM are documented directly in the BCBSIL IPA Access Portal)

Submission of members included in the CM and Condition Management Programs are required monthly, in the required format:

a) The IPA must have the appropriate resources to support the program and systems to provide the analysis, evaluation and reporting of IPA Condition Management, CM, and CCM results;
b) The IPA must complete an evidence-based Depression Screening assessment for all members (who have a minimum of one (1) face-to-face visit during measurement period) for all members greater than or equal to 12 years of age without a diagnosis of depression or dysthymia in the prior 12 months. The Depression Screen is completed during the face-to-face visit. These members meet the criteria of screening for incentive purposes. (The depression screen may be completed by the practitioner during a telehealth encounter)
c) The IPA must have a process in place to report to HMO any feedback received from the member regarding their Population Health Program experience, including but not limited to Complaints and inquiries related to the program; and
d) A quarterly summary of IPA Population Health Program results, must be reviewed by the UM Committee and reflected in the UM Committee meeting minutes, addressing goal setting, citing barriers, benefit coverage and community resources as applies to member. Identification of trends and interventions are to be documented, if applicable.

Identification of members for Condition Management and Case Management

a) The Sources used to identify members for CM and Condition Management Programs must be identified and uploaded to the BCBSIL IPA Access Portal on a monthly basis;
b) In addition to appropriate review and identification of members on a monthly basis, members must meet criteria for appropriate stratification in each program. Stratification is based on severity of the member’s condition, which includes information provided by the member along with clinical information available to the practitioner;
c) Depression Screening is required for all members $\geq$ 12 years of age within the entire Population. The depression screen is done at the face-to-face visit. If a member is active in the CCM or Condition Management program, screening for depression is a required element of their care plan. However, it does not meet the criteria of screening done in the PCP office for incentive plan purposes; and
d) The Case Manager provides support, education and intervention based on each member’s level of stratification.

Population Health Program Policy and Procedure

A written policy describing the IPA’s Population Health Management Program is required. Components of the Policy must include:

a) How member is notified of the Population Health Management Program, how to become eligible, and how to opt-out of the program;
b) How Providers are notified of the IPA Population Health Management Program and how the program can impact their patients;
c) How member is identified for the Population Health Management Program (e.g., IPA referral & Health Plan integrated data sources, etc.);
d) A written description of the Population Health Management Program structure and goals along with the components of each level of care;
e) Description of the IPA process for member assessment and risk stratification for the Condition Management Program along with the process for determining program effectiveness;
f) Process for transitioning member through the care continuum, as their condition changes; and
g) The IPA is required to post a letter describing all programs offered to their members.

Keeping Members Healthy and Safe: Wellness and Prevention Program

The Wellness and Prevention program currently consists of the following:

Influenza Vaccines for the following:

a) All members ages 18-64 years of age

Cancer Screening Program which includes screening for the following:

a) Breast Cancer Screening for all women ages 52-74;
b) Cervical Cancer Screening for all women ages 24-64; and
c) Colorectal Screening for all members ages 46-75.

Well Child Care for the following:

a) Childhood Immunization Combo 10: The percentage of children 2 years of age who have ALL of the following: four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophiles influenza type B (Hib); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugates (PCV); one hepatitis A (HepA); two or three rotaviruses (RV); and two influenza (flu) vaccines by their second birthday.
b) Adolescents Immunization Combo 1: The percentage of HMO members who turn age thirteen years during the measurement period, and received all of the following vaccines by their thirteenth birthday:
   - Meningococcal vaccine on or between the member's 11th and 13th birthdays, and
   - Tdap on or between the member's 10th and 13th birthdays.
c) Immunizations for Adolescents – HPV: The percentage of HMO members who turn age thirteen years during the measurement period and receive two doses of the HPV vaccine that are at least 146 days between the first and second dose on or between the member's 9th and 13th birthdays.
d) Child and Adolescent Well-Care Visits: The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Depression Screening:

a) All members ≥ 12 years of age;
   - Adolescent & Young Adult Depression Screening - Percent of members age 12 to 21
   - Adult Depression Screening - Percent of members age ≥ 22
b) Do not have a diagnosis of depression or dysthymia within the past 12 months (excluding members who have not had a face-to-face PCP visit in the prior year);
c) Any evidence-based depression screening tool is acceptable for use;
d) The depression screen is completed during a face-to-face visit.

Chronic Opioid Use Measure

a) The rate of current members (†)18 years and over who, during the 12-month window from November 1 prior to measurement year to October 31 of the measurement year have a new episode of opioid use, as defined by no prior opioid prescriptions for 180 calendar days prior to the new index prescription, for which the new episode lasts at least 15 calendar days of a 30 calendar day period following the dispensing of the index prescription.

Goals and details for each of these programs can be found in Appendix D: HMO 2024 Population Health Management Program Strategy.

Managing Members with Emerging Risk: Condition Management Programs

The Condition Management Programs aim to improve the member's health status and self- management of specific chronic conditions through condition monitoring, coaching, education, and behavioral strategies. The focus is on prevention, closing care gaps, and promoting a healthy lifestyle. Condition Management is monitored by licensed clinical professionals.

Program Objectives

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

Member Identification and Enrollment

Candidates are identified, on a monthly basis, by utilizing the following sources:

a) HMO integrated data report;
b) Medical management program referral (UM/Condition Mgmt./Health Info. Line referral);
c) Discharge planner referral;
d) Member or caregiver referral; and/or
e) Practitioner referral.

Members eligible for the Asthma or Diabetes Condition Management programs will be stratified appropriately by the IPA Case Manager and automatically enrolled into one of two (2) tiers based on their severity of illness. Tier 1 includes members whose condition is less severe than that of Tier 2. Tier 1 members receive educational materials from their health plan and are monitored by the IPA for change in clinical status requiring movement to Tier 2 services and intervention. Tier 2 members receive IPA monthly bi-directional intervention and care planning services.

Members may be enrolled in both the Asthma and the Diabetes Condition Management Programs, when appropriate. Once a member is enrolled in the Complex Case Management Program; however, the Condition Management case should be closed until the member is discharged from the Complex Case Management Program.

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

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

Opt-Out

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

The HMO measures program participation rates on an annual basis. Participation rates are calculated by including all eligible members in the denominator, and all members with at least one interactive contact in the numerator. Interactive contacts include either phone calls or surveys/quizzes completed by the member. Participation rates are calculated and documented annually and included in the UM Committee meeting minutes by the IPA. (Note: This is not the same population utilized for incentive payment purposes. Participation rates for the Condition Management Programs should include all members enrolled in both Tier 1 and Tier 2 of the program).

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

Program Components

Outreach

Targeted outreach to members may include but is not limited to:

a) Instructions on how to use the services;
b) How they were identified for the services;
c) How to opt-out of the program;
d) Reference to clinical practice guidelines;
e) Details and contact information regarding the program;
f) Condition-specific informational brochures and mailings.

Integration of Member Information Across all Population Health Programs:

The Condition Management Program integrates with other Population Health Management Programs such as:

a) Wellness and Prevention Programs;
b) Other Condition Management Programs;
c) Case Management Program;
d) Complex Case Management Program; and
e) Utilization Management Program (if applicable).

Communication with Practitioner

The IPA provides its contracted practitioners with written information about the organization’s Condition Management Programs. Information must include instructions on how to administer the Condition Management Services and how the IPA works with the practitioner to manage the patients in the program.

Member Experience

The Health Plan annually evaluates the member’s experience with the Population Health Management Program. Satisfaction Survey questions include satisfaction with the overall program, the helpfulness of program staff, the usefulness of the information disseminated, and the member’s experience in adhering to their treatment plans. An analysis of the survey results is reported to the HMO QIC annually.

Member Complaints regarding the Population Health Management Program are reported to the IPA UM Committee and HMO QIC on an annual basis to further assess member experience with the program.

Asthma Condition Management Program

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

The goals of the Asthma Condition Management Program are to improve member care by increasing the percentage of asthmatic members:

a) Whose asthma is well controlled demonstrated by use of ACT, ATAQ or ACQ testing, or other clinical evaluation resulting in the providers diagnosis defining the severity of the members asthma;
b) Who have a face-to-face visit with their physician to review asthma care if asthma is not well controlled;
c) Who achieve compliance with the QI Administrative Indicator for the Asthma Medication Ratio
d) Whose physicians provide asthma care in accordance with the National Asthma Education and Prevention Program (NAEPP) guidelines;
e) Who are screened for depression at twelve (12) years of age or older, and do not already have a diagnosis of depression or dysthymia; and
f) Who report ≥90% member satisfaction with the Asthma Condition Management Program.

Eligible Asthma Population

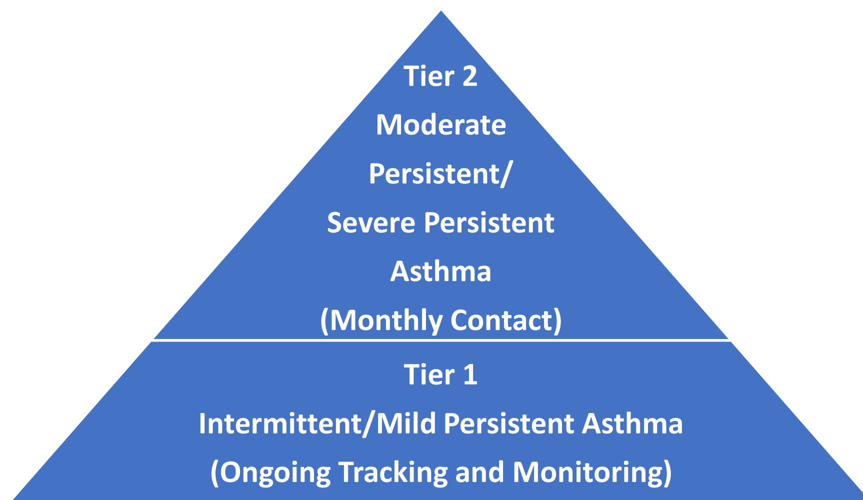
Members age 5 to 64, who met at least one of the following during a rolling 24-month period, are identified as eligible for the program:

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

Asthma Condition Management Stratification and Program Content

The Condition Management Program provides interventions to members based on assessment and condition risk stratification. The levels of condition stratification for the Condition Management portion of the Population Health program include:

Asthma Condition Management Program



Severity Stratification	Clinical Status	Interventions
Tier 2	Moderate Persistent/ Severe Persistent Asthma	-Semi-Annual Doctor Visit -HMO Mailings -IPA Ongoing Monitoring, (at minimum quarterly), -IPA Care Management Monthly Bi- Directional Phone Contact completed -Asthma Control, evidenced by results of ACT, ATAQ, ACQ testing, or documented diagnosis of Moderate Persistent/Severe Persistent Asthma. -Screened for Depression at least once per calendar year (≥12 years of age) - Transition of Care calls*
Tier 1	Intermittent/Mild Persistent Asthma	-Annual Doctor Visit - HMO Mailings -IPA Ongoing Monitoring, (at minimum quarterly), for changes in status of Asthma condition -Screened for Depression at least once per calendar year (≥ 12 years of age) -Transition of Care calls*

Tier 2

a) All Tier 1 Services; PLUS
b) Monthly bi-directional communication with an IPA Case Manager monitoring the members individualized Condition Management Care Plan;
c) Results of an Asthma Control Test (ACT), ATAQ, ACQ test, or documented diagnosis of Moderate Persistent/Severe Persistent Asthma, within the calendar year, to achieve Asthma Control;
d) Transition of Care call within 48 hours*of discharge from hospital (all cause-hospitalizations), if hospitalized; and
e) Depression Screening (with BH referral when indicated) within the calendar year for members ≥ twelve (12) years of age. Any evidence-based Depression Screening Tool is acceptable for use.

Tier 1

a) BCBSIL Mailings: Mailings for children identified with asthma are addressed to the parent/guardian of the child. Letters have been adapted to reflect that the recipient is a caregiver and not the member.
   - Asthma Condition Management Welcome Letter;
   - Newly Identified Member Letter;
   - Personal Asthma Management Brochure which includes:
     - Condition Monitoring (including self-monitoring and medical testing);
     - Adherence to Treatment Plans (including medication adherence);
     - Medical and Behavioral Comorbidities of Asthma (e.g., cognitive deficits, physical limitations;
     - Health Behaviors;
     - Psychosocial Issues that may impact Asthma Care;
     - Depression Screening and Asthma Care;
     - Providing Information about the patient's condition to caregivers who have the patient's consent;
     - Encouragement to see their doctor; and
     - Provides References to External Asthma Resources such as: The American Lung Association (http://www.lung.org/lung-disease/asthma/) and The National Heart, Lung, and Blood Institute ((http://www.nhlbi.nih.gov/health/health-topics/topics/asthma/).

b) Depression Screening (with referral when indicated) within calendar year for members ≥ twelve (12) years of age. Any evidence-based Depression Screening Tool is acceptable for use.

c) IPA continuous monitoring for changes in Asthma control, which would require that the member be moved to the Tier 2 Condition Management Program.

Member Information

The HMO provides all eligible members identified for the Asthma Condition Management Program with information about this program. The welcome letter and each subsequent mailing to members include:

a) A brief description of how members were identified for the program, referencing member identification using claims, pharmacy data, health risk assessment, physician referral, case management records or self-referral;

b) The phone number for members to call if they want to opt out of the program; and

c) Information about how to use the program.

Examples include:

- A recommendation to take the Asthma Action Plan to their physician for completion;
- A recommendation to get an annual flu shot;
- A recommendation for asthmatics to use information in the enclosed brochure to evaluate asthma control; and
- How to obtain information about asthma on Blue Access for Members, the secure member web portal.

The mailings encourage members to work with their doctor for management of their asthma. All members with gaps in care for asthma services during the current year receive outreach from their IPA. The goal is to encourage members to see their physicians for recommended asthma services at least twice per year.

Measurement of Asthma Condition Management Program Effectiveness

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

Performance Measure	Performance Threshold
-Asthmatic Members Stratified Appropriately	90%
-Asthma Medication Ratio (0.5 controller med or greater)	75%
-Member Satisfaction with the CCM and Condition Mgmt. Program	90%

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

Diabetes Condition Management Program

Diabetes Condition Management Risk Stratification and Program Content

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

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

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

a) Whose Diabetes is well controlled (evidenced by the Glycemic Status Assessment for Individuals with Diabetes (GSD) (HbA1c or GMI), retinal eye exams and kidney health monitoring);
b) Who have a face-to-face visit with their physician to review diabetes care if diabetes is not well controlled;
c) Who are screened for depression when greater than or equal to twelve (12) years of age and older, and do not already have a diagnosis of depression or dysthymia; (Any evidence-based depression screening tool is acceptable)?
d) Who report >90%-member satisfaction with the Diabetes Condition Management Program;

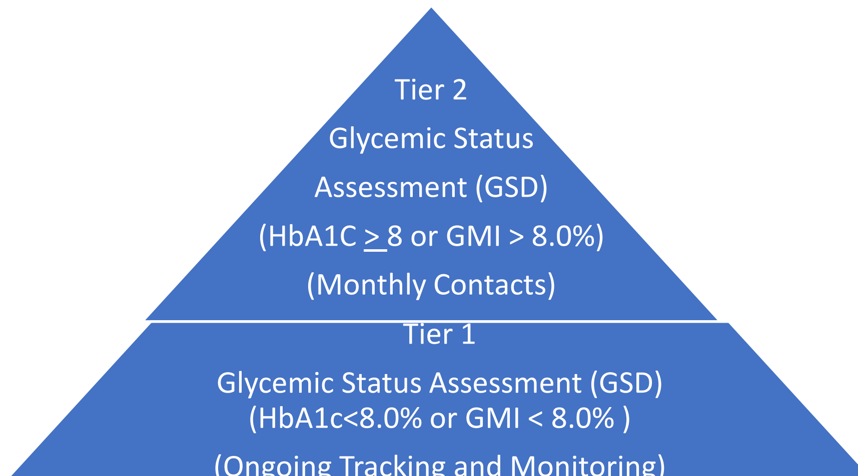
Eligible Diabetic Population

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

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

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

Diabetes Condition Management Program



Severity Stratification	Clinical Status	Interventions
Tier 2	Glycemic Status Assessment (GSD), HbA1c $\geq$ 8 or GMI > 8.0%	-HMO mailings -IPA Care Management monthly bi-directional phone contact completed - Ongoing monitoring, at minimum quarterly, for changes in status of Diabetes condition Glycemic Status Assessment for individuals with Diabetes (GSD) (HbA1c or GMI) -Ongoing monitoring of retinal eye exams -Ongoing monitoring of kidney health (eGFR and uACR) -Screened for Depression at least once per calendar year (≥12 years of age)
Tier 1	Glycemic Status Assessment (GSD), HbA1c<8.0% or GMI <8.0%	- HMO mailings -Ongoing monitoring, quarterly (recommended), for changes in status of Diabetes condition Glycemic Status Assessment for Individuals with Diabetes (GSD) (HbA1c or GMI) -Ongoing monitoring of retinal eye exams -Ongoing monitoring of kidney health (eGFR and uACR) -Screened for Depression at least once per calendar year (≥12 years of age) -Transition of Care calls*

Tier 2

a) All Tier 1 services; PLUS
b) Monthly bi-directional communication with an IPA Case Manager to monitor the members Individualized Condition Management Care Plan.
c) Transition of Care call within 48 hours* of discharge from hospital stay (all-cause hospitalizations)
d) Depression Screening (with BH referral when indicated) within the calendar year for members ≥ twelve (12) years of age. Any evidence-based depression screening tool is acceptable for use.

Tier 1

a) HMO Mailings: Mailings for children identified with diabetes are addressed to the parents/guardians of the child. letters have been adapted to reflect that the recipient is a caregiver and not the member.
   - Diabetes Condition Management Welcome Letter;
   - Newly Identified Member Letter;
   - Diabetes brochures and mailings to address the following:
     - Condition monitoring (including self-monitoring and medical testing);
     - Adherence to Treatment Plans (including medication adherence);
     - Medical and behavioral comorbidities of diabetes (e.g., cognitive deficits, physical limitations);
     - Health behaviors;
     - Psychosocial issues that may impact diabetes care;
     - Depression Screening and diabetes care;
     - Providing information about the member's condition to caregivers who have the member's consent;
     - Encouragement to see their health care provider; and
     - Provides references to external diabetes resources such as the American Diabetes Association web site (www.diabetes.org).

b) Depression Screening-(with BH referral when indicated) within the calendar year for members ≥ twelve (12) years of age. Any evidence-based depression screening tool is acceptable for use.

c) IPA continuous monitoring for changes in diabetic condition and Glycemic Status Assessment for Individuals with Diabetes (GSD) (HbA1c or GMI) which would require that the member be moved to the Tier 2 Condition Management Program if the value results in the abnormal range.

Member Information

The HMO provides all eligible members identified for the Condition Management Program with information about the program. The welcome letter and each subsequent mailing to members includes:

a) A brief description of how members were identified for the program: referencing member identification using claims, pharmacy data, health risk assessment, physician referral, case management records, or self-referral

b) The phone number for members to call if they want to opt out of the program

c) Information about how to use the program. While the specific content varies depending upon the mailing, examples include:
   - A reference to the mailings about diabetes that the member will receive;
   - How to obtain a free glucose meter;
   - Use of the diabetes care card to track diabetes services and lab results, weight, and blood pressure;
   - How to obtain information about diabetes on the bcbsil.com My Health on Blue Access for Members^{SM}, the secure member web portal.

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

Measurement of Diabetes Condition Management Program Effectiveness

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

Performance Measure	Performance
-Member Satisfaction with the CCM and Condition Mgmt. Program	90%
- Glycemic Status Assessment for Individuals with Diabetes (GSD) (HbA1c or GMI), retinal eye exam and kidney health evaluation (combined measures)	45%

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

Managing Safety and Outcomes Across Settings: Case Management Program

The Case Management (CM) Program, which focuses on transitions of care and member safety and outcomes across settings, is an integral part of the Population Health Program. Case Management addresses the needs of members who require assistance/education related to management of their health care, behavioral health and/or social needs. Case Management members typically consist of those persons who need assistance during transitions in care or needing shorter term assistance in navigating the health care system.

- Members should receive a follow-up visit with their PCP or Specialist within seven (7) calendar days of discharge from an emergency room visit.
- Members should receive a post discharge transition of care call within 48 hours of discharge from the hospital (when discharged to home).

Members will keep scheduled appointments with their PCP or Specialist within seven (7) calendar days following discharge from an acute care setting (excluding maternity newborn, BH/SUD, rehabilitation, skilled nursing (SNF) and residential treatment stays). Please note: Follow-Up After Hospitalization for Mental Illness, 7 calendar day rate (FUH 7 calendar day) is measured and reported separately.

Documentation of analysis of IPA findings is required on a quarterly basis in the IPA UM Committee minutes.

Managing Multiple Chronic Conditions: Complex Case Management Program

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

Members with catastrophic or multiple complex conditions, include the disabled, along with children and adolescents, whose care is often complicated by severe BH/SUD or social challenges. It involves the systematic assessment and coordination of care and services provided to members who are experiencing a Complex clinical situation and are at the highest risk within the population. All members with a BH or SUD diagnosis must be evaluated for inclusion in the IPA's Complex Case Management Program.

All BH/SUD cases, whether managed by the IPA, IPA delegate or IPA subdelegate, must be documented in the IPA Portal Complex Case Management (CCM) Plan. The IPA, as well as the HMO CDC, will provide delegation oversight of all complex case management activities.

A complex clinical situation involves one or more critical or catastrophic events or diagnoses that require extensive use of resources and help navigating the system to facilitate appropriate delivery of care and services. This may include Behavioral Health, Substance Use Disorders, barriers to care due to health inequities and/or identification of social determinants of health impacting the member. Appendix A: Complex Case Management Referral Guidelines outlines conditions appropriate for Complex Case Management services. These guidelines were created with oversight of the HMO Medical Director, HMO UM Workgroup.

The degree and Complexity of the member's illness or condition is typically severe, the level of Case Management and/or the number of resources required for the member is extensive.

Through the IPA Complex Case Management process, these members are assisted in the access to care and services and their care is coordinated with the assistance of the IPA. The goals are to help the member regain optimal health, aid in obtaining multiple services, learn self-management skills, and/or help gain improvements in level of functioning.

To assist with the identification of eligible Complex Case Management members, HMO shall provide the IPA with integrated data source reports on a monthly basis. The IPA's must also produce their own referral source reports on a monthly basis. **Eligibility for the Complex Case Management Program is defined as the date that the member is identified by either the HMO integrated data source report or IPA referral source.**

Members who are identified as eligible for Complex Case Management must have an Initial Assessment (IA) initiated within 30 days and completed within 60 days of the eligibility date. **The date that the Initial Assessment is completed is the date the member is enrolled in the Complex Case Management Program.**

Complex Case Management Program Referral and Data Sources

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

IPAs are required to identify members eligible for Complex Case Management services using all of the following referral and data sources:

a) BCBS HMO integrated data report;
b) Medical management program referral (UM/Condition Management/Health Info. Line referral);
c) Discharge planner referral;
d) Member or caregiver referral; and
e) Practitioner referral.

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

IPA Complex Case Management Requirements

I. Initial Assessment

The Initial Assessment (IA), documented in the BCBSIL IPA Access Portal, must include the following:

a) Document the date the member's eligibility for CCM was determined. The eligibility date is the date the member was identified by either data or referral source. The IA must be ***initiated*** within 30 calendar days of eligibility;
b) Document the date the Initial Assessment was completed. The IA must be ***completed*** within 60 calendar days of eligibility/identification. If the Initial Assessment is initiated greater than 30 calendar days after eligibility, user must attest that the information is current and complete;

c) If an IA is not initiated within 30 calendar days after member is determined by the IPA to be eligible for CCM, the IPA must document they attempted to contact the member at least three times over a two-week period within the first 30 calendar days of eligibility, to complete the Initial Assessment. Case should be closed if unable to contact the member after three attempts are documented (ideally on different days at different times of day);
d) The IPA Case Manager must provide conclusions and information in their documentation on the following required elements for the Initial Assessment:
   1. Initial assessment of the member's health status and condition specific issues (including the Case Managers conclusion regarding the members health status ***and*** the members self-reported health status);
   2. Diagnoses – acute and chronic conditions. BH and SUD diagnoses must include both current and past history.
   3. Procedures – relevant historical and current, including inpatient stays, or document "none";
   4. Current status of acute and chronic conditions/diagnoses documented, include behavioral health and/or Substance Use Disorder diagnoses;
   5. Behavioral health and substance use disorder conditions/diagnoses must include both current status and past history; clinical and treatment history – include disease onset, history from the onset of the condition(s) leading to the current health status;
   6. Medications ***including dosage, schedule, and history of discontinued medications***;
   7. Ability and/or barriers to performing activities of daily living (ADLs) and instrumental activities of daily living (IADLs) including assessment of eating, bathing, hygiene, ambulation, toileting, transportation, money management, meals, laundry, housekeeping, assistive devices (e.g., wheelchair, walker, etc.), dressing, transferring or functional mobility, medication management and physical disability. If a member needs assistance with any ADL or IADL, the documentation must describe the type of assistance and reason for the need for assistance.
   8. Current behavioral health status including any Behavioral Health Conditions or Substance Use Disorder, current or historical.
   9. Assessment of cognitive functioning including the member's ability to communicate and understand instructions and the member's ability to process information about an illness;
   10. Language Assessment including primary language member uses to communicate and health literacy assessment;
   11. Assessment of Cultural Preferences and cultural health beliefs, practices, or limitations. Documentation must identify potential barriers to effective communication or care and acceptability of specific treatments;
   12. Assessment of Behavioral Health status. Assess if the member with Behavioral Health/SUD diagnosis has signed a Release of Information allowing communication Initial Assessment between the PCP and Behavioral Health Specialist;
   13. Initial assessment of Social Determinants of Health (housing, housing security, access to food markets, exposure to crime/violence, personal safety, discrimination, access to media, social support, access to transportation and/or financial barriers, economic stability, education) and their potential impact on the member's ability to meet their goals;
   14. Assessment of life planning activities and documentation of collaboration with PCP if appropriate. If life planning activities are determined to be appropriate, the case manager documents what activities the member has taken and what documents are in place. If determined not to be appropriate, the case manager documents the reason.
   15. Documentation of hearing and vision limitations and identification of potential barriers to care, or "no limitations";

16. Evaluation of linguistic needs or preferences including health literacy. Documentation must include specific needs to include in the case management plan and barriers to effective communication of care.
17. Evaluation of the adequacy of caregiver resources, involvement, and understanding of care plan. Documentation must describe the resources in place, whether they are sufficient for the member's needs, and note any specific gaps to address.
18. Documentation of benefits, and benefit limitations including an assessment of the adequacy of the member's benefits to fulfill the treatment plan (Available benefits must be specific and adequate to meet the member needs and documentation must state member's understanding of the benefit). Example: member with a diagnosis of acute CVA with secondary hemiplegia. Documentation of available benefits should reference whether the member's benefits cover the required treatments and prescriptions, session limitations of PT/OT and ST per calendar year, and documentation must state that the member is aware of this;
19. Documentation must include the case manager's evaluation of the member's eligibility for community resources, the availability of those resources and which resources the member may need. At minimum, the following community resources must be assessed: community Behavioral Health programs, transportation, wellness programs, nutritional support, and palliative care programs; (ex.- Meals on wheels, township services, legal aid), or not (document reason if not needed);
20. Assessment of life planning activities; and
21. Member self-management plan. The member self- management plan is verbally communicated to the member and agreed upon by the member.

e) Process for collecting dates as part of the clinical history.
- The case manager will record dates of disease onset, current and past medications, test and lab results, procedures, and all other clinical history.
- Dates may be obtained from the member or member's caregiver and/or extracted from the electronic health record or other clinical documents. If a date is not available, the case manager notes that in the free text portion of the member's case file.

II. Complex Case Management Care Plan Requirements

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

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

a) Prioritized goals selected by the Case Manager and member must be in SMART (Specific, Measurable, Achievable, Relevant, Time-Bound) Goal format. Prioritized goals are specific to the member's situation and needs and include goals that reflect issues identified in the initial assessment and the supporting rationale for each selected goal. Time frames for reevaluation of goals are specified in the care plan.
b) Progress and assessment toward goals as levels of interventions are implemented;
c) Assessment of Barriers to a member receiving or participating in a case management plan and to achieving the goals of the care management plan. (Assessment of barriers must be documented even if none were identified); A barrier analysis can assess:
    - Language or literacy level.
    - Access to reliable transportation.
    - Understanding of a condition.
    - Motivation.

- Financial or insurance issues.
- Cultural or spiritual beliefs.
- Visual and hearing impairment.
- Psychological impairment.

d) Depression screening for all members in CCM who do not have a diagnosis of depression or dysthymia. This is a required element of the member's care plan. However, it does not meet the criteria of screening done in the PCP office for incentive plan purposes.
e) Social Determinants of Health incorporated into the Complex Case Management Care Plan;
f) Assessment of Community Resources incorporated into the Complex Case Management Care Plan; Complex Case Management plan of care reflects community resources based on the Case Manager's utilization/application of the IPAs Population Health data.
g) Revising SMART goals and treatment plan as appropriate (if the member does not demonstrate progress over time, the Case Manager reassesses the applicability of the goals to the member's circumstances and modifies the goals, as appropriate); ongoing collaboration and planning with the member, family/caregiver, the PCP, and other health care providers. The Case Manager must apprise the PCP of the member's progress at least every 6 months;
h) Educating the member and the family/caregiver, about treatment options and available resources to improve quality of care; and
i) Transitioning the member to the next level of care when outcomes have been attained or when the needs of the member change.

III. Member Contact

The IPA must perform and document at least one-member bi-directional contact monthly between member and Case Manager. The documentation must meet the following criteria:

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

In addition, members enrolled in Complex Case Management must have at least one (1) PCP face-to-face visit with a physician every six (6) months. For members identified with BH or SUD needs, the CM will assess if the member has a Release of Information (ROI), allowing coordination of care between the BH and PCP providers. If the member does not have a ROI, the CM will attempt to facilitate the process to promote communication, coordination of care, treatment compliance and optimal health benefits.

IV. Complex Case Management Case Closure

When a member's Complex Case Management goals have been met or progress is no longer anticipated, the Case Manager should close the case. The member may then be followed in the IPA Condition Management Programs, if appropriate. The case must also be closed upon member request (Opt-Out) or if the member does not respond to three (3) attempts toward the CCM Monthly Contact for more than 45 days (It will be assumed that the member wished to opt out and will need to be documented as such). **The Case Manager must document the date and reason(s) for the closure of the case. This includes documenting the status of all goals and whether they were achieved.** There must be documentation that the member was notified that their case was closed (this may require documentation that a letter was mailed to the member).

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

a) Monthly submission of members enrolled in the CCM Program;
b) Timeframes Met (IA, Monthly Contact);
c) Appropriate Goal Setting (Follow-Up, Member Self-Management Goal, SMART Goal format);
d) Assessment of Barriers to Achievement of Goals;
e) Assessment of Member Benefits;
f) Assessment of Community Resources and findings incorporated into the Care Plan;
g) Assessment of Social Determinants of Health and findings incorporated into the Care Plan;
h) Transition of Care (TOC) calls made within 48 hours* of discharge (all cause) when hospitalized≥;
i) Eligible members (Condition Management Tiers 1 and 2 and CCM) who keep a follow-up appointment with PCP or Specialist within 7 days of discharge following an ER visit or discharge from an acute care setting, excluding maternity, newborn, BH/SUD, rehabilitation, skilled nursing (SNF) and residential treatment stays). Please note: Follow-Up After Hospitalization for Mental Illness, 7-day rate (FUH 7-day) is measured and reported separately. ⏶

*Transition of Care calls are encouraged and should be made within 48 hours of discharge unless the discharge occurs on a weekend or legal holiday.

⏶ These items are not audited

-END-

APPENDIX A: 2024 Complex Case Management Guidelines

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

Note the following:

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

The following three (3) categories of members must be evaluated for inclusion in the HMO Complex Case Management Program:

a) All HMO members receiving Private Duty Nursing (PDN) services;
b) All HMO members approved to receive CAR T services; and
c) All Transplant candidates (pre/post-transplant)

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

Diabetes Mellitus	Complications including neuropathy, retinopathy, or nephropathy, newly diagnosed renal failure, new amputation and/or HbA1c 8 or greater.
Dialysis	Any member new to dialysis or member currently receiving dialysis (hemodialysis or peritoneal dialysis)
End of Life Care	Hospice, Advance Directives, Living Will, Palliative Care
High Risk Obstetric and Neonatal care	Premature births, complex discharge, multiple gestation, gestational diabetes, hemorrhage, medical co-morbidities of mother, pre-eclampsia/Hypertension, OB plan of care requires close surveillance and monitoring for depression.
HIV/AIDS/ARC	Complications, challenges w/ maintaining a pharma regime, financial challenges w/medications
Multiple Sclerosis	New diagnosis, Chronic w/relapsing or deteriorating functional status, symptoms that are affecting ADL's.
Oral Health	Impaired hygiene, chronic disease, and frequent hospitalizations
Spinal cord injury	Recent-onset or chronic complications (skin, urinary, respiratory)
Severe and Persistent Mental Illness (Serious Mental Illness or Serious Emotional Disturbance)	Including schizophrenia, schizoaffective disorder, and bipolar disorder
Sickle Cell Disease	New Onset and/or Exacerbation, uncontrolled pain management, or chronic complications
Specialty Infusion	Services rendered in an Infusion Center, acute/chronic decline in functional status
Stroke	Acute onset, residual impairments, medication non-adherence, inconsistent family support or resources
Substance Use Disorder	ETOH, illicit substances, tobacco, e-cigs, opioids
Suicide Attempt	Initial/multiple attempts. Complex SDoH challenges, any inpatient admission
Transgender	Individuals considering gender reassignment, psychosocial needs
Traumatic brain Injury	Acute injury requiring extended inpatient admission and/or complex rehab needs.
Physical, Sexual, Emotional Violence/Abuse/Neglect	May include: Child Abuse, Spousal Abuse/Domestic Violence, Elder Abuse, Gun Violence

APPENDIX B: 2024 Utilization Management Timeframe Requirements

MEDICAL AND BEHAVIORAL HEALTH/SUD UM DECISION TYPE	UM DECISION MAKING TIME FRAME
Commercial/ IFM: **Non-urgent Pre-certification/Pre-Service Requests including Specialist Referrals** *(approval and denial)*	Within 5 calendar days of receipt of request, including the collection of all necessary information (no additional time is allowed for obtaining information), including notification to practitioner and member.
Urgent Pre-certification/Pre-Service includes Specialist Referrals *(approval and denial)*	Within 72 hours of receipt of request, including the collection of all necessary information (no additional time is allowed for obtaining information), including notification to practitioner and member.
Certification and Initial Review Process for emergent admissions *(approval and denial)*	For INN emergent admissions- Within 24 hours of receipt of the request, including notification to practitioner and member. For OON emergent admissions- No Surprises Act (NSA) requirements specify that the facility is not required to make notification of admissions made through the Emergency Department. Notification may; however, be encouraged.
Concurrent *(Approval and Denial)*	Within 24 hours of receipt of request, notification of practitioner(s) within 24-hour timeframe. If the IPA states in their UM Plan that the practitioner may assume approval of continued stay unless they are informed otherwise, then the practitioner does not need to be notified of continued stay approval. Excludes those identified by the IPA as not requiring review. Include additional criteria used in decision- making.
Retrospective/ Post-service	Within 30 (thirty) calendar days of receipt of the request. If the decision results in a denial, the member and practitioner(s) must be notified in writing by mail, fax, or e-mail within 30 calendar days of the receipt of request. Member **should not be sent a denial letter when services have already been delivered in an inpatient or ambulatory care setting.**
Appeals	***Not delegated to the IPAs for any line of business*** Refer to the language included in the product specific denial letter.
Member Complaints/Grievances	***Not delegated to the IPAs for any line of business*** If a member complaint/grievance is misdirected to the IPA, follow the HMO process for standard and expedited misdirected complaints outlined in the HMO UM Plan.

Note: Timeframes are monitored and audited during the IPA's semi-annual annual Adherence Audit. IPA policies and procedures must address timeframes, and reference controls in place to document, monitor and correct any discrepancies identified.

APPENDIX C: 2024 HMO and Delegate Responsibility Matrix (UM & PHM)

HMO *Utilization Management* Delegation Matrix			
Delegated Activity	**Health Plan Responsibilities**	**Delegate Responsibilities**	**Delegate Reporting Requirements**
Program Structure	Health Plan (HP) retains accountability for the structure of the UM Program, including the HMO Program Description. HMO ensures the involvement of HMO Medical Directors in design and structure of the UM program. All medical necessity decisions are delegated to the member's Primary Care Physician HMO delegation oversight activities are reported at Health Plan UM Workgroup and Health Plan QIC.	Delegate will develop its own Utilization Management and Population Health Management Plan and submit to the Health Plan for approval annually. Delegate will implement its UM Program, in alignment with Health Plan UM Program structure. Delegate will ensure IPA Medical Director involvement and, as applicable, BH Medical Director involvement in the delegates UM program. Delegate is responsible for all medical necessity and clinical decision-making activities.	Annually, the delegate will provide HP with the delegate's UM and PHM Program Description, policies, and procedures, and required 'UM Plan Attachments' relating to all delegated functions. Delegate policies and procedures must be on IPA letterhead and will be annotated, bookmarked, and signed prior to their final submission. HMO will provide Policy Guidelines for annotation. The delegate will upload their signed monthly UM/QI Committee meeting minutes. Meeting Minutes must document active involvement of physical medicine and Behavioral Health/SUD Medical Directors in the UM program.
Clinical Criteria for UM Decisions	The HMO delegates the selection, annual review, application, and dissemination of nationally recognized clinical criteria (medical and BH/SUD) to the IPA. The HMO uses the delegates' approved policies and procedures to support UM structural requirements. Clinical Practice guidelines are available to additionally assist Delegate in making determinations.	HP delegates Policies and Procedures for: • Selection, adoption, and approval of UM criteria; • Dissemination of UM criteria to Practitioners and availability of UM criteria; • Evaluation of the consistency of the application of UM criteria in UM decision making, and interventions for results below target.	Annually, Delegate will upload their Policies and Procedures for UM Criteria selection and evaluation of consistency of application. Annually, Delegate will document the review and approval of UM criteria in their UM/QI Committee minutes. If UM criteria are revised after initial adoption, this must be documented on the Delegate's QI/UM Committee minutes.

HMO *Utilization Management* Delegation Matrix			
Delegated Activity	**Health Plan Responsibilities**	**Delegate Responsibilities**	**Delegate Reporting Requirements**
		Delegate maintains responsibility for selection of nationally recognized clinical criteria (including behavioral health and substance use disorder), the development of additional UM criteria, if necessary and for informing all practitioners of the availability of criteria upon request. Delegate will evaluate consistency in the application of UM criteria for all staff involved in the UM process semi-annually.	Annually, Delegate will provide evidence of notice sent to practitioners advising about the availability of criteria. Upon request, the IPA must provide evidence that it distributes UM criteria annually and to new practitioners by mail, fax, or email, or on its website if it informs practitioners that the information is available online and that it mails the criteria to practitioners who do not have fax, email, or internet access. Semi-annually, the delegate will upload to the BCBSIL IPA Access Portal an adherence-to-timeframes report for all staff who make UM decisions. Findings will be discussed at the delegate's QI/UM Committee and documented in the minutes. Semi-annually, delegate will upload a report (including a summary of findings in addition to results for all staff tested) on the consistency of application of criteria to the BCBSIL IPA Access Portal. Findings will be discussed at the delegate's UM/QI Committee Meeting and documented in the Meeting Minutes.

HMO *Utilization Management* Delegation Matrix			
Delegated Activity	**Health Plan Responsibilities**	**Delegate Responsibilities**	**Delegate Reporting Requirements**
Communication Services	HMO delegates responsibility of notification of members and practitioners regarding access to UM staff for questions related to UM.	Delegate maintains responsibility for notification of members and practitioners regarding access to UM staff for questions about UM. HP delegates Policies and Procedures for access to UM Staff, including: • How Delegate informs members about access to UM Staff Management. • Staff are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues and how to use program services. • Staff can receive inbound communication regarding UM issues after normal business hours. • Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.	Annually, IPA will provide member Welcome Letter template to HMO. Upon request, the IPA must provide evidence that it distributes the notices to all members at least annually and to all new members and practitioners by mail, fax, or email. If the notices are posted on the IPA Website, the push notifications inform members and practitioners that the information is available on-line. The IPA mails the notice to members and practitioners who do not have fax, email, or internet access. Annually, Delegate will upload their Policies and Procedures for Access to UM Staff.

HMO *Utilization Management* Delegation Matrix			
Delegated Activity	**Health Plan Responsibilities**	**Delegate Responsibilities**	**Delegate Reporting Requirements**
Appropriate Professionals	HP delegates the **policies and procedur**e requirements for: -Appropriate Use of Professionals for UM Decision Making -Denials and Adverse Determinations, including Benefit Denials. -Use of Board-certified Specialists -Notification of Staff, Members, and Providers of its Affirmation Statement on an annual basis.	HP delegates Policies and Procedures for: • Requirements for appropriately licensed professionals to supervise all medical necessity decisions, including specifying the type of personnel responsible for each level of UM decision-making. • Use of Board-Certified consultants to assist in making medical necessity decisions Delegate ensures that all UM decisions are made by appropriate professionals, per HP requirements (Refer to page 26) This includes all medical and behavioral health determinations Delegate will ensure that board-certified consultants are used, as needed, for medical necessity decisions, following HP policies. Delegate will notify its own staff, existing and newly employed practitioners, and new members of is affirmative statement regarding incentives.	Annually, Delegate will upload their Policies and Procedures for Appropriate Professionals and use of Board-Certified Consultants. Annually, IPA will provide evidence of its Affirmation Statement.

HMO *Utilization Management* Delegation Matrix			
Delegated Activity	**Health Plan Responsibilities**	**Delegate Responsibilities**	**Delegate Reporting Requirements**
Timeliness of UM Decisions	HMO monitors Delegate Timeliness of UM Decisions. This is done through oversight of adverse determination timeframes on a monthly basis, and review of Delegate Adherence to Timeframe Audits semi-annually.	Delegate will ensure that all UM decisions (medical and behavioral health) are made within NCQA timeliness standards (as outlined in Appendix B). Delegate maintains responsibility for timeliness of all (approved, denied and case closed) UM decisions.	Adherence to Timeframe Audits and UM Timeliness Reports must be conducted and documented as having been discussed in the UM/QI Committee Meeting Minutes. Reports are to be submitted semi-annually to the BCBSIL IPA Access Portal. (March/September). For the UM Timeliness Report, a separate report must be run for each line of business: Commercial HMO and IFM HMO
Clinical Information	Health Plan does not make any medical necessity decisions based on clinical information.	Delegate will ensure that all UM decisions (medical and behavioral health) are made with appropriate clinical information.	Delegate will submit appropriate UM Criteria and relevant clinical information for each denial via the BCBSIL IPA Access Portal.
Denial Notices	The HMO conducts monthly oversight of Delegate Denials and provides feedback and education and requests for corrective action as needed.	Delegate is responsible for ensuring the following for all denials notices (medical and behavioral health): ▪ Review by appropriate practitioner; BH denials must be reviewed and signed by the BH Medical Director ▪ The right to discuss the denial with a reviewer ▪ Written notification to the member and practitioner of the reason for denial in easy-to-understand language and specific to the member ▪ The specific criteria used to make the decision	Quarterly Report of denials which includes: ▪ Total number of denials by type (Medically Necessary and Non-Covered Benefit)

HMO *Utilization Management* Delegation Matrix			
Delegated Activity	**Health Plan Responsibilities**	**Delegate Responsibilities**	**Delegate Reporting Requirements**
		▪ The right to obtain a copy of the criteria upon request. ▪ Appeal rights, including timeframes to appeal, timeframes for completing the review, and member rights to submit documentation, be represented, IRO review and how to use state department of insurance to support them in the appeal. ▪ A member non-discrimination notice should be provided with all medical group approvals and denials pursuant to Section 1557 of the Affordable Care Act.	
UM Denial System Controls	Health Plan Provides a Denial Management Documentation Platform to the IPA via the BCBSIL IPA Access Portal. The Health Plan will have a written policy and/or procedure describing internal system controls specific to UM denial notification and receipt dates. The HMO also uses the delegates' approved policies and procedures to support UM structural requirements. During the case file review portion of the Utilization Management and Population Health Management Plan Semi-Annual Adherence Audit, HMO will request to view the most recent evidence that the IPA is	Annually, the Delegate will submit their policy/procedure describing internal system controls specific to UM denial notification and receipt dates. Semi-Annually, the IPA audits their internal denial system controls by: • Analyzing all changes to receipt dates and decision notification dates, including reasons for the change; • Analyzing instances of date changes that did not meet the modification criteria (quantitative and qualitative analysis required) • Taking actions based on findings related to changes made to the date of receipt and date of written notification. • Implementing a quarterly	Annually, the Delegate will upload the UM Denial System Controls Policy/procedure to the BCBSIL IPA Access Portal. Semiannual Audit Findings will be discussed at the delegate's UM/QA Committee Meeting with discussion documented in the Meeting Minutes. Denial system audit reports are to be submitted semi-annually (March-September) to the BCBSIL IPA Access Portal. If audit results require intervention, the IPA will upload an improvement plan to the BCBSIL IPA Access Portal.

HMO *Utilization Management* Delegation Matrix			
Delegated Activity	**Health Plan Responsibilities**	**Delegate Responsibilities**	**Delegate Reporting Requirements**
	continually auditing their own UM Denial System Controls.	monitoring process to assess the effectiveness of its actions on all findings Audit results will be discussed in the IPA UM/QI Committee meeting and the discussion will be documented in the minutes and uploaded to the BCBSIL IPA Access Portal with the audit report and any corrective actions, if indicated.	
Appeals	HP maintains accountability for all first and second level member appeals, including maintenance of appeals policies and procedures.	Delegate is responsible for informing members regarding appeal rights. Appeal rights are included in the denial letter. Delegate must also explain member appeal rights in the New Member Welcome Letter.	None.
Evaluation of New Technology	HP maintains accountability for evaluation of all new technology for incorporation as a benefit.	To contact the HP for information related to New Technology benefit requests.	None.
Procedures for Pharmaceutical Management	HP delegates Pharmacy Benefit Management to Prime Therapeutics.	None.	None.
Triage and Referral for BH Management	The HMO delegates BH triage and Referral to the IPAs.	IPAs must describe their process for members requesting BH services (which include Behavioral Health or Substance Use Disorder); including written standards for ensuring appropriate BH triage and referral decisions.	Any delegated BH Organization or IPA providing BH Services with a centralized triage and referral process must submit telephone reports quarterly to the HMO.
Oversight of Delegated Activities The UM PHM Plan is an extension of HMO MSA. "The 2024 HMO Utilization Management and Population Health Management Plan means the HMO document which	HP reviews Delegate UM activity monthly, quarterly, semi-annually, and annually as outlined in the HMO MSA and the HMO UM and Population Health Plan. The HMO provides feedback, educational interventions and/or	Delegate shall cooperate and fully participate in audits, site visits and other monitoring of delegated activities conducted by the HP.	Annually, the delegate will provide HP its Utilization Management and Population Health Management Program Description as well as their policies and procedures. Annually, the delegate will provide HP with all documents required to

HMO *Utilization Management* Delegation Matrix			
Delegated Activity	**Health Plan Responsibilities**	**Delegate Responsibilities**	**Delegate Reporting Requirements**
delineates the minimum required utilization management and Population Health Management responsibilities of the IPA and is used as a guideline for the development of the IPA's Utilization Management and Population Health Management Plan, as well as the HMO's Utilization Management and Population Health Management Plan oversight (p.9-10, 2024 HMO MSA)."	requests for corrective action for any deficiencies identified. Sharing clinical performance data: Quarterly, HMO will upload clinical performance data to BCBSIL IPA Access Portal. Sharing member experience data: Annually (in the 3rd quarter), or upon request the HMO will upload results of member experience surveys to the BCBSIL IPA Access Portal.	Deficiencies and Corrective Action Requirement (CAR): In the event deficiencies are noted during audit or within required report submissions, Delegate shall develop a Corrective Action Requirement (CAR) for the specific Delegated Activity that is determined by HP to be deficient, and which shall include specifics of and timelines for correcting the deficiency and shall be provided to HP within 30 calendar days of HP report of its findings. The corrective action requirement shall be implemented by delegate within the specified timeframes listed therein.	conduct the annual audit of the UM and Population Health Management Program. Semi-annually, delegate will upload daily ER logs to the BCBSIL IPA Access Portal. Quarterly, Delegate will upload a report of out-of-network referrals received for all HMO Commercial and IFM HMO members to the BCBSIL IPA Access Portal. Clinical performance data will be analyzed and discussed as part of the IPA UM/QI Committee meeting. The discussion will be documented in the minutes and uploaded to the BCBSIL IPA Access Portal to be reviewed by the HMO during the semi-annual and annual delegation oversight review process Member experience data will be discussed annually in the IPA UM/QI Committee meeting and the discussion will be documented in the minutes and uploaded to the BCBSIL IPA Access Portal to be reviewed by the HMO during the second semi-annual delegation oversight review process. If interventions for results below goal are required, the IPA uploads their plan for improvement as well.

Population Health Management *(PHM) Program * --Partially Delegated Program *The Complex Case Management (CCM); Case Management (CM); Condition Management and Wellness and Prevention Programs are integrated components of the overall HMO PHM Strategy and the PHM Program.			
Delegated Activity	**Health Plan Responsibilities**	**Delegate Responsibilities**	**Delegate Reporting Requirements**
Strategy Description	The Health Plan has a comprehensive strategy for Population Health Management, including promoting health equity. This program will address goals and population targeted in the following four areas of focus: ▪ Keeping members healthy (Wellness & Prevention Program) ▪ Managing members with emerging risk (Condition Management Program) ▪ Patient safety or outcomes across settings (Case Management Program) ▪ Managing multiple chronic illness (Complex Case Management Program) The strategy describes: ▪ Goals and populations targeted for each of the four areas of focus (above). ▪ Program or services offered to members. HMO delegates responsibility of informing members about all available PHM Programs.	The delegate will perform the operational components required to carry out the delegated PHM Program Strategy. Delegate maintains responsibility for notifying members of all PHM programs available to them via the new member welcome letter (template provided by HMO)	Annually, delegate will provide HP with the delegate's UM and PHM Program Description, policies, and procedures, and required 'UM Plan Attachments' relating to all delegated functions. Annually, delegate will provide evidence of notices. Upon request, the delegate must provide evidence that it distributes the notice to all members annually, including all new members, by mail, fax, or email, or on the delegate's website.
Informing Members	HMO delegates responsibility of informing members eligible for programs that include interactive contact, with the exception of Tier 2 Condition Management Programs (Asthma and Diabetes).	HP delegates Policies and Procedures for informing members of all the available PHM programs and services, including notifying members eligible for programs that include interactive contact (see Appendix D) of the following:	Annually, Delegate will upload their Policies and Procedures for informing members to the BCBSIL IPA Access Portal. Annually, Delegate will provide evidence of letters.

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Delegated Activity	**Health Plan Responsibilities**	**Delegate Responsibilities**	**Delegate Reporting Requirements**
		• How members become eligible to participate. • How to use program services. • How to opt in or opt out of the program. Delegate maintains responsibility for informing members eligible for programs that include interactive contact regarding: ▪ How members become eligible to participate ▪ How to use program services ▪ How to opt out of the program (See Appendix D)	Annually, the delegate submits its new member Welcome Letter template. Additional optional communication methods include distributing the information to members by mail, fax, or email, or through messages to members' mobile devices, through real-time conversation. The delegate mails information to members who do not have fax, email, telephone, mobile device, or internet access. If the organization uses telephone or other verbal conversations, it provides a script used to guide the conversation.
Population Identification	Health Plan will provide the delegate with a predictive list of members eligible for the Population Health Management Program on an annual basis. The Health Plan integrates the following data to use in the predictive model: ▪ Medical and BH claims or encounter data ▪ Pharmacy Claims ▪ Lab results and/or Electronic health records ▪ Health Appraisal results ▪ Health services programs within the organization	Monthly, Delegate will identify members for the Population Health Management Program from referral sources (PCP, UM Process, and/or Member Self-Referral).	Monthly, the delegate will upload referral source reports to the BCBSIL IPA Access Portal. If there are not any referral sources for the month, the log must still be uploaded stating "None".

Population Health Management *(PHM) Program * --Partially Delegated Program *The Complex Case Management (CCM); Case Management (CM); Condition Management and Wellness and Prevention Programs are integrated components of the overall HMO PHM Strategy and the PHM Program.**			
Delegated Activity	**Health Plan Responsibilities**	**Delegate Responsibilities**	**Delegate Reporting Requirements**
Community Resource Integration	Health Plan will annually assess the characteristics and needs, including social determinants of health, of its member population and relevant sub-populations including children, adolescents, members with disabilities and members with Serious and Persistent Mental Illness (SPMI). Health Plan delegates review of community resources for integration into IPA PHM programs The health plan defines the PHM risk stratification strategy and methodology. At minimum, the Health Plan will report on the number of eligible members for services in each of the PHM programs for which they are eligible on an annual basis.	IPAs are delegated to review community resources for integration into program offerings to address member needs.	Annually the delegates will submit minutes from their UM/QI Committee that demonstrate the delegates' assessment of the appropriate community resources to be integrated into program offerings based on their review of the Health Plan Population Assessment.
PHM Program Delivery Supports	The Health Plan will work with practitioners and providers to achieve population health management goals. Quarterly, HMO uploads Utilization Management data Quality Management data Quality Improvement data (HEDIS care gaps) to the BCBSIL IPA Access Portal. Annually, in the first quarter, HMO uploads a shared-decision-making aid to the BCBSIL IPA Access Portal for delegates to share with their	Annual notification to participating providers that a shared-decision-making aids is available for use. Notification must be included in the BCBSIL HMO Annual Notification and include instructions on accessing the shared decision-making aid.	Evidence of notification must be uploaded to the IPA's "NCQA Documents" folder on the BCBSIL IPA Access Portal within one week of distribution.

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Delegated Activity	**Health Plan Responsibilities**	**Delegate Responsibilities**	**Delegate Reporting Requirements**
	practitioners. Supports IPAs in achieving PHM goals through educational assistance, workshops, or seminars. The Health Plan offers its delegates value-based payment (VBP) arrangements.		
Wellness and Prevention	The Health Plan offers Health Risk Appraisals and self-management tools to their members. Member Health Risk Appraisal results will be integrated with additional data utilized to provide predictive modeling reports to the delegate.	Health Risk Appraisals are not delegated to the IPA. The IPA will manage members identified in the Population Health Management Wellness and Prevention Program. The IPA screens members for the Cancer Screening Program (Breast Cancer, Cervical Cancer, and Colorectal Cancer) The IPA will screen members for childhood and adolescent immunizations: • *Childhood Immunizations – Combination #10*: The percentage of HMO Members who turn age two years during the measurement period and receive *all* the following immunizations for Combination 10 by their second birthday: ○ 4 DTaP ○ 3 IPV	Semi-annually, upon request.

Delegated Activity	Health Plan Responsibilities	Delegate Responsibilities	Delegate Reporting Requirements
		○ 1 MMR ○ 3 Hib ○ 3 Hepatitis B ○ 1 Varicella ○ 4 Pneumococcal conjugate vaccine ○ 2 Influenza ○ 1 Hepatitis A ○ 2-3 rotavirus (requirements per vaccine administered) • *Immunizations for Adolescents – Combination #1*: The percentage of HMO Members who turn age thirteen years during the measurement period, and received <u>all</u> of the following vaccines by their thirteenth birthday: ○ Meningococcal vaccine on or between the Member's 11th and 13th birthdays, *and* ○ Tdap on or between the Member's 10th and 13th birthdays. • *Immunizations for Adolescents – HPV*: The percentage of HMO Members who turn age thirteen years during the measurement period and receive two doses of the HPV vaccine that are at least 146 days between the first and	

Delegated Activity	Health Plan Responsibilities	Delegate Responsibilities	Delegate Reporting Requirements
		second dose on or between the Member's 9th and 13th birthdays. -Child and Adolescent Well-Care Visits -IPA screens ALL members ≥ 12 years of age for depression who does not have a diagnosis of depression or dysthymia. This is completed during a face-to-face visit. IPA screens members who meet the criteria for Continued Opioid Use measure. IPA screens members ages 18-64 for Influenza vaccine program.	
Access to Case Management	Health Plan provides integrated data reports to the IPA to identify potential candidates for Complex Case Management and delegates the monthly identification of members via referral sources to the IPA (described in the **Population Identification** section). Members are considered "identified" Annually, Health Plan notifies members about access to case management via the annual HMO regulatory letter.	HP delegates Policies and Procedures for access to Case Management: • How Delegate informs members about access to Case Management. • How members become eligible to participate. • How to use program services. • How to opt in or opt out of the program. HMO delegates notification of new *members* regarding access to complex case management programs via the new member welcome letter. HMO delegates the annual notification	Annually, Delegate will upload their Policies and Procedures for Access to Case Management. Annually, IPA will provide evidence of the member welcome letter template with the required notifications (template provided by HMO.) Annually, the IPA must provide evidence that it notified all practitioners of access to case management mail, fax, or email, or on its website if it informs practitioners that the information is available online and that it mails the notice to practitioners who do not have fax,

Population Health Management *(PHM) Program** --Partially Delegated Program *The Complex Case Management (CCM); Case Management (CM); Condition Management and Wellness and Prevention Programs are integrated components of the overall HMO PHM Strategy and the PHM Program.			
Delegated Activity	**Health Plan Responsibilities**	**Delegate Responsibilities**	**Delegate Reporting Requirements**
		to IPA *practitioners* regarding how to refer their members to access the complex case management program. The member welcome letter must describe the different avenues for referral to Complex Case Management. Annually, IPA will provide evidence that all *practitioners* were notified of access to case management. Monthly, Delegate will identify members to be considered for the Complex Case Management Program. Referral sources to include: ▪ Medical Management program referral ▪ Discharge planner referral ▪ Member or caregiver referral ▪ Practitioner referral Delegate maintains responsibility for notifying members about how they can access the Population Health and/or Complex Case Management Programs.	email, or internet access. Monthly, the delegate will upload referral reports source to the BCBSIL IPA Access Portal. If there are not any referral sources for the month, the log must still be uploaded stating "None". The IPA must provide evidence that it distributes the notice annually to all members and practitioners by mail, fax, or email, or on its website if it informs members and practitioners that the information is available on-line and that it mails the notice to members and practitioners who do not have fax, email, or internet access.
Case Management Systems	Health Plan Provides a Complex Case Management Documentation Platform to delegate via the BCBSIL IPA Access Portal. The HMO delegates the selection, annual review, application, and dissemination of one of the following	Annually, Delegate will submit their case management systems Policies and Procedures for: • Adopting and approving evidence-based guidelines or algorithms to conduct assessment and ongoing management • Automated prompts for follow-up,	Annually, Delegate will upload their Policies and Procedures for Case Management Systems. The policy must include the documented procedure for automated prompts to remind staff of next follow-up interaction. Annually, Delegate will document the

Population Health Management *(PHM) Program** --Partially Delegated Program *The Complex Case Management (CCM); Case Management (CM); Condition Management and Wellness and Prevention Programs are integrated components of the overall HMO PHM Strategy and the PHM Program.			
Delegated Activity	**Health Plan Responsibilities**	**Delegate Responsibilities**	**Delegate Reporting Requirements**
	to the IPA Complex Case Management • Clinical guidelines or, • Algorithms, or • Other evidence-based materials.	as required by the case management plan Delegate will manage members eligible for Complex Case Management within the BCBSIL IPA Access Portal. Delegate will utilize the following to manage the members in Complex Case Management: ▪ Evidence-based clinical guidelines or algorithms to conduct assessment and management. ▪ Automated prompts for follow-up, as required by the case management plan. (IPA may use Outlook, or their own EMRs to meet this requirement) ▪ Automatic documentation of staff ID, and the date and time of action on the case or when interaction with the member occurred. ▪ Delegate maintains responsibility for selection of nationally recognized clinical criteria (including behavioral health and substance use disorder), algorithms, or other evidence-based materials utilized in the management of members in the Complex Case Management Program.	review and approval of CCM criteria in their UM/QI Committee minutes. Annually, the Delegate will submit their documented materials demonstrating the evidence based clinical guidelines or algorithms used for assessment and management of members in Complex Case Management.

Population Health Management *(PHM) Program --Partially Delegated Program* *The Complex Case Management (CCM); Case Management (CM); Condition Management and Wellness and Prevention Programs are integrated components of the overall HMO PHM Strategy and the PHM Program.			
Delegated Activity	**Health Plan Responsibilities**	**Delegate Responsibilities**	**Delegate Reporting Requirements**
Experience with Case Management	Annually, the Health Plan evaluates experience with its Complex Case Management program and Population Health Management Program by: ▪ Obtaining feedback from members. ▪ Analyzing member complaints/grievances. The Health Plan analyzes participant survey feedback on the CCM and PHM Programs and shares the results with the delegate. Complaints are not delegated to the IPA.	Delegate maintains accountability for submitting member complaints/grievances, which may have been inadvertently misdirected to the IPA, following the HMO process described in the HMO UM Plan. ▪ Any complaints regarding the delegate's CCM Program and Population Health Management Programs will be forwarded to the Health Plan via the BCBSIL IPA Access Portal.	Document discussion of results of the Health Plan member satisfaction survey in UM/QI Committee minutes on an annual basis. Member complaints are submitted to the BCBSIL IPA Access Portal within 1 business day of receiving the complaint. Expedited complaints/grievances: • Complete IPA Complaint Check List for Required Documents: E-Mail all documentation to HP, within 1 Business Day. Standard complaints/grievances. • Complete IPA Complaint Check List for Required Documents: E-Mail all additional supporting documentation within 14 Calendar Day. Quarterly, the Delegate will discuss and document all complaints/grievances at the IPA QI/UM Committee. IPA will document discussion of results of the PHM member satisfaction survey in UM/QI Committee minutes on an annual basis.

Population Health Management *(PHM) Program * --Partially Delegated Program* *The Complex Case Management (CCM); Case Management (CM); Condition Management and Wellness and Prevention Programs are integrated components of the overall HMO PHM Strategy and the PHM Program.			
Delegated Activity	**Health Plan Responsibilities**	**Delegate Responsibilities**	**Delegate Reporting Requirements**
PHM Impact Analysis	Annually, the HMO monitors the Effectiveness of the PHM Program. Results of the analyses are used to shape the PHM strategy and goals for the subsequent year.	Annually, the delegate must discuss HMO results of Effectiveness of the PHM Program and incorporate improvements into their IPA's UM and Population Health Management Plan in subsequent years.	Document discussion of PHM Program Effectiveness in the UM/QI Committee on an annual basis.
Improvement and Action	The Health Plan uses results from the PHM impact analysis to annually identify opportunities for improvement and act on at least one opportunity.	Based on Health Plan results of measuring the experience with CCM and satisfaction of the PHM programs, the delegate: ▪ Implements one intervention to improve ***clinical*** performance ▪ Implements one intervention to improve ***member*** experience	Submits required semi-annual reporting requirements to the health plan (see UM and Population Health Management Plan) Discusses and documents CCM and Population Health interventions annually in the UM/QI Committee Meeting Minutes.
Oversight of Delegated PHM Activities The UM PHM Plan is an extension of the HMO MSA. "The 2024 HMO Utilization Management and Population Health Management Plan means the HMO document which delineates the minimum required utilization management and Population Health Management responsibilities of the IPA and is used as a guideline for the development of the IPA's Utilization Management and Population Health Management Plan, as well as the HMO's Utilization Management and Population Health Management Plan oversight (p.9), HMO MSA)."	Health Plan will conduct an annual review of PHM Program Description or policies/procedures for all PHM program activities. The Health Plan will perform pre-delegation assessments to evaluate new delegates capacity to meet NCQA requirements before delegation begins. The Health Plan evaluates semi-annual and annual reporting and performance of the delegate. The health plan will describe its process for evaluating the delegates performance and describes remedies if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement, if necessary.	Delegate shall cooperate and fully participate in audits, site visits and other monitoring of delegated activities conducted by the HP.	Annually, the delegate will provide HP its PHM Program Description, required policies and procedures and other required reports, documents and materials as requested by the Health Plan. Additional IPA Reporting Required for HMO Oversight (not all inclusive): Quarterly, a summary of IPA Population Health Program results, must be reviewed by the QI/UM Committee and reflected in the UM Committee Minutes. Documented discussion includes: goal setting, citing barriers, benefit coverage and community resources as applies to member. Identification of trends and interventions are to be

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Delegated Activity	**Health Plan Responsibilities**	**Delegate Responsibilities**	**Delegate Reporting Requirements**
	Sharing clinical performance data: Quarterly, HMO will upload clinical performance data to the BCBSIL IPA Access Portal for IPA administrators to access and act upon. Sharing member experience data: Annually (in the 3rd quarter) or upon request the HMO will upload results of (Condition Management and Complex Case Management) member experience surveys to the BCBSIL IPA Access Portal IPA administrators to access and act upon.		documented, if applicable. Quarterly, IPA will report their analysis of office follow-up visits for members in the Case Management Program at their QI/UM Committee. Clinical performance data will be analyzed and discussed as part of the IPA UM/QI Committee meeting. The discussion will be documented in the minutes and uploaded to the BCBSIL IPA Access Portal to be reviewed by the HMO during the semi-annual and annual delegation oversight review process Member experience data will be discussed annually in the IPA UM/QI Committee meeting and the discussion will be documented in the minutes and uploaded to the BCBSIL IPA Access Portal to be reviewed by the HMO during the second semi-annual delegation oversight review process. If interventions for results below goal are required, the IPA uploads their plan for improvement as well.

APPENDIX D: 2024 Population Health Management Program Strategy

Area of Focus	Program/Service	Targeted Population	Measurable Goal (goals represent minimum threshold levels of expected performance)	Type of Member Interaction *(Phone, In-Person*, Online)*
Managing Multiple Chronic Conditions	**Complex Case Management**	Members with Significant Illness or Utilization of Services (See Appendix A: 2024 Complex Case Management Referral Guidelines)	Compare Inpatient Admission Rates and ER Rates for members in CCM 2-6 months vs. 7-12 months ≥90% of members satisfied with Complex Case Management Program	Phone and/or In-Person* (Interactive Contact)
Managing Safety and Outcomes Across Settings	**Acute Care Transitions Case Management**	All Members discharged from Acute Hospital Stay. Eligible members keep follow-up office visits with their PCP or Specialist. (See body of UM Plan for specific criteria)	Management and measurement of Safety Across Settings. Achieve 30-Day All Cause Readmission Rate ~~7~~ 5.0% 90% Commercial and IFM HMO Case Management TOC call made within 48 hours of discharge, including documented medication reconciliation. ≥ 25% of members with a follow-up visit with their PCP or Specialist within seven (7) days of discharge from an emergency room visit. ≥ 25 of eligible members are seen by their PCP or Specialist within 7 days of discharge (may include telehealth visit	Phone and/or In-Person* (Non-Interactive Contact)
Managing Members with Emerging Risk	**Condition Management -Asthma Condition Management Program** - Tier 1 (Intermittent/Mild Persistent Asthma) - Tier 2 (Moderate Persistent/Severe Persistent Asthma)	Members with Asthma	>75% of HMO Members 5- 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater	Phone and/or In-Person* and Mailings Tier 2 (Interactive Contact) --- Mailings Tier 1 (Non-Interactive)
			≥90% of members satisfied with the Asthma Condition Management Program	
			>90% of Asthmatic members stratified appropriately (as documented by IPA in the BCBSIL IPA Access Portal Asthma Condition Management Form)	
	Condition Management-Diabetes Condition Management Program - Tier 1 (Glycemic Status Assessment (GSD) (HbA1c<8.0% or GMI < 8.0%) - Tier 2 (Glycemic Status Assessment (GSD) (HbA1c ≥8 or GMI > 8.0%)	Members with Diabetes	>90% of Diabetic members stratified appropriately (as documented by IPA in ~~the~~ BCBSIL IPA Access Portal Diabetes Condition Management Form)	Phone and/or In-Person* and Mailings Tier 2 (Interactive Contact) *** Mailings Tier 1 (Non-Interactive)
			≥90% of members satisfied with the Diabetes Condition Management Program	
			45% percent of identified HMO Members whose most recent (last) Glycemic Status Assessment (GSD), HbA1c<8.0% or GMI < 8.0%, negative retinal eye exam, and kidney health evaluation (eGFR and uACR) during the associated measurement periods as assessed in the PHMQI Combined Diabetes Management measure.	
Keeping Members Healthy and Safe	**Wellness and Prevention: -Cancer Screening Program**	Breast Cancer Screening ages 52-74 who had a mammogram	60% of members who had Breast Cancer Screening	In Person (Non-Interactive Contact)
		Cervical Cancer Screening ages 24-64	60%of members who had Cervical Cancer Screening	
		Colorectal Screenings ages 46-75 with current screening	50%of members who had Colorectal Screening	

	Wellness and Prevention: Childhood and Adolescent Immunizations	*Childhood Immunizations* – Combination #10: The percentage of HMO Members who turn age two years during the measurement period and receive all the immunizations for Combination 10 by their second birthday *Immunizations for Adolescents* – Combination #1: The percentage of HMO Members who turn age thirteen years during the measurement period, and received all of the vaccines by their thirteenth birthday: *Immunizations for Adolescents* – HPV: The percentage of HMO Members who turn age thirteen years during the measurement period and receive two doses of the HPV vaccine that are at least 146 days between the first and second dose on or between the Member's 9th and 13th birthdays.	40% of qualified members received all indicated vaccinations as assessed in the PHM QI Combined Immunizations measure	
	Wellness and Prevention: Child and Adolescent Well Care Visits	Members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	50% of qualified members receive a well care visit.	
	Wellness and Prevention: Depression Screening	All members ≥ 12 years of age without a diagnosis of depression or dysthymia **Adolescent and Young Adult**: Percent of members age 12 to 21 with a primary care visit screened for depression utilizing an approved evidence-based tool. **Adult**: Percent of members age ≥ 22 with a primary care visit screened for depression utilizing an approved evidence-based tool	≥ 80% of members who are ≥ 12 years of age	
	Wellness and Prevention: Continued Opioid Usage	Measure definition: The rate of current members (†) who, during the 12-month window from November 1 prior to October 31 of the measurement year have a new episode of narcotic use, as defined by no prior narcotic prescriptions for 180 days prior to the new index prescription, for which the new episode lasts at least 15 days of a 30-day period following the dispensing of the index prescription. (†)Excludes members with cancer or sickle cell disease or members in hospice. (††)Excludes prescriptions for injectables, opioid-containing cough and cold products, buprenorphine products, and fentanyl patch. (†††)Excludes members who die any time during the measurement year. (††††)Excludes Laboratory Claims	<5% of members whose new episode of opioid use lasts as least 15 days in the past 30 days.	In Person* (Non-Interactive Contact)
	Wellness and Prevention: Influenza Vaccine	All members 18-64 years of age	>48% (Plan Level CAHPS® Survey)	Measured with HEDIS Data and an area of focus through use of Provider Incentives (Non-Interactive) In Person (Non-Interactive Contact)

*A telehealth visit may be utilized in lieu of an in-person visit.