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Note: all report formats are available on the IPA Access portal at
https://bcbsilezaccess.com/ipa_portal/default.aspx. If you do not have access, contact your Provider Network Consultant or Nurse Liaison.
2017 Medical Service Agreement (MSA) Highlights

This is a summary document intended to highlight some of the significant revisions to the MSA. Refer to the actual Medical Service Agreement for all details.

- The Definition section of the contract (pages 5-15) has several additions and clarifications – including, but not limited to:
  - Administrative Data – information obtained through claims, encounter or pharmacy data and is reported using NCQA certified software
  - Care Coordination Program – overarching term to describe the collective Disease Management, Case Management and Complex Case Management (CCM) Programs
  - Data Source and Referral Source Reports – new reports for identifying CCM eligible members
- Page 18 updates the termination clause of the MSA regarding member notification upon an issuance or receipt of a termination notice.
- Page 27 added new language to sync with Policy and Procedure Language regarding the marketing of PCPs with only one IPA for each IPA Affiliated Hospital.
- Page 31 indicates a new requirement for two Board Certified Medical Directors. One must oversee the Medical programs, the other Behavioral Health programs.
- Page 32 updates the CMF delegation notice to 90 days. Also, the termination of a CMF must be approved by the HMO 90 days in advance.
- Page 37 updates the provision of Immediate Care to cite the services must be available without any referral requirement.
- Page 37 updates the provision regarding the maintenance of answering service logs to be ten years.
- Page 42 updates the process for submission of Member Complaints
- Page 44 includes the new provision that both the IPA and CMF (if applicable) are required to maintain a current URO license.
- Page 45 references that all QIRA data must include all applicable diagnosis codes.
- Page 46 includes a submission requirement for the CMF's most recent audited financial statement within 150 days after the end of the CMF’s fiscal year.
- Page 46 amends the due date to 1/31/2017 the annual submissions that are due 2/1/2016.
- Page 47 includes additional language regarding the monthly submission of the coding gap reports for the Blue Precision HMO and Blue FocusCare HMO programs.
- Page 49 adds a notation that the Overpayment section survives termination of the MSA.
- Pages 51 and 65 denote the reinsurancethreshold is increased to $16,000.00. On pages 65 - 66 – the phrase “responsible charges” is replaced with the phrase “IPA payments”.
- Exhibit 2 (pages 63-83) cites the compensation terms of the agreement.
  - Page 64 - the risk adjusted capitation factors have been revised for the various HMO programs.
  - Page 67 cites revised Target Risk Adjustment Factors for the Utilization Management Fund.
  - Page 68 cites an additional 0.75 unit for Appendix B procedures, as set forth in the Provider Manual.
  - Page 69 cites revised unit values for specific gastroenterology procedures performed in hospital based setting.
  - Page 70 cites the termination of the hospitalist program differential for the UM Fund.
  - Page 71 summarizes the Quality Improvement (QI) Funds available.
  - Pages 73-73 outline the Care Coordination Program.
  - Page 76 contains revisions for QIRA validation and payments.
  - Page 77 indicates the removal of the separate payment section for Special HEDIS and QRS payments.
  - Page 80 indicates the Blue FocusCare HMO program will be incorporated into the Annual Health Assessment payment program.
  - Pages 81 - 82 show the revised parameters for the Prescription Drug Funds.
- The Quality Improvement Projects are detailed in Exhibit 3 (pages 84-92). On page 84, there is a new reference that any discrepancies in the results must be brought to the HMO’s attention within 60 days of the posting date.

Revised 1/17
## 2017 Submission Grid

**HMOs* of Blue Cross Blue Shield of Illinois – 2017 Submission Grid**

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<th>Report Due Date:</th>
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<th>10th of each month</th>
<th>1/31/2017</th>
<th>2/15/17</th>
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Rev. 1/17
2017 Submission Grid Overview

ANNUAL HEALTH ASSESSMENT (AHA) FORMS (FOR BLUE PRECISION\textsuperscript{SM} HMO AND BLUE FOCUSCARE\textsuperscript{SM} HMO)
Pursuant to Exhibit 2 “Payment” has an overview of the AHA project. The project documentation that will be located on the BCBSIL IPA Secure Access Portal will outline the requirements.

ANNUAL CAPITATED - SALARIED PROVIDER ROSTER
Pursuant to Section C “IPA Responsibilities” Paragraph 9. “Reporting” Subparagraph i) of the MSA, the IPA must provide to the HMO an annual report of all IPA Providers who have executed a capitated payment arrangement with the IPA. The report template can be found on the BCBSIL IPA Secure Access Portal.

BEHAVIORAL TELEPHONE ACCESS STANDARDS REPORT
Pursuant to Section C “IPA Responsibilities” Paragraph 3. “Availability and Accessibility” Subparagraph g) of the MSA, the IPA must meet the telephone access standards for behavioral health as set forth in the HMO Utilization Management and Care Coordination Plan. The HMO will submit a request for the report, the IPA must respond according to the instructions in the request.

CMF FINANCIAL STATEMENT - ANNUAL AUDITED
Pursuant to Section C “IPA Responsibilities” Paragraph 9. “Reporting” Subparagraph f) of the MSA, the IPA must have the CMF provide this report to the HMO one-hundred and fifty (150) days after the end of the CMF’s fiscal year. The report must be prepared using the accrual basis of accounting and prepared by an independent CPA who is not an employee of the IPA or CMF.

CMF OVERSIGHT PLAN
Pursuant to Section C “IPA Responsibilities” Paragraph 8. “Quality Improvement” Subparagraph B)10) of the MSA, the IPA must submit a plan for monitoring the performance of a CMF, including Behavioral Health Care CMFs, if applicable, to include oversight of all functions delegated to the CMF as set forth in the current HMO Utilization and Care Coordination Plan. There is no template for the oversight plan.

CMF OVERSIGHT REPORT
Pursuant to Section C “IPA Responsibilities” Paragraph 9. “Reporting” Subparagraph d) of the MSA, the IPA must submit a quarterly report of oversight activities performed by the IPA to oversee the functions delegated to a CMF. The report template can be found on the BCBSIL IPA Secure Access Portal. If the IPA has delegated functions to more than one CMF, a separate report must be submitted for each CMF. If a function has not been delegated to the CMF (e.g. Case Management) indicate N/A in the designated space. The report must include the signature of the IPA Administrator. The report is divided into activities that are performed month, quarterly and annually.

Monthly Oversight Requirements:
The IPA should document the actual data element (e.g. the actual number of denials, the number of emergency room visits per 1000/members) as well as the review date. In the Care Coordination Program Review section – the actual number of active members in Case, Complex Case and Disease Management needs to be documented.

Quarterly Requirements:
The IPA must document the oversight activities related to claim payment activities and the MSA required report submissions. In the Claims Payment section - the IPA must review the CMF’s claim payment activities and supporting documentation. This would include, but not be limited to reports prepared by the CMF for the IPA’s review related to the delegated functions. The date of the review must be documented on the CMF oversight report, as well as a summary of the IPA’s review. Supporting documentation must be submitted with the CMF Oversight Report, as indicated.
In the Reporting section - the IPA must document the date that the MSA required reports were reviewed. Any identified issues (such as late submission, inaccuracies, or missed submission) should be documented as well as actions to be taken to prevent further occurrences. The actual MSA required report submissions do not need to be submitted again with the CMF Oversight Report. Any other key performance reports that the IPA has reviewed needs to be listed, with the date reviewed. Supporting documentation must be submitted with the CMF Oversight Report, as indicated.

**Quality Improvement (QI) Project Submissions:**
The IPA should document all oversight activities performed related to the QI Projects including all associated submissions. Supporting documentation is not required for this section. Any issues identified during the oversight review needs to be described in the appropriate section. This should also include steps that will be taken to resolve the identified issue.

**Quality Improvement Project Results**
The IPA must document the date the results for each QI Project was reviewed by the IPA Medical Director. Any additional comments, including outliers, identified barriers, corrective actions must be included.

**Annual Requirements**
The IPA must document oversight activities for the following at least once per calendar year. The documentation must include the date reviewed/approved, if the policies, systems, procedures meet criteria, the details of the review and any applicable corrective actions being taken to ensure that the requirements are met.

- CMF Policy and Procedures
- CMF Policies and adherence to policies related to privacy and security
- HMO Oversight Audit Results – The score for each, and the date the audit results were reviewed by the IPA must be documented. If a corrective action plan was required related to any of the audits listed – the IPA must document its monitoring of the corrective action plan. This section also includes a review of the PCP and Member Satisfaction surveys.
- HEDIS – the IPA must document the review and approval of the HEDIS submission by the IPA Personnel. It is generally scheduled to be done in the first and second quarters of the calendar year. The number of records being requested, submitted and reviewed with the date of the activity must be included.
- Select Administrative Quality Indicator Results – usually will occur in the third or fourth quarter of the calendar year. The IPA must document its review of the results; identify any barriers or causes for any results below the payment threshold and actions that will be taken to address each identified barrier. The IPA must document who has performed the analysis including their title and the date it was performed.
- Clinical QI Fund Summary Report – The report will usually be available during the third or fourth quarter of the calendar year. If any of the Quality Study results were below the network rate, the IPA must document the date the study results were taken to the QI Committee and the planned intervention for each.

**CMF SERVICE AGREEMENT**
Pursuant to Section C “IPA Responsibilities” Paragraph 1. “Representation of IPA and IPA Providers” Subparagraph s) of the MSA, if applicable, the IPA must submit a written service agreement between the IPA and a CMF, including Behavioral Health CMFs that describes, at minimum:

- Responsibilities of the parties
- Extent of services to be provided by the CMF
- CMF reporting process
- IPA oversight process
- agreement by the CMF to preserve patient confidentiality
- agreement to follow the HMO Standards stated in the HMO UM Plan
- A copy of the approval letter for URO designation
- Submission of any complex case management files as requested by the HMO

There is no report template for the service agreement.
CONDITION CODING GAP REPORT (FOR BLUE PRECISION™ HMO AND BLUE FOCUSCARE™ HMO)
Pursuant to Section C “IPA Responsibilities” Paragraph 9. “Reporting” Subparagraph f) 3) of the MSA, the IPA must submit a monthly report using the approved HMO report template as per the project documentation that will be located on the BCBSIL IPA Secure Access Portal.

CONTRACTED PROVIDER ROSTER REPORT
Pursuant to Section C “IPA Responsibilities” Paragraph 9. “Reporting” Subparagraph i) of the MSA, the IPA must submit a Contracted Provider Roster to the HMO that lists all contracted providers including speech, occupational and physical therapy, hospital based physicians and nurse practitioners and physician assistants working under the supervision of IPA PCPs. The roster must be on a spreadsheet in a format approved by the HMO and include the following data elements (see report template on the BCBSIL IPA Secure Access Portal):
- IPA number
- Employed by IPA (indicate with a yes if the provider is employed)
- Provider First Name
- Provider Last Name
- Group Practice / Facility Name (if applicable)
- Street Address
- City
- State
- Zip Code
- Phone Number
- Fax Number
- Tax ID Number
- License Number
- NPI #
- Original Effective Date with IPA
- Specialty (not abbreviated)
- Provider Degree Type e.g. MD/DO/NP/PA

Hospital Affiliation (for hospital based physicians) (if has multiple hospital affiliations – list each hospital in separate columns)

FINANCIAL STATEMENT - ANNUAL AUDITED OR REVIEWED
Pursuant to Section C “IPA Responsibilities” Paragraph 9. “Reporting” Subparagraph f) of the MSA, the IPA must provide this report to the HMO one-hundred and fifty (150) days after the end of the fiscal year. The report must be prepared using the accrual basis of accounting and prepared by an independent CPA who is not an employee of the IPA or CMF. IPAs with a membership at or above 2,500 Members as of 12/31/2017 must submit an audited statement. If the IPAs membership is below 2,500 as of 12/31/2017 the statement can be audited or reviewed. The HMO also may require that an audit be done at the IPA’s expense, and conducted by an independent certified public accountant according to GAAP. If the IPA is submitting the statement of a parent or other related entity as approved by the HMO, a HMO Approved financial performance guarantee of IPA’s financial obligations under the MSA must also be submitted. There is no report template for this report.

HIGH VOLUME BEHAVIORAL HEALTH PRACTITIONERS REPORT
Pursuant to Section C “IPA Responsibilities” Paragraph 9 “Reporting” Subparagraph e) of the MSA, the IPA must submit an annual listing of the IPA’s high volume behavioral health practitioners. This report will include both mental health and substance use (chemical dependency) providers. The report must include all individual providers who have provided services to 50 or more unique Blue Cross members in the previous calendar year. This should include psychiatrists, psychologists, licensed clinical social workers (LCSW) and licensed professional counselors (LCPC). Individual Providers should be listed - not group practices. Do not include Psychologists that perform only psych testing. If an IPA utilizes a mental health vendor, the IPA must work with the vendor obtain the list. The report must include all data included on the HMO report template. If the IPA does not have any high volume providers - document this in the space provided on the report. The report template can be found on the BCBSIL IPA Secure Access Portal.
INCOME AND EXPENSE REPORT WITH BALANCE SHEET
Pursuant to Section C “IPA Responsibilities” Paragraph 9. “Reporting” Subparagraph f) of the MSA, the IPA must provide to the HMO quarterly these financial reports. The report template for the income and expense report can be found on the BCBSIL IPA Secure Access Portal.

IPA ATTESTATION
Pursuant to Section C “IPA Responsibilities” Paragraph 9. “Reporting” Subparagraph i) of the MSA, the IPA must submit a verified attestation from an authorized representative for the IPA that the written agreements between the IPA and all IPA Providers comply with the terms of the MSA and the Provider Manual. The report template can be found on the BCBSIL IPA Secure Access Portal.

IPA ACCESS ATTESTATION
Section C “IPA Responsibilities” Paragraph 3 “Availability and Accessibility” describes the contractual requirements. The project documentation that will be located on the BCBSIL IPA Secure Access Portal will outline the submission requirements.

IPA LIABILITY INSURANCE
Pursuant to Section C “IPA Responsibilities” Paragraph 4. “Insurance, Registration and Licensure” Subparagraphs a-c) of the MSA, the IPA must maintain a valid current policy (or policies) of insurance covering professional liability of the IPA, its agents and employees, at a minimum of $1,000,000 per claim and $3,000,000 annual aggregate coverage. The IPA shall also carry such other insurance as shall be necessary to insure the IPA, its agents and employees, against any and all damages arising from the IPA’s various duties and obligations. The IPA should submit a copy of the policy upon request by the HMO. There is no report template for this.

MAXIMUM OUT OF POCKET EXPENSE REPORT (OPX)
Pursuant to Section C “IPA Responsibilities” Paragraph 9. “Reporting” Subparagraph j) of the MSA, the IPA must provide on a weekly basis a Maximum out of pocket expense report. This report must be in the format acceptable to the HMO. Detailed requirements will be found in the claims processing section of the Provider Manual and on the BCBSIL IPA Secure Access Portal.

MEMBER COMPLAINT FORMS
There is an interactive complaint form on the BCBSIL IPA Secure Access Portal to enter complaints as they are received.
The form is located at: IPA Portal > Care Coordination (CM/CCM/DM/UM) > HMO > Complaint Form. The IPA UM Committee must discuss all complaints (Medical and Behavioral Health) received by the IPA. Complaint types include, but are not limited to, Quality of Care, Access, Administrative, Attitude and Service, Claims, Referrals, Benefits, Quality of Practitioner Office Site, or complaints regarding the IPA Complex Case Management, Case Management or Disease Management Programs.

MEMBER NOTIFICATION LETTER FOR PROVIDER TERMINATION
Section C “IPA Responsibilities” Paragraph 1 “Representation of IPA and IPA providers” Subparagraph o) identifies the 90 day advance notice requirement for member notification of the discontinuance of operation of any facility, provider or site. The letter requirements can be found in the MSA Highlights and Process Summary section of this Provider Manual.

OPERATING OR MANAGEMENT AGREEMENT
Pursuant to Section C “IPA Responsibilities” Paragraph 9 “Reporting” Subparagraph i) of the MSA, the IPA must submit the current Operating or Management Agreement that includes the ownership structure. Each subsequent year, the IPA must submit any addendum to the agreement, or submit a notification that it has not changed.

PRIMARY CARE PHYSICIAN – MEMBER DETAIL ASSIGNMENT REPORT
Pursuant to Section C “IPA Responsibilities” Paragraph 9 “Reporting” Subparagraph h) of the MSA, the IPA must a semi-annual list of PCPs and assigned Members. The report must include the Member Group and ID #, Member Name, assigned PCP, and in a format acceptable to the HMO. The report template can be found on the BCBSIL IPA Secure Access Portal.
PRIMARY CARE PHYSICIAN SUMMARY ASSIGNMENT REPORT
Pursuant to Section C "IPA Responsibilities" Paragraph 9 “Reporting” Subparagraph g) of the MSA, the IPA must submit quarterly a list of PCPs with the number of members assigned to each, and a total number of unassigned members for the IPA. The report must include WPHCPs. If the IPA does not assign or track membership for WPHCPs – this must be indicated on the report. The report template can be found on the BCBSIL IPA Secure Access Portal.

QIRA DATA
Pursuant to Section C “IPA Responsibilities” Paragraph 9 “Reporting” Subparagraph b) of the MSA: The IPA must submit a semimonthly QIRA data file. All encounters paid between the 1st and 15th of the month, must be submitted between the 16th and 23rd of the current month. Encounters paid between the 16th and end of the month must be submitted between the 2nd and the 8th of the subsequent month.

- The claims must be submitted within 3 weeks of payment
- IPA must correct and resubmit rejected records no later than 10 days from HMO notification of such error
- To be considered for reinsurance, all claims must be paid by June 30 of the following year the service was incurred and submitted in the July upload. For example, all 2016 dates of service must be paid by June 30, 2017 and uploaded in July 2017.
- The QIRA file data element requirements are located on the BCBSIL IPA Secure Access Portal. QIRA data submitted for Physician services must have a valid specialty code other than multi-specialty, clinic or group practice, and must include all applicable diagnosis codes.

The HMO will validate the data for accuracy and completeness. In addition, the IPA must certify with each submission, that the data has been evaluated for accuracy and completeness. If the HMO becomes aware that the data is not accurate and/or complete – penalties as outlined in the MSA may be applied.

QUARTERLY CAPITATED – EMPLOYED (SALARIED) ENCOUNTER DATA ANALYSIS REPORT
Pursuant to Section C “IPA Responsibilities” Paragraph 9 “Reporting” Subparagraph b) of the MSA, the IPA must provide to the HMO a quarterly summary report of claims/encounters submitted and adjudicated for each capitated and employed Provider. This report template can be found on the BCBSIL IPA Secure Access Portal.

PCP report (all PCPs should be included) - Create a spreadsheet that contains the following columns:
- PCP name, group practice name, specialty, license #, NPI #, Tax ID #
- Average current membership assigned to this PCP
- Number of claims received in the quarter
- Average number of claims adjudicated in the quarter – this is obtained by dividing the number of claims received in the quarter by the average current PCP membership

The Average number of claims adjudicated for each PCP should look similar to the other PCPs in that specialty. If the data for a particular PCP does not look within the range of the other values, then the IPA should investigate whether the PCP is not submitting complete claim/encounter data and document the IPA’s action plan for obtaining complete claim/encounter data (with follow up reports on action items in subsequent quarters).

Specialist/Ancillary provider report - Create a spreadsheet for each that contains the following columns:
- Specialty/Ancillary provider name, group practice/facility name, specialty, license #, NPI #, tax ID #
- IPA average current membership
- Number of claims received
- Average number of claims adjudicated in the quarter – this is obtained by dividing the number of claims received in the quarter by the average IPA membership.

The Average number of claims adjudicated received for each Specialty/Ancillary Group should be within the range of the other values established for that Specialty/Ancillary Group or the PMPM value should approximate the PMPM sub-capitated amount paid to the Specialty/Ancillary Group. If this is not the case, then the IPA should investigate whether the Specialty/Ancillary Group is not submitting complete claim/encounter data and document the IPA’s action plan for obtaining complete claim/encounter data (with follow up reports on action items in subsequent quarters).
SERVICE AGREEMENTS
The IPA must submit a fully executed Service Agreement and/or Addendum for all providers including but not limited to PCPs, specialists, facilities, ancillary providers, hospital based specialists listed in the MSA, non-targeted physicians and sub-specialists that have not been previously submitted to the HMO. There is no report template for the service agreement. The Service Agreement must include:

- provider responsibilities
- agreed upon compensation, at least in general terms
- requirement that provider submit a claim no less than 90 days after date of service if the HMO is the primary insurance
- agreement to seek compensation not from HMO or Member but solely from the IPA for services provided to Members
- agreement to participate in quality of care review activities as requested by the IPA, including allowing access to medical records for HEDIS reporting and other HMO quality improvement initiatives
- professional liability insurance coverage as specified in Section I.C.4. of the MSA
- agreement to preserve patient confidentiality
- agreement not to charge any provider that has a contractual or other affiliation with another Participating IPA more than the Blue Cross Blue Shield of Illinois PPO Schedule of Maximum Allowance for referred or Emergency covered services provided to Members of such Participating IPA if such claims are paid within 30 days of the Participating IPA’s receipt of such claims unless payment was delayed as a result of the Member’s eligibility for an Advance Premium Tax Credit Grace Period. IPA and IPA Providers agree to accept the Blue Cross Blue Shield of Illinois PPO Schedule of Maximum Allowance for referred or emergency services provided to Members of such Participating IPA if such claims which are determined to be eligible for payment are paid within 30 days following the required 3 month grace period.
- an agreement to comply with the terms of the MSA and Provider Manual

UTILIZATION MANAGEMENT / CARE COORDINATION RELATED REPORTS
All report descriptions and requirements are outlined in the HMO Utilization Management and Care Coordination Plan. All related report templates are located on the BCBSIL IPA Secure Access Portal. These include:

- Inpatient Physician Advisor Referral Log
- Out of Network Referral Log
- Admission Log
- Behavioral Health Referral Request Log
- Case Management Forms
- Complex Case Management forms
- Denial Logs and files
- Care Coordination Data/Referral Source (DM, CM, CCM) reports
- Disease Management Forms
- UM Plan
- URO License
WELCOME LETTER
Pursuant to Section C “IPA Responsibilities” Paragraph 10. “Members” Subparagraph a) of the MSA, the IPA shall submit a welcome letter to newly enrolled members. The template for the welcome letter can be found on the BCBSIL IPA Secure Access Portal. The welcome letter must include, but is not limited to:

- process for choosing a PCP and notifying the IPA office of the PCP selection
- process for scheduling a PCP get acquainted visit
- process for selecting a WPHCP and the Physician’s role in coordinating care with the PCP
- how to change a PCP and WPHCP and any HMO restrictions that may apply
- the availability of preventive services
- procedures for Emergency, Routine and Immediate Care Services – must include detailed description
- procedures regarding referrals
- the IPA’s Utilization Management procedures
- the IPA’s expectations of the Member
- how the Member can access their HMO benefits; including how Member can access early morning, evening, and weekend office hours
- how to contact the IPA Member Representative to facilitate the handling of complaints, appeals or grievances-in compliance with applicable law, including The Managed Care Reform and Patient’s Rights Act
- assurance of patient confidentiality
- procedures regarding the obtaining of Behavioral Health Care services
- how the Member can obtain access to their medical records
- how the Member can discuss Utilization Management issues or the UM process by calling the IPA’s toll free number or by making a collect call to IPA
- How the Member can request consideration for the IPA’s Care Coordination Services (Case Management, Complex Case Management and Disease Management programs)
- How an Adolescent Member will transition to Adult Health Care Services.

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Sample Report Formats

These reports are available for download on the IPA Access portal at https://bcbsilezaccess.com/ipa_portal/default.aspx. If you do not have access, contact your Provider Network Consultant or Nurse Liaison.

Welcome Letter Template  
High Volume Behavioral Health Report  
IPA Attestation  
Behavioral Health Referral Request Log  
Denial Log  
Admission Log  
Out-of-Network Referral Request Log  
Inpatient Physician Advisor Referral Log  
Referral Inquiry Log  
Complex Case Management Case Log  
Member Complaint Report  
Income, Expense and Balance Sheet Quarterly Report

Quarterly Capitated Employed (Salaried) Encounter Data Analysis Report

Utilization Management Fund Worksheet  
Primary Care Physician (PCP) Summary Assignment Report  
PCP Member Detail Assignment Report

Contracted Provider Roster Report  
Annual Capitated Salaried Provider Roster

CMF Oversight Report
IPA Standards for Emergency Services

All IPAs participating in the HMO Network must meet the following minimum standards for emergency services:

1. The IPA is required to have a 24-hour answering service available every day including weekends and holidays to handle emergency calls. The IPA must also assure that each PCP and WPHCP provides a 24-hour answering arrangement, including a 24-hour on call PCP arrangement.

2. The IPA must provide the answering service with written guidelines and procedures that include, at a minimum, the following information:
   a) An updated schedule of the physician on call, depending on the specific schedule of the IPA.
   b) A complete list of Primary Care Physicians
   c) Written procedures for handling emergency calls which include keeping a documented log with the following information:
      1) Patient's name and age
      2) Caller's name
      3) Date of call
      4) Patient's symptoms
      5) Physician contacted and time of such contact
      6) Instructions given by service to patient (caller)

3. The answering service should send this log to the IPA at a minimum, weekly, to facilitate the IPA's ability to confirm phone contact from members. Each PCP, WPHCP and Behavior Health Practitioner should maintain an answering service log.

4. The IPA should review the answering service log for any discrepancies and problems. The Medical Director or Quality Review Committee should review any discrepancies or identified problems.

5. The IPA should maintain the log in their files for at least one year.

6. Those IPAs in heavily ethnic areas (e.g., Spanish) should provide an answering service that speaks the particular language of the population served.

The HMO reserves the right to survey IPA's answering service to assure compliance with these standards.

Each HMO member is instructed through the Marketing Account Executive, product brochures, literature, newsletters and the IPA administration to call his/her IPA when an emergency situation arises.
Member Notification Process when a Provider leaves the IPA

As stated in the Medical Service Agreement (MSA) (Section 1.C.1.0):

the IPA agrees to notify the HMO in writing at least ninety (90) days in advance of the discontinuance of any operation of any facility, Provider, or site to Members and transition Members under care to another Provider, as set forth in the Provider Manual.

As defined in the MSA, a provider is:

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

The process for member notification is listed below:

- The IPA must communicate to all affected members at least 90 days prior to the termination date.
- All letters sent to the affected HMO members must be approved by the Provider Network Consultant prior to the letter being sent. The letter must include the mailing date. At a minimum, the following information needs to be included in the letter(s):
  - If an HMO Product name is used, it must be written as follows (the first time it is cited, subsequent usage does not need to include the service or register marks):
    - HMO Illinois®
    - Blue Advantage HMO®
    - Blue Precision HMO®
    - BlueCare Direct®
  - Reason for letter-Primary Care Physician (PCP) or Participating Specialist Provider (PSP) or other provider is leaving the IPA and/or medical group closing, with effective date
  - Instructions on how members choose a new PCP and/or if members will be assigned a new PCP
  - What required actions must members take if a PSP is leaving
  - a reference that the member may call the HMO for assistance in choosing another IPA if necessary. The member should be instructed to call the Customer Service telephone number on the back of their ID card.
  - Transition of Care Language as written below:
    - If you and/or one of your family members are currently in an ongoing course of treatment and wish to receive transition of care services, you may request that you continue seeing your current physician for up to 90 days from the date of this notification. To receive this transition of care service you must submit a request in writing within 30 days of this notification or call:
      - Blue Cross and Blue Shield of Illinois
      - Consumer Affairs Unit
      - 300 East Randolph, 24th Floor
      - Chicago, Illinois 60601
      - 312-653-6600
  - A dated copy of the letter must be submitted to the Provider Network Consultant prior to the member mailing.
    - If the IPA is submitting the letter with less than 90 days’ notice, an explanation must be included in the communication to the Provider Network Consultant. At the HMO’s discretion, an Administrative Complaint may be issued to the IPA if the letter is submitted with less than 90 days’ notice for each occurrence. There are situations where an Administrative Complaint may not be issued, including, but not limited to a provider death, an unexpected medical emergency preventing the provider from continuing to practice or a termination for cause - such as suspension/revocation of the provider’s license.
    - A copy of the termination notice that was sent to the BCBS network notification email must also be sent to the Provider Network Consultant.
  - In addition, the IPA must submit a template letter annually as documented on the Submission Grid referenced in this section of the Provider Manual.