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2009 Blue Cross Blue Shield of Illinois HMOs Medical Service Agreement (MSA) Highlights

This is not intended to be an all-inclusive listing of changes - please refer to the actual Medical Service Agreement for all details.

- Appendix E (contracted dialysis providers) has been incorporated into Appendix D. Appendix E is now the Capitation Fee Schedules.
- The phrase “IPA Affiliated Hospital” has been defined to mean any listed hospital in the Provider Directory for the IPA (page 6). This phrase is also used on pages 19 and 20 – to reference the required physician panel at each IPA Affiliated Hospital.
- The HMO reserves the right to withhold all or a portion of the Reinsurance Payments upon IPA default (page 13).
- Page 36 outlines additional requirements related to the submission of the quarterly Income and Expense Report, and the annual Audited Financial Statement. The Income and Expense report must be submitted using the HMO required format, based upon a calendar quarter, contract specific, be on a cash basis. The annual Audited Financial statement (or financial statement as described in the MSA) must include a balance sheet, be prepared according to generally accepted accounting principles, must include an attestation re the solvency of the IPA.
- Language revision that the IPA shall not re-insure any of the first \$13,000 of costs. Other re-insurance thresholds have also been adjusted (page 49).
- The amount payable to the IPA for each assumed but unutilized Unit for the Utilization Management Fund has been increased to \$725.00. If the IPA has implemented a hospitalist program, the unit value has been increased to \$750.00 or \$800.00 as described on page 50.
- The Utilization Management Fund is now calculated on a Calendar year (page 50).
- The Utilization Management Fund Unit Value Table (page 52) has been updated. Note the following:
 - The MSA does not list Class III under the Hospital Based Ambulatory Surgery type – these still do exist
- Refer directly to the MSA (pages 54-64) for the details of the Quality Improvement Fund revisions.
- The Prescription Drug Management Fund thresholds have been revised. Refer directly to page 64 for the details.
- The Welcome letter template has been amended with suggested language for notifying members regarding the availability of case management. This language is not required to be added to the welcome letter if the IPA has another method of member notification.

Submission Grid

HMOs* of Blue Cross Blue Shield of Illinois 2009 Submission Grid

Due Date:	10th of each Month	2/15/2009	1st qtr 05/01/2009	1st qtr 05/31/2009	2nd qtr 07/31/2009	2nd qtr 08/31/2009	3rd qtr 10/31/2009	3rd qtr 11/30/2009	4th qtr 01/31/2010	4th qtr 02/28/2010	Annual - 150 days after the end of the IPA's fiscal year
	Denial/Appeal Log & Files	UM Plan	IPA/CMF Oversight report (if applicable)	Capitated/Employed Provider Encounter Report	IPA/CMF Oversight report (if applicable)	Capitated/Employed Provider Encounter Report	IPA/CMF Oversight report (if applicable)	Capitated/Employed Provider Encounter Report	IPA/CMF Oversight report (if applicable)	Capitated/Employed Provider Encounter Report	Annual Financial Statement (incl balance sheet) (audited or independently prepared)
			IPA attestation	Income and Expense Report, electronically submitted, YTD, cash basis, contract specific	BH telephone Access standards report - if applicable	Income and Expense Report, electronically submitted, YTD, cash basis, contract specific	BH telephone Access standards report - if applicable	Income and Expense Report, electronically submitted, YTD, cash basis, contract specific	BH telephone Access standards report - if applicable	Income and Expense Report, electronically submitted, YTD, cash basis, contract specific	
			IPA Provider Roster Spreadsheet electronically submitted								
			Welcome letter - (if not already submitted with UM plan)								
			CMF Service Agreement + Oversight Plan, incl. Beh. Health Care CMFs, if appl.								
			BH telephone Access standards report - if applicable								
Upon HMO Request:		1. Behavioral Health Referral Request Log 2. Complaint Report 3. Out of Network Referral Log 4. Inpt. Phys. Advisor Referral Log 5. Admission Log 6. Complex Case Mngmt Log									

Revised 12/08 * HMO Illinois and Blue Advantage HMO

All submissions should be sent to: Ernestine Brown - Browne@BCBSIL.com or fax - 312-540-8206

2009 Denial/Appeal Log

IPA #/Name: _____

Product: HMOI [] BA HMO []

Month: _____

For questions regarding log:

Contact Name: _____

Phone: _____

Member Group #	Member ID #	Date Referral Received	*Type of Service Denial Code (1-8)	Denial Reason Codes: 1 Medical Necessity; 2 Out of Network; 3 Noncovered Benefit	Date of Denial	Date of Member Letter	Date of Physician Letter	Date of Appeal (date or N/A)

*HMO Illinois and BlueAdvantage HMO
Nov-08

Type of Service Denial Codes:

1 - Inpatient days 2 - Specialist Referral 3 - Outpatient Surgery 4 - Labs/Diagnostic Testing 5 - DME/Medical Equipment 6 - Drugs 7- Investigational Treatment 8 - Other

2009 Admission Log

IPA #/Name: _____

Month: _____

Member Name and ID:	Facility	Diagnosis/Procedures Performed	PCP or Admitting Physician	Admit Date	Discharge Date

*HMO Illinois and BlueAdvantage HMO
11/08

2009 Referral Request Log

DO NOT SUBMIT QUARTERLY

IPA #/Name: _____

Month: _____

Member ID #:	Service Requested	Type of Service	Name of PCP Requesting Referral	Date Referral Received	Date Referral Approved	Date PCP Notified

* HMO Illinois and Blue Advantage HMO

If Referral is approved record on this form.
If denied, record on the Denial/Appeal Log.

2009 CMF Oversight Report

**HMOs* of Blue Cross Blue Shield of Illinois
2009 CMF Oversight Report**

Quarterly Submission Schedule

Due at HMO on	1 st Quarter April 30	2 nd Quarter July 31	3 rd Quarter October 31	4 th Quarter January 31
---------------	-------------------------------------	------------------------------------	---------------------------------------	---------------------------------------

IPA #: _____	Quarter : 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> 4 th <input type="checkbox"/>
IPA Name: _____	Product: <input type="checkbox"/> HMO Illinois (✓Check One) <input type="checkbox"/> BA HMO

List all services delegated to CMF

- | | |
|---|---|
| <input type="checkbox"/> Claims | <input type="checkbox"/> Utilization Management |
| <input type="checkbox"/> Membership/Eligibility | <input type="checkbox"/> Quality Review |
| <input type="checkbox"/> Customer Service | <input type="checkbox"/> MSA/Contracting |
| <input type="checkbox"/> Credentialing | |

List dates and attendance of meetings where IPA personnel reviewed CMF activities:

List name of report and date of review/approval for all reports provided to the IPA by the CMF for oversight purposes:

List date of review and approval of CMF Quality Plan (annually):

Were any of the complaints submitted to the HMO related to the CMF activities? If so, list the complaints, the resolution of the complaints, and the IPA action addressing the CMF's process that may have resulted in the complaint. (What action was taken to prevent reoccurrence of the complaint?)

Revised 12/08 *HMO Illinois and Blue Advantage HMO

2009 Member Complaints

**HMOs* of Blue Cross Blue Shield of Illinois
2009 Member Complaints
Cover Sheet --Submit Upon HMO Request Only**

Instructions

1. Use **separate** submission covers for HMOI and Blue Advantage HMO products & for individual IPA sites.
2. Assign **ONE** category per complaint: Choose the type that best fits the description.
3. **Attach** (staple or bind) all relevant documentation behind this submission cover sheet for each HMO product.
4. If no complaints were submitted, please indicate "0" in appropriate boxes.
5. Submit complaints only. **NO inquiries** please.
6. Please submit data to your Network Consultant by the dates outlined below, **IF REQUESTED**.

Quarterly Submission Schedule

IF REQUESTED, due at HMO on	1st Quarter April 30	2nd Quarter July 31	3rd Quarter October 31	4th Quarter January 31
IPA #: _____	Quarter : 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> 4 th <input type="checkbox"/>			
IPA Name: _____	Product: <input type="checkbox"/> HMO Illinois (✓Check One) <input type="checkbox"/> BA HMO			

	Month 1	Month 2	Month 3	Total Complaints by Type <i>(Add three months of data per category)</i>
Name of Month	_____	_____	_____	
Complaint Category:				
ADM	_____	_____	_____	<input style="width: 50px; height: 20px;" type="text"/>
R	_____	_____	_____	<input style="width: 50px; height: 20px;" type="text"/>
B	_____	_____	_____	<input style="width: 50px; height: 20px;" type="text"/>
ACC	_____	_____	_____	<input style="width: 50px; height: 20px;" type="text"/>
C	_____	_____	_____	<input style="width: 50px; height: 20px;" type="text"/>
QOC	_____	_____	_____	<input style="width: 50px; height: 20px;" type="text"/>
OTH	_____	_____	_____	<input style="width: 50px; height: 20px;" type="text"/>
	Total Complaints per Quarter			<input style="width: 50px; height: 20px;" type="text"/>

Complaint Category Descriptions:

ADM	R	B	ACC	C	QOC	OTH
<i>Administrative</i>	<i>Referral</i>	<i>Benefit</i>	<i>Access</i>	<i>Claims</i>	<i>Quality of Care</i>	<i>Other</i>

11/08

2009 Member Complaint Log Report

**HMOs* of Blue Cross Blue Shield of Illinois
2009 Member Complaint Log Report-Submit Upon Request Only**

Complaint: an expression of dissatisfaction, oral or written. All complaints must be resolved within 30 days of receipt. All complaints must be discussed in monthly QR/UM meetings.

Quarterly Submission Schedule

IF REQUESTED due at HMO on	1 st Quarter April 30	2 nd Quarter July 31	3 rd Quarter October 31	4 th Quarter January 31
-------------------------------	-------------------------------------	------------------------------------	---------------------------------------	---------------------------------------

IPA #: _____	Quarter : 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> 4 th <input type="checkbox"/>
IPA Name: _____	Product: <input type="checkbox"/> HMO Illinois (✓Check One) <input type="checkbox"/> BA HMO

Member Name: _____ Group & ID #: _____
 Category of Complaint: ADM ___ R ___ B ___ ACC ___ C ___ QOC ___ OTH ___

PCP/Provider Name: _____ License #: _____

Receipt Date:	Date of Incident:	Resolution Date:	Date letter sent to member:	UM Mtg. Review Date:

Problem:

Findings of Investigation:

Recommendation of UM/QR Committee:

Resolution and follow-up:

Member Complaint/Inquiry Categories

Complaint: An expression of dissatisfaction, oral or written

Inquiry: A request for information or a request for investigation of a potential problem

ADM = Administrative

Member inquiring about an administrative issue. For example:

- member complains of rudeness, attitude, or inattentive staff
- clerical, facility issues
- management issues
- membership/eligibility/ID card issues
- provider related concerns not related to Quality of Care

ACC = Access

Member inquiring about access issues such as:

- availability/timeliness/appropriateness of appointments
- difficult access to PCP and/or support staff by telephone
- answering service issues
- insufficient PCPs to cover geographic location
- reduced access to PCP and medical services because patient is an HMO member

R = Referrals

Any referral related issues. For example:

- availability/timeliness/appropriateness/processing
- denied access to a specialist

C = Claims

Member inquiring about any claim issues. For example:

- unpaid claim
- claim payment amount

B = Benefits

Member dissatisfied with HMO benefits or benefit coverage.

QOC = Quality of Care

Member inquiring about the quality of medical care received through HMO providers. This may include:

- provider prescribed the wrong medication
- member feels illness was misdiagnosed or not properly treated

OTH = Other

Member inquiring about any other problems that require investigation that does not fit into the other categories.

2009 Capitated Employed Encounter Date Report Overview

PCP report (all PCPs should be included)

Create a spreadsheet that contains the following columns:

- PCP name
- PCP specialty
- Average current membership assigned to this PCP
- Number of claims received in the quarter.
- Average number of claims adjudicated in the quarter.
- Average number of claims received divided by the average current PCP membership will give us the average number of claims received/adjudicated by capitated/employed PCP.

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 that contains the following columns:

- Specialty/Ancillary provider/provider group name
- IPA average current membership
- Number of claims received
- Average number of claims received in the quarter divided by Average current membership will give us the average number of claims received/adjudicated by capitated/employed Specialist and capitated Ancillary facility.

The Average number of claims adjudicated or allowed charges 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 subcapitated 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).

Revised 12/08

2009 Capitated Employed Encounter Data Report Example

HMOI/BA SPECIALIST and ANCILLARY PROVIDER REPORT

1ST QUARTER

<u>SPECIALTY</u>	<u>GRP NAME</u>	<u>AVG MBR</u>	<u>#CLM RCV</u>	<u>AVG # CLM ADJ</u>
RADIOLOGY	#####	127	67	0.53

1st QUARTER

<u>ANCILLARY</u>	<u>FACILITY</u>	<u>AVG MBR</u>	<u>#CLM RCV</u>	<u>AVG # CLM ADJ</u>
Radiology Facility	#####	123	76	0.62

2009 Sample Welcome Letter Format

IPA Name
Address
City State Zip
Phone Number

Dear Managed Care Member:

On behalf of the physicians and staff of _____, I would like to thank you for selecting us as your managed care provider. (Short description of IPA.)

As you may know, a major factor of your managed care plan is the active role of your Primary Care Physician (PCP). Your Primary Care Physician will be responsible for directing all of your health care needs. Be sure to contact your Primary Care Physician whenever you need to seek health care services. Services rendered outside of _____ may not be covered if prior authorization has not been obtained.

This plan provides for preventive services intended to help maintain your health and to promote early detection of disease. We strongly encourage you and the enrolled members of your family to work with your personal Primary Care Physicians to obtain general physicals.

Your IPA has the ability to provide case management services if your condition warrants. If you think you might be a candidate for these services, you or you PCP may contact us at _____

It is important that each member selects a Primary Care Physician and knows how to reach him or her. To further assist you in understanding your health care coverage, our staff has prepared the enclosed reference sheet. If you have any questions, please feel free to call us at _____. We look forward to a long and healthy relationship.

Sincerely,

**MAKE YOUR HMO WORK FOR YOU
FOLLOW THESE EASY STEPS:**

Choosing or changing your Primary Care Physician (PCP) from the enclosed list

- Please make sure the PCP you have selected is on the enclosed list.
- Select or change your PCP by contacting our office at _____.

Choosing or changing your Woman's Principal Health Care Provider (WPHCP)

- A Woman's Principal Health Care Provider (WPHCP) is an Obstetrician/Gynecologist (OB/GYNE) who has been selected to be directly accessible for treating and coordinating a female Member's health care needs. The WPHCP must have a referral arrangement with the female Member's PCP.
- Please make sure the WPHCP you have selected is on the enclosed list.
- Select or change your WPHCP by contacting our office at _____.

Call your Primary Care Physician and WPHCP for a get acquainted visit

- Have your HMO Identification Card with you.
- Please be aware that co-payment amounts vary by HMO plan and are payable at the time of the visit.

Behavioral Health Care Services

- If you are in need of Behavior Health Care services, you should _____. (outline how member should access care)

Chemical Dependency Services

- Benefits are available through the HMO Illinois Chemical Dependency Network for the treatment of Substance Abuse whether or not the Covered Services rendered have been ordered by your Primary Care Physician or Woman's Principal Health Care Provider. To obtain benefits for Substance Abuse Treatment, you must call the HMO Illinois Chemical Dependency Hotline at **1 (800) 346-3986**.

Medical Records and Patient Confidentiality

- If you have medical records that need to be transferred to this facility, please have those records transferred as soon as possible.
- If you need a copy of your medical record, you must _____.
- Medical Records are held in strict confidence.

Emergency Services

- Prior to seeking care in an emergency room, we recommend that you call your PCP for treatment advice.
- In situations where you feel you can't call your PCP, such as when you think you may be having a heart attack or a stroke, go directly to the nearest hospital emergency room. Notify your PCP as soon as possible of any treatment you receive.
- To contact your PCP call _____.

A referral for services not directly provided by your PCP may be required

- Your PCP will coordinate your overall health care and determine the need for specialty care referrals for medically necessary services.
- All referrals undergo a review process.
- If a referral is denied, the reason for the denial, the alternative treatment, a telephone number for questions, and the mechanism for appeal will be communicated to you in writing.
- Be sure to verify the date and type of referral you receive.

Utilization Management Process

- Pre-Admission Certification and Concurrent Review are two programs established to ensure that you receive the most appropriate and cost effective health care.
- Your PCP must obtain approval from your Participating IPA prior to inpatient hospital admission other than emergency situations.
- Your participating IPA may recommend other courses of treatment that could help you avoid an Inpatient stay.
- It is your responsibility to cooperate with the recommendations made by your PCP.
- Concurrent Review ensures that your length of stay is appropriate given your diagnosis and treatment.
- You may contact us to discuss the Utilization Management Process or any issues regarding it by calling our toll free phone number _____ or by calling _____ collect.

Appeal Process

- Communication with your physician is an important part of your health care. If you do not understand any course of your care, please discuss this with your PCP.
- You can also contact our Patient Advocate at _____. The role of the Patient Advocate is to help with Member issues or concerns that cannot be resolved through normal channels.
- As an HMO member, you have the right to appeal any payment or denial of covered services by contacting our HMO office at _____ or in writing at _____ or this can be initiated by contact the HMOs of Blue Cross Blue Shield of Illinois at (312) 653-6600 or in writing at:

HMO Appeal Committee
300 East Randolph
Chicago IL 60601

- Following an adverse determination for a clinical service, procedure or treatment that is not reviewed as medically necessary, any involved party may request an external independent review.

HMO/BA HMO Quarterly Income Statement and Balance Sheet Report Format

This report is only available electronically. Contact your Provider Network Consultant to obtain the report.

2009 Directions for Complex Case Management Log

The case management log does not need to be sent in quarterly. The log will be requested prior to the case management audit. The case management audit cases will be chosen at least two weeks prior to the audit. The HMO log is a sample log, but any IPA log must have all the elements that are requested.

1. Patient ID/ Name – can be any number that enables the IPA to find the patient. Name or initials should also be included.
2. Date Opened - the date the case was opened as a complex case managed case.
3. Identified by – how the case was identified as a complex case management case. Use the sources identified in the HMO UM Plan.
4. Diagnosis – this should be the diagnosis that is associated with the case managed case.
5. Guidelines used – this is not a Yes or No. This column should be completed with the name of the guideline the IPA has adopted.
6. Date closed - this column will remain blank until the patient is no longer being case managed.

Cases should be chosen from this log for audit (AT LEAST 1). Try to choose cases that encompass the different methods of case identification.

2009 Complex Case Management Case Log

SAMPLE LOG

IPA # and NAME: _____

Patient ID/ Name	Date Opened	Identified by (code 1)	Diagnosis	Guidelines used to manage case	Date Closed
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					

1. Identification codes:
- A. Claims data
 - B. Hospital discharge data
 - C. Pharmacy data
 - D. Data collected through UM process
 - E. D2 Hawkeye report

IPA Attestation

Hospital Affiliation(s): _____ site number(s): _____

IPA attests that it has written agreement with all IPA Physicians or other providers of professional or ancillary services (“Provider”) that render care to Blue Cross and Blue Shield of Illinois (“BCBSIL”) HMO Members. A list of Providers that the IPA has written agreements with is attached hereto as Exhibit A). This list includes but is not limited to: PCPs, specialists, facilities, ancillary providers, sub-specialists and hospital based physicians, and includes any and all agreements in place for the provision of care to BCBSIL HMO Members. IPA further attests that the IPA’s written agreements with each of its Providers contain, at a minimum, the following:

- a) Provider’s responsibilities;
- b) Provider’s compensation;
- c) Agreement to seek compensation not from HMO or Member but solely from the IPA for services provided to Members;
- d) 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;
- e) Professional liability insurance coverage – each Provider shall maintain a valid current policy (or policies) of insurance with a solvent insurer of national reputation covering professional liability of each Provider, his/her agents and employees, which is in an amount not less than \$1,000,000 per claim and \$3,000,000 annual aggregate coverage. Each Provider shall carry such other insurance as shall be necessary to insure each Provider, his/her agents and employees against any and all damages arising from each Provider’s various duties and obligations;
- f) Agreement to preserve patient confidentiality;
- g) Agreement not to charge any Provider that has a contractual or other affiliation with another Participating IPA more than the BlueCross BlueShield of Illinois PPO Schedule of Maximum Allowances for referred or Emergency services, provided to Members of such Participating IPA, if such bills are paid within 30 days of the Participating IPA’s receipt of such bills; and
- h) Agreement that IPA Physicians and/or IPA are solely responsible for the provision of all healthcare services to Members. All decisions regarding Member treatment and care are the sole responsibility of IPA Physicians and such decisions are neither directed nor controlled by HMO. And, except as to the amount and manner of payment, the Agreement shall in no way affect the usual physician/patient relationship. 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 of the IPA/IPA Physicians that are not HMO Members.

- 1) _____ IPA attests that the above listed terms and conditions are in the current written agreements between the IPA and IPA Physicians and Providers (provide copies of each written agreement)
- 2) _____ IPA attests that it has obtained a written Addendum from all contracting IPA Physicians and providers which includes the information set forth in (a) – (h) above (provide copies of each executed Addendum)
- 3) _____ IPA has communicated the above listed terms and conditions to IPA Physicians and Providers in some other manner as set forth in the attachment hereto , that is legally binding, acceptable to the HMO and ensures that IPA Physicians and Providers acknowledge and agree with the above listed terms and conditions. IPA agrees to hold harmless and indemnify HMO for the failure of any IPA Physician or Provider to adhere to the above listed terms and conditions set forth in (a) – (h) above.

"IPA" Authorized Signature

Title

Print name

Date

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:
 - An updated schedule of the physician on call, depending on the specific schedule of the IPA.
 - A complete list of Primary Care Physicians
 - Written procedures for handling emergency calls which include keeping a documented log with the following information:
 - Patient's name and age
 - Caller's name
 - Date of call
 - Patient's symptoms
 - Physician contacted and time of such contact
 - 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.