

<b>Medical Service Agreement (MSA) Highlights .....</b>	<b>2</b>
<b>Submission Grid .....</b>	<b>3</b>
<b>Sample Report Formats .....</b>	<b>4</b>
2008 Behavioral Health Referral Request Log.....	4
2008 Denial/Appeal Log.....	5
2008 Admission Log .....	6
2008 Out of Network Referral Request Log .....	7
2008 Inpatient Physician Advisor Referral Log .....	8
2008 Referral Request Log.....	9
2008 Referral Inquiry Log .....	10
2008 CMF Oversight Report .....	11
2008 Member Complaint Log Report.....	12
Member Complaint/Inquiry Categories.....	14
2008 Capitated Employed Encounter Date Report Overview .....	15
2008 Capitated Employed Encounter Date Report Example .....	16
2008 Sample Welcome Letter Format .....	17
HMOI/BA HMO Quarterly Income Statement and Balance Sheet Report Format .....	20
<b>IPA Standards for Emergency Services .....</b>	<b>20</b>

## 2008 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.

- The definition for “Out of Area” has been updated – services... more than 30 miles away from the IPA or IPA affiliated hospital in which the Member is enrolled (page 6). Language has also been updated on pages 39, 53 and 54 to remain consistent with this definition change.
- The HMO reserves the right to de-participate from the HMO any IPA provider who does not provide a written service agreement that contains the required elements (page 23).
- The IPA shall not contract or employ a Physician or other provider who: has been terminated by BCBS-IL for fraudulent billing practices (page 24).
- On page 25 – the MSA states the IPA shall send one (1) physician ... to a minimum of 66% of the BCBSIL Managed Roundtable Meetings. **An update to the MSA: BCBSIL will only be conducting two of the Meetings in 2008; therefore, the IPA shall send the physician to a minimum of 50% of the meetings.**
- Language has been added that the IPA shall ensure that ancillary and therapy service providers provide reasonable access for all members as cited in the MSA (page 27).
- On page 33 of the MSA, the maintenance and submission of the neonate log is described. This log has been removed from the HMOs of Illinois’ Utilization Management plan. **An update to the MSA: the maintenance and submission of this log will not be required in 2008.**
- Language has been added to clarify that the quarterly financial report that is required is an income and expense report; a balance sheet is not required. However, the annual financial report must still include a balance sheet. (page 36).
- Language has been deleted from the MSA requiring the submission of a semi-annual top ten (10) ambulatory diagnosis and the top five (5) high volume specialties (page 36).
- Language revision that the IPA shall not re-insure any of the first \$12,000 of costs (Page 37). Other re-insurance thresholds have been adjusted on page 53.
- The factors for the calculation of the UM fund have been adjusted (page 55).
- Effective 1/1/2008, the IPA has financial responsibility for Group Approved Outpatient Hospital Based Day Rehabilitation services (MSA cover letter). The UM fund unit charge for these services has been removed (page 56).
- The UM fund unit charge for all group approved hospitalizations for a newborn dependent has been changed to no units being charged for the first year of life (page 56).
- Refer directly to the MSA (pages 58-66) for the details of the Quality Improvement Fund revisions. Note that the separate payment for having the hospital based providers on the roster, and the submission of those service agreements has been removed.
- The Prescription Drug Management Fund thresholds have been revised. Refer directly to pages 66-67 for the details.

## Submission Grid

### HMOs\* of Blue Cross Blue Shield of Illinois 2008 Submission Grid

Due Date:	10th of each Month	2/15/2008	1st qtr 05/01/2008	1st qtr 05/31/2008	2nd qtr 07/31/2008	2nd qtr 08/31/2008	3rd qtr 10/31/2008	3rd qtr 11/30/2008	4th qtr 01/31/2009	4th qtr 02/28/2009	Annual - 150 days after the end of the IPA's fiscal year	Upon Request by HMO
	Denial & Appeal Log	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 (including balance sheet) (audited or independently prepared)	Behavioral Health Referral Request Log
			IPA attestation	Income and Expense Report, electronically submitted, YTD, cash basis, contract specific		Income and Expense Report, electronically submitted, YTD, cash basis, contract specific		Income and Expense Report, electronically submitted, YTD, cash basis, contract specific		Income and Expense Report, electronically submitted, YTD, cash basis, contract specific		Complaint Report
			IPA Provider Roster Spreadsheet electronically submitted									Out of Network Referral Log/ Inpt. Phys Advisor Referral Log/Admission log
			Welcome letter									
			CMF Service Agreement + Oversight Plan, incl. Beh. Health Care CMFs, if appl. Must include a copy of the approval letter for the URO designation from the Dept. of Insurance, State of IL (if not submitted with UM plan).									

Revised 12/07 \* HMO Illinois and Blue Advantage HMO

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



## Sample Report Formats (cont.)

### 2008 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-07

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

## Sample Report Formats (cont.)

### *2008 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  
11/07









## Sample Report Formats (cont.)

### 2008 CMF Oversight Report

#### HMOs\* of Blue Cross Blue Shield of Illinois 2008 CMF Oversight Report

##### Quarterly Submission Schedule

Due at HMO on	1 <sup>st</sup> Quarter May 1	2 <sup>nd</sup> Quarter July 31	3 <sup>rd</sup> Quarter October 31	4 <sup>th</sup> Quarter January 31
---------------	----------------------------------	------------------------------------	---------------------------------------	---------------------------------------

IPA #: _____	Quarter : 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> <input type="checkbox"/> 3 <sup>rd</sup> <input type="checkbox"/> 4 <sup>th</sup> <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 12/07 \*HMO Illinois and Blue Advantage HMO

## Sample Report Formats (cont.)

## 2008 Member Complaint Log Report

### HMOs\* of Blue Cross Blue Shield of Illinois 2008 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

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

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

11/07

## Sample Report Formats (cont.)

### 2008 Member Complaint Log Report (cont.)

#### HMOs\* of Blue Cross Blue Shield of Illinois 2008 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 <sup>st</sup> Quarter April 30	2 <sup>nd</sup> Quarter July 31	3 <sup>rd</sup> Quarter October 31	4 <sup>th</sup> Quarter January 31
-------------------------------	-------------------------------------	------------------------------------	---------------------------------------	---------------------------------------

IPA #: _____	Quarter : 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> <input type="checkbox"/> 3 <sup>rd</sup> <input type="checkbox"/> 4 <sup>th</sup> <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:

Legend: ADM - Administrative    R - Referrals    B - Benefits    ACC - Access  
C - Claims    QOC - Quality of Care    OTH - Other

\* HMO Illinois and Blue Advantage HMO

Revised 11/07

## Sample Report Formats (cont.)

### ***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.

## Sample Report Formats (cont.)

### *2008 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).

## Sample Report Formats (cont.)

### *2008 Capitated Employed Encounter Date Report Example*

## HMOI/BA 1ST QTR PCP REPORT

<u>PCP</u>	<u>SPEC</u>	<u>AVG MBR</u>	<u>#CLM RCV</u>	<u>AVG # CLM</u> <u>ADJ</u>
##### 1	PEDIATRIC	82	24	0.29
##### 2	FAMILY PRAC	297	233	0.78
##### 3	FAMILY PRAC	104	60	0.58
##### 4	FAMILY PRAC	156	56	0.36
##### 5	PEDIATRIC	48	25	0.52
##### 6	INTERNAL MED	18	7	0.39
##### 7	INTERNAL MED	224	131	0.58
##### 8	PEDIATRIC	55	43	0.78
##### 9	PEDIATRIC	0	0	0.00
##### 10	INTERNAL MED	70	81	1.16
##### 11	INTERNAL MED	35	0	0.00

## Sample Report Formats (cont.)

### *2008 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.

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,

## Sample Report Formats (cont.)

### 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.

## Sample Report Formats (cont.)

### *Make Your HMO Work For You (cont.)*

#### **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.

## Sample Report Formats (cont.)

### *HMOI/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.

## 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.