BLUE CROSS AND BLUE SHIELD OF ILLINOIS
MEDICARE ADVANTAGE HMO POLICY

DEPARTMENT: IL Provider Performance Management	**PROCEDURE NUMBER:** GCS-IL-MA-13B	**ORIGINAL EFFECTIVE DATE (IF KNOWN):** 01/01/2013
POLICY TITLE: IPA Request for Member Transfer Procedure		**EFFECTIVE DATE:** 08/09/2022
		LAST REVISION DATE: 08/09/2022
EXECUTIVE OWNER: Executive Director, Provider Performance	**BUSINESS OWNER:** Manager, Provider Performance	**LAST REVIEW DATE:** 08/09/2022

I. SCOPE

This Procedure applies to Provider Performance Management government product Medicare Advantage HMO.

This Procedure applies to the following lines of business and products:

Line of Business / Product Scope / Plan Scope/Contract Number (if applicable)	In Scope [x]
Medicare MAPD/ H3822/H8547	X
NOTE: Future fully executed contracts will fall under this procedure.	

II. POLICIES IMPLEMENTED BY PROCEDURE

This Procedure implements the following Policies:

IPA or any contracted provider Request for Member Transfer Policy, GCS-IL-MA-13A. This procedures document ensures there is a documented process for IPA or any contracted provider Request for Member Transfer.

III. PROCEDURE

1. The IPA or contracting provider has the right to initiate the process of requesting a member transfer. Prior to an IPA's or contracting provider's request to transfer a member out of the IPA or contracting provider practice, a minimum of one (1) warning letter must be sent by certified mail to the member when one of the following situations applies:

a. Living outside of the MA HMO Service Area.

i. A member resides at such a distance from the Primary Care Physician (PCP) that it does not allow the Physician to coordinate care appropriately; or

ii. A member resides at such a distance from the PCP that the member persistently demonstrates noncompliance.

b. Persistent noncompliance of prescribed medical regimens.

i. A member has demonstrated clear noncompliance with a prescribed medical regimen that has or is likely to result in substantive adverse outcomes for the member. It is presumed that, in lieu of the disputed medical care, there are no other appropriate medical treatments that are acceptable to the member. The member must have received written communication describing the need for the treatment, the medical consequences that have or are likely to result from not following the treatment, and the potential consequences of being transferred out of the IPA if the regimen is not followed.

Concurrence by the IPA's Quality Review Committee about the need for the care and the relationship between noncompliance and the adverse outcomes that have occurred or are likely to occur is a necessary component of documentation for the IPA to provide to BCBSIL with the request. This requirement is not applicable to non-delegated contracted providers.

ii. Instances of refusal to make certain prescribed lifestyle changes, such as stop smoking, or loss of weight, generally will not be considered a refusal of a prescribed medical regimen.

iii. A request for a member's transfer may not be based on the type, amount, or cost of service that a member legitimately requires. The MA HMO will not approve IPA or contracted provider requests for members to be transferred out of the IPA or contracted provider practice for the following reasons:

- Members who have not received recommended preventive care services
- Members who have not seen an IPA or contracted physician

- Members who have not obtained recommended routine condition-specific care

c. Missing scheduled appointments.

i. A member misses appointment such that the lack of medical care becomes a serious health issue; or

ii. Member misses three (3) appointments without calling at least twenty-four (24) hours prior to the appointment, in a period not greater than eighteen (18) months. It is expected that the member be warned in writing of the IPA's policy and the consequences of continued missed appointments.

Also, the letter to the member should include instructions how the member can contact the IPA administration or MA HMO for assistance in resolving the issue.

d. Behavior that is significantly disruptive to the delivery system or which causes an irreparable breach in the member/physician relationship.

i. A member acts in a way that causes significant disruption to the delivery system operation.

ii. It is expected that an administrative staff member speaks with the member so that a complete understanding of the incident can be achieved.

iii. If after this conversation the IPA or contracted provider believes the member acted unreasonably and inappropriately, a letter should be sent to the member reviewing the incident and issuing a warning that repeated occurrence could result in being asked to leave the IPA or contracted provider practice .

e. Verbal or written threat of legal action against the IPA or contracted provider.

i. If a member threatens legal action against the IPA Physician or contracted provider, it is expected that the IPA Administration or contracted provider contact the member to investigate the member's complaint. Because a threat of legal action is a clear indication by a member of a complaint against the group, the complaint and results of the investigation must be documented in the IPA Complaint Log, if applicable. The findings of the complaint could initiate a warning letter to the member.

f. Non-payment of required co-payments.

A member refuses to pay the required co-payments for services or any previously unpaid bills after being warned in writing that the consequences of refusal would be removal from the IPA or contracted provider practice. The warning letter must direct the member to contact the IPA or contracted provider by a specific date to

make payment arrangements. If non-compliance continues, the IPA or contracted provider will initiate the member transfer request process.

2. The warning letter must include the following information:

    a. The nature of the infraction.
    b. The required member action with related time frames. Examples of member actions include contacting the IPA or contracted provider to make an appointment by a certain date, submit payment of outstanding charges by a certain date etc.
    c. Instructions on how the member can contact the IPA administration or contracted provider for assistance in resolving the issue.
    d. Must include all consequences, including the potential that the IPA or contracted provider may request that BCBSIL transfer the Member to another IPA or contracted provider.
    e. Must be sent Certified or Registered mail with return receipt requested.

    The warning letter for this incident will be valid for a 12-month period. If this incident occurs again, outside of the 12-month period, a new warning letter will be required.

3. After the warning letter, requirements have been met and the IPA or contracted provider requests to transfer the member out of the IPA or contracted provider practice , the request must be sent in writing via Email or fax to the MA HMO Government Provider Network Consultant (PNC).

    The letter must include all relevant documentation sent to or received from the member including:

    a. Written documentation of the events that led up to the request by the IPA or contracted provider.
    b. Evidence of the IPA's or contracted provider's good faith attempt to resolve the problem.
    c. Evidence that the IPA or contracted provider followed their own internal due process for the member complaint resolution.
    d. A copy of the warning letter with a signed delivery receipt.

4. The PNC will review the IPA or contracted provider's request for member transfer letter and approve the request if policy protocol has been met.

5. MA HMO sends a member transfer request letter via certified mail to the member explaining that a problem has occurred between the IPA or contracted provider and the member. The member is given a period of 30 to 45 calendar days from the date of receipt of the member transfer request letter to select a new IPA or contracted provider. The current IPA or contracted provider is responsible for providing or coordinating emergency and urgent care up to the effective date with the new IPA or contracted provider.

Note: The only situation that does not require the 30 to 45-day grace period to place a member in a new IPA or contracted provider is when a member has been previously removed from the

IPA or contracted provider. After the request for removal has been communicated by the IPA or contracted provider to MA HMO, the member will be reassigned to a new IPA or contracted provider.

IV. CONTROLS/MONITORING

Control Document or Control Description	Control Owner
Annual review of the Medicare Advantage Provider Manual to ensure the documented processes to review, modify and amend this policy meets contractual requirements. The Provider Network Consultant reviews the IPA member documentation including the certified mailing receipt and warning letter(s) to ensure the requirements of the IPA are being met. Review is conducted on an ad-hoc basis.	Manager, Illinois Provider Performance Management

V. AUTHORITY AND RESPONSIBILITY

- Lupita Monroy (Manager, Illinois Provider Performance Management)

VI. SOURCES/REFERENCES

Federal/State	Regulatory Requirements & References
Federal 2021 Illinois MMAI Demonstration Contract	42 C.F.R. § 422.74 Disenrollment by the MA organization

	2.5.4 Transition of Care 2.5.4.1 Transition of Care Process. The Contractor will manage transition of care and continuity of care for new Enrollees, Enrollees moving from hospital back to Enrollee's home or NF. The Contractor's process for facilitating continuity of care will include: 2.5.4.1.1 Identification of Enrollees needing transition of care. 2.5.4.1.2 Communication with entities involves in Enrollees' transition 2.5.4.1.3 Making accommodations so that all community supports, including housing, are in pace prior to the Enrollee's move and that Providers are fully knowledgeable and prepared to support the Enrollee, including interface and coordination with and among social supports, clinical services and LTSS 2.5.4.1.4 Environmental adaptions and equipment and technology the Enrollee needs for a successful care setting transition 2.5.4.1.5 Stabilization and provision of uninterrupted access to covered services for the Enrollee 2.5.4.1.6 Assessment of Enrollees' ongoing care needs. 2.5.4.1.7 Monitoring of continuity and quality of care, and services provided 2.5.4.1.8 Medication reconciliation 2.5.4.2 Transition of Care Plan. 2.5.4.3 Transition of Care Team. 2.5.4.4 Transition of Enrollees 2.5.4.4.1 2.5.4.4.2 2.5.4.4.3 2.5.4.4.5 2.5.4.4.6 2.5.4.5 2.5.4.5 2.5.4.7

VII. PROCEDURE REVIEWERS

Person Responsible for Review	Title	Date of Review
Lupita Monroy	Manager, Illinois Provider Performance Management	06/07/2022
Sandra Hopson	Provider Affairs Project Consultant, Illinois Provider Performance Management	06/05/2022

VIII. PROCEDURE REVISION HISTORY

Description of Changes	Revision Date
Annual Review	07/12/2022
New Template	06/16/2021

IX. PROCEDURE APPROVALS

Company, Division, Department and/or Committee	By: Name	Title	Approval date
Medicare P&P Comm.			08/09/2022
IL Provider Performance Management	Joanne Obrien	Executive Director, Provider Performance	06/10/2022
IL Provider Performance Management	Joanne Obrien	Executive Director, Provider Performance	06/18/2021