Blue Cross and Blue Shield of Illinois Provider Manual

HMO Payment/Compensation to the IPA Section

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Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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Capitation Payment

As outlined in the Medical Service Agreement (MSA), the IPA will receive a monthly base capitation payment for every member that selects their IPA. The HMO also provides a semi-annual risk-based capitation payment as outlined in the MSA.

Risk-based Capitation Payment

BCBSIL developed an in-house risk adjustment model to replace the Cotiviti vendor model currently utilized for risk-based capitation. For the 2025 performance year, BCBSIL is taking an on-ramp approach for IPAs to become more familiar with the new BCBSIL model. As such, there will be no financial penalty to groups if their risk scores drop in the new model. Medical groups will receive risk-adjusted capitation based on the greater of comparison of the Risk Adjustment Factor associated with the IPA's Cotiviti Average Risk Score (ARS) or the IPA's BCBSIL Average Risk Score (ARS). Starting in 2026, BCBSIL will move away from the Cotiviti model altogether.

Member Risk Report

This report is located on the BCBSIL IPA Access Portal at https://ipa.bcbsilezaccess.com/SitePages/Home.aspx. If you do not have access to the website, complete and submit the form located here: https://www.bcbsil.com/pdf/standards/hmo/hmo_user_access_request_form.pdf.

This report contains member level BCBSIL risk scores.

Calculation of Base Capitation Payment

The Base Capitation Payment is made to the IPA by the 10th of each month. The payment is calculated based upon the Member's age, gender and benefit plan. The Benefit Plan Matrix (Appendix G of the MSA) indicates the capitation schedule for each benefit plan. The Capitation Fee Schedule (Appendix C of the MSA) lists the payment for each capitation schedule based upon age and gender. Both reports are located on the BCBSIL IPA Access Portal at www.https://bcbsilezaccess.com/ipa_portal/default.aspx. If you do not have access to the portal, complete and submit the form located here:
https://www.bcbsil.com/pdf/standards/hmo/hmo_user_access_request_form.pdf.

Dependents beyond the age of 26 may remain on the policy. These dependents can be identified on the Capitation Reconciliation Report (information regarding this report can be found in the HMO Membership section of this manual). The capitation for an overaged dependent is based upon the age, gender and benefit plan of the member.

A change to the member's eligibility or demographic status can alter the capitation payment. The change can affect the current month of payment, or it may affect a period prior to the current month (a retroactive change). These changes will be reflected in on the Capitation Reconciliation Report in the "change reason" column. The following is a key to this column and the rules that apply to retroactive changes:

MA	Member Add:	Limited to 24 member months
MC	Member Cancel:	Limited to 3 member months
TI	Transfer In:	Limited to 24 member months
TO	Transfer Out:	Limited to 24 member months
RI	Reinstate:	Limited to 24 member months
NC	Name Change:	Limited to 24 member months
BC	Date of Birth Change:	Limited to 24 member months
CC	Cancel Date Change:	Limited to 24 member months
EC	Effective Date Change:	Limited to 24 member months
GC	Gender Change:	Limited to 24 member months
MM	Medicare Maintenance:	Limited to 24 member months
HC	History Change:	Limited to 24 member months
RA	Rate Adjustment:	Limited to 24 member months

Capitation Summary Report
This report is located on the BCBSIL IPA Access Portal at https://ipa.bcbsilezaccess.com/SitePages/Home.aspx.

The report includes the following:

- Current capitation payment – payment for each member for the current month
- Retroactive capitation payment – adjustments for member additions/deletions for periods prior to the current month
- Additional adjustments/payments – on a summary and member detail basis (as needed)

Use the key below to understand the Sample Capitation Summary Report on the following page.

a) Month: Month for which capitation is being paid.
b) IPA Number and IPA NPI Number: Identification number and the National Provider Identifier of the IPA to whom capitation is being paid.
c) Current and Retroactive Capitation: Dollar amount of current and retroactive calculated capitation.
d) Additional Adjustments/Payments: Dollar amount (positive or negative) of manual adjustments to the month's capitation.
e) Description: A brief description of the Additional Adjustment/Payment

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Sample HMO Capitation Payment Summary

BlueCross BlueShield of Illinois

300 East Randolph
Chicago, Illinois 60601-5099

PAGE: 2

CAPITATION SUMMARY

a FOR THE MONTH OF DECEMBER, 2009

b SUMMARY FOR PAYEE ID 123 NPI# 1234567890

H M O I

c CURRENT AND RETROACTIVE CAPITATION :	$	9,409.45
d ADDITIONAL ADJUSTMENTS/PAYMENTS :	$	.00
TOTAL AMOUNT FOR CAPITATION PERIOD :	$	9,409.45

ADDITIONAL ADJUSTMENTS/PAYMENTS

DESCRIPTION	ADJUSTMENT AMOUNT
e NO EXTRA PAYMENTS OR ADJUSTMENTS FOR CAP PERIOD	$ .00

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Request for Manual Capitation

If there is a question regarding the capitation payment for a specific member; use the form on the following page. This page is also available on the BCBSIL IPA Access Portal at https://ipa.bcbsilezaccess.com/SitePages/Home.aspx. If you do not have access to the website, complete and submit the form located here: https://www.bcbsil.com/pdf/standards/hmo/hmo_user_access_request_form.pdf.

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REQUEST FOR MANUAL CAPITATION ADJUSTMENT

Note: *ALL FIELDS with an asterisk (*) ARE MANDATORY AND MUST BE COMPLETED IN ORDER FOR YOUR FORM TO BE PROCESSED. If any of the fields are left blank, your form will not be processed and will be returned.*

***Date:** ____________________

***MG Name:** ____________________

***MG Site Number:** ____________________

***Contact Name:** ____________________

***Contact Phone Number:** ____________________

***Contact Fax Number:** ____________________

***Contact Email Address:** ____________________

***Subcriber Name** ____________________

***Member(s) Name:** ____________________

***Member(s) DOB** ____________________

***Member Group #** ____________________

***Member ID #:** ____________________

***Eligibility Period(s) in Question (for example, 7/1-8/1/2003):** ____________________

***Type of Issue: (Please attach the pertinent eligibility list pages)**

☐ **PCP Issue**

☐ **WPHCP Issue**

☐ **Newborn Capitation** – Services rendered in birth month, cap not paid
What months should you have received capitation? ____________________
Amount of Cap due: $ ____________________

☐ **Retroactive Capitation** -
What months did you receive cap? ____________________
What months should you have received cap? ____________________
Amount of Cap due: $ ____________________

☐ **Current Capitation** -
What months did you receive cap? ____________________
What months should you have received cap? ____________________
Amount of Cap due: $ ____________________

☐ **Other** (please include what month member appeared on eligibility list, if you received cap and if cap is due): ________
____
____
____
____
____

***Amount of Cap due: $** ____________________

****Email this form to: MANUALCAP@BCBSIL.COM or Fax to: 312-819-1650****
(Note: Emailing the form will expedite processing)

Do not write below this line - For office Use only

Response:

☐ Capitation adjustment of $ __________ will be made on the ____________________Capitation Payment Summary Report. This is __________ months @ $__________ for a total of $__________.

☐ Eligibility system has been updated. The change will be reflected on the ____________________Eligibility List.

☐ No capitation is due - Capitation was already paid on ____________________. (copy of page attached)

☐ Other: ____________________
____
____

Preparer: ____________________ Response Date: ____________________

Page 1 of 1

Utilization Management Fund

The Utilization Management (UM) Fund is a shared savings opportunity to the IPA for its medically appropriate use of Hospital and other facility services, in accordance with generally accepted standards of quality and necessity of medical care for its enrolled members.

The UM fund is calculated on a Calendar Year and is based on the difference between the number of units charged to the IPA and the target number of units established for the IPA, as described in the MSA. The MSA includes a Table of Units and Unit Values for each type of medical service that will be charged to the IPA's UM Fund. The UM Fund is paid semi-annually; divided into an Interim and a Final payment.

Summary of UM Fund Calculation and Payment

This is a summary of the calculation and payment process. The following pages contain a detailed example. It is for illustrative purposes only and does not reflect the current MSA. Refer directly to the current MSA for current information.

1. Membership is calculated for UM fund period.
2. The number of target units is calculated. The number of units will be risk adjusted by using the IPA's BCBSIL Average Risk Score (ARS), normalized to the HMO network average. The risk adjustment will be calculated and applied to the Final UM Fund payment.
3. The number of actual units charged is calculated.
4. The actual units are subtracted from the target units.
5. Appendix B units and UM Fund exceptions are applied, if applicable.
6. The difference between the actual and target units, if positive, is multiplied by the amount cited in the MSA for each assumed but unutilized unit. This is the earned amount.
7. If the Interim UM fund is being calculated, the earned amount is divided in half.
8. Monthly advances and any other payments are deducted, if applicable.
9. The UM Fund for each product (Blue Precision HMO℠, HMO Illinois® and Blue Advantage HMO℠) is calculated independently and separately from all other HMO products.
10. The UM fund payment will be included in the Additional Payment/Adjustment section on the monthly Capitation Summary Report.

UM Fund Calculation and Payment Reports

UM fund reports are posted electronically on the BCBSIL IPA Access Portal at https://ipa.bcbsilezaccess.com/SitePages/Home.aspx. If you do not have access to the website, complete and submit the form located here: https://www.bcbsil.com/pdf/standards/hmo/hmo_user_access_request_form.pdf.

Estimated UM Fund reports are posted monthly. The Interim UM fund report is calculated for the period of January through June. The Final UM fund report is for the period of January to December. The following is a list of the claim service type abbreviations and descriptions used in these reports.

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Claim Service Type Abbreviations used in the detail UM Fund report

Claim Service Type Description	Claim Service Type
Catastrophic Care	CATASTR
Inpatient Baby	IPBABY
Inpatient Chemical Dependency	IPCD
Inpatient Exception Payments	IPEXCPTN
Inpatient Hospice	IPHOSPIC
Inpatient Infertility	IPINFER
Inpatient Maternity	IPMATERN
Inpatient Medical w/ER	IPMEDER
Inpatient Medical w/o ER	IPMEDNER
Inpatient Mental Health	IPMH
Residential Chemical Dependency	IPRESCD
Residential Mental Health	IPRESMH
Inpatient Surgery w/ER	IPSER
Inpatient Surgery w/o ER	IPSNER
Inpatient Transplant	IPTRANS
Inpatient Transition of Care	IPTRNSCR
Outpatient Chemical Dependency	OPCD
Outpatient Dialysis	OPDIALY
Outpatient Durable Medical Equipment	OPDME
Outpatient ECF/SNF	OPECF
Outpatient ER	OPER
Outpatient Exception Payments	OPEXCPTN
Outpatient Home Health	OPHHLTH
Outpatient Hospice	OPHOSPIC
Outpatient Infertility	OPINFER
Outpatient 23 Hour Observation ER Admit	OPOBSER
Outpatient 23 Hour Observation not ER Admit	OPOBSNER
Outpatient Other	OPOTHER
Outpatient ER PCED	OPPCEDER
Outpatient Day/Night Psych	OPPSYCH
Outpatient Surgery - Arthroscopy subset done at Hospital	OPSARTH
Outpatient Surgery - Arthroscopy subset done at Surgi-Center	OPSARTSC
Outpatient Surgery - Cardiac Care	OPSCARD
Outpatient Surgery - Gastroenterology	OPSGAS
Outpatient Surgery - Gastroenterology subset done at Hospital	OPSGASH
Outpatient Surgery - Gastroenterology subset done at Surgi Center	OPSGASSC
Outpatient Surgery - Lithotripsy	OPSLITHO
Outpatient Surgery - Other	OPSOTHER
Outpatient Transplant	OPTRANS
Outpatient Transition of Care	OPTRNSCR
Pre Admission Testing	PAT

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Example Calculation of the Interim and Final UM Fund

1. Calculate enrollment for six-month period by category of member. (The Final UM Fund would use a twelve-month period).

	Adult Male	Adult Female	Child Male	Child Female
June	124	119	56	62
July	133	120	58	65
August	140	138	58	66
September	150	148	59	67
October	155	127	60	70
November	122	134	60	75
Total Member Months	824	786	351	405
Total Member Years (Member Months ÷ 12)	68.67	65.5	29.25	33.75

2. Calculate target units per category using factors* stated in the MSA.

	Adult Male	Adult Female	Child Male	Child Female
Total Member Years	68.67	65.5	29.25	33.75
multiplied by HMO factors	0.4517	0.5882	0.3081	0.2806
Total Target Units	31.02	38.53	9.01	9.47

To determine the number of Total Target Units for the IPA's population, add the Total Target Units per Category. [31.02 + 38.53 + 9.01 + 9.47 = 88.03]

***Check the MSA for the current factors.**
Additional information regarding calculation of target factors is on the following pages.

3. From claim records determine incurred units during six-month period. (The Final UM Fund would use a twelve-month period).

	Actual Days	Unit Value	Charged Units
Hospital days(Class I, Contracting Facility)	25	1.0	25
Extended Care Facility days (Contracting)	12	0.50	6
Home Health Care Visits (Contracting Facility)	10	0.33	3.30
Hospital Based Ambulatory Surgery Cases(Class I Contracting Facility)	5	1.00	5
Free Standing Ambulatory Surgery Cases	1	1.00	1
Total			40.30

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4. To determine the number of units assumed but unutilized, subtract the results from step 3 (total charged units) above from step 2 (total target units) above.

Target Units	88.03
Units Charged	40.30
Total Units saved	47.73

Additional information regarding calculation of actual units used is on the following pages.

5. Multiply results of step 4 above by the amount cited in the MSA for each assumed but unutilized unit**

a. Interim Calculation of UM Fund:

Total number of units assumed but not utilized	47.73
Multiplied by amount for each unit (as cited in MSA)	$760.00
Total Utilization Management Fund earned	$36,274.80
Interim Amount (Earned amount ÷ 2)	$18,137.40
less advance or other payments, (if applicable)	$6,403.29
Interim Utilization Management Fund earned and paid to the IPA	$11,734.11

This amount, if positive, as in this example, will be paid to the IPA. If the interim amount is negative, no payment will be made for the Interim Calculation.

b. Final Calculation of UM Fund:

Total number of units assumed but not utilized	71.00
Multiplied by amount for each unit (as cited in MSA)	$760.00
Total Utilization Management Fund earned	$53,960.00
less Interim Amount paid	$11,734.11
less advance or other payments, (if applicable)	$582.12
Final Utilization Management Fund earned and paid to the IPA	$41,643.77

** Check the MSA for the current amount.

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Calculation of Target Units

1. The target number of units for each IPA is calculated based on enrollment figures. The IPA's target units for each type of member can be found in the MSA. The enrollment figures for the first 6 months of the Calendar Year are used for the Interim Payment. The enrollment figures for all 12 months of the Calendar Year are used for the Final Payment.

2. The number of members in each category is totaled for the month. A six- or twelve-month figure is then calculated, depending on whether the Interim or Final UM Fund Calculation is being done. These totals are also known as "member months."

3. The six- or twelve-month total is then divided by 12 to arrive at an annualized member count. This figure is also known as "member years."

4. The annualized member count in each category is then multiplied by the target factor stated in the MSA. All categories are added together to arrive at the total number of target units for the IPA.

Calculation of the Actual Units Charged

The Unit charged for a service is based upon factors including, but not limited to:
- Type of Service utilized.
- Classification and contracting status of the facility
- If the service is in area or out of area
- Exceptions to the UM Fund
- Appendix B Units
- Appendix F Units

A full table of Units and Unit Values can be found in the MSA.

Exceptions to the UM Fund

All contracted providers are listed on Appendix D of the MSA. This list is located on the BCBSIL IPA Access Portal at. https://ipa.bcbsilezaccess.com/SitePages/Home.aspx. If you do not have access to the website, complete and submit the form located here: https://www.bcbsil.com/pdf/standards/hmo/hmo_user_access_request_form.pdf. An exception to the UM Fund unit charge can be prospectively requested if an IPA needs to utilize a non-contracted facility based on medical necessity. Contact your Provider Network Consultant to request the exception.

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Appendix B Units – Procedures performed in Physician's Office – Description and Exception Requests

Certain medical procedures performed in an outpatient or free-standing facility, which could have been performed in a physician's office, will incur an additional charge to the Utilization Management (UM) Fund. Appendix B (of the Medical Service Agreement) contains a list of CPT codes for procedures which would be expected to be performed in the provider office setting.

The HMO will review the IPA's Encounter Data submissions. When a claim contains surgical codes which are all from this list, and the procedure(s) were performed in an outpatient surgical center, hospital outpatient department or GI lab rather than a provider office, an additional unit charge will apply to the UM Fund in the annual UM Fund reconciliation (This is in addition to the units normally charged for any surgical procedure in an outpatient facility).Refer to the current MSA for the specific unit charge.

An Exception Request process is available to waive the Appendix B penalty for a specific claim, when mitigating clinical circumstances exist. The process is outlined below.

<u>Automatic Exceptions (no form needed)</u>

The HMO will review claim data and make certain automatic exceptions. The following exceptions are automatic, and do not require a written exception request from the IPA:

- Inpatient services
- Emergency room services
- 23-hour observation services
- Service in question is performed in conjunction with a non-office surgical procedure (not on Appendix B), on the same claim

All Other Exceptions – faxed form required – (Note*:* form is located at end of this section)

- <u>This exception request is a retrospective process</u>.
- All requests must be submitted by March 31 of the following year. For example, all 2020 dates of service must be submitted by March 31, 2021. No exceptions will be approved after this deadline.
- If the only surgical CPT codes on the claim are on the Appendix B list and none of the above circumstances apply, the IPA must fax a completed Exception Request Form to request an exception. The IPA must attach a copy of the physician's claim and any supporting information. A copy of the facility claim, if available, should be included.

- Complete the form as indicated with the following guidelines:
  Several types of situations (children under age 14, use of laser for skin lesions, fluoroscopy used) do not require a narrative explanation. In the case of one of these, check the appropriate box, sign the form and fax as directed.

  All other situations will need a written explanation of the reason the service could not be performed in an office setting, including the type of anesthesia that was used.

  Please be aware of the following examples of explanations which will not generally be accepted:
  - "The surgeon felt it was necessary." *[For what reason?]*
  - "The office is not equipped to perform the procedure." *[The Appendix B list of CPT codes was based on the fact that the majority of surgeons perform them in the office setting.]*
  - "A procedure in this location is at high risk for bleeding or infection." *[If there is something unique about the location (i.e., a deep lesion in the axilla), please specify*.*]*

    Once a decision has been made, the HMO will fax a copy of the completed form back to the IPA at the number specified on the form.

- Once the UM fund is calculated, the IPA may not challenge the unit charge if there is no approved UM Fund Exception on file.

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Office-Based Surgery (Appendix B) - Exception Request to the Utilization Management Fund Form

A written request from IPA to waive a Utilization Management Fund assessment for a particular surgical procedure on the Appendix B list. This is a retrospective process to address UM fund charges – Do not delay care. Please fax completed form to **312-228-9060**. **Attach physician claim form and any supporting information.**

IPA Name: ________________________ IPA # ________________

IPA Contact Name: ________________________ Fax: ________________

Email ________________________ Phone ________________

Subscriber Group & ID: ________________________

Subscriber's Name: ________________________

Patient's Name: ________________________ Date of birth ________________

Date(s) of Service: ________________________

Place of Service: ☐ Outpatient Surgical Center ☐ Other
☐ Hospital Outpatient Department

CPT Code(s): ________________________

Exception Requests that do not require written explanation or claim form. (Check any that apply and sign below):

- ☐ Child under age 14
- ☐ Laser destruction of skin lesion
- ☐ Fluoroscopy used in procedure

All other Exception Requests DO need a written explanation. (Please explain in the space below and/or on attachment.):

Specify anesthesia: ☐ Local ☐ Regional ☐ Other ________________
☐ General ☐ Conscious sedation

Please explain why this procedure had to be performed in a non-office setting.
Also, if anesthesia other than local was needed, please explain why this was the case.

Signature of Requestor: ________________________ Date of Request ________________

For BCBSIL use only:

BCBSIL decision: ________________________ Reason: ________________

BCBSIL signature ________________________ Date ________________

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Payment of UM Fund

- Monthly Advance
  A Monthly Advance payment of three percent of the IPA's previous year's UM Fund can be requested, in writing to the HMO. Contact your Provider Network Consultant for further information.

- Interim Payment
  The interim payment is due to the IPA on or about 8 months following the end of the sixth month of the Calendar Year. This will be one-half of the Utilization Management Fund amounts earned in that period, minus any advance payments paid to the IPA.

- Final Payment
  The final payment will be paid to the IPA on or about 8 months following the end of the calendar year. If the amount due is positive, the HMO will pay the IPA the earned amount minus any interim payment and advance payments. If the amount due is negative, any unearned and previously paid interim or advance payments must be paid to the HMO by the IPA within 30 days of the HMO informing the IPA of the amount due.

- Upon Termination
  In cases where the Medical Service Agreement is terminated, one-half of the UM Fund will be paid 175 days following the date of termination. This is called the Preliminary Final UM Fund Calculation. A second calculation (called the Final Final) will be made 365 days after the date of termination. The reason for the second calculation is to include any units which were not processed and paid during the initial calculation. Any amount owed to the IPA will be paid 30 days following this Final Calculation. If an overpayment has been made to the IPA, the IPA will pay the HMO within 30 days of notification of the amount overpaid.

IPA Challenges to the UM Fund Report

If an IPA finds a discrepancy in the Final Calculation of the UM Report, a challenge can be submitted to the HMO. Refer to the HMO Policy and Procedure section on the BCBSIL website prior to submitting the challenge.

Reinsurance

Refer to the HMO Claims Processing section of this manual for information on reinsurance.

Non-Capitated Services (Catastrophic) Claims

Refer to the HMO Claims Processing section of this manual for information on non-Capitated services (catastrophic) claims.

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Quality Improvement (QI) Fund

HMO makes available to the IPA additional compensation under the Quality Improvement Fund as outlined below. Refer to the Medical Service Agreement (MSA) for complete information.

The QI Fund is divided into the following categories:

- Administrative Compliance
- Encounter Data Submission
- Clinical Compliance
- Population Health Management and Quality Improvement Projects (PHMQI)

The QI Fund payments are calculated using the Base Capitation Fee paid to IPA. All payments will be reflected on the Capitation Summary Report under the Additional Adjustments and Payment section. The following is a brief description of each category within the QI Fund. The IPA must meet the thresholds as outlined in the MSA to earn the additional compensation.

Administrative Compliance: The IPA must meet the following requirements:

- The HMO shall make available to the IPA up to one-half percent (0.50%) of the IPA Base Capitation Fee for compliance, as determined by the HMO. IPA Base Capitation Fee will be reduced by 0.25% for the first unresolved Administrative Complaint and Submission requirements that does not meet the Service Level Agreement (SLA) timeframe. An additional 0.25% will be reduced for the second unresolved Administrative Complaint and Submission requirements that does not meet the SLA timeframe. Administrative Complaint Resolution and Submissions requirements will be integrated under the same QI Fund incentive, with the requirements listed below:

  - Resolve all Administrative Complaint issues within the SLA timeframe as listed below:
    a) Quality of Care – In accordance with the Medical Service Agreement, it is required that the IPA responds within seven (7) calendar days of receiving an email requesting information in response to a potential Quality of Care complaint. Failure to provide a response by the end of the 7th calendar day will result in the initiation of an administered complaint on the 8th day.
    b) IPA Complaint/Grievance: IPAs are required to email the necessary supporting documentation to the CAU within fourteen (14) calendar days. In the event the IPA fails to submit the information by the fifteenth (15th) calendar day, the health service assistant is authorized to issue an Administered Complaint and seek the support of the appropriate Provider Network Consultant and HMO team leader to facilitate the IPA's response.
    c) Medical Group Response: IPAs are required to adhere to the specified timeframes for responding to inquiries. Failure to do so will result in an Administered Complaint. Urgent/expedited appeals within 24 hours, Illinois Department of Insurance within 4 calendar days.
    d) Submissions: IPAs must submit all required submissions as documented in the MSA Section I.C.1. a, b, and c within 3 calendars of due date.
        i. Submissions that are submitted after the due date and/or require correction must be submitted within 3 calendars of email notification from the Provider Network Consultant.

  - Monthly submission of a complete and accurate roster of contracted providers and the current written service agreement for those providers referenced in Section I.C.1. a, b, and c in this Agreement, and Advanced Practice Nurses and physician assistants working under the

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supervision of an IPA PCP, as required by Laws. The report must also indicate the IPA Providers who have an executed capitated payment or salaried arrangement with the IPA as outlined in Section I.C.9.g in this Agreement. Additionally, the report must document the IPA providers that provide Telehealth services.

- Submission of the IPA financial statements per the requirements referenced in Section I.C.9.e in this Agreement.
- Submission of a semi-annual report listing IPA PCPs and the total number of assigned Members as outlined in Section I.C.9.f in this Agreement.
- Submission of a weekly Maximum Out-of-Pocket Expense report, in a format acceptable to HMO, as outlined in Section I.C.9.h in this Agreement.
- Submission of an annual Subcontractor Disclosure Attestation

g) Participation in all regularly scheduled Medical Directors Value Based Care Roundtable meetings by the IPA Medical Director or an IPA Physician. These will be held in person unless otherwise notified.

The HMO shall calculate compliance rates for semiannual payments at the end of two measurement periods: January 1, 2025, through June 30, 2025; and July 1, 2025 through December 31, 2025. The HMO shall pay the IPA within 90 days of the end of each measurement period.

The Administrative Compliance section of the QI Fund is paid semi-annually. The measurement periods are January through June and July through December. The payments are made within 90 days of the end of the period.

Population Health Management Programs: Wellness and Prevention, Condition Management, Case Management (Safety across settings) and Complex Case Management

The IPA is required to establish programs designed to provide support and coordination for a member's care in collaboration with the Member's PCP and interdisciplinary care team to ensure that quality medical care is provided in the appropriate setting.

The HMO makes an additional payment available to the IPA for providing Population Health Management Program services which meet HMO requirements as described in the HMO Utilization Management and Population Health Management Plan. The HMO Plan is located in another section of this manual. The HMO will calculate the payment at the end of the calendar year. The payment will be made on or about 9 months following the end of the contract year.

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Encounter Data Submission

The HMO will make an additional payment available to the IPA for compliance with the twice monthly submission of complete and accurate Encounter Data. The HMO will validate and determine that the data is complete and accurate, as described in the MSA. The payments are calculated on the periods listed below:

- First Semi-Annual Payment – Data validation is based on the Encounter Data submitted between January 1, 2025, through June 30, 2025.
- Second Semi-Annual Payment – Data validation is based on the Encounter Data submitted no later than January 10, 2025
- Payment will be made to the IPA within 90 days of the end of each period.

Clinical Compliance

The HMO makes additional compensation available to the IPA for compliance, as determined by the HMO, with the requirements below. The payment is calculated annually, within 90 days of the end of the calendar year. Refer to the MSA and Utilization Management (UM) Plan for further details.

- Program Compliance, Annual Submissions and Audits related to:
  - Submission of and the HMO's approval of the IPA's UM and Population Health Management Plan.
  - Acceptable performance as demonstrated through the semi-annual HMO onsite UM and Population Health Management Plan Adherence Audit.
- Acceptable monthly submission of the IPA's denial logs, denial files and referral logs.
- Acceptable Performance as demonstrated through the quarterly HMO Denial File Audit.
- Acceptable quarterly submission of documentation of office follow-up visits after hospitalization according to the project instructions
- Acceptable performance as demonstrated through the Quality Site Survey.

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Population Health Management and Quality Improvement Projects (PHMQI)

The IPA is required to establish and maintain a Population Health Management and Quality Improvement program designed to provide support and coordination and promote quality for a Member's care in collaboration with the Member's PCP and interdisciplinary care team. IPA also agrees to comply with the HMO Utilization Management and Population Health Management Plan which contains additional requirements and information pertaining to the terms set forth in this Section. In brief, the Population Health Management Plan identifies the following population strata of focus for the HMO which encompasses the individual components and projects as described in Exhibit 2 of the MSA.

The HMO makes additional compensation available to the IPA for participation and IPA performance in the Quality Improvement Projects (QIP) as outlined in Exhibit 3 located in the MSA.

The IPA is required to submit complete and accurate data, including supporting documentation, in a format acceptable to the HMO based upon the HMO criteria included in the QIP instructions. The IPA's submission for each project must include an attestation of accuracy and completeness signed by the IPA's Medical Director. The Medical Director must also attest that the submitted information is included in the Member's medical permanent record. The Medical Director must also confirm that they have reviewed the submission for a sample of the Member's records that are included in the project. Full details are outlined in the MSA and will be included with each QIP. Payments for QIP will be made on or about 9 months following the end of the Calendar year.

Prescription Drug Management Funds

The Prescription Drug Management Fund is based on a Calendar year and is additional compensation provided to the IPAs for appropriately managing the use of prescription drug benefits for their members, in accordance with accepted standards of quality and necessity of medical care. The Prescription Drug Management fund is paid on or about 5 months following the end of the calendar year. Complete information can be found in the Medical Service Agreement (MSA).

Generic Drug Management Fund

This is based upon the overall generic drug utilization rate.

Medication Adherence Management Fund

The IPA's performance for this fund will be calculated by the proportion of days covered, which is the percentage of medication days filled as compared to the total number of medication days eligible for Members enrolled with the IPA under the Members prescription drug benefit. Medication Adherence reports shall be Physician-specific for all prescribers and will be posted on the BCBSIL IPA Access Portal.

Monthly Prescription drug usage reports will be posted on the BCBSIL IPA Access Portal at https://ipa.bcbsilezaccess.com/SitePages/Home.aspx. In addition, other prescription and formulary reports will be posted quarterly to the Cotiviti website at https://pophealthproducts.cotiviti.com.
If you do not have access to either of these websites, complete and submit the form located here: https://www.bcbsil.com/pdf/standards/hmo/hmo_user_access_request_form.pdf.

All prescription drug reports are based on monthly membership snapshots as submitted to the HMO by the HMO's Pharmacy Benefits Manager and adjustments for retroactive members are not taken into consideration. Therefore, appeals based on retroactive membership adjustments are not permitted.

Copayments

(The Benefit Matrix referenced below is located on the BCBSIL IPA Access Portal at https://bcbsilezaccess.com/ipa_portal/default.aspx. If you do not have access to the website complete and submit the form located here: https://www.bcbsil.com/pdf/standards/hmo/hmo_user_access_request_form.pdf.).

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1. Claims for professional outpatient services that include an Evaluation and Management (E & M) code may be subject to a copayment per visit. The copayment will vary by Benefit Plan. Refer to the most current Benefit Plan Matrix. Effective Jan. 1, 2007, an outpatient office-based service rendered by an Advanced Practice Nurse (includes Certified Nurse Midwife, Certified Nurse Practitioner, Certified Registered Nurse Anesthetist and Certified Clinical Nurse Specialist) or a Physician Assistant can also be subject to a copayment per visit. Generally, services rendered by any other health professional are not subject to the copayment. See related notes below regarding copayments for rehabilitative therapy services and preventive medicine services.
2. When Medicare is primary and the HMO is secondary, the IPA, at their discretion, may charge the member an office visit copayment when applicable, (for those members whose policies include an office visit copayment).
3. When a member (with copayment) also has co-coverage as a dependent through a spouse's HMO insurance (who has lesser or no copayment); the lesser copayment should be collected.
4. Many benefit plans have a multi-tier copayment structure. There is a level for a Primary Care Physician (PCP) office visit. PCPs include Family Practice, General Practice, Internal Medicine, Pediatrics, Obstetrics-Gynecology and Chiropractors who are serving in a PCP role. There is a second tier is for a Specialist Physician office visit. There may be a third tier for a wellness office visit. A wellness visit is defined by the use of the Preventive Medicine Services codes (99381-99249) that are used to report routine evaluation and management of adults and children in the absence of patient complaints or counseling and/or risk factor reduction intervention services to healthy individuals. Effective Oct. 1, 2010, and as outlined in the Affordable Care Act (ACA) - there are also certain preventive services that are covered at one hundred (100) percent. No copayment should be collected for these services.
5. Behavioral health services rendered by a physician or any other licensed behavioral health professional may be subject to a copayment. This includes an office visit for behavioral health medication management. The copayment will vary by Benefit Plan and will be found on the Benefit Plan Matrix. There are some benefit plans that include an outpatient rehabilitative therapy copayment. In determining the copayment, the following should be considered: A single date of service by the same provider will be counted as one treatment/visit for the collection of a copayment. In other words, if a member is sent for PT but at the visit the member is also provided ST, there is only one visit, regardless of the fact that more than one modality of treatment was provided. A copayment should also be collected for a PT, ST or OT evaluation visit, if applicable.
6. For Chiropractic Services: If the chiropractor is acting as a Primary Care Physician (PCP), PCP copayment should be collected. If the member is being referred to the chiropractor by the PCP, the chiropractor is considered a specialist. The specialist copayment should then be collected.

   Chiropractor Manipulations: If an office visit (E&M) code is billed with the manipulation code, office visit copay should be collected. If the manipulation is billed without an office visit (E&M) code, no copayment should be collected.
7. Routine eye exams: As outlined in the Affordable Care Act (ACA), routine eye exams in a member up to age 5 are covered at 100 percent. No copayment should be collected for these services. If a member over age 5 has a wellness copayment tier – it should be collected. If the member only has a PCP and specialist copayment benefit plan, the PCP copayment should be collected.
8. Copayments required by the member's benefit plan are not to exceed 50% of the Usual and Customary Fee for any single service. This does not apply for the Blue Precision HMO, and BlueCare Direct
9. For Outpatient ABA Therapy: An outpatient rehabilitative therapy copayment applies. In determining the copayment, the following should be considered: A single date of service by the same provider will be counted as one treatment/visit for the collection of a copayment. No copayment applies if ABA therapy is provided in a home setting.
10. Blue Precision HMO, and BlueCare Direct members receiving group-approved IPA telepsychiatry services should be charged the behavioral health office visit copay applicable to the member's benefit plan.
11. Group Approved Urgent Care Facility services being performed in lieu of a PCP visit should have the PCP office visit copay collected.
12. HMO Retail Plans: Stackable Copays could apply when multiple procedures are performed in multiple benefit service categories, per day per provider. (Example: Member has High Tech Imaging and an X-ray on the same day and same bill - -Applicable High-Tech Copay and x-ray copay apply.) **Please reference the BP, BCD, HMO Copay Grid in MXO/IPA Portal.** (Please note: this applied to BFC prior to 1/1/2025)

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