Blue Cross and Blue Shield of Illinois
Provider Manual

HMO Medical Service Agreement – Highlight and Process Summary Section
2019

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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Note: all report formats are available on the BCBSIL IPA Access portal at
https://bcbsilezaccess.com/ipa_portal/default.aspx. If you do not have access, contact your Provider Network
Consultant or Nurse Liaison.
2019 Medical Service Agreement (MSA) Highlights

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

- The Definition section of the contract (pages 5-15) has several additions and clarifications – including, but not limited to:
  - Advanced Practice Nurse has been added to replace the phrase Nurse Practitioner throughout MSA
  - CEHRT definition has been updated
  - Health Equity has been added as a defined term
  - In-Area and Out of Area definitions have been updated to reference within or outside of a 30-mile radius from an IPA Physician or IPA Affiliated Hospital site
  - Social Determinants of Health has been added as a defined term

- Pages 17, 73 and 81 note the removal of the Annual Health Assessment Program

- A notation has been added to separate sections throughout the MSA noting that the section shall survive the termination or expiration of the MSA

- Page 31 has been revised to reflect current standard practice for physician board certification

- Page 33 revises the required advanced notification for an IPA to engage or terminate a Contract Management Firm (CMF) to 120 days

- Page 36 added new language that mandates an IPA requires at least 50% of the IPA Physicians utilize Certified Electronic Health Record Technology (CEHRT). In addition, the IPA will make available information to the HMO as requested to confirm compliance

- Page 54 revises the description regarding Physicians not charging another participating IPA more than the BCBSIL PPO Schedule of Maximum Allowance

- Exhibit 2 (pages 64-83) describes the compensation terms of the agreement.
  - Page 66 - the risk adjusted capitation factors have been revised for the various HMO programs as cited.
  - Page 69 – the UM Fund target units have been revised for the various HMO programs as cited. In addition, the HMO Illinois and Blue Advantage HMO UM funds will be calculated and paid independently
  - Page 73 summarizes the Quality Improvement (QI) Funds available.
  - Page 74 has new language advising the HMO retains the right to modify the Qi Fund requirements at any time, other than the available compensation, as described
  - Page 77 updates the payment schedule for the Population Health Management Program to on or about 9 months following the end of the contract year
  - Pages 80-81 update the payment schedule for the QI Projects to: Projects involving medical record retention will continue to be made within 90 days after the year ending 12/31/19; and the Projects involving administrative data only will be made on or about 9 months after the year ending 12/31/19
  - Page 82 shows the revised parameters for the Generic Prescription Drug Management Fund

- The Quality Improvement Projects are detailed in Exhibit 3 (pages 84-92).
## 2019 Submission Grid

### HMOs of Blue Cross Blue Shield of Illinois – 2019 Submission Grid

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## 2019 Submission Grid

| Report Due Date | as indicated | 12th of each month | 1/31/2019 | 2/10/19 | 2/28/19 | 3/31/19 | 4/2/19 | 5/31/19 | 6/30/19 | 7/31/19 | 8/31/19 | 9/30/19 | 10/31/19 | 11/30/19 | 12/31/20 | 2/28/20 | 100 days after the end of fiscal year | Upon request of HMO |
|-----------------|-------------|-------------------|-----------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|----------------|-------------------|
| Encounter Data - due semi-monthly, 1st submission due between 2nd - 8th, second submission due between 10th - 24th | x | | | | | | | | | | | | | | | | |
| Financial Statement - Audited or Reviewed w/ Balance Sheet | | | | | | | | | | | | | | | | | |
| High Volume Behavioral Health Practitioners Report | | | | | | | | | | | | | | | | | x |
| Income and Expense Report with Balance Sheet | | | | | | | | | | | | | | | | | x - 4th of 2019 |
| Inpatient Physician Advisor Referral Log | | | | | | | | | | | | | | | | | x |
| IPA Attestation | x | | | | | | | | | | | | | | | | |
| IPA Liability Insurance | | | | | | | | | | | | | | | | | x |
| IPA Operating (or Management) Agreement Report | | | | | | | | | | | | | | | | | x |
| Maximum Out of Pocket Expense Report - weekly | x | | | | | | | | | | | | | | | | |
| Member Access - PCP Services Attestation Form | | | | | | | | | | | | | | | | | x |
| Member Complaint Forms | x | | | | | | | | | | | | | | | | |
| Member Notification Letter for Provider Termination | | | | | | | | | | | | | | | | | x |
| Out of Network Referral Log | | | | | | | | | | | | | | | | | x |
# HMOs* of Blue Cross Blue Shield of Illinois – 2019 Submission Grid (cont.)

| Report Due Date: | as indicated | 10th of each month | 1/31/2020 | 2/15/20 | 2/28/19 | 3/30/19 | 4/30/19 | 5/31/19 | 6/30/19 | 7/31/19 | 8/31/19 | 9/30/19 | 10/31/19 | 11/30/19 | 12/31/19 | 1/31/20 | 2/28/20 | 150 days after the end of fiscal year | Upon request of HMO |
|------------------|--------------|--------------------|------------|---------|--------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|-----------------------------------|-------------------|
| PCP Member Detail Assignment Report | x - 4th qtr 2018 | x | x | x | x - 4th qtr 2010 |
| PCP Summary Assignment Report | x - 4th qtr 2018 | x | x | x | x - 4th qtr 2010 |
| Population Health Migrating Referral Source Report (CM, CCM, Condition Migrant) | x | | | | |
| Provider Service Agreements/Report new, not previously submitted to the HMO, with Cover Sheet | x | | | | |
| Quarterly Capitated - Employed (Balanced) Encounter Data Analysis Report | x - 4th qtr 2019 | x | x | x | x - 4th qtr 2019 |
| UIM Plan | x | | | | |
| URO License | x | | | | |
| Welcome Letter | x | | | | |

Rev 12/18 – all 2019 revisions are red, bold
2019 Submission Grid Overview

(All report templates are located on the BCBSIL IPA Access Portal unless otherwise indicated). New language is in red and bold.

**ANNUAL CAPITATED – EMPLOYED (SALARIED) PROVIDER ROSTER**

Pursuant to Section C “IPA Responsibilities” Paragraph 9. “Reporting” Subparagraph i) of the MSA, the IPA must provide to the HMO an annual report of all IPA Providers who have executed a capitated payment arrangement with the IPA. The IPA must also submit an updated roster to the HMO with 30 days’ prior notice of any changes in such payment arrangements including, but not limited to, additions or terminations of capitated or salaried agreements with an IPA Provider or any changes to the financial terms to such agreements which could reasonably be calculated to increase HMO’s reinsurance payments to IPA. When reporting the license number – do not use the hyphen, enter only numbers. If the IPA does not have any capitated-employed (salaried) providers - document this in the space provided on the report.

**BEHAVIORAL TELEPHONE ACCESS STANDARDS REPORT**

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

**CEHRT Attestation**

Pursuant to Section C “IPA Responsibilities” Paragraph 9. “Reporting” Subparagraph i) of the MSA, the IPA must submit an attestation of the total number of physicians, and the total number of IPA physicians that utilize Certified Electronic Health Record Technology (CEHRT) as defined in 42 C.F.R. § 414.1305, as amended from time to time, to document and communicate clinical care, that meets the US Health and Human Services’ Office of the National Coordinator for Health Information Technology’s 2015 Edition Base EHR Definition requirements.

**CMF ANNUAL AUDITED FINANCIAL STATEMENT**

Pursuant to Section C “IPA Responsibilities” Paragraph 9. “Reporting” Subparagraph f) of the MSA, the IPA must have the CMF provide this report to the HMO one-hundred and fifty (150) days after the end of the CMF’s fiscal year. The report must be prepared using the accrual basis of accounting and prepared by an independent CPA who is not an employee of the IPA or CMF. There is no template for this report.

**CMF OVERSIGHT PLAN/REPORT**

Pursuant to Section C “IPA Responsibilities” Paragraph 8. “Quality Improvement” Subparagraph B)10) of the MSA, the IPA must submit a plan for monitoring the performance of a CMF, including Behavioral Health Care CMFs, if applicable, to include oversight of all functions delegated to the CMF as set forth in the current HMO Utilization and Population Health Management Plan. The IPA must describe in detail, all activities that it will be performing to ensure that the CMF is meeting the contractual requirements that have been sub-delegated. The CMF Oversight Plan must be submitted when the IPA initially contracts with the CMF, and annually if there have been any revisions. There is no template for the oversight plan itself, however, if there have not been any changes since the previous year’s submissions or if the IPA does not use a CMF, document this in the space provided on the CMF Oversight Plan report.

**CMF QUARTERLY OVERSIGHT REPORT**

Pursuant to Section C “IPA Responsibilities” Paragraph 9. “Reporting” Subparagraph d) of the MSA, the IPA must submit a quarterly report of oversight activities performed by the IPA to oversee the functions delegated to a CMF. If the IPA has delegated functions to more than one CMF, a separate report must be submitted for each CMF. If a function has not been delegated to the CMF (e.g. Case Management) indicate N/A in the designated space. The report must include the signature of the IPA Administrator. The report is divided into activities that are performed month, quarterly and annually. If the IPA does not use a CMF - document this in the space provided on the report.
Monthly Oversight Requirements:
The IPA should document the actual data element (e.g. the actual number of denials, the number of emergency room visits per 1000/members) as well as the review date. In the Population Health Management Program Review section – the actual number of active members in Case, Complex Case and Condition Management needs to be documented.

Quarterly Requirements:
The IPA must document the oversight activities related to claim payment activities and the MSA required report submissions. In the Claims Payment section - the IPA must review the CMF’s claim payment activities and supporting documentation. This would include, but not be limited to reports prepared by the CMF for the IPA’s review related to the delegated functions. The date of the review must be documented on the CMF oversight report, as well as a summary of the IPA’s review. Supporting documentation must be submitted with the CMF Oversight Report, as indicated.

In the Reporting section - the IPA must document the date that the MSA required reports were reviewed. Any identified issues (such as late submission, inaccuracies, or missed submission) should be documented as well as actions to be taken to prevent further occurrences. The actual MSA required report submissions do not need to be submitted again with the CMF Oversight Report. Any other key performance reports that the IPA has reviewed needs to be listed, with the date reviewed. Supporting documentation must be submitted with the CMF Oversight Report, as indicated.

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

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

CMF QUARTERLY OVERSIGHT REPORT - continued
Annual Requirements
The IPA must document oversight activities for the following at least once per calendar year. The documentation must include the date reviewed/approved, if the policies, systems, procedures meet criteria, the details of the review and any applicable corrective actions being taken to ensure that the requirements are met.
- CMF Policy and Procedures
- CMF Policies and adherence to policies related to privacy and security
- HMO Oversight Audit Results – The score for each, and the date the audit results were reviewed by the IPA must be documented. If a corrective action plan was required related to any of the audits listed – the IPA must document its monitoring of the corrective action plan. This section also includes a review of the PCP and Member Satisfaction surveys.
- HEDIS – the IPA must document the review and approval of the HEDIS submission by the IPA Personnel. The number of records being requested, submitted and reviewed with the date of the activity must be included.
- Select Administrative Quality Indicator Results –The IPA must document its review of the results; identify any barriers or causes for any results below the payment threshold and actions that will be taken to address each identified barrier. The IPA must document who has performed the analysis including their title and the date it was performed.
- Clinical QI Fund Summary Report – If any of the Quality Study results were below the network rate, the IPA must document the date the study results were taken to the QI Committee and the planned intervention for each.
CMF SERVICE AGREEMENT/REPORT
Pursuant to Section C “IPA Responsibilities” Paragraph 1. “Representation of IPA and IPA Providers” Subparagraph s) of the MSA, if applicable, the IPA must submit a written service agreement between the IPA and a CMF, including Behavioral Health CMFs that describes, at minimum:

- Responsibilities of the parties, including which party is responsible for maintaining the ten (10) years of information required by the MSA in format that is acceptable to BCBSIL.
- Extent of services to be provided by the CMF
- CMF reporting process
- IPA oversight process
- agreement by the CMF to preserve patient confidentiality
- agreement to follow the HMO Standards stated in the HMO UM Plan
- A copy of the approval letter for URO designation
- Submission of any complex case management files as requested by the HMO
- A 120 day termination notification

There is no report template for the service agreement itself, however, if there have not been any changes since the previous year’s submissions or if the IPA does not use a CMF, document this in the space provided on the CMF Service Agreement report.

CONDITION CODING GAP REPORT (FOR BLUE PRECISION HMO AND BLUE FOCUSCARE)
Pursuant to Section C “IPA Responsibilities” Paragraph 9. “Reporting” Subparagraph f) 3) of the MSA, the IPA must submit a monthly report using the approved HMO report template as per the project documentation that will be located on the BCBSIL IPA Access Portal.

CONTRACTED PROVIDER ROSTER REPORT – CEHRT COMPLIANCE REPORT
Pursuant to Section C “IPA Responsibilities” Paragraph 9. “Reporting” Subparagraph i) of the MSA, the IPA must submit a Contracted Provider Roster to the HMO. The roster should include all providers that the IPA has a contract with including but not limited to PCPs, Specialists, Therapy providers (i.e. speech, occupational and physical therapy), hospital based physicians, nurse practitioners and physician assistants working under the supervision of IPA PCPs, ancillary providers (i.e. stand-alone MRI center, lab vendor, radiology vendor, etc.), surgi-centers, hospitals, etc. The roster must be on a spreadsheet in the exact format approved by the HMO. Do not delete, hide or change the order of columns. The report must include the following data elements:

- IPA number
- Employed by IPA (indicate with a yes if the provider is employed)
- Provider First Name
- Provider Last Name
- Group Practice / Facility Name (if applicable)
- Street Address
- City
- State
- Zip Code
- Phone Number
- Fax Number
- Tax ID Number
- License Number – do not use the hyphen, enter only numbers.
- NPI #
- Original Effective Date with IPA
- Specialty - This should not be abbreviated - this field should only include the full spelling of the specialty type. For example, it should be written as: Family Practice, Emergency Medicine, Allergy, etc.
- Provider Degree Type e.g. MD/DO/NP/PA
- Hospital Affiliation – This column only needs to be completed for hospital based physicians If the physician has multiple hospital affiliations – list each hospital in separate columns)
**ENCOUNTER DATA**

Pursuant to Section C “IPA Responsibilities” Paragraph 9 “Reporting” Subparagraph b) of the MSA: The IPA must submit a semimonthly QIRA data file. The first submission is due between the 2nd – 8th of the month. The second submission is due between the 16th – 24th of the month.

- The claims must be submitted within 3 weeks of payment
- IPA must correct and resubmit rejected records no later than 10 days from HMO notification of such error
- To be considered for reinsurance, all claims must be paid by June 30 of the following year the service was incurred and submitted in the July upload. For example, all 2018 dates of service must be paid by June 30, 2019 and uploaded in July 2019.
- The Encounter file data element requirements are located on the BCBSIL IPA Access Portal. Data submitted for Physician services must have a valid specialty code other than multi-specialty, clinic or group practice, and must include all applicable diagnosis codes.
- The HMO will validate the data for accuracy and completeness. In addition, the IPA must certify with each submission, that the data has been evaluated for accuracy and completeness. If the HMO becomes aware that the data is not accurate and/or complete – penalties as outlined in the MSA may be applied.

**FINANCIAL STATEMENT - ANNUAL AUDITED OR REVIEWED**

Pursuant to Section C “IPA Responsibilities” Paragraph 9 “Reporting” Subparagraph f) of the MSA, the IPA must provide this report to the HMO one-hundred and fifty (150) days after the end of the fiscal year. The report must be prepared using the accrual basis of accounting and prepared by an independent CPA who is not an employee of the IPA or CMF. IPAs with a membership at or above 2,500 Members as of 12/31/2018 must submit an audited statement. If the IPAs membership is below 2,500 as of 12/31/2018 the statement can be audited or reviewed. The HMO also may require that an audit be done at the IPA’s expense, and conducted by an independent certified public accountant according to GAAP. If the IPA is submitting the statement of a parent or other related entity as approved by the HMO, a HMO Approved financial performance guarantee of IPA’s financial obligations under the MSA must also be submitted. There is no report template for this report.

**HIGH VOLUME BEHAVIORAL HEALTH PRACTITIONERS REPORT**

Pursuant to Section C “IPA Responsibilities” Paragraph 9 “Reporting” Subparagraph e) of the MSA, the IPA must submit an annual listing of the IPA's high volume Behavioral Health Practitioners. This report will include both mental health and substance use (chemical dependency) providers. The report must include all individual providers who have provided services to 50 or more unique Blue Cross members in the previous calendar year. This should include psychiatrists, psychologists, licensed clinical social workers (LCSW) and licensed professional counselors (LCPC). Individual Providers should be listed - not group practices. Do not include Psychologists that perform only psych testing. If an IPA utilizes a mental health vendor, the IPA must work with the vendor obtain the list. The report must include all data included on the HMO report template. If the IPA does not have any high volume providers - document this in the space provided on the report. When reporting the license number – do not use the hyphen, enter only numbers.
INCOME AND EXPENSE REPORT WITH BALANCE SHEET
Pursuant to Section C “IPA Responsibilities” Paragraph 9. “Reporting” Subparagraph f) of the MSA, the IPA must provide to the HMO these financial reports quarterly.

IPA ATTESTATION
Pursuant to Section C “IPA Responsibilities” Paragraph 9. “Reporting” Subparagraph i) of the MSA, the IPA must submit a verified attestation from an authorized representative for the IPA that the written agreements between the IPA and all IPA Providers comply with the terms of the MSA and the Provider Manual.

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

IPA OPERATING OR MANAGEMENT AGREEMENT
Pursuant to Section C “IPA Responsibilities” Paragraph 9 “Reporting” Subparagraph i) of the MSA, the IPA must submit the current Operating or Management Agreement that includes the ownership structure. Each subsequent year, the IPA must submit any addendum to the agreement. There is no report template for the Agreement itself, however, if there have not been any changes since the previous year’s submissions, document this in the space provided on the IPA Operating or Management report.

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

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

MEMBER COMPLAINT FORMS
There is an interactive complaint form on the BCBSIL IPA Access Portal to enter complaints as they are received. The form is located at: IPA Portal > Population Health Management > HMO > Complaint Form. Once the resolution of the complaint by the HMO has been communicated to the IPA, the IPA UM Committee must discuss at their next meeting. Complaint types include, but are not limited to, Quality of Care, Access, Administrative, Attitude and Service, Claims, Referrals, Benefits, Quality of Practitioner Office Site, or complaints regarding the IPA Complex Case Management, Case Management or Condition Management Programs.

MEMBER NOTIFICATION LETTER FOR PROVIDER TERMINATION
Section C “IPA Responsibilities” Paragraph 1 “Representation of IPA and IPA providers” Subparagraph o) identifies the 90-day advance notice requirement for member notification of the discontinuance of operation of any facility, provider or site. The letter requirements can be found in the MSA Highlights and Process Summary section of the HMO Provider Manual.
PRIMARY CARE PHYSICIAN – MEMBER DETAIL ASSIGNMENT REPORT
Pursuant to Section C “IPA Responsibilities” Paragraph 9 “Reporting” Subparagraph h) of the MSA, the IPA must a semi-annual list of PCPs and assigned Members. The report must include the Member Group and ID #, Member Name, assigned PCP, and in a format acceptable to the HMO.

PRIMARY CARE PHYSICIAN SUMMARY ASSIGNMENT REPORT
Pursuant to Section C “IPA Responsibilities” Paragraph 9 “Reporting” Subparagraph g) of the MSA, the IPA must submit quarterly a list of PCPs with the number of members assigned to each, and a total number of unassigned members for the IPA. The report must include WPHCPs. If the IPA does not assign or track membership for WPHCPs – this must be indicated on the report.

PROVIDER SERVICE AGREEMENTS
The IPA must submit a fully executed Service Agreement and/or Addendum for all providers including but not limited to PCPs, specialists, facilities, ancillary providers, hospital based specialists listed in the MSA, non-targeted physicians and sub-specialists that have not been previously submitted to the HMO. There is no report template for the service agreement; however if the IPA is not submitting any new Provider Service Agreements for the annual submission, document this on the space provided on the Provider Service Agreement Annual Submission Report. A completed cover sheet must be submitted with all service agreements. The Service Agreement must include:

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

QUARTERLY CAPITATED – EMPLOYED (SALARIED) ENCOUNTER DATA ANALYSIS REPORT
Pursuant to Section C “IPA Responsibilities” Paragraph 9. “Reporting” Subparagraph b) of the MSA, the IPA must provide to the HMO a quarterly summary report of claims/encounters submitted and adjudicated for each capitated and employed Provider. When reporting the license number – do not use the hyphen, enter only numbers. If the IPA does not have any capitated – employed providers - document this in the space provided on the report.

PCP report (all PCPs should be included) - Create a spreadsheet that contains the following columns:
- PCP name, group practice name, specialty, license #, NPI #, Tax ID #
- Average current membership assigned to this PCP
- Number of claims received in the quarter
Average number of claims adjudicated in the quarter – this is obtained by dividing the number of claims received in the quarter by the average current PCP membership. The Average number of claims adjudicated for each PCP should look similar to the other PCPs in that specialty. If the data for a particular PCP does not look within the range of the other values, then the IPA should investigate whether the PCP is not submitting complete claim/encounter data and document the IPA’s action plan for obtaining complete claim/encounter data (with follow up reports on action items in subsequent quarters).

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

The Average number of claims adjudicated received for each Specialty/Ancillary Group should be within the range of the other values established for that Specialty/Ancillary Group or the PMPM value should approximate the PMPM sub-capitated amount paid to the Specialty/Ancillary Group. If this is not the case, then the IPA should investigate whether the Specialty/Ancillary Group is not submitting complete claim/encounter data and document the IPA’s action plan for obtaining complete claim/encounter data (with follow up reports on action items in subsequent quarters).

UTILIZATION MANAGEMENT / POPULATION HEALTH MANAGEMENT RELATED REPORTS
All report descriptions and requirements are outlined in the HMO Utilization Management and Population Health Management Plan. These include:
- Inpatient Physician Advisor Referral Log
- Out of Network Referral Log
- Admission Log
- Behavioral Health Referral Request Log
- Case Management Forms
- Complex Case Management forms
- Denial Logs and files
- Population Health Management Data/Referral Source (condition management, CM, CCM) reports
- Disease Management Forms
- UM Plan
- URO License
WELCOME LETTER

Pursuant to Section C “IPA Responsibilities” Paragraph 10. “Members” Subparagraph a) of the MSA, the IPA shall submit a welcome letter to newly enrolled members. The welcome letter must include, but is not limited to:

- process for choosing a PCP and notifying the IPA office of the PCP selection
- process for scheduling a PCP get acquainted visit
- process for selecting a WPHCP and the Physician’s role in coordinating care with the PCP
- how to change a PCP and WPHCP and any HMO restrictions that may apply
- the availability of preventive services
- procedures for Emergency, Routine and Immediate Care Services – must include detailed description
- procedures regarding referrals
- the IPA’s Utilization Management procedures
- the IPA’s expectations of the Member
- how the Member can access their HMO benefits; including how Member can access early morning, evening, and weekend office hours
- a statement advising the member to contact the Health Plan to facilitate the handling of complaints, appeals or grievances-in compliance with applicable law, including The Managed Care Reform and Patient’s Rights Act
- assurance of patient confidentiality
- procedures regarding the obtaining of Behavioral Health (BH) Care services, including a statement that the IPA encourages the member to discuss received BH services with their PCP
- how the Member can obtain access to their medical records
- how the Member can discuss Utilization Management issues or the UM process by calling the IPA’s toll free number or by making a collect call to IPA
- Access to Utilization Management (UM) Staff
  - UM Staff are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.
  - UM Staff can receive inbound communication regarding UM issues after normal business hours by calling (insert phone number or process)
  - UM Staff are identified by name, title and organization name when making or returning calls regarding UM issues.
  - Please provide the TDD/TTY number or IL/711 Relay Services number and instructions services for members who need them.
  - Language assistance (free of charge) is available for members to discuss UM issues (Please note: language assistance does not apply to after-hours calls)
- Who Makes Decisions About Your Care
  - Utilization Management decisions are based on medical necessity, which includes appropriateness of care and services, and available benefits. [IPA name] does not reward health care providers or other individuals for issuing denials of coverage, care or service or provide financial incentives for UM decision makers that encourage decisions that result in underutilization. [IPA name] also confirms that there is no conflict of interest between themselves and the UM decision makers.
- How the Member can request consideration for the IPA’s Population Health Management Services (Case Management, Complex Case Management and Condition Management programs)
- How an Adolescent Member will transition to Adult Health Care Services.

Rev 1/19 – all 2019 revisions are red, bold
Sample Report Formats

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

Admission Log
Annual Capitated Salaried Provider Roster
Behavioral Health Referral Request Log
CEHRT Attestation
CMF Oversight Plan Report
CMF Quarterly Oversight Report
CMF Service Agreement Report
Complex Case Management Case Log
Contracted Provider Roster – CEHRT Compliance Report
Denial Log
High Volume Behavioral Health Practitioners Report
Income, Expense and Balance Sheet Report
Inpatient Physician Advisor Referral Log
IPA Attestation
IPA Operating – Management Agreement Report
Member PCP Access to Medical Services Attestation Form
Out-of-Network Referral Request Log
PCP Member Detail Assignment Report
PCP Summary Assignment Report
Provider Service Agreement Annual Submission Report
Quarterly Capitated Employed (Salaried) Encounter Data Analysis Report
Referral Inquiry Log
Utilization Management Fund Worksheet
Welcome Letter Template
IPA Standards for Emergency Services

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

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

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

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

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

5. The IPA should maintain the log in their files for at least ten years.

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

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

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

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

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

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

The process for member notification is listed below:

- The IPA must communicate to all affected members at least 90 days prior to the termination date.
- All letters sent to the affected HMO members must be approved by the Provider Network Consultant prior to the letter being sent. The letter must include the mailing date. At a minimum, the following information needs to be included in the letter(s):
  - If an HMO Product name is used, it must be written as follows (the first time it is cited, subsequent usage does not need to include the service or register marks):
    - HMO Illinois®
    - Blue Advantage HMO®
    - Blue Precision HMO®
    - BlueCare DirectSM
    - Blue FocusCareSM
  - Reason for letter-Primary Care Physician (PCP) or Participating Specialist Provider (PSP) or other provider is leaving the IPA, with effective date
  - Instructions on how members choose a new PCP and/or if members will be assigned a new PCP
  - What required actions must members take if a PSP is leaving
  - A reference that the member may call the HMO for assistance in choosing another IPA if necessary. The member should be instructed to call the Customer Service telephone number on the back of their ID card.
  - Transition of Care Language as written below:
    - If you and/or one of your family members are currently in an ongoing course of treatment and wish to receive transition of care services, you may request that you continue seeing your current physician for up to a maximum of 90 calendar days from the date of this notification. To receive this transition of care service you must submit a request within 30 calendar days of this notification by writing to or by calling:
      - Blue Cross and Blue Shield of Illinois
      - Consumer Affairs Unit
      - 1100 Warrenville Rd., 4th Floor
      - Naperville, Illinois 60563
      - 312-653-6600
    - A reference that the member may contact the Illinois Department of Insurance, as written below:
      - You can contact the Illinois Department of Insurance - Office of Consumer Health Insurance at 877-527-9431 or 320 W. Washington Street, Springfield, IL 62767 with questions or concerns.
- A dated copy of the letter must be submitted to the Provider Network Consultant prior to the member mailing.
  - If the IPA is submitting the letter with less than 90 days’ notice, an explanation must be included in the communication to the Provider Network Consultant. At the HMO’s discretion, an Administrative Complaint may be issued to the IPA if the letter is submitted with less than 90 days’ notice for each occurrence. There are situations where an Administrative Compliant may not be issued, including, but not limited to a provider death, an unexpected medical emergency preventing the provider from continuing to practice or a termination for cause - such as suspension/revocation of the provider’s license.
  - A copy of the termination notice that was sent to the BCBS network notification email must also be sent to the Provider Network Consultant.
- In addition, the IPA must submit a template letter annually as documented on the Submission Grid referenced in this section of the Provider Manual.