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Medical Service Agreement (MSA) Highlights

Document Purpose: this is a summary document intended to highlight some of the significant revisions to the 2021 MSA. Refer to the actual 2021 MSA for complete details.

- Pages 5-16: Several additions and deletions include, but not limited to:
  - Emergency Medical Condition has been revised. Additional language has been added with regards to the final diagnosis not determining if an emergency condition exists. In addition, additional language has been added with regards to pregnant women.
  - HMO Member Survey has been removed.
  - The term ‘family practice’ has been replaced with ‘family medicine’ in this section, and throughout the MSA.
  - Telemedicine has been added as a defined term.
  - Telepsychiatry definition has been revised to indicate that it is a subset of Telemedicine and simplified to reflect if must be performed in accordance with applicable Law.
- Page 18: Added language that the HMO may terminate the MSA with at least 60 calendar days’ notice if the IPA does not maintain an affiliated hospital that is contracted with or approved by the HMO.
- Page 19: Added language that reflects the addition of the term pandemic to the termination clause related to a disaster or epidemic. The HMO also reserves the right to revise or adjust any financial provision of the Agreements with 30 day notice due to any disaster, epidemic or pandemic.
- Page 29: Reflects the requirement for the IPA to provide Telemedicine and Telepsychiatry services as clinically appropriate. Telemedicine services will be included when the HMO is determining if the IPA meets criteria as set forth in the MSA.
- Page 34: Amends the CMF approval process and termination clause to require a 180-day notice to the HMO.
- Page 40: Revises the insurance requirement for mental health providers and providers who are licensed and practicing in the state of Indiana.
- Page 45: Reflects a change in the Utilization Management and Population Health Management Plan whereas; the IPA is no longer required to have a procedure to enable an IPA provider to appeal decisions by an IPA to a Physician not affiliated with the IPA.
- Page 46: Reflects new language identifying that the IPA is responsible for maintaining its own Utilization Review Organization (URO) license and any of its delegated entities’ URO license. A failure to do so will result in a 1% reduction of the IPA’s Annual Capitation.
- Page 47: Denotes a change for the Capitated – Employed (Salaried) Encounter Data Analysis report – it is now due quarterly, upon request of the HMO.
- Page 51: Additional clarification language citing when a State of Illinois Department of Insurance non-urgent request is due vs. an urgent request.
- Page 67: Revises some of the HMO Illinois® and Blue Advantage HMO℠ Base Capitation Fee Payment Risk Adjustment Factors
- Page 70: Revises some of the Utilization Management Fund Risk Adjustment target factors.
• Page 72: Revised with a reference clarifying the unit charge for organ and tissue transplants that are pre-approved by the HMO.
• Pages 74 – 83: Reflect the changes to the Quality Improvement Fund, including:
  o The Compliance section of the QI fund has been revised to show an earned amount up to 2.5% of IPA Base Capitation Fee.
  o The Population Health Management Program has several updates. (page 77)
  o The Compliance section has several revisions. (pages 80 – 81)
  o The Quality Improvement Project revisions are summarized on pages 81- 83 and detailed in Exhibit 3 (pages 86-93). Note specific changes such as:
    o Payment schedule differs dependent upon the if the project involves medical record submission/electronic health data or administrative data.
    o Pages 81- 82 reference specific requirements related to the use of electronic health data.
    o Page 82 outlines the new requirements and process related to Quality Site Visits.
• Pages 83-84: Reflect the changes of the Prescription Drug Fund Compliance rates for HMO Illinois and Blue Advantage HMO.
# 2021 IPA Submission Grid

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HMO Illinois®, Blue Advantage HMO®, Blue Precision HMO®, BlueCare Direct® and Blue FocusCare®

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

rev: 12/2020
**Document Purpose:** The purpose of this document is to provide the HMO IPAs a reference guide on submitting required HMO information to BCBSIL per the Medical Service Agreement (MSA) between BCBSIL and IPA.

All HMO report forms/templates are available via BCBSIL IPA Access Portal at [https://ipa.bcbsilezaccess.com](https://ipa.bcbsilezaccess.com). If you do not have access to this portal, please contact your assigned Provider Network Consultant or Nurse Liaison.

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**Behavioral Health Telephone Access Standards Report**

**Report Overview**
- Pursuant to Section I (C)(3)(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.
- As per the UM and Population Health Management Plan, any delegated BH Organization or IPA providing BH services with a centralized triage and referral process, must submit telephone reports quarterly to the HMO.
- The reports must include the average speed of answer and the call abandonment rate.
- BH calls should include mental health and/or Substance Use Disorder related calls.
- Combined mental health and Substance Use Disorder telephone stats are acceptable.
- If the IPA does not use a centralized process, document this in the space provided on the report, and submit the report.
- All quarterly reports should be completed with data as it is reflected on the last month and/or day of the quarter.
- Additional instructions may be found on the report.

**Submission Information**
- **Report Due Dates:** 4/30/2021; 7/31/2021; 10/31/2021 and 1/31/2022
- **Email completed report to:** HMOSubmissions@bcbsil.com

**Behavioral Health Vendor Attestation**

**New for 2021**
- ✓ Created a separate Behavioral Health (BH) Vendor Attestation to ensure all BH Vendors are being reported to HMO Plan.
- ✓ Report is an Adobe fillable form with digital signature capability.
- ✓ This document is required for all IPAs, regardless if they have a BH Vendor.
Report Overview

- Per the MSA, CMF means a subcontractor retained by the IPA and approved by the HMO to perform certain management and administrative functions for the IPA. In this instance, the CMF is the BH Vendor.
- If the IPA does not use a BH Vendor, document this in the space provided on the attestation and submit the report.
- BH Vendor Service Agreement: Pursuant to Section I (C)(1)(r) of the MSA, the IPA agrees to submit a written service agreement between the IPA and a CMF, including Behavioral Health care CMF, if applicable. At a minimum, this agreement must describe the following:
  - 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 BH Vendor
  - 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 180-day termination notification
- BH Vendor Oversight Plan: Pursuant to Section I (C)(8)(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.

Submission Information

- **Report Due Date:** 4/31/2021
- **Email completed report to:** HMOSubmissions@bcbsil.com

Capitated – Employed (Salaried) Encounter Data Analysis Report

**New for 2021**
- Added report Instructions tab.
- This report is now only required semi-annually and upon HMO request.

**Report Overview**

- Pursuant to Section I (C)(9)(b) of the MSA, upon HMO request, the IPA must provide to the HMO a summary report of claims/encounters submitted and adjudicated for each capitated and employed Provider in a format acceptable to the HMO.
- If the IPA does not have any capitated – employed providers - document this in the space provided on the report.
• 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).
• 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).
• Additional instructions may be found on the report.

Submission Information

• **Report Template Location:** (BCBSIL IPA Access Portal) Provider Network Management > Commercial & Exchange > MSA Required Submissions – Report Templates > 2021
• **Report Due Date:** 7/31/2021, 1/31/2022 and upon HMO request
• **Email Completed Report to:** HMOSubmissions@bcbsil.com

**Capitated – Employed (Salaried) Provider Roster**

**New for 2021**
- Added IPA Name and IPA Number at the top of report.
- Combined Provider Facility Name and Group Practice Name into one column (Group Practice/Facility Name).
- Added report Instructions tab.

Report Overview

• Pursuant to Section I (C)(9)(i)(1) of the MSA, the IPA must provide a list of IPA Providers who have executed a capitated or salaried payment arrangement with the IPA.
• Per MSA definition, IPA Providers means any Provider, licensed in accordance with all applicable Laws, that has a written agreement with the IPA to perform medical services, to include, but not limited to, a Physician, physical therapist, psychologist, hospital facility, health care facility, laboratory, and any other Provider of medical services.
• The report shall include the IPA Provider name, NPI, TIN and effective date of the capitated or salaried agreement with the IPA, in a format acceptable to HMO.
• 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.
• If the IPA does not have any capitated-employed (salaried) providers - document this in the space provided on the report.
• Additional instructions may be found on the report.

Submission Information

• **Report Template Location:** (BCBSIL IPA Access Portal) Provider Network Management > Commercial & Exchange > MSA Required Submissions – Report Templates > 2021
• **Report Due Date:** 1/31/2021 and as needed when changes occur  
• **Email completed report to:** HMOSubmissions@bcbsil.com

### CMF/BH Vendor Audited Financial Statement

**Report Overview**
- Pursuant to Section I (C)(9)(f)(3) of the MSA, if the IPA utilizes a CMF, IPA shall cause CMF to submit a copy of the most recent audited financial statements for the CMF, including balance sheet, to the HMO.
- CMF audited financial statements must be submitted to HMO within 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.
- Annual Audited Financial Statement is required if the IPA has a CMF and/or Behavior Health Vendor.

**Submission Information**
- **Report Template Location:** N/A  
- **Report Due Date:** Annually (150 days after the end of the CMF/BH Vendor’s fiscal year)  
- **Email Audit To:** HMOSubmissions@bcbsil.com

### Condition Coding GAP Report

**Report Overview**
- ONLY for Blue Precision HMO and Blue FocusCare  
- Pursuant to Section I (C)(9)(l) of the MSA, the IPA must provide on a monthly basis the completed condition coding gap report in accordance with HMO guidelines as outlined in the Provider Manual and BCBSIL IPA Access Portal.
- The document should be returned in the exact format as it is placed on the BCBSIL IPA Access Portal and comments should be entered in the ‘Comments’ field. Please do not alter the format of the file(s).
- The main purpose is to close the gap on Hierarchal Condition Code (HCC) risk scores as the month's go by.

**Submission Information**
- **Report Location:** (BCBSIL IPA Access Portal) HMO Financial Reporting> Commercial & Exchange> HMO Financial and Reporting CE Documents> Condition Documentation Gap Report> Year> Month  
- **Report Due Date:** Monthly  
- **Email completed report to:** ConditionDocumentationGapReport@bcbsil.com

### Contract Management Firm Attestation

**New for 2021**
- ✓ Several documents (CMF Service Agreement and CMF Oversight Plan) were combined into one.  
- ✓ Report is an Adobe fillable form with digital signature capability.  
- ✓ This document is required for all IPAs, regardless if they have a CMF.
Report Overview

- Per the MSA, CMF means a subcontractor retained by the IPA and approved by the HMO to perform certain management and administrative functions for the IPA.
- If the IPA does not use a CMF, document this in the space provided on the attestation and submit the report.
- CMF Service Agreement: Pursuant to Section I (C)(1)(r) of the MSA, the IPA agrees to submit a written service agreement between the IPA and a CMF. At a minimum, this agreement must describe the following:
  o 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.
  o Extent of services to be provided by the CMF
  o CMF reporting process
  o IPA oversight process
  o Agreement by the CMF to preserve patient confidentiality
  o Agreement to follow the HMO Standards stated in the HMO UM Plan
  o A copy of the approval letter for URO designation
  o Submission of any complex case management files as requested by the HMO
  o A 180-day termination notification
- CMF Oversight Plan: Pursuant to Section I (C)(8)(B)(10) of the MSA, the IPA must submit a plan for monitoring the performance of a CMF, to include oversight of all functions delegated to the CMF as set forth in the current HMO Utilization and Population Health Management Plan.
  o 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.
  o The CMF Oversight Plan must be submitted when the IPA initially contracts with the CMF, and annually if there have been any revisions.

Submission Information

- **Report Due Date:** 4/31/2021
- **Email completed report to:** HMOSubmissions@bcbsil.com

Contracted Provider Roster

**New for 2021**

✓ Added provider CEHRT Compliance information to this report. The following has been added to the Contract Provider Roster:
  o Column Z: Indicate if provider uses CEHRT Program
  o Column AA: CEHRT Product Name
  o Column AB: CEHRT Product Version
  o Column AC: CHPL ID #

Report Overview

- Pursuant to Section I (C)(9)(i)(2) and Section I (C)(9)(j) of the MSA, the IPA must submit a complete updated roster, in a format acceptable to the HMO, of current contracted Providers and their specialties.
• The roster should include all providers that the IPA has a contract with including but not limited to (as outlined in Section I (C)(1)(a), (b) and (c)):
  o PCPs,
  o Specialists,
  o Therapy providers (i.e. speech, occupational and physical therapy),
  o Hospital-based physicians,
  o Behavioral Health providers
  o Chiropractor
  o Nurse practitioners and physician assistants working under the supervision of IPA PCPs
  o Ancillary providers (i.e. stand-alone MRI center, lab vendor, radiology vendor, etc.),
  o Surgi-centers, hospitals, etc.
• CEHRT Compliance: Pursuant to Section I (C)(1)(y) of the MSA, the IPA shall make available to the HMO any information or documentation requested by HMO to confirm compliance with 75% threshold.
  o If the provider is a group practice – each provider should be listed separately in the report. If the Provider uses the CEHRT, the IPA must document the product name, version # and CHPL (Certified Health IT Product List) ID # in the appropriate columns.
• If the provider is employed by the IPA, they should be reporting on the Contracted Provider Roster and the Capitated or Salaried Provider Roster.
• Additional instructions may be found on the report which outlines all required data elements.

Submission Information
• **Report Template Location:** ((BCBSIL IPA Access Portal) Provider Network Management > Commercial & Exchange > MSA Required Submissions – Report Templates > 2021
• **Report Due Date:** 1/31/2021 and 7/31/2021
• **Email completed report to:** HMOSubmissions@bcbsil.com

Delegated Quarterly Oversight Report

**New for 2021**
✓ Previous name of report was CMF Quarterly Oversight Report
✓ Several items from this report were removed since they are being reported through other HMO audit functions.
✓ Report is now an Adobe fillable form with digital signature capability.

Report Overview
• Pursuant to Section C(9)(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, including Behavioral Health Care Services oversight.
  • 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.
  • If the IPA does not use a CMF - document this in the space provided and submit the report.

Submission Information
• **Report Template Location:** (BCBSIL IPA Access Portal) Provider Network Management > Commercial & Exchange > MSA Required Submissions – Report Templates > 2021
• **Report Due Date:** 4/31/2021; 7/31/2021; 10/31/2021 and 1/31/2022
• **Email completed report to:** [HMOSubmissions@bcbsil.com](mailto:HMOSubmissions@bcbsil.com)

## Encounter Data

### Report Overview
- Pursuant to Section I.C.9.b of the MSA, the IPA Shall provide a semimonthly Encounter Data file containing all data elements required by the HMO, in a format acceptable to the HMO and in timeframes as outlined in the Provider Manual and Encounter Data Companion Guide.
- Data is to be transmitted to Change Healthcare electronically via the Change Healthcare SFTP.
- There are two submitting timeframes each month
  - First submission each month is from the 2nd to the 8th
    - The first submission should include all claims paid from the 16th to the end of the previous month.
  - Second submission each month is from the 16th to the 23rd
    - The second submission should include all claims paid from the 1st to the 15th of the current month.
- 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 2020 dates of service must be paid by June 30, 2021 and uploaded in July 2021.
- 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.
- With each submission, IPA must certify the data has been evaluated for accuracy and completeness.
- If the HMO becomes aware that the data is not accurate, complete, and/or timely, HMO may elect to impose penalties as outlined in this provision.
- IPA must correct and resubmit rejected records no later than 10 days from HMO notification to IPA of such error.

### Submission Information
- **Report Due Date:** Semimonthly
  - 1st submission due between 2nd to the 8th
  - 2nd submission due between 16th to the 23rd
- **Submission Process:** refer to Encounter Submission Companion Guide

## High Volume Behavioral Health Practitioners Report

**New for 2021**
- Added report instructions tab.

### Report Overview
- Pursuant to Section I (C)(9)(e) of the MSA, the IPA must provide an annual listing of IPAs high-volume Behavioral Health Care Practitioners.
- This report will include both mental health and substance use (chemical dependency) providers.
• The report must include all individual behavioral health providers who have provided services to 50 or more unique Blue Cross members in the previous calendar year.

• This should include:
  o Psychiatrists,
  o Psychologists (do not include Psychologists that perform only psych testing),
  o Licensed clinical social workers (LCSW) and
  o Licensed professional counselors (LCPC)

• Individual Providers should be listed - not group practices.

• If an IPA utilizes a BH Vendor, the IPA must work with the vendor to obtain a high-volume provider list.

• If the IPA does not have any high-volume providers, document this in the space provided on the report.

• Additional instructions may be found on the report.

Submission Information


• Report Due Date: 4/30/2021

• Email completed report to: HMOSubmissions@bcbsil.com

Income Expense and Balance Sheet Report

Report Overview

• Pursuant to Section C(9)(f)(1) of the MSA, the IPA shall submit contract specific income and expenses on a calendar quarter-to-date basis and balance sheet as of the last day of the quarter within 60 days after the end of the quarter.

Submission Information


• Report Due Date: 5/31/2021; 8/31/2021; 11/30/2021 and 2/28/2022

• Email completed report to: HMOSubmissions@bcbsil.com

IPA Attestation

New for 2021

✓ IPA Attestation was revised to address IPA specific attestation requirements as indicated below.

  The following items are now incorporated into this document:

  o CEHRT Attestation
  o IPA Operating – Management Agreement Report

✓ Last year's 2020 IPA Attestation items is now incorporated into the 2021 Provider Service Agreement Attestation.

✓ Please submit the current IPA Operating/Management Agreement and/or Amendments with this form.

✓ Report is an Adobe fillable form with digital signature capability.

Report Overview

• Pursuant to Section I (C)(9)(i)(6) of the MSA, the IPA authorized representative must attest to the following:
- Total number of IPA Physicians
- Total number of IPA Physicians that utilize Certified Electronic Health Record Technology (CEHRT)

Pursuant to Section I(C)(9)(i)(5) of the MSA, the IPA must submit a copy of the current IPA Operating or Management Agreement currently in effect, along with any amendments to the Operating or Management Agreement.

**Submission Information**
- **Report Due Date:** 1/31/2021
- **Email Completed Report to:** HMOSubmissions@bcbsil.com

### IPA Audited Financial Statement

**Report Overview**
- Pursuant to Section C(9)(f)(2) of the MSA, the IPA shall submit within 150 days after the end of the IPA’s fiscal year:
  - Copies of IPA’s audited financial statements prepared using the accrual basis of accounting by an in independent CPA who is not an employee of the IPA or CMF.
  - IPAs with a membership at or above 2,500 Members as of 12/31/2020 must submit either an audited statement or reviewed financial statement.
- IPAs submitting audited or reviewed financial statements of a parent or other related entity, as approved by the HMO, to fulfill its financial reporting requirements must include an HMO approved financial performance guarantee of IPA’s financial obligations under the MSA.
- Report should be prepared according to Generally Accepted Accounting Principles (GAAP).

**Submission Information**
- **Report Template Location:** N/A
- **Report Due Date:** Annually (150 days after the end of the IPAs fiscal year)
- **Email Audit To:** HMOSubmissions@bcbsil.com

### IPA Liability Insurance

**Report Overview**
- Pursuant to Section C (4)(a), (b-c) of the MSA, the IPA shall 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.
- Annually, the IPA shall provide a copy of the policy (or policies) to the HMO.

**Submission Information**
- **Report Template Location:** N/A
- **Report Due Date:** 1/31/2021
- **Email Insurance Documents:** HMOSubmissions@bcbsil.com
Maximum Out of Pocket Expense Report (OPX)

Report Overview

- Pursuant to Section I (C)(9)(k) of the MSA, IPA must provide on a weekly basis a Maximum Out-of-Pocket Expense report.
- This report must be in the HMO required format and will be submitted using an SFTP server.
- The IPA must send an email to HMOCAUUnit@bcbsil.com if a file is not going to be submitted due to no OPX claim data for the week.
- For additional instructions on OPX process, please refer to the HMO Claims Processing Provider Manual via www.BCBSIL.com.

Submission Information

- **Report Due:** Weekly
- **Report Submission Process:** SFTP Server

Member Access to PCP Services Attestation

**New for 2021**

- Added additional clarification of all supporting documentation required to be submitted with this attestation, which includes IPA Policy and Procedures related to Immediate Care Services and Immediate Care Vendor Agreement(s), if applicable.
- Added IPA Name and IPA Site # field at top of the form.
- Form and supporting documents should be submitted to HMOSubmissions@bcbsil.com.
- Report is now an Adobe fillable form with digital signature capability.

Report Overview

- Pursuant to Section C (3)(c)(1) and (2), describes the IPAs contractual requirements for meeting Availability and Accessibility.
- Additional instructions may be found on the report.

Submission Information

- **Report Due Date:** 4/30/2021
- **Email Completed Report to:** HMOSubmissions@bcbsil.com

Member Complaint Forms

Report Overview

- There is an interactive complaint form on the BCBSIL IPA Access Portal to enter member complaints as they are received.
- 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:
  - Access
  - Administrative
  - Attitude and Service
• Benefits
• Case Management or Condition Management Programs
• Claims
• Complaints regarding the IPA Complex Case Management
• Quality of Care
• Quality of Practitioner Office Site
• Referrals

• For additional instructions, please refer to the IPA Guidelines for Member Complaints, Inquiries, Appeals and Grievances HMO Policy and Procedure via BCBSIL.com.

Submission Information

• **Report Template Location:** (BCBSIL IPA Access Portal) Population Health Management> Commercial & Exchange> Complaint Form
• **Report Due Date:** within one (1) business day upon receipt of a member complaint
• **Email Completed Report to:** N/A

**Member Notification Letter for Provider Termination**

**Report Overview**

• Pursuant to Section I (C)(1)(o), 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.
  o As defined in the MSA, a Provider is, any licensed Physician, Advanced Practice Nurse, practitioner or facility, including, but not limited to, a physical therapist, psychologist, Hospital, health care facility, laboratory, and any other health care practitioner providing medical or behavioral health services licensed in accordance with all applicable Laws.
• The IPA must submit all template letter(s) annually and must be approved by the Provider Network Consultant prior to the letter being sent to the member.
  o If different letter templates are used for PCPs, Specialists and/or Ancillary providers, all letter templates should be submitted to HMO for approval.
• At the time of the provider termination, a dated copy of the letter must be submitted to the Provider Network Consultant prior to the member mailing.
  o Additionally, a copy of the provider termination email notice sent to BCBSIL HMO Network, must be submitted to the Provider Network Consultant.
• Specific letter requirements can be found in the **HMO Medical Service Agreement – Highlight and Process Summary Section 2021** of the HMO Provider Manual.

Submission Information

• **Report Template Location:** N/A
• **Letter Template Due Date:** 1/31/2021
• **Email Member Letter to:** HMOSubmissions@bcbsil.com

**PCP Member Detail Assignment Report**

**New for 2021**

✓ Added IPA Name, IPA Number and Report Date to the top of this report.
✓ Added report Instructions tab.
Report Overview

- Pursuant to Section C(9)(h) of the MSA, the IPA must provide a semi-annual detailed list of the IPA PCPs and assigned Members.
- The report must include the Member identification number, Member Name, assigned PCPC and shall be provided in a format acceptable to the HMO.
- Additional instructions may be found on the report.

Submission Information

- **Report Due Date:** 7/31/2021 and 1/31/2022
- **Email Completed Report to:** HMOSubmissions@bcbsil.com

PCP Summary Assignment Report

**New for 2021**

- Added IPA Name, IPA Number and Report Date to the top of this report.
- Added report Instructions tab.

Report Overview

- Pursuant to Section C(9)(g) of the MSA, the IPA must provide quarterly a list of all IPA PCPs with the number of assigned Members for each IPA PCP, and, if applicable, a total number of unassigned Members for the IPA.
- The data submitted in the report must reflect the member counts as of the last month in the quarter.
- Primary Care Physician (PCP) includes: Internal Medicine; Family Practice; General Practice; Obstetrics-Gynecology; and Pediatrics.
- The report must include WPHCPs.
  - If the IPA does not track WPHCP membership, please indicate "Not tracked" per the report instructions.
- Additional instructions may be found on the report.

Submission Information

- **Report Due Date:** 4/30/2021; 7/31/2021; 10/31/2021 and 1/31/2022
- **Email Completed Report to:** HMOSubmissions@bcbsil.com

Provider Service Agreement Attestation

**New for 2021**

- Report previously named Provider Service Agreement Annual Submission Report.
- Incorporated 2020 IPA Attestation info into this report since it all relates to Provider Service Agreements/Addendums.
- Report is an Adobe fillable form with digital signature capability.

Report Overview

- Pursuant to Section I (C)(9)(i)(3) of the MSA, the IPA must submit a copy of each written agreement not previously provided to the HMO.
• Pursuant to Section I (C)(9)(i)(4) of the MSA, authorized IPA representative must attest that the written agreement between the IPA and all IPA Providers requires all IPA Providers to comply with the terms and conditions established in the MSA and Provider Manual.

• Providers Service Agreement: Pursuant to Section 1 (C)(1)(q) of the MSA, IPA agrees to provide a copy of the current written service agreements between the IPA and any or all current contracted IPA Providers.

• 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.

• A completed Provider Service Agreement Cover Sheet must be submitted with all new provider service agreements/addendums sent to BCBSIL.

**Submission Information**

- **Report Due Date:** 1/31/2021
- **Email Completed Report to:** HMOSubmissions@bcbsil.com

**Provider Service Agreement Coversheet**

**Report Overview**

- Pursuant to Section I (C)(9)(i)(3) of the MSA, the IPA must submit a copy of each written agreement not previously provided to the HMO.

- Completed Provider Service Agreement along with the executed Provider Service Agreement is required when submitting provider credentialing applications to HMO Network.

**Submission Information**

- **Report Due Date:** see comments above
- **Email Completed Report to:** see comments above

**Utilization Management/Population Health Management Related Reports**

**Report Overview**

- The following report descriptions and requirements are outlined in the HMO Utilization Management and Population Health Management Plan:
  - Admission Log
  - Behavioral Health Referral Request Log
  - Case, Complex and Condition Management Forms
Denial Logs and files
Inpatient Physician Advisor Referral Log
Out of Network Referral Log
Population Health Management Referral Source Report (CM, CCM, Condition Management)
UM Plan (Due 2/15/2021)
URO License

Submission Information
- **Report Due Date:** as indicated or upon HMO request
- **Submission Process:** See HMO Utilization Management and Population Health Management Plan

**Welcome Letter Template (Member)**

**Report Overview**
- Pursuant to Section I (C)(10)(a) of the MSA, the IPA shall contact and orient newly enrolled Members within sixty (60) days from eligibility notification from the HMO via an HMO approved welcome letter.
- IPAs welcome letter template must be submitted to HMO for review and approval prior to use.
  - Any changes to such letter must also be approved by the HMO prior to use.
- The welcome letter must include, but not limited to:
  - IPAs expectation of the Member
  - Choosing or changing PCP
    - Process for choosing a PCP and notifying the IPA office of the PCP selection
    - How to change a PCP and any HMO restrictions that may apply
  - Choosing or changing WPHCP
    - Process for selecting a WPHCP and the Physician’s role in coordinating care with the PCP
    - How to change a WPHCP and any HMO restrictions that may apply
  - Process for scheduling a get acquainted visit
  - The availability of preventive services
  - Procedures regarding obtaining Behavioral Health (BH) Care services, including a statement that the IPA encourages the member to discuss any BH services that are being received with their PCP
  - How an Adolescent Member will transition to Adult Health Care Services.
  - Medical Records and Patient Confidentiality
    - Assurance of patient confidentiality
    - How the Member can obtain access to their medical records
  - Procedures for Emergency, Routine and Immediate Care Services – must include detailed description
  - How the Member can access their HMO benefits; including how Member can access early morning, evening, and weekend office hours
  - Procedures regarding referrals
  - IPA’s Utilization Management procedures
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, including but not limited to the following statements:

- UM Staff is 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 is identified by name, title and organization name when making or returning calls regarding UM issues.
- 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. (Language assistance does not apply to after-hours calls)

Who Makes Decisions About Member’s Care

- Utilization Management decisions are based on medical necessity, which includes appropriateness of care and services, and available benefits.
- IPA 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 confirms that there is no conflict of interest between themselves and the UM decision makers.

Information about the IPA’s Population Health Management Services that must include the IPA’s process (include how members can use the service, how members become eligible to participate and how to opt out of the Program) for:

- Condition Management, including at a minimum for members with asthma and diabetes
- Case Management (CM), including at a minimum for members who need assistance transitioning to home after a hospital stay or in navigating the health care system. When advising members how they can access CM, must include:
  - The member or their caregiver can ask to enroll in the program
  - A hospital or other discharge planner referral to the program
  - The member’s PCP or other Practitioner referral to the program
  - Referral through Utilization Management programs
- Complex Case Management (CCM) including at a minimum for members facing multiple or complicated medical conditions
- Wellness and Prevention Program including at a minimum:
  - An influenza vaccine program
  - Breast cancer, cervical cancer and colorectal cancer screening programs
  - Well-child screenings for health BMI and counseling on physical activity
- 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
  - Name and contact information of a designated Member representative of the IPA
Submission Information

- **Sample Welcome Letter Location**: (BCBSIL IPA Access Portal) Provider Network Management > Commercial & Exchange > MSA Required Submissions – Report Templates > 2021
- **Welcome Letter Template Due**: 1/31/2021
- Email IPAs Template: HMOSubmissions@bcbsil.com
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 HMOSM
    - Blue Precision HMOSM
    - 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.