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Medical Service Agreement (MSA) Highlights

This is not intended to be an all-inclusive listing of changes - please refer to the actual Medical Service Agreement for all details.

- Appendix C is now the Capitation Fee Schedules. Appendix E is now the sample of Office Based Surgery Procedures.
- On page 6, definitions have been added for Office Based Surgery and Outpatient procedures to differentiate those procedures that are in Appendix E from those in Appendix B.
- On page 18, b, 1, the reference to Preadmission testing claims has been removed from the business associate use paragraph.
- Language has been added to quantify that the IPA must notify the HMO within five (5) business days if any of the actions have occurred against the IPA or one of the IPA’s physicians.
- Language has been added on page 30 to reflect the name change for the Quality Site Visit Standards. In addition, allergies being noted in a prominent location for each medical record have been added as a chart requirement.
- Page 33 has been updated to reflect that the IPA’s Utilization Management plan must meet IDPH requirements as well as URAC. The requirement to notify the IPA physicians regarding how to obtain the IPA UM plan and medical criteria for decision making has also been added.
- Page 43 reflects a new item F – all PAT language has been removed and Office based surgery has been added. Appendix E has been created and is a sample of potential Office Based Surgeries. It is separate and unique from Appendix B. Procedures in Appendix B do not qualify for reimbursement under the Office Based Surgery provision.

Additional information clarifying the MSA language: Appendix E is attached to the January 2010 Agenda. This is a sample of surgeries that may be able to be performed in an office. This list is only to serve as a sample as the standard of care may change over time. The HMO will reimburse the IPA $200 per case for every surgery that met the following criteria:

1. The surgery would have otherwise been HMO risk, performed in a Hospital Based Surgery Center or free standing Ambulatory Surgery Center
2. The HMO did not pay a facility fee
3. The provider was accredited by: Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Accreditation Association for Ambulatory Health Care (AAAHC) or American Association for Accreditation of Ambulatory Surgical Facilities (AAASAF)

The HMO will reimburse the IPA annually, at the same time that it calculates Utilization Management Fund earnings and payments. The IPA will continue to receive payment for assumed but unutilized Unit associated with these surgeries.

- Language revision that the IPA shall not re-insure any of the first $14,000 of costs. Other re-insurance thresholds have also been adjusted (page 49). Language has also been added to ensure that any changes to the Provider Manual or any other contractual revision that changes the IPA’s financial responsibility or liability would not become effective until the subsequent Agreement Year.
- The amount payable to the IPA for each assumed but unutilized Unit for the Utilization Management Fund has been increased to $760.00. If the IPA has implemented a hospitalist program, the unit value has been increased to $790.00 or $840.00 as described on page 50.
- Page 53 reflects a new timeline for the payment of the Utilization Management Fund – will now be paid on or about 8 months following the end of the sixth month and the end of the calendar year.
- Refer directly to the MSA (pages 54-65) for the details of the Quality Improvement Fund revisions. As distributed in the Cover letter sent with the 2010 MSA, the following summarizes the changes to the Quality Improvement Fund.
Medical Service Agreement (MSA) Highlights (cont)

1. **Semi-annual Payment**
   The total amount of the semi annual payment (2.0% of Capitation Fees) did not change but the payment was divided into two components. One percent of Capitation Fees is available based upon the IPA meeting the first five criteria, and one percent of Capitation Fees is available to IPAs that submit complete encounter data.

   Specific criteria have been added as a minimum definition of “complete” encounter data. Most IPAs are already meeting these criteria. Note that for most IPAs, rates will be much higher than these minimums. IPAs are required to submit documentation of all encounters:
   - An Evaluation & Management visit rate of at least 2.5 visits per member per year
   - A laboratory services rate of at least 2.5 per member per year
   - Confirmation that all claim and encounter data has been submitted by all IPA providers

   Also note that IPAs that do not meet these criteria for submission of complete encounter data are not eligible to participate in those QI Fund projects for which the denominator requires complete encounters:
   - Controlling High Blood Pressure
   - Pediatric Wellness and Prevention
   - Adult Wellness and Prevention

   BCBSIL will begin to provide IPAs with periodic reports on their status with respect to these indicators of encounter data completeness.

   **Additional information clarifying the MSA language regarding complete encounter data:**
   The “Evaluation & Management visits” rate includes all E&M codes (CPT codes 99201-99499).
   The “lab services” rate includes all CPT codes in the “Pathology and Laboratory” section of the CPT book (CPT codes 80047-89356).
   Starting in the first quarter of 2010, BCBSIL will provide quarterly reports summarizing the IPA encounter data rates for Evaluation & Management visits and lab services. Please note that the MSA requires that IPA encounter data be complete, including, for example, all physician visits and all laboratory, radiology and other diagnostic services provided by or through the IPA. Consistent submission of the specialty of the physician providing a service is also important. IPA encounter data must include only services that were actually provided and must reflect the dates of services on which the services were rendered. Encounter data should not include services that are ordered but not provided or services for which a referral was issued but for which the member did not actually have the service.

2. **Annual Payments**
   The overall annual payment available to IPAs has increased by 0.25%.

3. **Special HEDIS Payments**
   In 2010, BCBSIL will be collecting data on several new HEDIS measures that involve medical record review. Some of the new measures include more than one indicator to be assessed for each sampled member.

   Through 2008, the Special HEDIS Payment was $1100 per numerator event. In 2009, the payment was reduced to $550 per numerator event for the diabetes measures, for which several indicators were being reported for each sampled member. For 2010, BCBSIL considered a two or three tier payment methodology for the new indicators. However, to reduce complexity, a decision was made to reduce the payment to $750 per numerator event and use the same payment amount for all indicators, regardless of whether BCBSIL is requesting data for one indicator or several indicators for a given member.

   Overall, with the new HEDIS measures for 2010 that involve medical record review, it is likely that most IPAs will have the opportunity to earn a larger Special HEDIS Payment in 2010 than in 2009.
Medical Service Agreement (MSA) Highlights (cont)

4. **Seasonal Influenza Vaccination Project**
   1. The QI Fund project was renamed to reflect that it includes only seasonal influenza vaccination, not H1N1 vaccination.
   2. Payment thresholds were not changed from 2009.
   3. The 2010 Seasonal Influenza Vaccination Project will include members with asthma, diabetes, cardiovascular disease and members age 50 and older. While the Advisory Committee on Immunization Practices has recommended for several years that all persons age 50 and older receive a flu shot, inclusion in the project of members age 50-64 is new. [Previously, members age 65 and older were included along with younger members with one of the specified conditions.]

   As previously communicated to IPAs, because of this change in the age range, in 2010 BCBSIL will calculate the IPA influenza vaccination rate two ways (including and excluding members identified solely on the basis of being age 50-64) and IPAs will be paid on the basis of the better of the two rates.

d. An outreach component was added to the project. This payment will be based upon outreach to high risk members in the fall of 2010.

5. **Cervical Cancer Screening Project**
   For the 2009 QI Fund, the payment thresholds were set very low as BCBSIL did not have baseline data on which to estimate results. For 2010, the payment thresholds were adjusted in accordance with HEDIS results and 2009 project performance. Note that this project incorporates administrative data only; medical record data will not be accepted for this project.

6. **Asthma**
   a. In 2009, payments were based upon the percentage of members who both receive a written asthma action plan and have an assessment of asthma control. For 2010, these components have been separated. One payment will be based upon the IPA asthma action plan rate and a second payment will be based upon the IPA assessment of asthma control rate.
   b. A new component of the asthma project for 2010 is payment based upon the percentage of asthmatic members meeting NAEPP criteria for having Well Controlled asthma. Asthma control must be assessed using a standardized tool for the member to be considered Well Controlled for this portion of the payment.

7. **Diabetes**
   a. Payment thresholds were adjusted in accordance with 2008 results.
   b. The criteria for Overall Diabetes Preventive Care were changed. In 2009, a member had to meet four of four criteria (HbA1c<8.0%, LDL-C<100 mg/dL, dilated retinal exam and receipt of medical attention for nephropathy) for the member to meet criteria for Overall Diabetes Preventive Care. For 2010, the member must meet at least four of five criteria (HbA1c<8.0%, LDL-C<100 mg/dL, BP<140/90, dilated retinal exam and receipt of medical attention for nephropathy) to meet criteria for Overall Diabetes Preventive Care.

8. **Follow-Up After Hospitalization for Mental Illness**
   Payment thresholds were adjusted in accordance with 2008 results.

9. **Childhood Immunization**
   a. Payment thresholds were adjusted in accordance with 2008 results.
   b. As discussed at the QI Forum in 2009, the 2010 QI Fund includes a new payment based upon the percentage of two year old children who received at least two doses of rotavirus vaccine.
Medical Service Agreement (MSA) Highlights (cont)

10. Management of Members with Cardiovascular Conditions
   a. An additional payment was added to the project. There are now two payment tiers for LDL-C control.
   b. Payment thresholds were adjusted in accordance with 2008 results.
   c. Advice to quit smoking will be counted only when there is documentation that smokers have received face to face advice to quit smoking during the one year timeframe for the project.
   d. A change was made in the methodology for calculating the Advice to Quit Smoking rate. For most IPAs, few identified members smoke so the denominator for this measure can be quite small. Therefore, to reduce variation in results due to small numbers, the Advice to Quit Smoking rate will be a two year rate. [The denominator for this indicator will be all members included in the denominator for the 2009 project plus all members included in the denominator for the 2010 project. The numerator will be all members included in the numerator for the 2009 project plus all members included in the numerator for the 2010 project. Members included in the project both years will be counted twice, once for each year.] In 2010, the Advice to Quit Smoking rate will be calculated as both a one year rate and a two year rate, and IPAs will receive credit for the better of the two rates.

11. Breast Cancer Screening
   Payment thresholds were adjusted in accordance with 2009 project results. As in previous years, this project incorporates administrative data only; medical record data will not be accepted for this project.

12. Colorectal Cancer Screening
   Payment thresholds were adjusted in accordance with 2009 project results.

13. Controlling High Blood Pressure
    a. Payment thresholds were adjusted in accordance with 2009 project results.
    b. Criteria for assessing the completeness of encounter data were updated for consistency throughout the MSA.

14. Pediatric Wellness and Prevention
    a. The Wellness and Prevention project was divided into pediatric and adult components.
    b. For children, IPAs can earn two payments: one based upon the percentage of children who have had an assessment of BMI percentile in 2009 and one based upon the percentage of children who received counseling for both physical activity and nutrition in 2009.
    c. Numerator and denominator criteria were revised in accordance with HEDIS specifications.
Medical Service Agreement (MSA) Highlights (cont)

15. Adult Wellness and Prevention
   a. The Wellness and Prevention project was divided into pediatric and adult components.
   b. For adults, IPAs can earn two payments: one based upon the percentage of adults who had an
      assessment of BMI in 2008 or 2009 and one based upon Advice to Quit Smoking and Screening for
      Problem Drinking.
   c. Payment for the Advice to Quit Smoking and Screening for Problem Drinking measure will be based
      upon the percentage of identified members who meet the following four criteria:
      i. Smoking status is documented.
      ii. If the member is a smoker, the member received advice to quit smoking in 2008 or 2009.
      iii. The member has had an assessment of alcohol use
      iv. If the member uses alcohol, the member was screened for problem drinking using a
         standardized assessment tool in 2008 or 2009.
   d. Numerator and denominator criteria were revised in accordance with HEDIS specifications.

16. Patient Safety Physician Education Project
   This program was removed from the MSA for 2010.

   • The Prescription Drug Management Fund thresholds have been revised. Refer directly to page 65 for the
details. Please note that there may be two typographical errors in this section. The first is in the
description of the top tier. Eleven percent (11%) is available for reaching at least seventy-six percent of
all prescriptions for members enrolled in the IPA are generic. The second is tier four percent tier is from
sixty to sixty-three point nine-nine percent (60.00% - 63.99%). Also note that the HMO now provides a
report on the top 150 prescribers for the IPA instead of the 25 that was previously available. In addition,
the Prescription Drug Fund will now be paid on or about five (5) months after the end of the calendar
year.
## Submission Grid

**HMOs* of Blue Cross Blue Shield of Illinois**

**2010 Submission Grid**

<table>
<thead>
<tr>
<th>Due Date: 10th of each Month</th>
<th>1st qtr 05/01/2010</th>
<th>1st qtr 05/31/2010</th>
<th>2nd qtr 07/31/2010</th>
<th>2nd qtr 08/31/2010</th>
<th>3rd qtr 10/31/2010</th>
<th>3rd qtr 11/30/2010</th>
<th>4th qtr 01/31/2011</th>
<th>4th qtr 02/28/2011</th>
<th>Annual - 150 days after the end of the IPA's fiscal year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case Mngmt Report due the 10th of the month after the quarter ends</strong></td>
<td>IPA attestation</td>
<td>Income and Expense Report, electronically submitted, YTD, cash basis, contract specific</td>
<td>BH telephone Access standards report - if applicable</td>
<td>Income and Expense Report, electronically submitted, YTD, cash basis, contract specific</td>
<td>BH telephone Access standards report - if applicable</td>
<td>Income and Expense Report, electronically submitted, YTD, cash basis, contract specific</td>
<td>BH telephone Access standards report - if applicable</td>
<td>Income and Expense Report, electronically submitted, YTD, cash basis, contract specific</td>
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</tr>
<tr>
<td><strong>Upon HMO Request:</strong></td>
<td>IPA Provider Roster Spreadsheet electronically submitted</td>
<td>Welcome letter - (if not already submitted with UM plan)</td>
<td>CMF Service Agreement + Oversight Plan, incl. Beh. Health Care CMFs, if appl.</td>
<td>BH telephone Access standards report - if applicable</td>
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**Revised 1/10** * HMO Illinois and Blue Advantage HMO

All submissions should be sent to: Ernestine Brown - Browne@BCBSIL.com or fax - 312-540-8206.
### Sample Report Formats

**2010 Behavioral Health Referral Request Log**

IPA #/Name: _______________________________  Month: ____________

<table>
<thead>
<tr>
<th>Member ID #:</th>
<th>ICD - 9 Code</th>
<th># of Visits Approved (Include Initial Assessments)</th>
<th>Name of PCP Requesting Referral</th>
<th>Date Referral Received</th>
<th>Date Referral Approved</th>
<th>Date PCP Notified</th>
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* HMO Illinois and Blue Advantage HMO

If Referral is approved record on this form. If denied, record on the Denial/Appeal Log.

11/09
**2010 Denial/Appeal Log**

**MG/IPA #/Name:** ________________________________  **Product:** HMOI [ ] BA HMO [ ]  **Month:** ________

For questions regarding log:

**Contact Name:** ________________________________  **Phone:** ________________________________

<table>
<thead>
<tr>
<th>Member Group #</th>
<th>Member ID #</th>
<th>Date Referral Received</th>
<th><em>Type of Service Denial Code (1-8)</em></th>
<th>Denial Reason Codes: 1 Medical Necessity; 2 Out of Network; 3 Noncovered Benefit</th>
<th>Date of Denial</th>
<th>Date of Member Letter</th>
<th>Date of Physician Letter</th>
<th>Date of Appeal (date or N/A)</th>
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*HMO Illinois and BlueAdvantage HMO
Nov-09

Type of Service Denial Codes:
1 - Inpatient days  2 - Specialist Referral  3 - Outpatient Surgery  4 - Labs/Diagnostic Testing  5 - DME/Medical Equipment  6 - Drugs  7 - Investigational Treatment  8 - Other
## 2010 Admission Log

| IPA #/Name: | Month: | | | | |
|-------------|--------|---|---|---|

<table>
<thead>
<tr>
<th>Member Name and ID:</th>
<th>Facility</th>
<th>Diagnosis/Procedures Performed</th>
<th>PCP or Admitting Physician</th>
<th>Admit Date</th>
<th>Discharge Date</th>
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*HMO Illinois and BlueAdvantage HMO
11/09
## 2010 Out of Network Referral Request Log

<table>
<thead>
<tr>
<th>Member ID #:</th>
<th>Out of Network Service Requested</th>
<th>Name of PCP Requesting Referral</th>
<th>Date Referral Requested</th>
<th>Date Referral Approved</th>
<th>Date PCP/MBR Notified</th>
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</table>

No. of Referrals for ALL Medical Specialties _______

No. of Referrals for Behavioral Health ________

*HMO Illinois, BlueAdvantage HMO

Reviewed 11/09
# 2010 Inpatient Physician Advisor Referral Log

IPA #/Name: ____________________________________________________________  
Month: ______

<table>
<thead>
<tr>
<th>Member ID #:</th>
<th>Admit Date</th>
<th>Date of Referral to PA</th>
<th>Reason for Referral</th>
<th>Approved</th>
<th>Denied</th>
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*HMO Illinois, BlueAdvantage HMO  
Reviewed 11/09
## 2010 Referral Inquiry Log

<table>
<thead>
<tr>
<th>IPA #/Name</th>
<th>Service Requested</th>
<th>Date Inquiry Initiated</th>
<th>Date Inquiry Discussed with PCP and/or Attending</th>
<th>Referral Inquiry Outcome Deny/Approve</th>
</tr>
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*HMO Illinois, BlueAdvantage HMO 11/09*
2010 CMF Oversight Report

HMOs* of Blue Cross Blue Shield of Illinois
2010 CMF Oversight Report

Quarterly Submission Schedule

<table>
<thead>
<tr>
<th></th>
<th>1st Quarter</th>
<th>2nd Quarter</th>
<th>3rd Quarter</th>
<th>4th Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due at HMO on</td>
<td>April 30</td>
<td>July 31</td>
<td>October 31</td>
<td>January 31</td>
</tr>
</tbody>
</table>

IPA #: __________________________  Quarter : 1st 2nd 3rd 4th

IPA Name: __________________________  Product:  HMO Illinois  BA HMO

(✓ Check One)

List all services delegated to CMF

- [ ] Claims
- [ ] Membership/Eligibility
- [ ] Customer Service
- [ ] Credentialing
- [ ] Utilization Management
- [ ] Quality Review
- [ ] MSA/Contracting

List dates and attendance of meetings where IPA personnel reviewed CMF activities:

List name of report and date of review/approval for all reports provided to the IPA by the CMF for oversight purposes:

List date of review and approval of CMF Quality Plan (annually):

Were any of the complaints submitted to the HMO related to the CMF activities? If so, list the complaints, the resolution of the complaints, and the IPA action addressing the CMF’s process that may have resulted in the complaint. (What action was taken to prevent reoccurrence of the complaint?)

Revised 12/09  *HMO Illinois and Blue Advantage HMO
# Instructions

1. Use **separate** submission covers for HMOI and Blue Advantage HMO products & for individual IPA sites.
2. Assign **ONE** category per complaint: Choose the type that best fits the description.
3. Attach (staple or bind) all relevant documentation behind this submission cover sheet for each HMO product.
4. If no complaints were submitted, please indicate “0” in appropriate boxes.
5. Submit complaints only. NO inquiries please.

### Quarterly Submission Schedule

<table>
<thead>
<tr>
<th>IPA #: __________________________</th>
<th>Quarter:</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPA Name: ______________________</td>
<td>Product:</td>
<td>![ ]</td>
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<tr>
<td>(Check One) ![ ]</td>
<td>BA HMO ![ ]</td>
<td>HMO Illinois ![ ]</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Name of Month

<table>
<thead>
<tr>
<th>Month 1</th>
<th>Month 2</th>
<th>Month 3</th>
<th>Total Complaints by Type</th>
</tr>
</thead>
</table>

### Complaint Category Descriptions:

<table>
<thead>
<tr>
<th>ADM</th>
<th>R</th>
<th>B</th>
<th>ACC</th>
<th>C</th>
<th>QOC</th>
<th>OTH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Administrative</strong></td>
<td><strong>Referral</strong></td>
<td><strong>Benefit</strong></td>
<td><strong>Access</strong></td>
<td><strong>Claims</strong></td>
<td><strong>Quality of Care</strong></td>
<td><strong>Other</strong></td>
</tr>
</tbody>
</table>

**Total Complaints per Quarter**

11/09
# 2010 Member Complaint Log Report

**HMOs* of Blue Cross Blue Shield of Illinois**  
2010 Member Complaint Log Report-Submit Upon Request Only  

Complaint: an expression of dissatisfaction, oral or written. All complaints must be resolved within 30 days of receipt. All complaints must be discussed in monthly QR/UM meetings.

<table>
<thead>
<tr>
<th>Quarterly Submission Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>IF REQUESTED</td>
</tr>
<tr>
<td>due at HMO on</td>
</tr>
<tr>
<td>1st Quarter</td>
</tr>
<tr>
<td>April 30</td>
</tr>
</tbody>
</table>

IPA #: __________________________  
Quarter:  
1st 2nd 3rd 4th  

IPA Name:__________________________  
Product:  
☐ HMO Illinois  
( ✗ Check One)  
☐ BA HMO

Member Name:__________________________  
Group & ID #: ________________________  
Category of Complaint:  
ADM  R  B  ACC  C  QOC  OTH  

PCP/Provider Name: _______________  License #: _______________

<table>
<thead>
<tr>
<th>Receipt Date:</th>
<th>Date of Incident:</th>
<th>Resolution Date:</th>
<th>Date letter sent to member:</th>
<th>UM Mtg. Review Date:</th>
</tr>
</thead>
</table>

Problem: 

Findings of Investigation:

Recommendation of UM/QR Committee:

Resolution and follow-up:

---

HMO Illinois and Blue Advantage HMO  
Revised 11/08
Member Complaint/Inquiry Categories

**Complaint:** An expression of dissatisfaction, oral or written

**Inquiry:** A request for information or a request for investigation of a potential problem

**ADM = Administrative**
Member inquiring about an administrative issue. For example:
- member complains of rudeness, attitude, or inattentive staff
- clerical, facility issues
- management issues
- membership/eligibility/ID card issues
- provider related concerns not related to Quality of Care

**ACC = Access**
Member inquiring about access issues such as:
- availability/timeliness/appropriateness of appointments
- difficult access to PCP and/or support staff by telephone
- answering service issues
- insufficient PCPs to cover geographic location
- reduced access to PCP and medical services because patient is an HMO member

**R = Referrals**
Any referral related issues. For example:
- availability/timeliness/appropriateness/processing
- denied access to a specialist

**C = Claims**
Member inquiring about any claim issues. For example:
- unpaid claim
- claim payment amount

**B = Benefits**
Member dissatisfied with HMO benefits or benefit coverage.

**QOC = Quality of Care**
Member inquiring about the quality of medical care received through HMO providers. This may include:
- provider prescribed the wrong medication
- member feels illness was misdiagnosed or not properly treated

**OTH = Other**
Member inquiring about any other problems that require investigation that does not fit into the other categories.
2010 Capitated Employed Encounter Date Report Overview

PCP report (all PCPs should be included)
Create a spreadsheet that contains the following columns:
- PCP name
- PCP specialty
- Average current membership assigned to this PCP
- Number of claims received in the quarter.
- Average number of claims adjudicated in the quarter.
- Average number of claims received divided by the average current PCP membership will give us the average number of claims received/adjudicated by capitated/employed PCP.

The Average number of claims adjudicated for each PCP should look similar to the other PCPs in that specialty. If the data for a particular PCP does not look within the range of the other values, then the IPA should investigate whether the PCP is not submitting complete claim/encounter data and document the IPA’s action plan for obtaining complete claim/encounter data. (with follow up reports on action items in subsequent quarters)

Specialist/Ancillary provider report
Create a spreadsheet that contains the following columns:
- Specialty/Ancillary provider/provider group name
- IPA average current membership
- Number of claims received
- Average number of claims received in the quarter divided by Average current membership will give us the average number of claims received/adjudicated by capitated/employed Specialist and capitated Ancillary facility.

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

Revised 12/09
### HMOI/BA 1ST QTR PCP REPORT

<table>
<thead>
<tr>
<th>PCP</th>
<th>SPEC</th>
<th>AVG MBR</th>
<th>#CLM RCV</th>
<th>AVG # CLM ADJ</th>
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<tbody>
<tr>
<td>###### 1</td>
<td>PEDIATRIC</td>
<td>82</td>
<td>24</td>
<td>0.29</td>
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<tr>
<td>###### 2</td>
<td>FAMILY PRAC</td>
<td>297</td>
<td>233</td>
<td>0.78</td>
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<tr>
<td>###### 3</td>
<td>FAMILY PRAC</td>
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<td>###### 4</td>
<td>FAMILY PRAC</td>
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<td>###### 5</td>
<td>PEDIATRIC</td>
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<td>0.52</td>
</tr>
<tr>
<td>###### 6</td>
<td>INTERNAL MED</td>
<td>18</td>
<td>7</td>
<td>0.39</td>
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<tr>
<td>###### 7</td>
<td>INTERNAL MED</td>
<td>224</td>
<td>131</td>
<td>0.58</td>
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<tr>
<td>###### 8</td>
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<td>43</td>
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<td>###### 10</td>
<td>INTERNAL MED</td>
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<tr>
<td>###### 11</td>
<td>INTERNAL MED</td>
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### HMOI/BA SPECIALIST and ANCILLARY PROVIDER REPORT

#### 1ST QUARTER

<table>
<thead>
<tr>
<th>SPECIALTY</th>
<th>GRP NAME</th>
<th>AVG MBR</th>
<th>#CLM RCV</th>
<th>AVG # CLM ADJ</th>
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</thead>
<tbody>
<tr>
<td>RADIOLOGY</td>
<td>#######</td>
<td>127</td>
<td>67</td>
<td>0.53</td>
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</table>

#### 1st QUARTER

<table>
<thead>
<tr>
<th>ANCILLARY</th>
<th>FACILITY</th>
<th>AVG MBR</th>
<th>#CLM RCV</th>
<th>AVG # CLM ADJ</th>
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</thead>
<tbody>
<tr>
<td>Radiology Facility</td>
<td>#######</td>
<td>123</td>
<td>76</td>
<td>0.62</td>
</tr>
</tbody>
</table>
2010 Sample Welcome Letter Format

IPA Name  
Address  
City State Zip  
Phone Number

Dear Managed Care Member:  

On behalf of the physicians and staff of ___________, I would like to thank you for selecting us as your managed care provider. (Short description of IPA.)

As you may know, a major factor of your managed care plan is the active role of your Primary Care Physician (PCP). Your Primary Care Physician will be responsible for directing all of your health care needs. Be sure to contact your Primary Care Physician whenever you need to seek health care services. Services rendered outside of ___________ may not be covered if prior authorization has not been obtained.

This plan provides for preventive services intended to help maintain your health and to promote early detection of disease. We strongly encourage you and the enrolled members of your family to work with your personal Primary Care Physicians to obtain general physicals.

Your IPA has the ability to provide case management services if your condition warrants. If you think you might be a candidate for these services, you or your PCP may contact us at ____________

It is important that each member selects a Primary Care Physician and knows how to reach him or her. To further assist you in understanding your health care coverage, our staff has prepared the enclosed reference sheet. If you have any questions, please feel free to call us at ____________. We look forward to a long and healthy relationship.

Sincerely,

Rev 12/09
MAKE YOUR HMO WORK FOR YOU
FOLLOW THESE EASY STEPS:

Choosing or changing your Primary Care Physician (PCP) from the enclosed list
- Please make sure the PCP you have selected is on the enclosed list.
- Select or change your PCP by contacting our office at

Choosing or changing your Woman’s Principal Health Care Provider (WPHCP)
- A Woman’s Principal Health Care Provider (WPHCP) is an Obstetrician/Gynecologist (OB/GYNE) who has been selected to be directly accessible for treating and coordinating a female Member’s health care needs. The WPHCP must have a referral arrangement with the female Member’s PCP.
- Please make sure the WPHCP you have selected is on the enclosed list.
- Select or change your WPHCP by contacting our office at _________________________.

Call your Primary Care Physician and WPHCP for a get acquainted visit
- Have your HMO Identification Card with you.
- Please be aware that co-payment amounts vary by HMO plan and are payable at the time of the visit.

Behavioral Health Care Services
- If you are in need of Behavior Health Care services, you should_______________. (outline how member should access care)

Chemical Dependency Services
- Benefits are available through the HMO Illinois Chemical Dependency Network for the treatment of Substance Abuse whether or not the Covered Services rendered have been ordered by your Primary Care Physician or Woman’s Principal Health Care Provider. To obtain benefits for Substance Abuse Treatment, you must call the HMO Illinois Chemical Dependency Hotline at 1 (800) 346-3986.

Medical Records and Patient Confidentiality
- If you have medical records that need to be transferred to this facility, please have those records transferred as soon as possible.
- If you need a copy of your medical record, you must ________________.
- Medical Records are held in strict confidence.

Emergency Services
- Prior to seeking care in an emergency room, we recommend that you call your PCP for treatment advice.
- In situations where you feel you can’t call your PCP, such as when you think you may be having a heart attack or a stroke, go directly to the to the nearest hospital emergency room. Notify your PCP as soon as possible of any treatment you receive.
- To contact your PCP call ________________.

A referral for services not directly provided by your PCP may be required
- Your PCP will coordinate your overall health care and determine the need for specialty care referrals for medically necessary services.
- All referrals undergo a review process.
- If a referral is denied, the reason for the denial, the alternative treatment, a telephone number for questions, and the mechanism for appeal will be communicated to you in writing.
- Be sure to verify the date and type of referral you receive.
Utilization Management Process
- Pre-Admission Certification and Concurrent Review are two programs established to ensure that you receive the most appropriate and cost effective health care.
- Your PCP must obtain approval from your Participating IPA prior to inpatient hospital admission other than emergency situations.
- Your participating IPA may recommend other courses of treatment that could help you avoid an Inpatient stay.
- It is your responsibility to cooperate with the recommendations made by your PCP.
- Concurrent Review ensures that your length of stay is appropriate given your diagnosis and treatment.
- You may contact us to discuss the Utilization Management Process or any issues regarding it by calling our toll free phone number _____________ or by calling ____________collect.

Appeal Process
- Communication with your physician is an important part of your health care. If you do not understand any course of your care, please discuss this with your PCP.
- You can also contact our Patient Advocate at _______________. The role of the Patient Advocate is to help with Member issues or concerns that cannot be resolved through normal channels.
- As an HMO member, you have the right to appeal any payment or denial of covered services by contacting our HMO office at _____________ or in writing at _____________ or this can be initiated by contact the HMOs of Blue Cross Blue Shield of Illinois at 312-653-6600 or in writing at:

  HMO Appeal Committee
  300 East Randolph
  Chicago Il 60601

- Following an adverse determination for a clinical service, procedure or treatment that is not reviewed as medically necessary, any involved party may request an external independent review.
HMOI/BA HMO Quarterly Income Statement and Balance Sheet Report Format

This report is only available electronically. Contact your Provider Network Consultant to obtain the report.
2010 Directions for Complex Case Management Log

The case management log does not need to be sent in quarterly. The log will be requested prior to the case management audit. The case management audit cases will be chosen at least two weeks prior to the audit. The HMO log is a sample log, but any IPA log must have all the elements that are requested.

1. Patient ID/ Name – can be any number that enables the IPA to find the patient. Name or initials should also be included.

2. Date Opened - the date the case was opened as a complex case managed case.

3. Identified by – how the case was identified as a complex case management case. Use the sources identified in the HMO UM Plan.

4. Diagnosis – this should be the diagnosis that is associated with the case managed case.

5. Guidelines used – this is not a Yes or No. This column should be completed with the name of the guideline the IPA has adopted.

6. Date closed - this column will remain blank until the patient is no longer being case managed.

Cases should be chosen from this log for audit (AT LEAST 1). Try to choose cases that encompass the different methods of case identification.
2010 Complex Case Management Case Log

SAMPLE LOG

IPA # and NAME: ____________________________________________________________

<table>
<thead>
<tr>
<th>Patient ID/ Name</th>
<th>Date Opened</th>
<th>Identified by (code 1)</th>
<th>Diagnosis</th>
<th>Guidelines used to manage case</th>
<th>Date Closed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
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<td>11</td>
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</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Identification codes:  
   A. Claims data  
   B. Hospital discharge data  
   C. Pharmacy data  
   D. Data collected through UM process  
   E. D2 Hawkeye report

12/09
IPA Attestation

Hospital Affiliation(s): ____________________ site number(s): _________________

IPA attests that it has written agreement with all IPA Physicians or other providers of professional or ancillary services (“Provider”) that render care to Blue Cross and Blue Shield of Illinois (“BCBSIL”) HMO Members. A list of Providers that the IPA has written agreements with is attached hereto as Exhibit A). This list includes but is not limited to: PCPs, specialists, facilities, ancillary providers, sub-specialists and hospital based physicians, and includes any and all agreements in place for the provision of care to BCBSIL HMO Members. IPA further attests that the IPA’s written agreements with each of its Providers contain, at a minimum, the following:

a) Provider’s responsibilities;

b) Provider’s compensation;

c) Agreement to seek compensation not from HMO or Member but solely from the IPA for services provided to Members;

d) 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;

e) Professional liability insurance coverage – each Provider shall maintain a valid current policy (or policies) of insurance with a solvent insurer of national reputation covering professional liability of each Provider, his/her agents and employees, which is in an amount not less than $1,000,000 per claim and $3,000,000 annual aggregate coverage. Each Provider shall carry such other insurance as shall be necessary to insure each Provider, his/her agents and employees against any and all damages arising from each Provider’s various duties and obligations;

f) Agreement to preserve patient confidentiality;

g) Agreement not to charge any Provider that has a contractual or other affiliation with another Participating IPA more than the BlueCross BlueShield of Illinois PPO Schedule of Maximum Allowances for referred or Emergency services, provided to Members of such Participating IPA, if such bills are paid within 30 days of the Participating IPA’s receipt of such bills; and

h) Agreement that IPA Physicians and/or IPA are solely responsible for the provision of all healthcare services to Members. All decisions regarding Member treatment and care are the sole responsibility of IPA Physicians and such decisions are neither directed nor controlled by HMO. And, except as to the amount and manner of payment, the Agreement shall in no way affect the usual physician/patient relationship. The IPA and IPA Physicians shall provide services to Members in the same manner and quality as those services that are provided to other patients of the IPA/IPA Physicians that are not HMO Members.
1) _________ IPA attests that the above listed terms and conditions are in the current written agreements between the IPA and IPA Physicians and Providers (provide copies of each written agreement)

2) _________ IPA attests that it has obtained a written Addendum from all contracting IPA Physicians and providers which includes the information set forth in (a) – (h) above (provide copies of each executed Addendum)

3) _________ IPA has communicated the above listed terms and conditions to IPA Physicians and Providers in some other manner as set forth in the attachment hereto, that is legally binding, acceptable to the HMO and ensures that IPA Physicians and Providers acknowledge and agree with the above listed terms and conditions. IPA agrees to hold harmless and indemnify HMO for the failure of any IPA Physician or Provider to adhere to the above listed terms and conditions set forth in (a) – (h) above.

“IPA” Authorized Signature _____________________________
Title _____________________________________________

Print name ___________________________________________

Date _______________________________________________
IPA Standards for Emergency Services

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

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

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

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

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

5. The IPA should maintain the log in their files for at least one year.

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

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

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