BLUE CROSS AND BLUE SHIELD OF ILLINOIS
POLICY

DEPARTMENT: Provider Performance Network	**POLICY NUMBER** **Administrative** 39	**ORIGINAL EFFECTIVE DATE**: 7/01/1999
POLICY TITLE HMO Administered Complaints		**EFFECTIVE DATE: 6/1/2022** **LAST REVISION DATE: 6/1/2022**
EXECUTIVE OWNER: Executive Director	**BUSINESS OWNER:** Unit Manager, Provider Performance	**LAST REVIEW DATE: 6/1/2022**

I. SCOPE

This Policy applies to the Service Center (SC) divisions for Blue Cross and Blue Shield of Illinois (BCBSIL) Health Management Organization (HMO) Commercial and Exchange health plans and applies to the following lines of business and products:

Line of Business / Product Scope / Plan Scope/Contract Number (if applicable)	In Scope [x]
HMO Commercial	X
HMO Exchange	X
PPO Commercial	
PPO Exchange	

II. POLICY

Blue Cross and Blue Shield of Illinois (BCBSIL) will issue an HMO Administered Complaint to the Medical Group/Individual Practice Association or Physician Hospital Organization (hereinafter the "IPAs"), if the IPA fails to adhere to any of the terms, obligations, or conditions set forth in the Medical Service Agreement (MSA) and Provider Manual.

III. PURPOSE:

1. To ensure that IPAs comply with the requirements as specified in the HMO MSA and outlined in the Provider Manual. Failure to meet the requirements will result in the IPA not earning the specified portion of the Quality Improvement (QI) Fund.
2. To provide a consistent mechanism for assigning HMO Administered Complaints to the IPAs for failure to adhere to terms of the MSA which may include but are not limited to:
   - Administrative
   - Access to Care
   - Quality of Care
   - Failure to Pay

IV. GUIDELINES:

The following guidelines will be followed to determine when an HMO Administered Complaint should be issued in each category:

1. Administrative:

   a. IPA has failed to respond to an HMO inquiry within (seven) 7 calendar days.

   b. IPA has failed to respond to Illinois Department of Insurance and/or Attorney General inquiry within (four) 4 calendar days.

c. Failure to submit required information within designated timeframes including but not limited to:

- Financial Reports
- Quarterly and annual reports
- Denial log and files
- Referral log and files
- Medical Group Inquiries
- Primary Care Physician and/or Participating Specialist Provider IPA Termination Notice letters
- Medicare Secondary Payment Inquiries, and
- Utilization Management (UM) and Population Health Management Plan requirements

2. Access to Care:
HMO Provider Network Consultant (PNC) or ***Clinical Delegation Coordinator*** staff determines that the IPA has failed to adhere to the following access standards, including, but not limited to the following

   a) Ensure that all IPA Physicians and Behavioral Health Care Practitioners provide reasonable access for all members enrolled with the IPA including, but not limited to the following

      1) Appointment for Preventive Care within four (4) weeks of request for members 6 months of age and older;

      2) Appointment for Preventive Care within two (2) weeks of request for infants under 6 months of age;

      3) Appointment for Routine Care within ten (10) business days or two (2) weeks of request, whichever is sooner;

      4) Appointment for Immediate Care within twenty-four (24) hours of request;

      5) Response by IPA Physicians within thirty (30) minutes of an emergency call;

      6) Notification to the Member when the anticipated office wait time for a scheduled appointment may exceed thirty (30) minutes;

      7) Behavioral Health Care Practitioners must provide access to care for non-life-threatening emergencies within six (6) hours.

   b) Ensure that HMO Members enrolled with the IPA have selected or are assigned a PCP, if applicable, and that all IPA physicians inform members of treatment options.

   c) Ensure that HMO Members enrolled with the IPA have access to PCP medical services including, but not limited to, the following:

      1) Routine Care – Each PCP or PCP office is required, at a minimum, to be available to provide routine care to HMO Members enrolled with the IPA for at

least eight hours per month outside the hours of 9:00 am – 6:00 pm Monday through Friday. PCP office is defined as a specific office location at which one or more PCPs are marketed to HMO Members as a location where primary care services are available.

2) Immediate Care – Each PCP or PCP office is required, at a minimum, to be available to provide or arrange access to care for HMO Members with immediate medical needs as outlined below, without any referral requirement:
   (a) Early morning or evening office hours three or more times per week. Early morning hours are defined as hours beginning at 8:00 a.m. and extending until 9:00 a.m. Evening hours are defined as hours beginning at 6:00 p.m. and extending until 8:00 p.m.
   (b) Weekend office hours of at least three hours two or more times per month.

Maintain a twenty-four (24) hour answering service and ensure that each PCP and WPHCP provides a twenty-four (24) hour answering arrangement and a twenty-four (24) hour on-call PCP arrangement for all Members enrolled with the IPA.

3 Quality of Care (QI):
When the HMO receives a complaint about the Quality of Care of clinical services provided by the IPA or one of their physicians, the complaint is initially screened by the QI clinical reviewer and passed onto the HMO Medical Director for a final determination.
Quality of Care issues may be related to clinical care or clinical services provided by a physician, IPA or other medical facility.

Each complaint is assigned a severity level based on the classification of the Quality of Care complaint. These are as follows:

0 - No quality issue.
1 - Minor issue, communication problem.
2 - Quality issue, patient outcome not affected adversely
3A - Quality issue, patient outcome affected adversely, minimal risk to patient safety.
3B - Quality issue, patient outcome adversely affected, moderate risk to patient safety.
3C - Quality issue, patient outcome serious, catastrophic risk to patient safety.

An HMO Administered complaint is issued for any Quality of Care inquiry determined to be either severity level 2 or severity level 3 A to C.

4. Failure to Pay:
   A Failure to Pay Complaint may be issued if an IPA has failed to pay a group approved claim.

V. CONTROLS/MONITORING

Line of Business and/or Area	Control Requirements
HMO Commercial and Exchange	Controls are described in HMO Medical Service Agreement and Provider Manual

VI. POLICY REVIEWERS

Person Responsible for Review	Title	Date of Review
Mary Ellen Merbeth	HMO Provider Network Consultant, Professional Provider Network	5/27/2021
Danielle Washington	HMO Provider Network Consultant, Professional Provider Network	5/3/2022

VII. POLICY REVISION HISTORY

Description of Changes	Revision Date

VIII. POLICY APPROVALS

Company, Division, Department and/or Committee	By: Name	Title	Approval date
BCBSIL P&P			5/27/2021
BCBSIL P&P			5/26/2022