BLUE CROSS AND BLUE SHIELD OF ILLINOIS
MEDICARE ADVANTAGE HMO POLICY

<table>
<tr><td>DEPARTMENT:
IL Provider Performance Management</td><td>POLICY NUMBER:
GCS-IL-MA-09A</td><td>ORIGINAL EFFECTIVE DATE (IF KNOWN): 01/01/2013</td></tr>
<tr><td colspan="2" rowspan="2">POLICY TITLE:
Administered Complaints Policy</td><td>EFFECTIVE DATE: 08/09/2022</td></tr>
<tr><td>LAST REVISION DATE:
08/09/2022</td></tr>
<tr><td>EXECUTIVE OWNER:
Executive Director, Provider Performance</td><td>BUSINESS OWNER:
Manager, Provider Performance</td><td>LAST REVIEW DATE:
08/09/2022</td></tr>
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I. SCOPE

This Policy applies to Provider Performance Management government product Medicare Advantage HMO.

This Policy applies to the following lines of business and products:

Line of Business / Product Scope / Plan Scope/Contract Number (if applicable)	In Scope [x]
Medicare MAPD/H3822/H8547	X
NOTE: Future fully executed contracts will fall under this policy.	

II. PURPOSE

- To ensure that IPAs comply with the requirements as specified in the MSA and the provider manual.
- To provide a consistent mechanism for assigning MA 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

III. DEFINITIONS

NOTE: The terms defined below are only applicable within the scope of this document.

The following guidelines are followed to determine when an MA HMO Administered Complaint should be issued in each of the following categories:

Administrative	• Independent Physician Association (IPA) has failed to respond to MA HMO inquiries within seven (7) calendar days. • IPA has failed to respond to Illinois Department of Insurance, Illinois Attorney General and/or CMS cases within four (4) calendar days. • IPA Failure to submit required information within designated timeframes including but not limited to: • Financial Reports • Quarterly and annual reports • Organization Appeals and Grievances (ODAG) • Utilization Management (UM) Plan • Encounter Data/837 Submission
Access to Care	MA HMO administrative staff determines that the IPA has failed to adhere to the following access standards: • 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 (8) 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 MA HMO Members as a location where primary care services are available. • Immediate Care – Each PCP or PCP office is required, at a minimum, to be available to provide care or arrange access to care for MA HMO Members with immediate medical needs as outlined below: o Early morning or evening office hours three (3) or more times per week. o Early morning hours are defined as hours beginning at 8:00 am and extending until 9:00 am. Evening hours are defined as hours beginning at 6:00 pm and extending until 8:00 pm. o Weekend office hours of at least three (3) hours two or more times per month. Alternate arrangements for ensuring MA HMO Members access to immediate care must meet the minimum access requirements outlined above and be approved in writing by the MA HMO. Facilities billing Immediate Care services as an emergency room visit shall not be considered an alternate arrangement for access to Immediate Care. o Maintain a twenty-four (24) hour answering service and ensure that each PCP 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. o Meet the telephone access standards for Behavioral Health set forth in the current MA HMO Utilization Management Plan.

Failure to Pay	Failure to Pay Complaint may be issued by the MA HMO if an IPA has failed to pay a group approved claim.

IV. POLICY

Blue Cross and Blue Shield of Illinois will issue an HMO Administered Complaint to the IPA if the IPA fails to adhere to the HMO policies and procedures requirements as specified in the Medical Service Agreement (MSA).

V. CONTROLS/MONITORING

Control Document or Control Description	Control Document or Control Description
Annual review of the Medicare Advantage Provider Manual to ensure the documented processes to review, modify and amend this policy meets contractual requirements	Manager, Illinois Provider Performance Management
Provider Network Consultant monitors IPA response. If IPA is non-complaint, Provider Network Consultant escalates to Medicare Manager/Executive Director, Provider Performance Complaints are reviewed on an Ad-hoc basis Annual review of documented process	Provider Network Consultant Executive Director, Provider Performance

VI. RELATED DOCUMENTS

Procedure ID	Procedure Name	Document Location
GCS-IL-MA-09B	Administered Complaints Procedure	GBS SharePoint Library

VII. SOURCES/REFERENCES

Federal/State	Regulatory Requirements & References
N/A	Blue Cross Medicare Advantage (HMO)- Utilization Management and Population Health Management Plan 2022 Blue Cross Medicare Advantage HMO Delegated Provider Manual

VIII. POLICY REVIEWERS

Person Responsible for Review, and Committee Reviewing as FYI	Title	Date of Review
Lupita Monroy	Manager, Illinois Provider Performance Management	06/07/2022
Sandra Hopson	Provider Affairs Project Consultant	06/03/2022

IX. POLICY REVISION HISTORY

Version No.	Revision Date
Annual Review	08/09/2022
New Policy Template	06/16/2021

X. POLICY APPROVALS

Company, Division, Department and/or Committee	By: Name	Title	Approval date
Medicare P&P Comm.			08/09/2022
IL Provider Performance Management	Joanne O’brien	Executive Director	06/15/2022
IL Provider Performance Management	Joanne O’brien	Executive Director	06/18/2021