Provider Performance – Adm 39 - HMO Administered Complaints

HMO Policy & Procedure

BLUE CROSS AND BLUE SHIELD OF ILLINOIS
POLICY

DEPARTMENT: Provider Performance	
POLICY NUMBER: Administrative 39	**POLICY TITLE:** HMO Administered Complaints
EXECUTIVE OWNER: Executive Director	**BUSINESS OWNER:** Unit Manager, Provider Performance
ORIGINAL EFFECTIVE DATE (IF KNOWN): 07/01/1999	**COMMITTEE APPROVAL DATE:** 12/19/2024

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 IFM	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
   - Monthly, 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
   - Subcontractor Disclosure Attestation
   - Submissions

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) days;

      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.

      8) Behavioral Health Care Practitioners must provide access to outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions within thirty (30) minutes or thirty (30) miles from the Member's

residence for Members that reside within the Illinois counties of Cook, DuPage, Kane, Lake, McHenry and Will;

9) Behavioral Health Care Practitioners must provide access to outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions within sixty (60) minutes or sixty (60) miles from the Member's residence for Members that reside within Illinois counties other than Cook, DuPage, Kane, Lake, McHenry and Will.

b) Ensure that HMO Members enrolled with the IPA have selected or are assigned a PCP.
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.
d) 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.
e) Maintain answering service log of IPA, PCP, WPHCP, and Behavioral Health Care Practitioner calls for ten (10) years.
f) Ensure that during a Member's Inpatient hospitalization the Member's participating PCP agrees to any substitution of attending physician in accordance with 215 ILCS 134/30.
g) Meet the telephone access standards for Behavioral Health as set forth in the current HMO Utilitization Management and Population Health Management Plan.

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
Danielle Washington	Manager, HMO Provider Relations	12/16/2024

VII. POLICY REVISION HISTORY

Description of Changes	Revision Date
No changes	12/16/2024

VIII. POLICY APPROVALS

Company, Division, Department and/or Committee	By: Name	Title	Approval date
Provider Performance	Geoff Guiton	Executive Director	12/16/2024
BCBSIL P&P			12/19/2024

BLUE CROSS AND BLUE SHIELD OF ILLINOIS
PROCEDURE

DEPARTMENT: Provider Performance Network	
PROCEDURE NUMBER: Administrative 39A	**PROCEDURE TITLE:** HMO Administered Complaints
EXECUTIVE OWNER: Executive Director	**BUSINESS OWNER:** Unit Manager, Professional Provider Network
ORIGINAL EFFECTIVE DATE (IF KNOWN): 07/01/1999	**COMMITTEE APPROVAL DATE:** 12/19/2024

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

II. POLICIES IMPLEMENTED BY PROCEDURE

This Procedure implements the following Policies:

1. HMO Administered Complaints, Admin 39
2. Quality of Care Complaints and Occurrences, QI 26

III. PROCEDURE

1. The HMO inquirer's i.e., Health Service Assistant (HSA), Provider Network Consultant (PNC) or Clinical Delegation Coordinator (CDC) complaint will be emailed to the IPA Administrator with a request for specific information needed related to the complaint. The response date will be clearly identified.

2. An extension will be granted for extenuating circumstances as determined by BCBSIL HMO to those IPAs who have requested additional time to do further investigation.

   Extenuating Circumstances include but not limited to:

   - Response is needed from physician, and he/she is on vacation/ill.
   - Medical records are needed, and/or
   - Further investigation is needed to determine approval status.

3. If the IPA does not adhere to the timeframes listed below, the PNC may issue an administrative complaint.

Requirement	**Due Date**
Delegation Oversight	7 Days
DOI Inquiries	4 Days
Emergencies/Appeals	24 Hours
IPA Grievance	14 Days
MG Responses	1 – 4 Days

Quality of Care	7 Days
Submissions	3 Days
VBC Roundtable	1 Occurrence

The HMO Administered Complaint is addressed to the IPA Administrator Copies are also distributed to the appropriate BCBSIL HMO staff.

- If there is no resolution by the due date, and the inquiry is a claim issue, the claim is paid and deducted from capitation. The complaint is categorized under "Failure to Pay". Upon receipt of a response to the inquiry, the PNC will provide a written response to the HSA within two business days and the Inquiry Documentation Tool file is updated with the final resolution and member notification is sent.
- If the unresolved inquiry is other than a claim issue (i.e., problem with office staff, quality of care etc.), The PNC and/or appropriate department will continue to work with the IPA for final resolution. Upon receipt of a response to the inquiry, the PNC will provide the written response to the HSA within the two business days and the Inquiry Documentation Tool file is updated with the final resolution and member notification is sent.

4. A Quality of Care Complaint is investigated in accordance with the Quality of Care Complaints and Occurrences Policy and Procedure (QI26 and QI26A). 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.

Reporting:

HMO Administered Complaint will be entered into the database. (**Attachment I**)

Biannual HMO Complaint Report is generated for the calculation of the Quality Improvement Fund. The HMO Complaints are compared to the average membership, and the number of HMO Complaints per 1,000 members per every six months is reported. The data is used to determine the Quality Improvement Fund.

IV. CONTROLS/MONITORING

Line of Business and/or Area	Control Requirements
HMO	Controls are detailed in the Policy itself

V. AUTHORITY AND RESPONSIBILITY

Clinical Delegation Coordinator
Customer Assistance Unit
HMO Provider Network Consultant

VI. IMPACTED BUSINESS AREAS

Clinical Delegation Coordinator
Customer Assistance Unit
HMO Provider Network Consultant

VII. IMPACTED EXTERNAL ENTITIES

HMO IPAs

VIII. PROCEDURE REVIEWERS

Person Responsible for Review	Title	Date of Review
Danielle Washington	Manager, HMO Provider Relations	12/16/2024

IX. PROCEDURE REVISION HISTORY

Description of Changes	Revision Date
Added grid which includes the requirements and timeframes	5/8/2024

X. PROCEDURE APPROVALS

Company, Division, Department and/or Committee	By: Name	Title	Approval date
Provider Performance	Geoff Guiton	Executive Director	12/16/2024
BCBSIL P&P			12/19/2024

XI. PROCEDURE ATTACHMENTS / ADDITIONAL INFORMATION

ATTACHMENT I

_____ (Date)
_____ (IPA)
_____ (IPA Administrator)
_____ (City/State/Zip)

RE: (Member)

(ID#)

Service Request #:

Dear (IPA Administrator):

The following inquiry has been determined to be an HMO Administered Complaint in accordance to the terms of the Medical Service Agreement.

Category of Complaint

Administrative: _____

_____

Access to Care: _____

_____

Quality of Care: _____

_____

Failure to Pay: _____

_____

Please report this action to your Peer Review Committee so they are aware of the problem.

Sincerely,

_____

Health Services Assistant

cc:

HMO Provider Relations Manager
HMO Provider Network Consultant