Illinois Health and Hospital Association

On February 21, 2020, the Illinois Department of Healthcare and Family Services (HFS) released the first in a series of three Provider Notices on the February 28, 2020 implementation of the new Medicaid Managed Care Organization (MCO) Dispute Resolution Process (DRP), as required under Public Act 101-0209 (Senate Bill 1321). A key piece of the IHA-supported Medicaid managed care reform law, the DRP offers a new, more robust pathway for hospitals to resolve disputed claims by requiring MCO adherence to strict response times, imposing sanctions on MCOs for non-compliance, and allowing providers to request a binding determination from HFS.

Please note that the DRP applies only to Medicaid MCO claims. Provider complaints regarding Medicaid Fee-for-Service should continue to be directed to HFS.

Administrative Rules

A proposed administrative rule to implement the DRP was published in the Illinois Register on October 25, 2019 [see pages 12000-12053]. The proposed rule outlines the process and timeframes for submission and resolution of a disputed claim, which is defined as "a determination made by an MCO that denies in whole or in part a claim for reimbursement to a provider for services rendered by the provider to an enrollee of the MCO with which the provider disagrees" (43 Ill. Reg. 12022).

In its comment letter on the proposed rule, IHA urged HFS to ensure balance between the rights of MCOs and providers and hasten the resolution process overall. IHA also recommended eliminating the 30-calendar day waiting period to file a complaint with HFS, restricting MCO requests for additional documentation, and limiting the timeframes and circumstances under which an MCO may request an extension. IHA expects the final rule to be issued in the near future.

Submission and Resolution Process

The DRP will replace HFS' current Managed Care Provider Complaint process as of February 28, 2020. Open complaints filed prior to that date will follow the existing resolution process. On or after February 28, providers must follow the steps below to submit complaints to HFS via a new, secure web-based Provider Complaint Resolution Portal, a link to which will be available on HFS' Care Coordination webpage. Please note that this process is based on the guidance in the proposed rule and the HFS Provider Notice and may change upon publication of the final rule.

- *Step 1: File a claim dispute directly with the MCO through its internal claim dispute/reconsideration process. HFS will dismiss any submissions that have not first gone through the MCO's internal process.* When a claim dispute is filed directly with the MCO, the plan has 30 calendar days to resolve it with the provider. If the provider finds the MCO's determination(s) or proposed resolution(s) unsatisfactory, or the MCO fails to respond within the required timeframe, the provider, or its billing agent, may submit a complaint to HFS.

- *Step 2: File a claim dispute with HFS through the Provider Complaint Resolution Portal within the timely filing period. Any disputes submitted outside of the filing window will be closed.* Providers may file a complaint with HFS no sooner than 30 calendar days but no later than 60 calendar days from the date the provider filed the claim dispute with the MCO. Multiple claims disputes involving the same MCO, regardless of whether the claims are for different enrollees, may be submitted together when the reason for non-payment involves a common question of fact or policy. Complaints must be filed at the facility rather than system level (i.e., by Medicaid Tax ID and location address). All provider submissions must include:

    - The date the provider filed its dispute request with the MCO;
    - The standard tracking number provided by the MCO upon submission of the internal dispute request; and/or
    - If submitting multiple related claims denied by the same MCO, HFS' standard Complaints/Claims Issue Excel template. A maximum of 100 claims may be on a template.

HFS will forward the complete submission within 10 business days of receipt to the MCO for resolution.

- *Step 3: Respond to any MCO requests for additional documentation. If a provider fails to respond, HFS will close the complaint.* Upon receipt of the complaint, the MCO has five business days to request additional information from the provider. If applicable, the provider must either respond within five business days with the information or demonstrate that the documentation was submitted previously.
- *Step 4: Review the MCO's written proposal to resolve the disputed claims and, if not resolved to the provider's satisfaction, request that HFS make a final determination.* Within 30 calendar days of receipt of the complaint, the MCO must develop and share with the provider and HFS a written proposal to resolve the dispute. If the provider finds the MCO's determination unsatisfactory, or the MCO fails to respond timely, the provider has 30 calendar days to request that HFS make a final determination. HFS must provide a written decision within 30 calendar days of receipt of all relevant information from the MCO and/or provider. HFS's decision will be based on the contractual terms between the provider and MCO, the contract between HFS and the MCO, and Medicaid policy. HFS' written decision is final.

Complaint Resolution Portal Training

The second HFS Provider notice will provide instructions on registering for the Provider Complaint Resolution Portal and more detailed submission instructions. IHA is working closely with HFS on implementation of the new Provider Complaint Resolution Portal, including engaging member hospitals to participate in testing prior to the launch. Information on webbased training will be shared with member hospitals and health systems as soon as it is available.