HB4893

LRB104 18033 KTG 31472 b

104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

HB4893

by Rep. Lindsey LaPointe

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-30.19 new

Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that the Department of Healthcare and Family Services must incorporate minimum standards governing behavioral health pre-payment and post-payment reviews into MCO contracts effective for all services covered on and after January 1, 2027. Requires the Department to develop or adopt behavioral health-specific pre-payment and post-payment review guidelines and incorporate such guidelines by reference into MCO contracts. Provides that the Department-issued guidelines must: (1) define the documentation and clearly specify the discrete data elements that may be requested prior to and during a pre-payment or post-payment review, and applicable response timeframes, ensuring that all requests are specific, reasonable, and directly tied to the review objectives; (2) identify regulatory, statutory, and contractual standards applicable to behavioral health services; (3) establish uniform evaluation criteria and checklists; and (4) be publicly available and updated as necessary. Contains provisions on MCO contracts and required contract terms; pre-payment and post-payment review processes and notice requirements; timeframes for providers to respond to a documentation request; communication protocols; contract transparency and extrapolation from a statistical sampling of claims; the timeliness and closure of claims reviews; submission methods; reviewer qualifications; and enforcement. Effective immediately.

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A BILL FOR

AN ACT concerning public aid.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Illinois Public Aid Code is amended by adding Section 5-30.19 as follows:

(305 ILCS 5/5-30.19 new)

Sec. 5-30.19. MCO behavioral health pre-payment and post-payment reviews.

(a) The General Assembly finds that:

(1) Behavioral health providers serving Medicaid enrollees are essential to ensuring timely access to mental health and substance use disorder services across the State of Illinois.

(2) MCOs contracted with the Department of Healthcare and Family Services conduct pre-payment and post-payment reviews to ensure program integrity and compliance with applicable requirements.

(3) Providers have reported significant procedural challenges in the conduct of such reviews, including excessive administrative burden, unclear documentation standards, inconsistent findings, inadequate communication, and lack of transparency regarding review criteria and methodologies.

(4) Requests for extensive historical records, unclear or inconsistent audit standards, delayed issuance of findings, and insufficient time to respond to determinations undermine provider capacity and may negatively impact service delivery.

(5) Transparency, consistency, and standardization in review processes are essential to promoting compliance, reducing unnecessary administrative burden, and ensuring fair and equitable treatment of providers.

(6) State-issued, service-specific review guidelines, reasonable timeframes, and clear communication protocols are commonly used by accreditation bodies and federal programs to promote objective and uniform oversight.

(b) The Department must incorporate minimum standards governing behavioral health pre-payment and post-payment reviews into MCO contracts effective for all services covered on and after January 1, 2027.

(c) As used in this Section:

"Behavioral health services" means mental health services, substance use disorder services, and co-occurring disorder services covered under the medical assistance program.

"Managed Care Organization" or "MCO" means an entity contracted with the Department to provide or arrange medical assistance services on a capitated basis, including Managed Care Community Networks.

"Managed Care Community Network" or "MCCN" means an

entity, other than a health maintenance organization, that is owned, operated, or governed by providers of health care services within Illinois and that provides or arranges primary, secondary, and tertiary managed health care services under contract with the Department exclusively to persons participating in programs administered by the Department.

"Pre-payment review" means a review, whether titled a review or not, conducted prior to payment to determine whether submitted claims meet coverage, documentation, and billing requirements.

"Post-payment review" means a review, whether titled a review or not, conducted after payment to assess compliance with applicable requirements.

"Provider" means a behavioral health provider, including a Community Mental Health Center, Behavioral Health Clinic, Certified Community Behavioral Health Clinic, or Substance Use Treatment and Recovery Center, enrolled in the medical assistance program and contracted with or reimbursed by an MCO.

"Extrapolation" means the application of review findings from a sampled set of claims to a larger universe of claims for purposes of determining overpayments or recoupments.

(d) Applicability. This Section applies solely to behavioral health pre-payment and post-payment reviews conducted by MCOs under contract with the Department to fulfill contractual requirements for program integrity and

compliance.

(e) Contract requirements. The Department must require, as a condition of any contract with an MCO, that the organization comply with the requirements of this Section with respect to behavioral health services.

(f) Standardized review guidelines. The Department must develop or adopt behavioral health-specific pre-payment and post-payment review guidelines and incorporate such guidelines by reference into MCO contracts. MCOs must conduct reviews in accordance with the Department-issued guidelines. The guidelines must:

(1) define the documentation and clearly specify the discrete data elements that may be requested prior to and during a pre-payment or post-payment review, and applicable response timeframes, ensuring that all requests are specific, reasonable, and directly tied to the review objectives;

(2) identify regulatory, statutory, and contractual standards applicable to behavioral health services;

(3) establish uniform evaluation criteria and checklists; and

(4) be publicly available and updated as necessary.

(g) Reasonable scope and timeframes. MCO contracts must provide the following:

(1) MCOs may conduct pre-payment or post-payment reviews only when supported by data indicating a

reasonable possibility of error, fraud, waste, or abuse or as requested by the State.

(2) MCOs must notify providers selected for pre-payment or post-payment review by individual written notice to the correspondence address identified in IMPACT with confirmed receipt by provider, stating the specific reason for selection, at least 45 calendar days prior to beginning the review.

(3) If the basis for selection of a provider for review is comparative data, the MCO must provide the data on how the provider varies significantly from other providers in the same provider type, service specialty, jurisdiction, or locality.

(4) Documentation requests must clearly specify the records being requested and the timeframe for provider response.

(5) Requests for documentation are limited to records for dates of service within 12 months of the date of the initiation of the review.

(6) Providers are afforded a minimum of 45 calendar days from the date of the request to submit additional documentation, with extensions permitted for good cause.

(7) MCOs must permit electronic or other least burdensome methods for submission of requested records.

(8) The date on which documentation is received in a secure electronic system is the official date of receipt

for purposes of compliance with submission deadlines.

(h) Provider right to dispute records requests.

(1) A provider may dispute or appeal any records request issued by an MCO if the provider reasonably believes that the request is:

(A) overly broad;

(B) duplicative;

(C) unduly burdensome; or

(D) not reasonably related to verification of payment, medical necessity, quality of care, or compliance with applicable law or contract requirements.

(2) The provider must notify the MCO in writing within 14 calendar days of receipt of the records request, specifying the basis for the dispute. Upon receipt of such notice, the MCO must pause the records request, and any associated payment holds pending resolution of the dispute.

(3) The MCO must respond in writing within 14 calendar days of receipt of the provider's dispute notice, either:

(A) narrowing the scope of the records request; or

(B) providing a written justification demonstrating the necessity of the requested documentation.

(4) If the dispute is not resolved between the provider and the MCO, the provider may escalate the matter

to the Department for review and determination. The MCO must comply with the Department's final determination regarding the dispute.

(5) Providers must not be subject to any adverse action, payment delay, sanctions, or contract termination solely for exercising the right to dispute or appeal a records request in accordance with this Section.

(i) Communication protocols. MCO contracts must require standardized communication protocols, including that:

(1) MCOs will clearly state in their initial communication to providers if a post-payment review is based on suspected fraud.

(2) MCOs will conduct entry and exit communications with providers to clearly convey the review scope, expectations, preliminary findings, compliance status, and next steps, ensuring consistent messaging throughout the review process.

(3) MCOs will provide advance written notice, delivered electronically, to providers of documentation requests for any pre-payment or post-payment review, including the applicable review period. Paper mail may be used as a secondary method of delivery through carriers that meet the following requirements:

(A) Standard Postal Services - any Protected Health Information (PHI) that is sent via USPS, UPS, or FedEx must be sent in sealed envelopes, and must

utilize a package tracking mechanism.

(B) Certified Mail - proof of delivery and a recipient signature of any PHI sent via this method is required as a means of providing additional security and accountability.

(4) All notifications and requests for additional documents must include specific MCO contact information for provider communication regarding the pre-payment or post-payment review.

(j) Transparency of findings and extrapolation. MCO contracts must require that:

(1) Providers receive written notification of final review findings, including clear references to applicable regulatory or contractual citations, an explanation of the rationale for each finding, guidance on required next steps or corrective actions, and information regarding the process and timelines for appealing the findings.

(2) All findings and related written communications are clear, consistent, and non-contradictory to prevent confusion or conflicting conclusions.

(3) Extrapolation from a statistical sampling of claims may only be used after a documented educational intervention has failed to correct the payment error. As used in this paragraph, "documented educational intervention" means:

(A) targeted communication or training provided to

the provider regarding identified billing, coding, or documentation errors;

(B) clear explanation of the correct billing or documentation practices required; and

(C) written documentation that such education was provided to the provider, including the date, format, and content of the intervention.

(4) Where an MCO elects to extrapolate findings from a sample to a larger universe of claims, the MCO must:

(A) ensure that any extrapolation methodology is statistically valid;

(B) provide the provider with written notice of the extrapolation methodology and sample used; and

(C) maintain records sufficient to demonstrate compliance with this Section, including documentation of the educational intervention and rationale for extrapolation.

(5) The provider has the right to dispute or appeal the use of extrapolation and the resulting overpayment determination under the contract's grievance and appeal process.

Providers must not be subject to adverse action, payment delay, or sanctions solely for exercising their right to dispute or appeal extrapolation.

(6) The provider may escalate unresolved disputes regarding extrapolation to the Department for review, and

the MCO must comply with the Department's final determination.

(k) Timeliness and closure. MCO contracts must require that:

(1) Claims be reviewed and findings issued within 60 calendar days of receiving the documentation initially requested from the provider, to allow providers sufficient opportunity to respond and implement corrective actions.

(2) Providers are afforded 60 calendar days to review and respond to findings, clearly specifying the basis for disputes of specific findings.

(3) Within 60 calendar days of receiving the provider's response to findings, MCOs must respond and supply a report addendum with a determination of whether the response warrants additional investigation and discussion.

(4) Upon completion of the review, a formal written notice of compliance or closure be issued to the provider.

(l) Submission methods. MCO contracts must require the use of the least burdensome and lowest-cost method of record submission, including secure electronic methods, when available.

(m) Compliance-oriented approach. MCO contracts must require an approach emphasizing education, technical assistance, and corrective action prior to punitive enforcement, except in cases involving fraud or willful

misconduct.

(n) Qualifications of reviewers. MCOs must ensure that reviewers who perform pre-payment and post-payment reviews have experience with Illinois-specific behavioral health care assessment, service delivery, billing, and documentation and receive training consistent with pre-payment and post-payment review requirements in managed care contracts.

(o) Enforcement. Failure by an MCO to comply with this Section constitutes a breach of contract subject to remedies available to the Department.

Section 99. Effective date. This Act takes effect upon becoming law.