Illinois Health and Hospital Association

July 2, 2025

ILLINOIS HEALTH AND HOSPITAL ASSOCIATION
M E M O R A N D U M

SUBJECT: **HFS Files Emergency Rules on Medicaid MCO Standardization and Transparency**

After several months of intense negotiations with the Illinois Dept. of Healthcare and Family Services (HFS), the Medicaid managed care organizations (MCOs), and the Illinois Association of Medicaid Health Plans (IAMHP), HFS has filed emergency administrative rules, **effective July 1, 2025**, to implement the standardization and transparency provisions of the Medicaid MCO prior authorization reforms under Public Act (PA) 103-0593. To view the emergency rules, *click here*.

PA 103-0593 was a significant IHA advocacy initiative passed during the spring 2024 legislative session to hold MCOs accountable for their egregious prior authorization tactics. The Act required HFS to adopt rules by July 1, 2025. The most recent Medicaid omnibus package passed by the General Assembly last month permitted HFS to file emergency rules to meet the July 1 implementation date. The statutorily required standardization and transparency rulemaking includes the following provisions:

- Publication of MCO authorization policies;
- Creation of an IPO list similar to Medicare's IPO list;
- Standardization of the Appointment of Representative (AOR) form;
- Limitations on second and subsequent medical necessity reviews;
- Standardized peer-to-peer processes and timelines;
- Defined criteria for urgent and standard post-acute requests to address delays in approval of Skilled Nursing Facility (SNF) and Long-Term Acute Care Hospital (LTACH) prior authorization requests;
- Standardized criteria for review of LTACH admission prior authorization requests to address inappropriate LTACH denials; and
- MCO reporting required to support the external quality review organization (EQRO) audit of the MCOs' service authorization programs.

Throughout the administrative rules development process, IHA worked closely with HFS to draft the rules that reflect the feedback provided by our member hospitals. Below is a detailed breakdown and summary of the emergency rules.

Guidelines related to the publication of MCO service authorization policies

- MCOs must establish a website where they post all their utilization management/service authorization policies.

- MCOs must identify all services that require service authorization and, to the extent that they utilize MCO-specific criteria in addition to nationally recognized standard criteria/guidelines, they must post those additional criteria.

- MCOs must include commonly used terms and definitions on their service authorization website. Today, MCOs use varying terms across plans that have different meanings, which adds another layer of complexity and confusion to the service authorization process.

- MCOs must include a summary of changes and rationale for changes to service authorization policies when they update a policy. This adds clarity so that changes are easily identifiable, eliminating the need to compare the prior and new policies. It also adds a layer of accountability by requiring the MCOs to disclose the clinical rationale for a policy change.

- MCOs must include a clear outline of the process for a patient, or provider on behalf of a patient, to request review of a service authorization denial by an external independent entity. Currently, many providers aren't aware of the HFS contractual requirement that MCOs must allow for a review by an external independent entity, or don't utilize the option. This makes that option, and the related process, clear to providers.

Medicaid Inpatient Only (IPO) List

- The administrative rules require that HFS adopt the Medicare IPO list, with exceptions specific to the Medicaid population allowed only if approved by the Department.

- While the rules allow exceptions to the IPO list specific to the Medicaid population, the exceptions must be approved by the Department and be standard across MCOs. This ensures that each MCO will adopt the same IPO list.

- The rules require HFS to post any exceptions to the Medicare IPO list 60 days prior to the effective date of the exception.

- The rules make it clear that if a hospital/physician determines that it is safe to perform an "IPO List" procedure in the outpatient setting, the procedure will be paid for in the outpatient setting.

Standardization of administrative forms used in the member appeal process

- The rules create a single standardized AOR form that all MCOs must adopt. This ensures that MCOs will no longer deny an AOR form simply because it is not their own plan-specific form.

- The rules allow for the use of any AOR form, including EMR generated forms, provided they contain all the elements required in the AOR form.

- The rules allow for the AOR form to be signed prior to the denial of the service authorization request.

Limitations on second or subsequent medical necessity reviews

- The rules prohibit a second or subsequent medical necessity review of a service already approved by the MCO.

- The rules require that the MCOs adopt processes to allow hospitals to identify claims for planned readmissions and allow those claims to bypass any denials or rejections for readmission policies.

- The rules prohibit MCOs from recovering payment from a provider as "waste" under fraud, waste, and abuse policies in cases where the patient meets nationally recognized criteria/guidelines for inpatient level of care.

Standardization of peer-to-peer processes and timelines

- The rules standardize the timeframe for a provider to request a peer-to-peer review. Currently, the MCOs have vastly different processes and timeframes. The rules set the timeframe at 10 days from the date of the denial, which is the longest timeframe allowed by any MCO today.

- The rules require that the MCOs make exceptions to the 10-day timeframe in provider-specific circumstances.

- The rules prohibit the MCOs from *requiring* a peer-to-peer review for any service.

- The rules require the MCO to respond and provide the date and time for the peer-to-peer review within one business day of receiving the request. They also require that the peer-to-peer review be held within three business days of receipt of the request for the peer-to-peer.

- The rules require that when the MCO fails to show up for a peer-to-peer review or is unable to hold the peer-to-peer review within three days, the MCO must treat all post denial actions (appeals and reconsiderations) as urgent if the provider marks them as urgent.

- The rules require a web-based option for requesting a peer-to-peer review and the web-based option must be available to non-network providers.

- MCOs must allow providers to submit three dates/times for a peer-to-peer review when they request it. The MCO can choose from those dates/times.

- The rules require that the MCO physician who holds the peer-to-peer review be in the same or similar specialty as a physician who typically manages the medical condition or disease.

- The rules require written notice of the peer-to-peer decision which must disclose all reconsideration options, such as appeals and review by an independent external entity.

LTACH criteria

- The rules require that the MCOs make medical necessity determinations in a manner that is no more restrictive than the state Medicaid program, including quantitative and non-quantitative treatment limits.

- The rules require that MCOs take all patient-specific circumstances into consideration and make exceptions to standard criteria when patients don't "check all the boxes" but still require LTACH level of care (LOC).

- The rules prohibit MCOs from denying requests for LTACH LOC when a patient meets certain criteria.

Defined criteria for urgent & standard post-acute care and LTACH service authorization requests

- Allows providers to identify a prior authorization for post-acute and LTACH services as "urgent," and therefore subject to the 48-hour timeframe for urgent requests, in cases where a delay could result in a hospital stay that is beyond medical necessity. Today, providers can only mark requests as urgent when there is serious risk to the patient's life or health.

- Prohibits the MCO from overriding the provider's assignment of "urgent" status, and "downgrading" a prior authorization request from urgent to standard timeframes.

- Under the rules, all standard post-acute care requests must be resolved within 10 calendar days, and all urgent requests must be resolved within 72 hours.

Quality and Compliance Audits

- The rules establish requirements for MCO quality and compliance reports to be used by the Department's QIO in determining MCO compliance. The IHA team drafted very

detailed report specifications to ensure that going forward, IHA has the data it needs for monitoring and advocacy.

While HFS has issued emergency rules effective July 1, 2025, they are required to adopt permanent rules by October 1, 2025. Members will have the opportunity to submit comments once the permanent rules are published by the Joint Committee on Administrative Rules (JCAR). With regard to next steps, IHA will soon provide guidance on how to submit comments and feedback to HFS. We will also continue working closely with HFS and key stakeholders to shape the implementation of the gold card program and 72-hour rule, which have been statutorily delayed until July 1, 2026, to ensure they are rolled out effectively.

For questions or comments regarding the standardization and transparency rules, please contact Jordan Powell at jpowell@team-iha.org or 217.541.1185 or Lisa Lynn at llynn@team-iha.org or 217.541.1181.