## HB 4028 A STAFF MEASURE SUMMARY

**Carrier:** Rep. Harbick

**House Committee On Behavioral Health**

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| **Action Date:** | 02/12/26 |
| **Action:** | Do pass with amendments and rescind<br>subsequent referral to Ways and Means. (Printed A-Eng.) |
| **Vote:** | 8-0-0-0 |
| **Yeas:** | 8 - Edwards, Harbick, Isadore, Javadi, Mannix, Nosse, Pham H, Valderrama |
| **Fiscal:** | Has minimal fiscal impact |
| **Revenue:** | No revenue impact |
| **Prepared By:** | Brian Nieubuurt, LPRO Analyst |
| **Meeting Dates:** | 2/5, 2/12 |

**WHAT THE MEASURE DOES:**

The measure imposes requirements and restrictions on behavioral health provider reimbursement claim audits by insurers and coordinated care organizations (CCOs), effective January 1, 2027.

Detailed Summary:

- Defines terms, including "audit," "behavioral health treatment," "claim," "clerical error," "fraud," and "provider"
- Requires insurers and CCOs to make a written description of claim filing requirements detailing specified information available to all providers, and give 30 days' notice of any changes to their audit policies
- Requires a behavioral health audit to be reviewed by a behavioral health professional and imposes other limitations on behavioral health audits, including lookback and completion timelines and a prohibition on the overturning of medical necessity determinations
- Imposes limitations and requirements on insurers that use sampling or similar methods in determining auditees
- Specifies required elements of a recoupment demand resulting from an audit, including prohibiting demands that are based on clerical errors
- Prohibits insurers and CCOs from structuring compensation that creates a financial incentive to identify errors in an audit
- Adds specified details related to behavioral health audits to information that must be filed annually by insurers with the Department of Consumer and Business Services

**ISSUES DISCUSSED:**

- Lookback period
- Importance of being able to differentiate between fraud and clerical errors

**EFFECT OF AMENDMENT:**

The amendment reduced the period during which an audit may be conducted after a claim is paid from five to three years. It also removes the 91-day effective date clause.

**BACKGROUND:**

Health insurers and other payers audit claims to help ensure claims are processed correctly and in compliance with applicable regulations. Audits can help identify payment errors, overpayments, and fraud. Audits can vary in scope, and it can be burdensome for providers to comply with documentation and other requirements. House Bill 4028 A establishes parameters for behavioral health provider claim audits conducted by insurers and CCOs.