HB 2455 A STAFF MEASURE SUMMARY

House Committee On Behavioral Health and Health Care

Action Date:	04/04/23
Action:	Do pass with amendments and be referred to Ways and Means. (Printed A-Eng.)
Vote:	8-2-1-0
Yeas:	8 - Bowman, Conrad, Diehl, Goodwin, Nelson, Nosse, Pham H, Tran
Nays:	2 - Dexter, Morgan
Exc:	1 - Javadi
Fiscal:	Fiscal impact issued
Revenue:	No revenue impact
Prepared By:	Brian Nieubuurt, LPRO Analyst
Meeting Dates:	3/14, 4/4

WHAT THE MEASURE DOES:

Requires insurer and coordinated care organization (CCO) that reimburses cost of behavioral health treatment to make detailed written description of all audit requirements available to all providers and specifies contents of description. Prohibits claim payment recoupment if insurer has not made detailed written description of audit requirements available to provider. Requires insurer or CCO to give 30 days notice of any changes to audit requirements. Specifies parameters of insurer and CCO claim audits and recoupment demands. Prohibits insurer or CCO from compensating auditor based on percentage of overpayments recouped or in other way that creates financial incentive to identify errors that result in recoupment. Requires Oregon Health Authority (OHA) to establish education unit to develop curriculum based on federal and state statutes and rules to inform providers regarding audits or reviews conducted by or on behalf of CCOs or OHA. Specifies curriculum contents and availability. Requires OHA to collaborate with health care providers that provide care to medical assistance enrollees, CCOs, community groups that advocate for diversity and equity, and health care industry representatives to develop recommendations for improving the processes by which payers audit health care providers' claims for reimbursement. Requires OHA to report to Legislative Assembly on collaborative's recommendations by July 1, 2024. Takes effect on 91st day following adjournment sine die.

ISSUES DISCUSSED:

- House Bill 3046 (2021)
- Current auditing and recoupment practices
- How excessive auditing harms access
- Federally required claims sampling in Medicaid programs
- Fraud, waste, and abuse standards in Medicare program

EFFECT OF AMENDMENT:

Clarifies audit timelines, including permitted audit look back period in cases of suspected fraud. Clarifies permitted use of sampling methods during audit. Clarifies prohibition on compensating auditor in way that creates financial incentive to identify errors. Requires Oregon Health Authority (OHA) to establish education unit to develop curriculum based on federal and state statutes and rules to inform providers regarding audits or reviews conducted by or on behalf of coordinated care organizations (CCOs) or OHA. Specifies curriculum contents and availability. Requires OHA to collaborate with health care providers that provide care to medical assistance enrollees, CCOs, community groups that advocate for diversity and equity, and health care industry representatives to develop recommendations for improving the processes by which payers audit health care providers' claims for reimbursement. Requires OHA to report to Legislative Assembly on collaborative's

recommendations by July 1, 2024.

BACKGROUND:

Provider audits help identify fraud, waste, and abuse in the health care system and encourage providers to use proper medical billing practices. For example, records of audits conducted of Medicare Advantage plans between 2011-2013 showed about $12 million in overpayments for the care of just over 18,000 patients; extrapolated across the total membership of the plans audited, the overpayment amount exceeded $600 million. While audits can reveal illegitimate or erroneous payment, complying with audit requirements also adds to the administrative cost of health care.

House Bill 2455 A imposes requirements and limitations on audits conducted by insurers, coordinated care organizations, and the Oregon Health Authority of claims for reimbursement for behavioral health services.