Submitter: Gail Hardman-Woung, LCSW

On Behalf Of: Committee: House Committee on Behavioral Health and Health Care

Measure: HB2455

I am a therapist (Licensed Clinical Social Worker) specializing in adoption, attachment and trauma for more than twenty years. I had a private practice for seventeen years in Portland Oregon prior to opening a mental health clinic in Portland five years ago.

I had a previous relationship with Healthshare, as I was one of eight local therapist who challenged Healthshare with Oregon Medicaid for not contracting with providers outside of county mental health clinics (that generally have the least experienced providers). We prevailed and Healthshare opened their doors to clinicians outside county mental health agencies. This was especially important to me because I worked with kids who had been in foster care or were still in foster care and had OHP insurance.

In early 2019, the clinic received several calls from Care Oregon Care Coordinators looking for both therapy and Neurofeedback for their members. The clinic was not in network and agreed to enter into single case agreements with their clients. Care Oregon recommended our 53-minute therapy billing code for the Neurofeedback sessions because Care Oregon didn't cover our regular Neurofeedback billing codes. Healthshare/Care Oregon's process of working with out of network clinicians, is to allow them just a couple of sessions to generate a Mental Health Assessment and a Treatment Plan for their member. Those documents are then submitted to their medical review process which takes 2-3 weeks. Upon approval, a single case agreement is in place for one year. Over the next eleven months our clinic submitted nearly two hundred Mental Health Assessments and Treatment plans to Care Oregon/Healthshare, few included Neurofeedback. Initially, Care Oregon's Medical Director had some questions regarding our Treatment Plans and requested clinical notes on several clients. He suggested we include pre and post measures in the assessments and in treatment, so we did.

In December of 2019, our treatment plans came to the forefront during a member's appeal. **The Healthshare Medical Director called Neurofeedback "dangerous' in a denial sent to the clinic.** I explained to everyone who would listen, that Care Oregon had requested Neurofeedback and our plans had been reviewed and approved by the Care Oregon Medical Director and medical team.

It wasn't long before we received a notice of audit. Our member charts were completed by several different clinicians, one of which had previously been a Medicaid Auditor in California.

Healthshare/Care Oregon denied nine of the ten charts, (our previous auditor's notes did not fare any better than anyone else's notes). The primary reason for denial was that we didn't "prove the diagnosis". Mental health diagnoses are hard to prove within the first few sessions, besides **THESE WERE THE SAME MEMBER CHARTS THAT HAD BEEN APPROVED BY CARE OREGON'S MEDICAL REVIEW TEAM.** We were told the tenth chart had not been uploaded but we could see it, (and the nine notes associated with it) in the portal.

In the end Healthshare/Care Oregon recouped more than $13,000.00. Most importantly they decided to no longer work with us and **one of their staff actually told a member, they were worried about fraud with our clinic**.

All of this took place during a mental health crisis in which we were receiving 10-25 calls a day from their members looking for a therapist.

Eventually with the help of an Ombudsperson, Healthshare/Care Oregon finally agreed to an exit interview with me:

During that exit interview, I asked the following questions.

1. Why weren't our MHAs, Tx Plans and notes denied in Medical Review?
2. Why didn't the original audit paperwork state that we had 14 days to appeal?
3. Why after many months were the audit documents sent when I mentioned I would be on vacation, so I would miss the appeal deadline?
4. Why wasn't the findings report dated?
5. Why were there no suggestions for improvements in consideration of 140 members being served at that time?
6. Why did the exact same types of MHAs and Tx plans continue to get approved by Care Oregon/ Healthshare throughout the audit process?
7. Why would Healthshare tell a client they were concerned regarding fraud and our clinic when Care Oregon's own Clinical Director had spoken to me directly on at least two occasions and approved our process and notes?

The Care Oregon representative thoughtfully wrote down my questions and assured me she would get back to me with the answers. I never heard from her and our relationship with Care Oregon and their 140 members we were serving, was over. During this time, most clinics had a long waitlist.

We continue to get several calls daily from Healthshare/Care Oregon members who cannot find the expertise we provide. A couple of months ago, we received a call from a Care Oregon Care Advocate asking us to provide Neurofeedback for one of their members. **I HAD A VISCERAL REACTION TO THE REQUEST.** I called the Care Oregon Care Advocate team and happened to reach an advocate I knew by name. He remembered our relationship and the previous situation from 2020. I asked him to inform the team that we would not be doing Neurofeedback for Healthshare/Care Oregon members, ever.

This situation was emotionally exhausting for our clinic and certainly not trauma informed care for the Healthshare/Care Oregon members. In fact, it was detrimental to member care, and certainly took away from the time and energy we could devote to our clients.

Moreover, I believe Healthshare's response with our clinic was punitive and related to our relationship in 2018.