3/7/2023

Amy Green, LMFT
Testimony Letter
RE: Support of Bill BH 2455

TO: Chair Nosse and Members of the House Committee of Behavioral Health and Health Care:

My name is Amy Green, and I am a Licensed Marriage Family provider in Oregon, as well as California, and Washington. I have been practicing in this field as a provider since 2006 and have held various roles including quality assurance manager for community and private mental health organizations and utilization manager for the largest commercial insurance company in the nation, in which I authorized and audited for all levels of behavioral health services for all the states in the US. I have also managed quality assurance and compliance, and utilization for Medicaid, Medicare, and commercial insurance. I am currently employed by a large private group practice that provides outpatient mental health services to members of Medicaid, Medicare, and Commercial Insurance. Our group practice provides services to over 600 clients per month. My role is to provide clinical oversight of all mental health services, oversee compliance with state rules and regulations (OARS), and meet managed care's requirements regarding access to care and quality of care provided. This includes ensuring we meet audit requirements so that we can continue to provide quality services.

This letter in testimony in favor of HB 2455 and request for the committee to pass HB 2455.

A managed care organizations (MCO) role is to ensure their members have access to appropriate services, at the appropriate level of care, and with appropriate qualified provider. MCO's mission is to enhance the quality of care, manage the cost of care, increase the effectiveness of care, and focus on prevention, including preventing the need for their members needing care at a higher level. The barrier we are facing is how MCO's, including CCO's, provide oversight of mental health outpatient services, include the lack of transparency regarding what they require to be documented to prove services were medically necessary, evidenced based, and effectively decreased symptoms and improved functioning.

I have had many years of experience with both county and state audits and can attest to the lack of transparency, consistency, support, and accuracy during those audits. An example from a recent audit includes the MCO's confusion regarding the correct OARS that were used and that we were supposed to be following for our non-contracted "out-of-network" group practice, and due to this, the audit feedback was not accurate. It took hundreds of hours over several months to review the audit feedback and create a corrective action plan. The claims that the CCO substantiated were not due to medical necessity but rather details that were missing or documentation that was not completed per the auditor's review. MCO's recoup claims due to administrative errors, not due to services that didn't meet medical necessity. The cost to practices is significant due to the resources it takes to work with the MCO/CCO to go

through the audit process. It creates extreme stress and burnout to staff who are trying to learn to meet requirements and understanding of what the requirements were.

Additionally, the CCO audited charts from many year prior based on current "documentation requirements" and there was no way to track what the specific documentation expectations were at the time the services were provided. When we have asked the CCO for exact examples of documentation requirements we were told to attend their documentation training. The examples in the training were vague and did not clearly meet the requirements that we were audited to. When the CCO was informed of the lack of clarity, they referred us to talk to their technical support, who then referred me to an "external contracted Medicaid consultant". This was very appreciated as we were seeking answers regarding what the requirements are with examples so that our providers clearly understood the requirements. However, the consultation could not provide any further clarification or examples. They did agree to review the documentation templates I created and "approved" them. However, we still do not have specific examples from the CCO's of what they require to be specifically documented within those templates to justify medically necessity and support services.

While the support was very appreciated, it was very evident that the CCO themselves were not clear regarding what specifically they are looking for in the documentation. The frustration providers and practices experience is due to the lack of clarity regarding exact documentation requirements with examples so that providers can meet the requirements and ensure continued access to services for clients who need it and would otherwise require a higher, more costly, level of care. The MCO's do not use standardized documentation requirements including what is required to meet medical necessity and what is required to support each service. They do not provide transparency and clarity with examples of what is required to be documented in an assessment, a service plan, or a progress note. This makes it extremely difficult, if not impossible, to train our providers to meet all the different requirements for each of the MCO's we work with. As a quality assurance manager, I have asked for clarity regarding the MCO's/CCO's current documentation requirements, for transparency regarding exact examples of what they are auditing to (as well as those during the look back period for their audits), and for support in meeting their expectations so that we can continue to focus on providing services to their members.

The hours that are spent to translate and interpret what each of the MCO's require, and to defend ourselves in audits, creates additional costs that mental health providers cannot recoup and results in extreme stress on our providers as well as quality assurance managers. Our practice currently has nearly four additional full-time staff whose sole purpose is to help ensure our providers meet audit requirements. We have 25 providers, so that is nearly one full time person for every five providers…to train providers and review the specific details of every piece of documentation. This is to ensure we pass all the requirements we "might" be required to follow, as the specific requirements remain unclear. Additionally, we must set aside an astronomical percentage of our budget, in case of an audit recoupment. Our mental health providers are experiencing the highest burnout rates in history, and the fear that MCO's create around audits and recoupments add significantly to that burnout. The highest qualified

providers are not willing to tolerate this treatment and are leaving group practices and community mental health, to go into private practices that are private pay to protect their licenses and their time, so they can focus on caring for clients. This reduces access to care for much of the population who can't afford to pay out of pocket for services.

Oregon is already in a mental health provider shortage crisis and MCO's are going to continue to be a barrier to addressing this due to how they audit and penalize providers through the lack of transparency in their expectations regarding documentation and audit requirements. The MCO's need to be held accountable to their own mission. They need to provide clear directions and examples of what is required in documentation and audits. They must become and educational resource for training and support so that providers can meet the requirements and be able to successfully pass audits and ensure continuity of care for clients who meet medical necessity. Recoupments must be approved only when services were not medically necessary per a standardized level of care utilization tool (LOCUS). Standards must be consistent among MCO's so that providers can reasonably meet those requirements. Recouped claims must be based on specific services audited that were proven to not meet medical necessity and not based on a statistical sampling that is often skewed. And finally, MCO's must not be allowed to function from a standpoint of financially gaining from audits that result in reduced access to care for their members due to provider's who can no longer afford to work with their members, or reduced quality of services as the highest qualified provider are refusing to continue to work within the current climate of MCO's oversight.

MCO's goal should be to support their providers who are caring for their members and make sure they have the resources and support necessary to provide services at the lowest level of care possible. Mental health outpatient services prevent the need for very costly higher levels of care and reduce risk for preventable client deaths due to lack of accessing the right services, at the right time, and with the right provider.

If we do not take care of our providers, there will be no one to take care of the MCO's members.

Please support HB 2455.

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Quality Assurance Manager

CC:
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