HB 2029 -1 STAFF MEASURE SUMMARY

House Committee On Behavioral Health and Health Care

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Meeting Dates: 3/13, 4/8

WHAT THE MEASURE DOES:

The measure establishes parameters for claim audits conducted by insurers, the Oregon Health Authority, and coordinated care organizations (CCOs).

Detailed Summary:

- Defines key terms, including "audit," behavioral health treatment," "claim," "clerical error," and "provider."
- **Insurer Audits** (Sections 2 and 3)
    - Requires insurer that provides reimbursement for behavioral health treatment to make available to providers a written description of all requirements for the successful resolution of a claim. Specifies form and contents of written description. Prohibits insurer from recouping payment on a claim if insurer has failed to comply with written description requirement.
    - Requires insurer to provide 30 days' notice to providers of any changes made to claim resolution requirements.
    - Specifies requirements for insurer audits of behavioral health providers including lookback period and audit completion timeline requirements.
    - Prohibits insurer from demanding recoupment of a payment made on based on a clerical error.
    - Requires insurers to provide an opportunity of not less than 30 days to correct errors identified in audit; requires insurer to allow provide to use repayment plan.
    - Prohibits insurers from conducting simultaneous audits of a provider.
    - Prohibits insurer from structuring payment paid to employee or agent in a manner that creates a financial incentive for the employee or agent.
    - Prohibits insurer from charging provider for audit costs.
- **Medicaid Audit Curriculum** (Section 4)
    - Requires OHA to establish an education unit to develop a curriculum in concert with CCO compliance officers and with input from communities and providers that informs providers regarding audits conducted by or on behalf of OHA or CCOs. Requires curriculum to include written information on necessary audit documentation and best practices.
    - Requires CCO to communicate any differences in CCO audit process in curriculum materials.
    - Specifies content and form of audit curriculum materials and presentations.
- **Medicaid Audits** (Section 5)
    - Requires OHA and CCOs to make available to all provider specified information regarding claim submissions and audits.
    - Requires OHA and CCOs to give providers 30 days' notice of any contract changes or changes to administrative rules.
    - Specifies requirements for CCO or OHA audits of behavioral health providers including lookback period and audit completion timeline requirements.
    - Requires OHA and CCOs to offer provider a repayment plan or revised audit, if requested, upon audit find that results in demand for recoupment.
    - Prohibits OHA and CCO from structuring payment paid to employee or agent in a manner that creates a financial incentive for the employee or agent.

- **Audit Improvement Report** (Section 6)
  - Requires OHA to collaborate with providers, CCOs, community groups, and health care industry representatives to developing recommendations for improving health care payer audits.
  - Requires OHA to report to Legislative Assembly by July 1, 2026 on status of recommendations and anticipated finalization date.
- Takes effect on 91st day following adjournment sine die.

FISCAL: May have fiscal impact, but no statement yet issued.

REVENUE: May have revenue impact, but no statement yet issued.

ISSUES DISCUSSED:

- Administrative burden of audits for providers.
- Audit requirements impact on providers' willingness to contract with insurers and access to behavioral health services.
- Medicaid and Medicare fraud, waste, and abuse prevention and detection requirements.
- Prevalence of fraud, waste, and abuse detection via auditing.

EFFECT OF AMENDMENT:

-1 **Replaces the measure.**

- Clarifies definition of "behavioral health treatment" to exclude services provided in hospitals, hospital-affiliated clinics, and group medical practices that include outpatient mental health or substance use disorder treatment.
- Clarifies definition of "clerical error."
- Specifies insurer's reimbursement responsibilities in the event of an audit dispute.
- Becomes operative on January 1, 2027.

BACKGROUND:

Health insurers and other payers audit claims to help ensure claims are processed correctly and in compliance with applicable regulations. Audits can help payment errors, overpayments, and fraud. Audits can vary in scope and can be burdensome for providers to comply with documentation and other requirements.

HB 2029 establishes parameters for claim audits conducted by insurers, the Oregon Health Authority, and coordinated care organizations.