HB 2029 A STAFF MEASURE SUMMARY

House Committee On Behavioral Health and Health Care

Action Date:	04/08/25
Action:	Do pass with amendments and be referred to Ways and Means. (Printed A-Eng.)
Vote:	9-0-0-0
Yeas:	9 - Diehl, Harbick, Isadore, Javadi, McIntire, Munoz, Nelson, Nosse, Pham H
Fiscal:	Fiscal impact issued
Revenue:	No revenue impact
Prepared By:	Brian Nieubuurt, LPRO Analyst
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 insurers that reimburse behavioral health providers to make available 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 insurers 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 insurers from demanding recoupment of a payment made based on a clerical error.
  - Requires insurers to provide an opportunity of not less than 30 days to correct errors identified in audit.
  - Requires insurers to allow providers to use repayment plan.
  - Prohibits insurers from conducting simultaneous audits of a provider.
  - Prohibits insurers 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 Provider Education** (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 providers 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 finding 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 develope 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.
- Becomes operative on January 1, 2027. Takes effect on 91st day following adjournment sine die.

ISSUES DISCUSSED:

- Administrative burden of audits for providers
- Impact of audit requirements on providers' willingness to contract with insurers and to provide 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:

Replaces the measure.

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