

House Bill 2029

Sponsored by Representative NOSSE (Pre-session filed.)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced**. The statement includes a measure digest written in compliance with applicable readability standards.

Digest: The Act limits how insurers, OHA and CCOs may conduct audits. (Flesch Readability Score: 64.9).

Imposes requirements and restrictions on insurer and coordinated care organization audits of claims for reimbursement submitted by behavioral health treatment providers.

Directs the Oregon Health Authority to collaborate with health care providers that provide care to medical assistance enrollees, coordinated care organizations, community groups that advocate for diversity and health equity and health care industry representatives to develop recommendations for processes by which payers audit health care providers' claims for reimbursement.

Takes effect on the 91st day following adjournment sine die.

A BILL FOR AN ACT

1
2 Relating to audits of claims for reimbursement of the costs of behavioral health treatment; creating
3 new provisions; amending ORS 414.592; and prescribing an effective date.

4 **Be It Enacted by the People of the State of Oregon:**

5 **SECTION 1. Section 2 of this 2025 Act is added to and made a part of the Insurance Code.**

6 **SECTION 2. (1) As used in this section:**

7 (a) **"Audit" means an on-site or remote review of records of or claims made by a provider**
8 **by or on behalf of an insurer.**

9 (b) **"Behavioral health treatment" includes:**

10 (A) **Mental health treatment and services as defined in ORS 743B.427; and**

11 (B) **Substance use disorder treatment and services as defined in ORS 743B.427.**

12 (c) **"Claim" means a request made by a provider to an insurer to reimburse the cost of**
13 **behavioral health treatment provided to a beneficiary of a policy or certificate of health in-**
14 **urance offered by the insurer.**

15 (d) **"Clerical error" means a minor error in the keeping, recording or transcribing of re-**
16 **ords or documents or in the handling of electronic or hard copies of correspondence.**

17 (e) **"Provider" means a person who is licensed, certified or otherwise authorized to pro-**
18 **vide behavioral health treatment in this state.**

19 (2) **An insurer that offers a policy or certificate of health insurance that reimburses the**
20 **cost of behavioral health treatment shall make available to all providers who submit claims**
21 **a separate document containing a detailed written description of all requirements for the**
22 **successful resolution of a claim that may be audited by the insurer in the future and the**
23 **requirements that applied in any previous period during which a claim of the provider was**
24 **audited. The description must:**

25 (a) **Be written in plain language that is easy to understand and that does not rely on**
26 **references to other sources such as statutes or contract provisions;**

27 (b) **Provide examples of documentation requirements for the submission of claims;**

NOTE: Matter in **boldfaced** type in an amended section is new; matter *[italic and bracketed]* is existing law to be omitted. New sections are in **boldfaced** type.

- 1 (c) Identify which requirements may result in recoupment for failure to comply;
- 2 (d) Explain which requirements apply to in-network providers and which apply to out-of-
- 3 network providers; and
- 4 (e) If the requirements differentiate between types of providers, explain the requirements
- 5 applicable to each type of provider.
- 6 (3) An insurer may not recoup from a provider a payment on a claim if the insurer has
- 7 failed to comply with subsection (2) of this section.
- 8 (4) An insurer shall notify providers no later than 30 days before the effective date of any
- 9 changes made by the insurer to the requirements described in subsection (2) of this section.
- 10 An insurer may not demand recoupment of a payment made on a claim based on new re-
- 11 quirements if the insurer has failed to comply with this subsection.
- 12 (5) An insurer's audit of a claim:
- 13 (a) May not be conducted on any paid claim submitted by a provider on a date more than
- 14 12 months earlier or, in the case of suspected fraud, may not be conducted more than six
- 15 years after the date payment was made on the claim;
- 16 (b) For an audit initiated after payment is made on a claim, must be completed no later
- 17 than 180 days from the date the audit is initiated on the claim, unless a provider fails to
- 18 submit records in a timely fashion or initiates an appeal of the insurer's audit finding;
- 19 (c) Must be reviewed by a behavioral health professional;
- 20 (d) May not result in reversing or overturning a medical necessity determination made
- 21 by the insurer when the claim was submitted or prior authorization of the service approved,
- 22 unless the patient was no longer insured at the time the service was provided; and
- 23 (e) May use sampling methods or other similar means to determine whether to initiate
- 24 an audit of a provider's claims but may recoup from the provider only payments on individual
- 25 claims for which the insurer specifically identifies an error.
- 26 (6) In the course of an audit initiated prior to payment on a claim, an insurer shall re-
- 27 spond to a provider with findings no later than 30 days after the date the provider responds
- 28 to the insurer's request for additional information regarding the claim.
- 29 (7) An insurer may not demand recoupment of a payment made on a claim based on a
- 30 clerical error.
- 31 (8) If an insurer identifies an error during an audit of a claim that results in the
- 32 insurer's demand for recoupment of the insurer's payment on the claim, the insurer:
- 33 (a) Shall provide a detailed description of the error and allow a provider a reasonable
- 34 opportunity of not less than 30 days to rectify the error; and
- 35 (b) Shall allow the provider to use a repayment plan of up to three years to repay the
- 36 claim unless the recoupment is based on an insurer's duplicate payment on a claim.
- 37 (9) An insurer may not begin a new audit of any claim submitted by a provider while
- 38 another audit is in process. A subsequent audit may not be initiated until the provider has
- 39 been given the opportunity to correct mistakes identified in the previous audit and complete
- 40 any corrective action plan resulting from the previous audit.
- 41 (10) An insurer conducting an audit may not structure compensation paid to an employee
- 42 or agent conducting an audit in any manner that creates a direct financial incentive to the
- 43 employee or agent to identify errors that result in recoupment.
- 44 (11) An insurer may not charge a provider for the costs of conducting an audit.
- 45 (12) The provisions of this section apply to audits conducted by an insurer and to audits

1 conducted by a third party on behalf of an insurer.

2 **SECTION 3.** Sections 4 and 5 of this 2025 Act are added to and made a part of ORS
3 chapter 414.

4 **SECTION 4.** (1) As used in this section:

5 (a) “Audit” has the meaning given that term in section 5 of this 2025 Act.

6 (b) “Provider” means an individual who is licensed, certified or otherwise authorized to
7 provide physical or mental health services and supplies and who contracts with a coordinated
8 care organization or is enrolled as a Medicaid provider in this state.

9 (2)(a) The Oregon Health Authority shall establish an education unit within the division
10 of the authority that is charged with overseeing the integrity of provider billing. The educa-
11 tion unit, in concert with the compliance officers of coordinated care organizations and with
12 input from communities and culturally competent providers, shall develop a curriculum
13 based on federal and state statutes and rules to inform providers regarding audits or reviews
14 conducted by or on behalf of coordinated care organizations or the authority. The curriculum
15 shall include, but is not limited to, written documents and presentations explaining the docu-
16 mentation that is necessary for audits or reviews and best practices for preparing and
17 managing records to best prepare providers for audits or reviews.

18 (b) If a coordinated care organization requires different documentation to comply with
19 an audit than the documentation required by the authority, the coordinated care organiza-
20 tion shall communicate those differences in the curriculum materials and presentations de-
21 veloped under this section.

22 (3) Curriculum materials and presentations must be:

23 (a) Easily understood and may not solely rely on references to statutes;

24 (b) Posted to the websites of the authority and each coordinated care organization; and

25 (c) Easily accessible and available to all providers.

26 (4) The authority and coordinated care organizations shall ensure that providers are
27 aware of the curriculum and how to access the curriculum.

28 (5) The education unit must be sufficiently staffed to allow for regular online presenta-
29 tions statewide.

30 **SECTION 5.** (1) As used in this section:

31 (a) “Audit” means an on-site or remote review of records of or claims made by a provider
32 by or on behalf of a coordinated care organization or the Oregon Health Authority.

33 (b) “Behavioral health treatment” includes:

34 (A) Mental health treatment and services as defined in ORS 743B.427; and

35 (B) Substance use disorder treatment and services as defined in ORS 743B.427.

36 (c) “Claim” means a request made by a provider to a coordinated care organization or
37 the authority to reimburse the cost of behavioral health treatment provided to a member
38 of the coordinated care organization or to a medical assistance recipient who is not enrolled
39 in a coordinated care organization.

40 (d) “Clerical error” means a minor error in the keeping, recording or transcribing of re-
41 cords or documents or in the handling of electronic or hard copies of correspondence that
42 does not result in financial harm to a coordinated care organization or to a patient.

43 (e) “Provider” means an individual who is licensed, certified or otherwise authorized to
44 provide behavioral health treatment in this state.

45 (2) A coordinated care organization and the Oregon Health Authority shall make avail-

1 able to all providers all of the following regarding the requirements for the submission of
 2 claims:

3 (a) Examples of documentation requirements for the submission of claims;

4 (b) Identification of which requirements may result in recoupment for failure to comply;

5 (c) An explanation of which requirements apply to in-network providers and which apply
 6 to out-of-network providers; and

7 (d) If the requirements differentiate between types of providers, an explanation of the
 8 requirements applicable to each type of provider.

9 (3) A coordinated care organization and the authority shall notify providers no later than
 10 30 days before the effective date of any contract changes by the coordinated care organiza-
 11 tion or changes by the authority to relevant administrative rules.

12 (4) An audit of a claim:

13 (a) May not be conducted on any paid claim submitted by a provider on a date more than
 14 five years earlier without an indication of fraud or an improper payment;

15 (b) Except as provided in subsection (5) of this section, must be completed no later than
 16 180 days from the date an audit is initiated on a claim;

17 (c) Must be conducted by a behavioral health professional; and

18 (d) May not result in reversing or overturning a determination that a service is medically
 19 necessary made by a coordinated care organization or the authority when prior authorization
 20 of the service was given.

21 (5) In the course of an audit, if a coordinated care organization or the authority requests
 22 additional information regarding a claim, the coordinated care organization or the authority
 23 shall respond to a provider with findings no later than 180 days after the date the audit was
 24 initiated, unless an extension is agreed to in writing by all parties.

25 (6) If a coordinated care organization or the authority identifies an error during an audit
 26 of a claim that results in a demand for recoupment of the payment on the claim:

27 (a) The coordinated care organization or the authority shall work with a provider on a
 28 repayment plan, if requested; and

29 (b) A provider may request, and is entitled to receive, a revised audit if the provider be-
 30 lieves that the coordinated care organization or the authority based the finding of error on
 31 an incorrect provision of law.

32 (7) Unless required by federal law, a coordinated care organization or the authority con-
 33 ducting an audit may not compensate an individual for conducting the audit in an amount
 34 that is based on a percentage of the overpayments recouped or in any other way that creates
 35 a financial incentive to identify errors that result in recoupment.

36 (8) The provisions of this section apply to audits conducted by a coordinated care organ-
 37 ization and the authority and to audits conducted by a third party on behalf of a coordinated
 38 care organization or the authority.

39 **SECTION 6.** (1) The Oregon Health Authority shall collaborate with health care providers
 40 that provide care to medical assistance enrollees, coordinated care organizations, community
 41 groups that advocate for diversity and equity and health care industry representatives to
 42 develop recommendations for improving the processes by which payers audit health care
 43 providers' claims for reimbursement of the cost of health care services delivered.

44 (2) No later than July 1, 2026, the authority shall report the status of the development
 45 of recommendations under subsection (1) of this section to the interim committees of the

1 **Legislative Assembly related to health and the anticipated date that the recommendations**
2 **will be submitted.**

3 **SECTION 7.** ORS 414.592 is amended to read:

4 414.592. Notwithstanding ORS 414.590:

5 (1) Contracts between the Oregon Health Authority and coordinated care organizations or indi-
6 vidual providers for the provision of behavioral health services must align with the quality metrics
7 and incentives developed by the Behavioral Health Committee under ORS 413.017 and contain pro-
8 visions that ensure that:

9 (a) Individuals have easy access to needed care;

10 (b) Services are responsive to individual and community needs; [*and*]

11 (c) Services will lead to meaningful improvement in individuals' lives[.]; **and**

12 **(d) Coordinated care organizations comply with section 4 of this 2025 Act.**

13 (2) The authority must provide at least 90 days' notice of changes needed to contracts that are
14 necessary to comply with subsection (1) of this section.

15 **SECTION 8. This 2025 Act takes effect on the 91st day after the date on which the 2025**
16 **regular session of the Eighty-third Legislative Assembly adjourns sine die.**

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