Health Allies Counseling
2950 SE Stark Street, Suite 130 Portland OR 97214
971-270-0167
www.healthalliescounseling.com

Dear Chair Patterson and members of the Healthcare Committee

I am a Licensed Professional Counselor and own Health Allies Counseling, a Portland group practice with 43 staff members and 900 clients, over half of which are Medicaid. I've been a member of COPACT for nearly 10 years and have worked extensively with the legislature around Medicaid access to care issues in the last decade. I've personally been through several Medicaid audits and have spoken to dozens and dozens of practitioners who have also been through them.

I am writing this letter in strong support of SB61 as it will end the practice of Medicaid unfairly recouping thousands and hundreds of thousands of dollars from individual providers for services they provided.

The typical Medicaid audit looks at a small number of client records – usually around 6 months of data on roughly 15 clients, to look for errors in documentation. When errors are found that the auditor believes violate the ORS, the money for that entire session is taken back. Errors can include things like the time in and time out documented in the note not matching the client appointment time on the calendar in the electronic health record, missing a license credential in a signature, or a vague reference to "not meeting medical necessity" but no explanation as to why. I've personally had this result after getting pre-authorization for services from the insurer which proved medical necessity. These are most often clerical errors at best, and miscommunication from the insurance company about what exactly they are expecting before the audit occurs…at its worst.

Once the auditor reviews all records, they total up the error rate and then can apply that across all billing for that entire time period. For example, a 50% error rate in an audit means 50% of all payments paid by Medicaid to that provider are taken back.

It is not uncommon to get error rates of 60, 80 or even 100% in a first audit, because, for example, the clinician did not know to correct the time in and time out on the clients calendar appointment time to match the exact minutes they were in session, and it is found in all of their records. It is not uncommon for solo providers to get clawbacks of $20,000 -40,000 or for group practices of even 12 providers to get clawbacks in the range of $100,000- $300,000, To be clear this is not fraud, waste and abuse. These are clerical errors, or errors in the insurance company not communicating their rules clearly before an audit occurs.

As you can imagine, this amount of money being recouped is devastating, even practice-ending, to many. The fear of audits either prevents clinicians from engaging in business at all with Medicaid, or it leaves them in daily fear and anxiety, constantly trying to figure out what they need to know to avoid clawbacks. They spend extensive time in their documentation trying to cover themselves, trying to understand what rules must be followed to avoid these devastating blows. Unfortunately, the rules are very unclear and very vague, often intentionally so, because insurers want to recoup money. We know this because paying money out for a client session is called a "loss" to the payor, not a benefit to the client. We know this because insurers have told providers in audits that they would not tell the provider what exactly the error was. And we know this because therapists don't find out clearly what is expected in documentation from an insurer until the clawback is being demanded.

Through my work with access to care for Medicaid, I personally know of dozens of providers who have ended their relationships with Medicaid, who have gone out of business, who have lived for over a year in daily extreme anxiety which affected their ability to care for clients while dealing with an audit, and who have become suicidal over their audit results.

This bill seeks to end this practice and end fear for providers so they can focus on providing care to their clients. It reinstates fairness to the providers, and ends the financial abuse that insurers can inflict on providers by allowing providers to keep money from sessions they clearly provided, and disallowing insurers from recouping money for these nominal errors. The insurer can still use the audit to educate the provider on what corrections need to be made going forward.

I can think of no other business where services are provided and the money is not only 100% taken back, but then also penalized at an imposed error rate on top of that.

Please end this abusive practice so that mental health counselors can focus on providing care to our clients and not have to live in fear of the insurance companies that control our financial security.

Tiffany Kettermann,
LPC, LMHC
Owner Health Allies Counseling