Health Allies Counseling

Chair Nosse and the Members of the House Committee on Behavioral and Health Care

My name is Tiffany Kettermann. I write this letter in followup to my verbal testimony provided in support of HB2029. I am an Oregon LPC, the owner of a group practice with 43 staff serving clients via 2400 counseling sessions each month, the Director of the Oregon Mental Health Providers PAC, and one of the authors of this bill.

There are two parts to this bill, one addressing audits from Medicaid and one addressing them from commercial insurance because these two industries are different, and their demands of providers are different. Its also important to note that federal Medicaid law is incredibly restrictive and we are very limited in the additional protections we can even ask for via this bill due to those federal restrictions. Those laws do not govern commercial insurance and should not be applied to them for the purpose of giving them further advantage and protections to commercial insurance companies. Its additionally important to note that every insurance company has different rules, lookback periods, different rules for repayment in an audit, etc. For example, most insurance companies require payback of an audit within 30 days, and others allow up to one year. This bill works to address the large variance between companies and level the playing field so that providers know what to expect at a minimum and ensures that the rules are fair, while respecting characteristics unique to that industry.

This bill requires insurance companies to provide written directions and/or training in how to pass an audit - a critical tool that supports providers in being successful in documenting their claims to meet insurance requirements, and a key component that will increase their sense of safety and ultimately, access to care.

Insurance providers may claim to currently provide written policies on various topics such as waste, fraud and abuse. This is not the same that we are asking for in this bill – training, education, or written directions regarding specific documentation that is required to pass an audit does not exist at the level we are asking for. We reviewed our nine commercial and three medicaid providers and found only three that provided any direction at all about documentation requirements, and it was not nearly enough to pass an audit. One Medicaid insurer we know provides training, but we found that the training contradicts what happens in audits. Putting audit requirements in writing holds both the insurance company and the provider to standards that are clearly communicated.

Despite some insurance companies' claims that they provide support to providers, in fact in recent years, many insurance companies have completely removed their provider support staff. For example, Regence BCBS of Oregon let go of their provider representative over two years ago, and you cannot reach a person to answer provider questions on the phone or via email any longer. This is true of several other insurance companies. Also, in regards to billing, in the cases when you can reach someone at an insurance company, every one of them consistently responds by saying "we cannot provide directions in how to bill" as the expectation is that providers must interpret the rules and sort out how to apply them. We are required to use written guides and to do our own interpretation.

This bill follows pharmacy statute and stops insurers from grossly penalizing therapists for clerical errors
This bill utilizes language from the statute for pharmacists which defines clerical errors in audits and governs how they are handled. Importantly, when a provider does make a clerical error, for example a mistake in using the wrong modifier for teletherapy, or missing putting their license in a signature, rather than recouping the entire session payment, we hold that insurance companies could act in good faith and simply allow a

provider to correct the error. Instead, currently these errors are recouped in full and often additionally being subjected to statistical sampling which multiplies the cost to providers exponentially, and therefore the recoupment to the insurance company, exponentially. This is a gross abuse of insurance company power to recoup money as an income stream, and has nothing to do with fairness in billing or documentation. This bill returns this practice to a reasonable and fair solution.

This bill is a continuation of HB2455 from 2023.
To be clear, this bill did not pass in 2023 due to the lack of quorum and having no time left to return to Ways and Means, not because of any identified flaw in the bill. It received widespread support, and we worked together with OHA on meeting their requests for meeting federal laws, and adding an education unit to train providers on how to pass an audit. In this most recent version, we made minor changes in the bill to reduce the cost incurred by OHA's suggested education unit, moving their education program to online training (which they do for all of their other public engagement) vs their suggested in person statewide training from the 2023 bill. This should significantly reduce the cost. We also added a provision that insurers could not charge therapists for the cost of an audit, which should be an obvious course of business given the gross imbalance in resources between a massive insurance company and a small provider, but it became necessary due to recent contract changes by one insurance company that has added this to their contract to put this burden on providers.

I urge you to look at the testimony from HB2455 as many providers gave specific stories of the ways that audits affected them. Some of those providers have since left the field due to abusive audits. Further, Senator Hayden's testimony on SB61 in this session also currently documents numerous high dollar recoupments that have occurred to providers in our state and provides additional context for why this bill is needed.

This bill recognizes the gross power imbalance that large insurance companies have over the large number of small practices that make up the therapist community in Oregon, and makes a positive step towards protecting them and increasing access to care. Insurance companies complain of the burden of having to adjust to changes this bill would create. This does not justify continuing the massive impact their practices are having on access to care, and the harm they are bringing to providers.

This bill carefully addresses many major issues with audits to protect therapists without infringing on the insurance company's ability to comply with law and protect against fraud. We worked with the Oregon Health Authority on this bill in 2023 to ensure that the bill complies with Medicare Fraud and Abuse standards. Their chief auditor reviewed the bill and provided feedback so we could ensure it was in compliance. We also looked at how other states handle lookback periods and our proposal is in alignment with other states. Finally, we utilized Oregon statutes and found that OAR 407-120- 1505, paragraphs 17 and 18 support our request for payment plans to be more accessible and flexible.

We are asking for your help to give us legal rights to transparent rules in how to pass an insurance audit so that therapists across the state can safely take insurance, as well as for the most basic of rights in audits. Protections like a document that tells us what the requirements are, shortened lookback periods, ending statistical sampling, and payment plans that do not reduce insurance's protection against fraud but only serve to increase the fairness in audits. **Most importantly, they will allow therapists to safely take insurance, and increase access to care. Please pass HB 2029.**

ATTACHMENT:

Examples of actual feedback we have received in audits of our progress notes that were rules not specified anywhere. We have similar lists for treatment plans, assessments as well as many other requirements to follow. This is in addition to the statutes or directions we were given.

- start/stop time or duration doesn't match the calendar start/stop time or duration
- do not vary enough in start/stop times or duration that they claim is "not accurate"
- don't include enough examples of interventions or client responses
- don't include enough, unknown number, of client direct quotes
- do not have specific examples of symptoms and functional impairments
- don't include clear enough examples of evidenced based treatment modalities/interventions
- doesn't have "clear" link to the treatment plan (arguable what that means)
- intervention isn't clearly described regarding what was resolved
- doesn't state modality used and only interventions are described
- reads as a report of the session and it's not clear was resolved
- not completed within 2 days from date of service
- not signed within 2 days from date of service
- provider signature does not include credentials written in a specific way
- any duplicated or copied over information from prior progress notes
- don't include specific cultural information identified/included
- don't include case management or coordination of care
- don't include the exact goal/objective being addressed
- missing measurable stated progress towards the plan/objective
- any sections that are missing any information
- for a date of service in which the assessment / treatment plan has not been updated within the past year
- for 53+min sessions and there is not "enough" in the progress note to justify extended session length
- does not have a clear safety plan for any risks, even if a prior one is in place, or no risks were identified