Eugene, March 13th 2023

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

My name is Henrietta Knox. I am a licensed professional counselor in Oregon. Together with my husband, I own and operate a group practice with locations in Eugene, Albany, and Salem. Our group practice aims to offer quality health mental health care services to people of all walks of life, ethnicities, orientation, religious background, and socio-economic statuses. We currently serve over 800 clients per month. We also care deeply about our employees and about educating the next generation of therapists. We accept most major insurances as well as Oregon Health Plan to accommodate as many community members as possible during this mental health crisis we are experiencing in Oregon.

I founded the company in early 2019 with the goal of helping as many community members as possible and helping associates who are therapists working towards licensure to become licensed while being supervised, well-supported, not overworked, and well-paid.

Before that, I worked in private practice for many years, and also was able to provide services to Oregon health plan members and most major insurance clients. While contracted, no training or preparation was ever offered by any of these to instruct me on documentation requirements, how to translate the OARs into clinical practice, or how to prepare for audits. So we did the best we could without this guidance in accordance with ethical and practice standards.

In the spring of 2021, one of the CCOs' (coordinated care organizations implementing the Oregon Health Plan) requested 53 client medical files to conduct an audit.
This particular CCO is owned by a large for-profit national corporation. This is a publicly traded corporation that has billions of dollars of revenue per year.
We were audited over a period of 18 months starting from August 2019 through January 2021. At the start of this audit period, we employed three therapists, and towards the end of that audit period, 8 therapists.
It's important to note that this included the first year of the pandemic, a very difficult time, with high demand for mental health services while working under very restrictive guidelines. We continued offering services to a great number of Oregonians suffering from high levels of anxiety, depression, isolation, and post-traumatic stress.

Six months after sending the medical charts, we received a letter from this CCO that they reported 88 findings in the 53 medical charts. We were also subjected to extrapolation or statistical sampling. This means that a small sample of the total claims are audited, and the

percentage of the claims audited that have been found to have errors are then multiplied by the total amount of our medical claims. To break this down, the 88 findings represented about $13.000, with extrapolation this became nearly a quarter of a million dollars.

We were in shock about this amount, but I was confident there would be a solution, trusting that an audit is a collaborative effort to improve clinical quality with client access to care, and equity in mind. I agree and support accountability, and the effort to reduce insurance fraud. We met virtually with several staff members of the local CCO, and the for-profit corporation that owns it.

To my great shock, we were told that we would not be given any opportunities to make any corrections or improvements to our documentation, or correct clerical errors, to lower the amount of the recouped in the audit. **We were told any correction would be considered fraud.** The only thing we could do is offer any additional documentation that we might have related to each of these claims and medical charts, even if it was a Post-it note. This seemed bizarre to me because I submitted the entire medical chart of each client, and it would not be legal or ethical for me to keep medical documentation on a Post-it note or anywhere else outside the client's medical chart.

We received a spreadsheet with an explanation of the findings. The vast majority of findings said “service code not met” as the reason for recoupment. I asked repeatedly for guidance on what "service code not met" meant, what was lacking in the documentation of each of these claims, to understand what we had missed, and how to defend ourselves in this audit. I did not get an answer and I kept rephrasing my question. Finally one of the participants said **"This is the process. We will not tell you what’s wrong with each of these findings. You will receive an education session after the audit is completed."**

I was in shock and had no idea what to do. A friend recommended we talk to an attorney. We found an attorney who had helped healthcare providers with audits like this before. We also sought consultation from other healthcare providers that had been audited before by a CCO or Oregon health authority.
We learned from different independent sources that the members of the audit team who conduct these audits may not be licensed mental health care providers, and we learned that these audit teams were paid commissions over the amount of money recouped. This was a shock to us.

How is it possible that tax dollars that are distributed by the Oregon Health Authority to hard-working providers to offer services to Oregon Health Plan members can be recouped by large corporate for-profit organizations that can then pay bonuses to their staff to audit and extrapolate large sums of dollars from small local providers in Oregon?

How is it legal, that after rendering services, my documentation of these services can be reviewed by a team that might not be licensed mental health care providers, who can claim that I did not meet the criteria, but also refuse to tell me which criteria we did not meet? How is statistical sampling or extrapolation legal?

How can they assume documentation is insufficient without even looking at any of this documentation? How come the burden of proof is not with the CCOs but the money that was already paid out to our hard-working therapists could be recouped based on statistical sampling? Needless to say, a small company like ours would not be able to survive a recoupment of a quarter million dollars.
We would need to close our doors, leaving therapists out of a job and hundreds of clients without services.

I started to prepare defense documents. I wrote defense documents for every single finding. I prepared over 150 documents for our defense. The amount of time that I spent for three months working on this was overwhelming. Every weekend and many evenings. There was a lot of pressure on myself and also several of the therapists that helped me defend their work. Our attorney also prepared a defense and submitted all this information with all the documents to the audit team.

Several weeks later we received the ruling. Several of the claims were approved after our defense but the extrapolation remained in place and we were still expected to pay $186,000.

We were devastated and did not know what to do. Even our attorney was surprised and said he had never seen this before. We were trying to figure out what to do and if we had any options. **The company told us we could appeal again, but if we did, they would audit even more detailed and more harshly, and would implement fines on top of the recoupment and extrapolation. In addition to that, we were warned by other healthcare providers that if there were findings in the CCO audit, this could trigger an audit with the Oregon Health Authority, meaning more fines on top of the recoupment.**

Several days went by. Our attorney called us, and shared that he had heard from the head of the audit team**,** that staff members employed by the local CCO had advocated for us since this was our first audit when we were a small provider and that there was a great need in the community. The extrapolation was removed and we only owed $6000 in recouped claims.
You can imagine the relief. We ended up paying more to our attorney than we did to the CCO. Needless to say, this was very expensive and extremely time-consuming, and stressful. I did lose a lot of sleep over this!

Shortly before this audit started, we as an organization had already started to try to interpret and implement the Oregon Administrative Rules related to medical documentation in more detail. During and after the audit, we increased this effort, and by the time the audit was completed, we had developed a very detailed and stringent policy for our staff regarding documentation. This put a lot of pressure on our staff and we also lost staff over it because of the stress and demands we put on them. We also hired a compliance officer and added billers because we had to add many steps to our billing process to double-check the coding of medical claims. Our company overhead costs have increased tremendously after we implemented these measures.

Since then, I've worked closely with other healthcare providers of group practices in Oregon to help each other learn from these audits and prepare. Needless to say, I still feel like a sitting duck, because what happened in 2021 can happen again. We were told by this CCO, we would be audited again in 6 months. So far, we have escaped this dance.

I ask you to please pass this bill.
The goal of improving audit fairness, and transparency and creating responsible limitations is to ultimately improve Oregonian's access to quality care. Mental health audits should be designed to improve and evaluate the quality of CARE, not the quality of data.

- Providers need transparency about the expectation and requirements and need sufficient training, so they can be more prepared and confident about dealing with insurance audits. T**he fear of audits ultimately restricts access to care for Oregonians, since fewer mental health providers are willing to work with insurance, and specifically the Oregon Health Plan. This leaves thousands of people in need without help.**
- Providers need to be able to practice free of fear of audits, knowing what to expect and that they are able to deal with audits and survive them financially.
- Audits should be conducted by behavioral/mental health professionals. Providers need to be able to have a clear insight into what was found lacking in meeting the standards, and not be left to guess. Not telling the provider what is wrong is merely an abuse of power and not an effort to increase the quality and accessibility of mental health care in Oregon.
- Audits need to be free of incentives for the auditor. Paying auditors incentives is highly unethical and threatens the integrity of the audit. The goal of an audit is to improve/evaluate quality care, not recover as much money as possible from the providers helping people. This practice incentivizes unethical practices and burdens providers disproportionately.
- The amount of time and resources spent by providers on compliance and dealing with audits is disproportionate. More time may be spent on client care and training and improving quality if providers were trained, expectations were transparent and audits were conducted in a fair way.
- Extrapolation/probability sampling is in direct contradiction to compliance standards. Making assumptions about how many errors have occurred without having to specifically prove those errors occurred should not be allowed in any fashion. This is an unjust use of power and perpetuates bias and stigma against mental health professionals and their provision of quality treatment.

Chair Nosse and members of the House Committee on Behavioral Health and Health Care, thank you for this opportunity to share our experience with you and thank you for your commitment to improving the quality and accessibility of mental health services for Oregonians.

Warm regards,

Henrietta Knox, LPC
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Clinical Director