March 14, 2023

Representative Rob Nosse, Chair
Representative Christine Goodwin, Vice-Chair
Representative Travis Nelson, Vice-Chair
House Committee on Health Care
900 Court Street NE
Salem, OR 97301

Delivered electronically.

Re: Opposition to House Bill 2455

Chair Nosse, Vice-Chairs Goodwin and Nelson, and members of the committee:

The PacificSource companies are independent, not-for-profit health insurance providers based in Oregon. We serve over 600,000 commercial, Medicaid, and Medicare Advantage members in four states. PacificSource Community Solutions is the contracted coordinated care organization (CCO) in Central Oregon, the Columbia River Gorge, Marion & Polk Counties, and Lane County. Our mission is to provide better health, better care, and better value to the people and communities we serve.

We write in opposition to House Bill 2455. From the outset, we note that we too want to ensure a balance between our provider partners' administrative burden and our responsibilities to the state and federal government (not to mention our members) to limit fraud, waste, and abuse. However, we believe that House Bill 2455 moves the pendulum too far away from ensuring program integrity and accountability.

First, we are unclear to what extent federal law would preempt application of the bill to the Oregon Health Plan. Medicaid payment integrity rules[1] and corresponding coordinated care organization (CCO) contract requirements[2] require CCOs to implement and maintain procedures designed to detect and prevent fraud, waste, and abuse. These rules require managed care organizations (like Oregon's CCOs) to adopt provisions for prompt reporting of all overpayments identified and recovered, especially those that specify overpayment due to fraud. Federal regulations specifically require that CCOs verify, through sampling or other methods, whether services were received by our members on a regular basis.[3] The Oregon Health Authority's (OHA) Program Integrity Unit performs audits on providers, which are generally conducted in synchronization with coordinated care organization audits. OHA regulations also require random sampling of claims to detect and deter fraud, waste, and abuse.[4]

[1] *See* 42 CFR § 438.608.
[2] 2023 contract template available at https://www.oregon.gov/oha/HSD/OHP/CCO/2023-CCO-Contract-Template.pdf
[3] 42 CFR § 438.608(a)(5).
[4] OAR 407-120-1505(8).

Second, we note that Oregon's Insurance Code already places conditions on how commercial health benefit plans may recoup claims paid to providers.[5] The limited conditions under which commercial health benefit plans may recoup claims have an exception for fraud, waste, and abuse. House Bill 2455 would likely conflict with and limit this existing law applicable to commercial insurers.

Our compliance and program integrity plan that apply to commercial health benefit plans look to Medicare standards:

- After receiving a complaint or through a random sampling, we request medical records for members, or for a date range.
- We make available an electronic portal for ease of submitting information. Providers have 30 calendar days to supply records.
- If the records received from the provider support the claims made, no further action is necessary. If records do not support the audited claims, then we may need to take further action (e.g., denying similar future claims, provider education, recoupment).

Under Medicare rules, recoupment for overpayment must be reported and returned within six years of the date the overpayment was received.[6] Guidance from the Office of the Inspector General within the US Department of Health and Human Services opines that the six-year lookback period only applies in cases of fraud. Limiting the lookback of claims to 12 months frustrates the purpose of lookback provisions.

Given the strong set of regulations in Medicaid and Medicare, we believe that solving federal preemption issues by limiting the scope of the bill to commercial health benefit plans (or setting different standards between differing insurance coverages) would simply create an unlevel playing field. Given that reimbursement rates are already higher in commercial plans, limiting the ability for health plans to deter and detect fraud, waste, and abuse inconsistent with federal standards creates risks for health plans and may lead to higher premiums paid by individuals and small businesses.

Finally, we ensure to make freely available to our provider partners a comprehensive manual that outlines, among other things, procedures on program integrity.[7] Our manual outlines examples of fraud, waste, and abuse as well as outlines the process of undertaking program integrity audits with providers. We feel that a separate document setting out these standards (of which failing to disclose bars us from engaging in reasonable auditing standards) is at best unnecessary.

Thank you for your consideration. For questions or concerns, please contact me at 541.284.7736 or richard.blackwell@pacificsource.com.

Sincerely,

/s/

Richard Blackwell
Director, Oregon Government Relations

[5] ORS 743B.451
[6] 42 CFR § 401.305
[7] https://pacificsource.com/sites/default/files/2023-03/PRV1_0323_ProviderManual.pdf