March 14, 2023

The Honorable Robb Nosse, Chair
Behavioral Health and Health Care Committee

RE: HB 2455 Testimony in Opposition

Chair Nosse and Members of the Committee,

Thank you for the opportunity to provide comments on **HB 2455** which amends the insurance code and imposes restrictions on insurers and Coordinated Care Organizations audits of claims submitted by behavioral health providers.

There have been both state and federal efforts aimed at ensuring behavioral health providers have parity with other provider types. Parity is the basic idea that mental health and addiction care are covered at the same level as care for other conditions. Health parity laws have helped remove barriers to affordable, accessible mental health care and have helped our understanding of the importance of mental health treatment in our communities. However, the requirements outlined in **HB 2455** do not follow these efforts and instead set different requirements for behavioral health providers and hold them to different standards than other medical providers, including accurate billing and documentation. Specifically, **HB 2455** states:

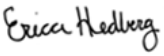
- A behavioral health professional will need to conduct claims audits. Audits for other medical services are not subject to any similar requirements. The knowledge base and professional competencies for medical and behavioral health practice differ from those for auditors. Most healthcare professionals are not certified coders. Behavioral health professionals practice in the field, but that does not mean they have expertise in coding, documentation standards, or detecting abusive or possible fraudulent billing practices.
- Insurers and CCOs cannot conduct an audit on any paid claims submitted on a date more than 12 months earlier. Currently, and for all other provider types, there is no set time limit on as long as there are questionable services to review.
- Insurers and CCOs cannot collect on a payment made on a claim that has a clerical error. There is reason to assume that many claims could be cited as having a clerical error based off a lack of documentation or incorrect coding. This standard would only be applied to claims submitted by behavioral health providers and would not apply to other provider types.
- Insurers and CCOs will be required to allow up to three years for providers to make any reimbursements. Currently, providers are allowed one year to make reimbursement. Allowing three years is different than the timeframe allowed for other provider types. In addition, allowing an extended timeframe could result in providers changing locations or closing their business, resulting in reimbursement not being made. In addition, if Medicaid overpayments are not fully recovered within one year from reporting them, then any outstanding overpayment amounts are withheld from payments from the state for Medicaid membership.

There have been a lot of efforts in ensuing behavioral health providers are treated equally with other medical providers. **HB 2455** creates different standards for behavioral health providers and limits the insurer's and CCO's ability to effectively hold behavioral health professions to the same standards as other provider types.

We ask you to please consider these points and the implications they will have on our ability to effectively manage the standards we place on behavioral health providers.

Thank you again for providing the opportunity to provide comments on **HB 2455**.

Sincerely,



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