A-Engrossed
House Bill 2029

Ordered by the House April 16
Including House Amendments dated April 16

Sponsored by Representative NOSSE; Representatives HARBICK, PHAM H (Presession filed.)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure. The statement includes a measure digest written in compliance with applicable readability standards.

Digest: The Act limits how insurers, OHA and CCOs may conduct audits. (Flesch Readability Score: 64.9).

Imposes requirements and restrictions on insurer and coordinated care organization audits of claims for reimbursement submitted by behavioral health treatment providers.

Directs the Oregon Health Authority to collaborate with health care providers that provide care to medical assistance enrollees, coordinated care organizations, community groups that advocate for diversity and health equity and health care industry representatives to develop recommendations for processes by which payers audit health care providers' claims for reimbursement.

Takes effect on the 91st day following adjournment sine die.

A BILL FOR AN ACT

Relating to audits of claims for reimbursement of the costs of behavioral health treatment; creating new provisions; amending ORS 414.592; and prescribing an effective date.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Section 2 of this 2025 Act is added to and made a part of the Insurance Code.

SECTION 2. (1) As used in this section:

(a) "Audit" means an on-site or remote review of records of or claims made by a provider by or on behalf of an insurer.

(b)(A) "Behavioral health treatment" includes:

(i) Mental health treatment and services as defined in ORS 743B.427; and

(ii) Substance use disorder treatment and services as defined in ORS 743B.427.

(B) "Behavioral health treatment" does not include treatment or services provided in:

(i) A hospital;

(ii) A hospital-affiliated clinic, as defined in ORS 442.612; or

(iii) A group medical practice that includes outpatient mental health or substance use disorder treatment.

(c) "Claim" means a request made by a provider to an insurer to reimburse the cost of behavioral health treatment provided to a beneficiary of a policy or certificate of health insurance offered by the insurer.

(d) "Clerical error" means a minor error in the keeping, recording or transcribing of records or documents or in the handling of electronic or hard copies of correspondence.

(e) "Provider" means a person who is licensed, certified or otherwise authorized to provide behavioral health treatment in this state.

(2) An insurer that offers a policy or certificate of health insurance that reimburses the

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

cost of behavioral health treatment shall make available to all providers who submit claims a separate document containing a detailed written description of all requirements for the successful resolution of a claim that may be audited by the insurer in the future and the requirements that applied in any previous period during which a claim of the provider was audited. The description must:

(a) Be written in plain language that is easy to understand and that does not rely on references to other sources such as statutes or contract provisions;

(b) Provide examples of documentation requirements for the submission of claims;

(c) Identify which requirements may result in recoupment for failure to comply;

(d) Explain which requirements apply to in-network providers and which apply to out-of-network providers; and

(e) If the requirements differentiate between types of providers, explain the requirements applicable to each type of provider.

(3) An insurer may not recoup from a provider a payment on a claim if the insurer has failed to comply with subsection (2) of this section.

(4) An insurer shall notify providers no later than 30 days before the effective date of any changes made by the insurer to the requirements described in subsection (2) of this section. An insurer may not demand recoupment of a payment made on a claim based on new requirements if the insurer has failed to comply with this subsection.

(5) An insurer's audit of a claim:

(a) May not be conducted on any paid claim submitted by a provider on a date more than 12 months earlier or, in the case of suspected fraud, may not be conducted more than six years after the date payment was made on the claim;

(b) For an audit initiated after payment is made on a claim, must be completed no later than 180 days from the date the audit is initiated on the claim, unless a provider fails to submit records in a timely fashion or initiates an appeal of the insurer's audit finding;

(c) Must be reviewed by a behavioral health professional;

(d) May not result in reversing or overturning a medical necessity determination made by the insurer when the claim was submitted or prior authorization of the service approved, unless the patient was no longer insured at the time the service was provided; and

(e) May use sampling methods or other similar means to determine whether to initiate an audit of a provider's claims but may recoup from the provider only payments on individual claims for which the insurer specifically identifies an error.

(6) In the course of an audit initiated prior to payment on a claim, an insurer shall respond to a provider with findings no later than 30 days after the date the provider responds to the insurer's request for additional information regarding the claim.

(7) An insurer may not demand recoupment of a payment made on a claim based on a clerical error.

(8) If an insurer identifies an error during an audit of a claim that results in the insurer's demand for recoupment of the insurer's payment on the claim, the insurer:

(a) Shall provide a detailed description of the error and allow a provider a reasonable opportunity of not less than 30 days to rectify the error; and

(b) Shall allow the provider to use a repayment plan of up to three years to repay the claim unless the recoupment is based on an insurer's duplicate payment on a claim.

(9) An insurer may not begin a new audit of any claim submitted by a provider while

another audit is in process. A subsequent audit may not be initiated until the provider has been given the opportunity to correct mistakes identified in the previous audit and complete any corrective action plan resulting from the previous audit.

(10) An insurer conducting an audit may not structure compensation paid to an employee or agent conducting an audit in any manner that creates a direct financial incentive to the employee or agent to identify errors that result in recoupment.

(11) An insurer may not charge a provider for the costs of conducting an audit.

(12) The provisions of this section apply to audits conducted by an insurer and to audits conducted by a third party on behalf of an insurer.

(13) In the event of an audit dispute between a provider and an insurer, the insurer:

(a) Shall continue to cover medically necessary services for the patient during the dispute, unless the insurer finds clear evidence of fraud or immediate patient safety concerns.

(b) May not hold the patient financially responsible for services deemed medically necessary at the time of delivery, even if the provider is later subject to recoupment.

SECTION 3. Sections 4 and 5 of this 2025 Act are added to and made a part of ORS chapter 414.

SECTION 4. (1) As used in this section:

(a) "Audit" has the meaning given that term in section 5 of this 2025 Act.

(b) "Provider" means an individual who is licensed, certified or otherwise authorized to provide physical or mental health services and supplies and who contracts with a coordinated care organization or is enrolled as a Medicaid provider in this state.

(2)(a) The Oregon Health Authority shall establish an education unit within the division of the authority that is charged with overseeing the integrity of provider billing. The education unit, in concert with the compliance officers of coordinated care organizations and with input from communities and culturally competent providers, shall develop a curriculum based on federal and state statutes and rules to inform providers regarding audits or reviews conducted by or on behalf of coordinated care organizations or the authority. The curriculum shall include, but is not limited to, written documents and presentations explaining the documentation that is necessary for audits or reviews and best practices for preparing and managing records to best prepare providers for audits or reviews.

(b) If a coordinated care organization requires different documentation to comply with an audit than the documentation required by the authority, the coordinated care organization shall communicate those differences in the curriculum materials and presentations developed under this section.

(3) Curriculum materials and presentations must be:

(a) Easily understood and may not solely rely on references to statutes;

(b) Posted to the websites of the authority and each coordinated care organization; and

(c) Easily accessible and available to all providers.

(4) The authority and coordinated care organizations shall ensure that providers are aware of the curriculum and how to access the curriculum.

(5) The education unit must be sufficiently staffed to allow for regular online presentations statewide.

SECTION 5. (1) As used in this section:

(a) "Audit" means an on-site or remote review of records of or claims made by a provider by or on behalf of a coordinated care organization or the Oregon Health Authority.

(b)(A) "Behavioral health treatment" includes:

(i) Mental health treatment and services as defined in ORS 743B.427; and

(ii) Substance use disorder treatment and services as defined in ORS 743B.427.

(B) "Behavioral health treatment" does not include treatment or services provided in:

(i) A hospital;

(ii) A hospital-affiliated clinic, as defined in ORS 442.612; or

(iii) A group medical practice that includes outpatient mental health or substance use disorder treatment.

(c) "Claim" means a request made by a provider to a coordinated care organization or the authority to reimburse the cost of behavioral health treatment provided to a member of the coordinated care organization or to a medical assistance recipient who is not enrolled in a coordinated care organization.

(d) "Clerical error" means a minor error in the handling, recording or transcribing of electronic or hard copy records or documents that does not affect:

(A) The completeness, accuracy or appropriateness of payment; or

(B) A determination of medical necessity or medical appropriateness that supports the specific care, items or services for which payment has been requested.

(e) "Provider" means an individual who is licensed, certified or otherwise authorized to provide behavioral health treatment in this state.

(2) A coordinated care organization and the Oregon Health Authority shall make available to all providers all of the following regarding the requirements for the submission of claims:

(a) Examples of documentation requirements for the submission of claims;

(b) Identification of which requirements may result in recoupment for failure to comply;

(c) An explanation of which requirements apply to in-network providers and which apply to out-of-network providers; and

(d) If the requirements differentiate between types of providers, an explanation of the requirements applicable to each type of provider.

(3) A coordinated care organization and the authority shall notify providers no later than 30 days before the effective date of any contract changes by the coordinated care organization or changes by the authority to relevant administrative rules.

(4) An audit of a claim:

(a) May not be conducted on any paid claim submitted by a provider on a date more than five years earlier without an indication of fraud or an improper payment;

(b) Except as provided in subsection (5) of this section, must be completed no later than 180 days from the date an audit is initiated on a claim;

(c) Must be conducted by a behavioral health professional; and

(d) May not result in reversing or overturning a determination that a service is medically necessary made by a coordinated care organization or the authority when prior authorization of the service was given.

(5) In the course of an audit, if a coordinated care organization or the authority requests additional information regarding a claim, the coordinated care organization or the authority shall respond to a provider with findings no later than 180 days after the date the audit was initiated, unless an extension is agreed to in writing by all parties.

(6) If a coordinated care organization or the authority identifies an error during an audit

of a claim that results in a demand for recoupment of the payment on the claim:

(a) The coordinated care organization or the authority shall work with the provider on a repayment plan, if requested.

(b) The provider may request a subsequent review of the audit report, as described in contract or rule, if a coordinated care organization or the authority applied incorrect statutes, rules, policies or guidelines during the course of the audit. After a subsequent review, a coordinated care organization or the authority may issue an amended audit report.

(7) Unless required by federal law, a coordinated care organization or the authority conducting an audit may not compensate an individual for conducting the audit in an amount that is based on a percentage of the overpayments recouped or in any other way that creates a financial incentive to identify errors that result in recoupment.

(8) The provisions of this section apply to audits conducted by a coordinated care organization and the authority and to audits conducted by a third party on behalf of a coordinated care organization or the authority.

(9) Nothing in this section requires a coordinated care organization or the authority to make payment on a claim for care, items or services provided if the documentation in the provider's files is not sufficient to determine the type, quantity or medical appropriateness of the care, items or services provided.

(10) In the event of an audit dispute between a provider and a coordinated care organization or the authority, the coordinated care organization or the authority:

(a) Shall continue to cover medically necessary services for the patient during the dispute, unless the coordinated care organization or the authority finds clear evidence of fraud or immediate patient safety concerns.

(b) May not hold the patient financially responsible for services deemed medically necessary at the time of delivery, even if the provider is later subject to recoupment.

SECTION 6. (1) The Oregon Health Authority shall collaborate with health care providers that provide care to medical assistance enrollees, coordinated care organizations, community groups that advocate for diversity and equity and health care industry representatives to develop recommendations for improving the processes by which payers audit health care providers' claims for reimbursement of the cost of health care services delivered.

(2) No later than July 1, 2026, the authority shall report the status of the development of recommendations under subsection (1) of this section to the interim committees of the Legislative Assembly related to health and the anticipated date that the recommendations will be submitted.

SECTION 7. ORS 414.592 is amended to read:

414.592. Notwithstanding ORS 414.590:

(1) Contracts between the Oregon Health Authority and coordinated care organizations or individual providers for the provision of behavioral health services must align with the quality metrics and incentives developed by the Behavioral Health Committee under ORS 413.017 and contain provisions that ensure that:

(a) Individuals have easy access to needed care;

(b) Services are responsive to individual and community needs; [*and*]

(c) Services will lead to meaningful improvement in individuals' lives[.]**; and**

(d) Coordinated care organizations comply with section 4 of this 2025 Act.

(2) The authority must provide at least 90 days' notice of changes needed to contracts that are

necessary to comply with subsection (1) of this section.

SECTION 8. Sections 2 and 5 of this 2025 Act apply to audits initiated on or after January 1, 2027.

SECTION 9. (1) Sections 2 and 5 of this 2025 Act become operative on January 1, 2027.

(2) An insurer, a coordinated care organization and the Oregon Health Authority may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the authority to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the authority by sections 2 and 5 of this 2025 Act.

SECTION 10. This 2025 Act takes effect on the 91st day after the date on which the 2025 regular session of the Eighty-third Legislative Assembly adjourns sine die.