COALITION FOR A HEALTHY OREGON

Oregon's Voice for Community Based Health

Oregon State Legislature
House Committee on Behavioral Health
900 Court St NE
Salem, OR 97301

Submitted Electronically

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Testimony in Opposition to HB 4028

Thank you, **Chair Pham**, **Vice-Chair Edwards**, **Vice-Chair Javadi**, and members of the Committee, for the opportunity to provide written testimony today. My name is Henry O'Keeffe, Vice President of Health Care Policy at Pac/West Lobby Group. I represent the **Coalition for a Healthy Oregon (COHO)**, which includes seven coordinated care organizations (**CCOs**) serving more than **450,000** Medicaid members through the Oregon Health Plan: Advanced Health, AllCare CCO, Cascade Health Alliance, InterCommunity Health Network Coordinated Care Organization, Trillium Community Health Plans, Umpqua Health Alliance, and Yamhill Community Care.

COHO respectfully urges the Committee to oppose HB 4028 in its current form. While we support the underlying goal of improving audit processes and transparency for behavioral health providers, **Section 4** of the bill—which applies specifically to **CCOs** and the **Oregon Health Authority (OHA)**—contains several provisions that would create significant operational, administrative, and legal challenges. These issues risk disrupting the behavioral health reimbursement system, straining **CCO** resources, conflicting with federal Medicaid requirements, and ultimately harming the providers and Medicaid members we collectively serve.

As we have noted to the bill's primary sponsor, **Representative Harbick**, **HB 4028** is very similar to **HB 2029 (2025)** and **HB 2455 (2023)**, so our objections may sound familiar to the bill's advocates. We shared these specific concerns and proposed amendments with **Representative Harbick** last week.

Our principal concerns with **Section 4** are as follows:

1. **Notification of Contract Changes – Section 4(3)**

   The bill requires **CCOs** and **OHA** to notify providers no later than **30 days** before the effective date of any contract changes by the **CCO** or relevant administrative rule changes by

OHA. This provision fails to account for circumstances in which **OHA** amends upstream contracts with **CCOs** on short notice or mandates immediate downstream implementation (e.g., to comply with urgent federal **CMS** directives, public health emergencies, or court-ordered deadlines). In such cases, **CCOs** would face conflicting legal obligations: comply with **OHA**'s timeline or violate this statute. The result could be a cascade of non-compliance that destabilizes behavioral health payments across the system.

Proposed fix: Add the qualifier "where practicable" to allow good-faith compliance while recognizing unavoidable situations subject to **OHA** oversight. The recommended language is:

"(3) A coordinated care organization and the authority shall, where practicable, 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."

2. **Lookback Period for Audits – Section 4(4)(a)**

The bill limits audits of paid claims to **five years** absent fraud or improper payment. This is preempted by federal Medicaid regulations at **42 CFR Part 401 Subpart D**, which require a **six-year** lookback period for identifying and reporting overpayments. The **2016 CMS** final rule explicitly establishes **six years** as the binding standard to balance program integrity with administrative burden and alignment with **False Claims Act** considerations. Even if enacted, this provision would be unenforceable to the extent it conflicts with federal law. The standard that **CCOs** will have to comply with will remain **six years** unless and until the federal government changes its standard, or the state of Oregon requires us to look back farther. Notably, **Section 2(5)(a)** of the same bill already applies a **six-year** lookback for commercial insurers in suspected fraud cases, creating an inconsistent standard that could confuse providers who will wonder why, despite the Oregon law being shorter, the **CCOs** are looking back **six years**.

Proposed fix: Align the Medicaid lookback period with the federal **six-year** requirement for consistency and compliance. The recommended language is:

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

3. **Response Time After Requesting Additional Information – Section 4(5)**

The **180-day** deadline for issuing audit findings begins on the date the audit is initiated, with no adjustment if the provider delays in providing requested records and refuses to agree to an extension. This structure renders the timeline unworkable when providers

control the flow of information, potentially forcing **CCOs** to issue incomplete findings or face statutory violations.

Proposed fix: Tie the **180-day** period to the date all requested additional information is received (unless an extension is mutually agreed upon in writing) to ensure fairness and practicality. The recommended language is:

"(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 all of the additional requested information is received, unless an extension is agreed to in writing by all parties."

4. **Entitlement to a Revised Audit – Section 4(6)(b)**

Providers are entitled to a revised audit merely upon having "reason to believe" that an error finding was based on an incorrect provision of law—no demonstration of the error or financial harm is required. "Reason to believe" is a lower standard than subjective belief and lacks the objective grounding that should apply here; it invites potentially unlimited revision requests, many of which could be speculative or minor, creating substantial administrative burden and delay for **CCOs** and **OHA** in an already resource-constrained environment.

Proposed fix: Require the provider to demonstrate (e.g., by citing the specific incorrect statute or rule) that the finding rested on an erroneous legal provision **and** that the provider suffered financial harm as a result. This maintains strong provider protections while preventing abuse and focusing revisions on material issues. The recommended language is:

"(b) A provider may request, and is entitled to receive, a revised audit if the provider can demonstrate that the coordinated care organization or the authority based the finding of error on an incorrect provision of law, and that the provider was financially harmed by the error."

In conclusion, while **HB 4028** seeks to address legitimate provider frustrations with audit practices, **Section 4** as currently drafted would impose unworkable burdens on **CCOs**, create direct conflicts with federal Medicaid rules, and risk unintended disruptions to behavioral health care delivery for Oregon Health Plan members. **COHO** remains committed to working collaboratively with the sponsor, the Committee, and behavioral health stakeholders to refine these provisions through targeted amendments that achieve the bill's objectives without compromising operational feasibility or federal compliance. We would welcome the opportunity to work directly with the bill's proponents on amendments to address these concerns and help move forward with a version that supports both providers and the Medicaid delivery system.

Thank you again for your consideration of this testimony. I am available to answer questions or provide further information at any time.

Respectfully submitted,

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