Health Share of Oregon

February 23, 2026

Senator Deb Patterson, Chair
Senator Cedric Hayden, Vice Chair

Senate Committee on Health Care
900 Court Street NE
Salem, OR 97301

**RE: Opposition to HB 4028 A (2026)**

Chair Patterson, Vice Chair Hayden, and Committee Members:

Health Share writes in opposition to HB 4028 A, which would greatly undermine fraud, waste, and abuse prevention efforts by Coordinated Care Organizations. We respectfully urge the Committee to not advance this legislation.

Health Share is Oregon's largest Coordinated Care Organization, serving over 465,000 members in Washington, Multnomah, and Clackamas Counties. Health Share was founded as a locally governed non-profit, bringing together the best of our region's health systems, county governments, and social service organizations to serve Oregon Health Plan members.

The CCO model was designed to contain costs under a global budget to maximize the best use of scarce health care resources. In the wake of H.R. 1's passage and its coming implementation, we must ensure that every health care dollar provides the greatest benefit to OHP members – limiting CCO oversight of behavioral health providers produces the opposite effect. Fraud, waste or abusive billing audits are some of the ways CCOs ensure good stewardship of public funds.

We appreciate the opportunity to provide examples of how HB 4028 A could have deleterious effects on our program integrity efforts:

**HB 4028 is inconsistent with federal and state False Claims Acts, the Code of Federal Regulations (CFR), and other federal and state regulations and guidance, and these inconsistencies pose compliance and legal risks to Coordinated Care Organizations and the Oregon Health Authority.** This includes "clerical errors: definition and limitations on audits and overpayment," and inconsistencies with the federal statute in the False Claims Act (FCA; 6 years statute). If passed, HB 4028 would put OHA and CCOs at risk of violation of these federal and state requirements.

According to the Center for Medicare and Medicaid Services (CMS) *Documentation Matters Toolkit* providers are responsible for documenting each patient encounter completely, accurately, and on time.[1] Providers must attest to the accuracy of the claims they submit. *If a provider is attesting that a claim is true, accurate and complete, their documentation must support their attestation*. Because providers rely on documentation to communicate important patient information, incomplete and inaccurate documentation can result in unintended and even dangerous patient outcomes. Accurate documentation supports compliance with federal and state laws and reduces fraud, waste, and abuse.

HB 4028 would in effect lower the standards of documentation, bringing Oregon into conflict with federal regulation.[2] Oregon's behavioral health certification board (MHACBO) also requires, in their code of conduct, that their licensed professionals shall "create, maintain, protect, and store documentation required per federal and state laws and rules, and organizational policies" and "maintain accurate and timely clinical and financial records for each client."[3]

**HB 4028, by making regulatory changes for behavioral health providers, creates a separate set of program integrity rules and FWA requirements than other providers.** This creates a risk of bias for OHA and CCOs, and is an inequitable application of FWA best practices. Providers should be subject to the same high standards for fraud, waste, and abuse regardless of their populations served. There is no provider type that is, by the nature of their work, deserving of differing standards for FWA compliance.

By contract, CCOs are required to have a Fraud, Waste, Abuse (FWA) prevention and detection program and policies and procedures that ensure compliance with the requirements set forth in 42 CFR Part 455, 42 CFR Part 438 Subpart H, OAR 410-141-3520, OAR 410-141-3625, and OAR 410-120-1510. FWA prevention and detection programs include fraud, waste and abuse audits; efforts to curtail these audits would likely run afoul

[1] CMS Documentation Matters Toolkit (https://www.cms.gov/medicare/medicaid-coordination/states/dcoumentation-matters-toolkit)
[2] § 455.18 Provider's statements on claims forms.
[3] MHACBO Code of Conduct

of OHA's stated goals in FWA detection and reporting, and provisions of current service contracts between CCOs and OHA.

HB 4028 only lists "clerical error" and "fraud" as audit types. This bill defines "Clerical error" as a minor error in the keeping, recording or transcribing of records or documents or in the handling of electronic or hard copies of correspondence. The bill does not address audits related to waste or abuse (abusive billing) as noted by 42 CFR Part 455.2 and OAR 410-120-0000.

**HB 4028 contains a problematic reduction in the statute of limitations to audit and recoup overpayment.** The statute of limitations under the False Claims Act (FCA) 31 U.S.C. § 3731(b), contains two separate limitations periods (along with a repose period) that can apply to an FCA suit. Under that law, an FCA action may be brought (1) 6 years from the date of the violation, or (2) 3 years from the date the U.S. official responsible for acting knew or should have known of the violation, but no later than 10 years from the date the violation occurred.

CCOs trigger investigative audits based on:

- Irregular patterns outliers upon claims analysis,
- Verification of Service process reveals concern from member service did not occur or did not occur as billed,
- Member grievances,
- High risk services or provider-type based on FWA trends,
- OIG workplan activity, etc.

*It is likely that HB 4028 as written would not allow Coordinated Care Organizations to recoup claims from these and other fraudulent billing practices if the offenses occurred greater than 36 months prior.*[4]

Importantly the definition of "know" (or "knowingly") in the False Claims Act does not only mean "has actual knowledge of [i.e., a claim being false]." It can also be interpreted as "acts in deliberate ignorance of [the False Claims Act in healthcare]" or "acts in reckless disregard of [the False Claims Act in healthcare]." This means that a qui tam lawsuit or

[4] A helpful example provided by the HHS OIG: A psychiatrist was fined $400,000 and excluded from Federal health programs for misrepresenting therapy sessions requiring 30 or 60 minutes of face-to-face time with the patient, when he had provided 15 minutes or less. The psychiatrist also misrepresented that he provided therapy sessions when a non-licensed individual did so. Under HB 4028, if these offenses had occurred greater than 3 years prior enforcement would not be allowed.

federal investigation into a false claim in healthcare does not have to demonstrate proof of specific intent to defraud.[5]

Finally – **future work of this Committee might consider how to best support small or single-source behavioral health providers in their billing and documentation practices on the front-end**; that is, OHA technical assistance and other education for providers should reinforce accurate, documented billing practices to avoid recoupment by Coordinated Care Organizations, among other payers. Instead of limiting recoupment of fraudulent billing we should ensure program integrity and assist providers in following existing federal and state guidelines.

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[5] A *qui tam* lawsuit is colloquially referred to as a "whistleblower suit"