LC3270: Medicaid External Medical Review

Background:

- The "External Medical Review" process allows a consumer to appeal a denial of coverage based on medical judgment to an independent medical expert appointed by the State
    - Example: the consumer or provider disagrees with the health plan on whether a treatment is medically necessary
- Oregon provides "External Medical Review" for consumers with commercial insurance plans through the Department of Consumer and Business Services – but hasn't implemented Federal Regulations permitting them for Medicaid enrollees
- External Medical Review is fast, efficient, fair, and effective
    - Decisions are made by independent medical experts with expertise in the condition and treatment in dispute, randomly selected from a pool of five Independent Review Organizations contracted by the State of Oregon
    - Decisions are normally completed within 30 days – but expedited review is available within 3 days
- Currently, Medicaid enrollees in Oregon have only one appeal option – to a "Fair Hearing" with an Administrative Law Judge
    - Patients without legal representation are pitted against CCO representatives in a legal proceeding
    - Administrative Law Judges are put in the position of reviewing CCO medical decisions without having the necessary medical expertise
    - Fair Hearing Process can take much longer than External Medical Review

Key Elements of New Legislation:

- Implements Federal Regulations (42 CFR 438.402) permitting States to offer and arrange for External Medical Review for Medicaid enrollees
    - See text of 42 CFR 438.402 on reverse
- Authorizes Oregon Health Authority to enter into an interagency agreement with the Department of Consumer and Business Services to provide External Medical Reviews to CCO enrollees, using the process that already exists for commercial insurance policy holders
    - Leverages existing infrastructure to support External Medical Reviews for minimal fiscal and agency impact

For More Information, Contact:

Paul Terdal,
Health Consumer,
paul@terdal.com

LC3270 implements “External Medical Review” provided for in 42 CFR 438.402

42 CFR 438.402 - General requirements.

(a) ***The grievance and appeal system.*** Each MCO, PIHP, and PAHP must have a grievance and appeal system in place for enrollees. Non-emergency medical transportation PAHPs, as defined in § 438.9, are not subject to this subpart F. For grievances and appeals at the plan level, an applicable integrated plan as defined in § 422.561 of this chapter is not subject to this subpart F, and is instead subject to the requirements of §§ 422.629 through 422.634 of this chapter. For appeals of integrated reconsiderations, applicable integrated plans are subject to § 438.408(f).

(b) ***Level of appeals.*** Each MCO, PIHP, and PAHP may have only one level of appeal for enrollees.

(c) ***Filing requirements*** -

(1) ***Authority to file.***

(i) An enrollee may file a grievance and request an appeal with the MCO, PIHP, or PAHP. An enrollee may request a State fair hearing after receiving notice under § 438.408 that the adverse benefit determination is upheld.

(A) ***Deemed exhaustion of appeals processes.*** In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in § 438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.

(B) ***External medical review.*** The State may offer and arrange for an external medical review if the following conditions are met.

(1) The review must be at the enrollee's option and must not be required before or used as a deterrent to proceeding to the State fair hearing.

(2) The review must be independent of both the State and MCO, PIHP, or PAHP.

(3) The review must be offered without any cost to the enrollee.

(4) The review must not extend any of the timeframes specified in § 438.408 and must not disrupt the continuation of benefits in § 438.420.

(ii) If State law permits and with the written consent of the enrollee, a provider or an authorized representative may request an appeal or file a grievance, or request a State fair hearing, on behalf of an enrollee. When the term “enrollee” is used throughout subpart F of this part, it includes providers and authorized representatives consistent with this paragraph, with the exception that providers cannot request continuation of benefits as specified in § 438.420(b)(5).

(2) ***Timing*** -

(i) ***Grievance.*** An enrollee may file a grievance with the MCO, PIHP, or PAHP at any time.

(ii) ***Appeal.*** Following receipt of a notification of an adverse benefit determination by an MCO, PIHP, or PAHP, an enrollee has 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the managed care plan.

(3) ***Procedures*** -

(i) ***Grievance.*** The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with the MCO, PIHP, or PAHP.

(ii) ***Appeal.*** The enrollee may request an appeal either orally or in writing.

[81 FR 27853, May 6, 2016, as amended at 84 FR 15844, Apr. 16, 2019; 85 FR 72842, Nov. 13, 2020]

LC 3270
2023 Regular Session
11/14/22 (LHF/ps)

D R A F T

SUMMARY

Establishes external medical review process for coverage determinations made by coordinated care organizations.

A BILL FOR AN ACT

Relating to external medical reviews; creating new provisions; and amending ORS 414.605 and 414.712.

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

SECTION 1. Section 2 of this 2023 Act is added to and made a part of ORS chapter 414.

SECTION 2. (1) The Oregon Health Authority shall enter into an interagency agreement with the Department of Consumer and Business Services to use the services of an independent review organization that contracts with the department under ORS 743B.253 to provide external medical reviews under ORS 414.712 using the process for external reviews described in ORS 743B.252 (3), (4) and (5).

(2) In an external medical review, an independent review organization may review a determination by a coordinated care organization:

(a) To reduce the duration or scope of a treatment or service;

(b) That a treatment or service is not medically necessary or is experimental;

(c) That the requested treatment or service is not paired with a condition that is funded on the prioritized list of health services developed by the Health Evidence Review Commission under ORS 414.690;

(d) Regarding the impact of the requested treatment or service on

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.

a comorbid condition of the member that is funded on the prioritized list of health services; or

(e) Any other determination that is based on an examination of the medical evidence.

(6) The external review process must:

(a) Be at the member's option;

(b) Be offered without cost to the member; and

(c) Not interrupt the member's continued receipt of benefits pending resolution of the appeal if the member files a timely request for review.

SECTION 3. ORS 414.712 is amended to read:

414.712. The Oregon Health Authority shall provide health services under [*ORS 414.591, 414.631 and 414.688 to 414.745*] **this chapter** to eligible persons who are determined eligible for medical assistance as defined in ORS 414.025. The Oregon Health Authority shall also provide the following:

(1) Ombudsman services for individuals who receive medical assistance under ORS 411.706 and for recipients who are members of coordinated care organizations. With the concurrence of the Governor and the Oregon Health Policy Board, the Director of the Oregon Health Authority shall appoint ombudsmen and may terminate an ombudsman. Ombudsmen are under the supervision and control of the director. An ombudsman shall serve as a recipient's advocate whenever the recipient or a physician or other medical personnel serving the recipient is reasonably concerned about access to, quality of or limitations on the care being provided by a health care provider or a coordinated care organization. **However, an ombudsman may not act as a recipient's representative during any grievance, hearing or external medical review process.** Recipients shall be informed of the availability of an ombudsman. Ombudsmen shall report to the Governor and the Oregon Health Policy Board in writing at least once each quarter. A report shall include a summary of the services that the ombudsman provided during the quarter and the ombudsman's recommendations for improving ombuds-

man services and access to or quality of care provided to eligible persons by health care providers and coordinated care organizations.

(2) Case management services in each health care provider organization or coordinated care organization for those individuals who receive assistance under ORS 411.706. Case managers shall be trained in and shall exhibit skills in communication with and sensitivity to the unique health care needs of individuals who receive assistance under ORS 411.706. Case managers shall be reasonably available to assist recipients served by the organization with the coordination of the recipient's health services at the reasonable request of the recipient or a physician or other medical personnel serving the recipient. Recipients shall be informed of the availability of case managers.

(3) A mechanism, established by rule, for soliciting consumer opinions and concerns regarding accessibility to and quality of the services of each health care provider.

(4) A choice of available medical plans and, within those plans, choice of a primary care provider.

(5)**(a)** Due process procedures for any individual whose request for medical assistance coverage for any treatment or service is denied **or reduced** or is not acted upon with reasonable promptness. These procedures shall include**:**

(A) An expedited process for cases in which a recipient's medical needs require swift resolution of a dispute[. *An ombudsman described in subsection (1) of this section may not act as the recipient's representative during any grievance or hearing process*]**; and**

(B) For a request for any treatment or service that is denied or is not acted upon with reasonable promptness or that is reduced in duration or scope by a coordinated care organization, an external medical review in accordance with section 2 of this 2023 Act.

SECTION 4. ORS 414.605 is amended to read:

414.605. (1) The Oregon Health Authority shall adopt by rule safeguards for members enrolled in coordinated care organizations that protect against

underutilization of services and inappropriate denials of services. In addition to any other consumer rights and responsibilities established by law, each member:

(a) Must be encouraged to be an active partner in directing the member's health care and services and not a passive recipient of care.

(b) Must be educated about the coordinated care approach being used in the community, including the approach to addressing behavioral health care, and provided with any assistance needed regarding how to navigate the coordinated health care system.

(c) Must have access to advocates, including qualified peer wellness specialists, peer support specialists, personal health navigators, and qualified community health workers who are part of the member's care team to provide assistance that is culturally and linguistically appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services.

(d) Shall be encouraged within all aspects of the integrated and coordinated health care delivery system to use wellness and prevention resources and to make healthy lifestyle choices.

(e) Shall be encouraged to work with the member's care team, including providers and community resources appropriate to the member's needs as a whole person.

(2) The authority shall establish and maintain an enrollment process for individuals who are dually eligible for Medicare and Medicaid that promotes continuity of care and that allows the member to disenroll from a coordinated care organization that fails to promptly provide adequate services and:

(a) To enroll in another coordinated care organization of the member's choice; or

(b) If another organization is not available, to receive Medicare-covered services on a fee-for-service basis.

(3) Members and their providers and coordinated care organizations have the right to appeal decisions about care and services**:**

(a) Through the authority in an expedited manner and in accordance with the contested case procedures in ORS chapter 183**; or**

(b) Using the external medical review described in section 2 of this 2023 Act.

(4) A health care entity may not unreasonably refuse to contract with an organization seeking to form a coordinated care organization if the participation of the entity is necessary for the organization to qualify as a coordinated care organization.

(5) A health care entity may refuse to contract with a coordinated care organization if the reimbursement established for a service provided by the entity under the contract is below the reasonable cost to the entity for providing the service.

(6) A health care entity that unreasonably refuses to contract with a coordinated care organization may not receive fee-for-service reimbursement from the authority for services that are available through a coordinated care organization either directly or by contract.

(7)(a) The authority shall adopt by rule a process for resolving disputes involving:

(A) A health care entity's refusal to contract with a coordinated care organization under subsections (4) and (5) of this section.

(B) The termination, extension or renewal of a health care entity's contract with a coordinated care organization.

(b) The processes adopted under this subsection must include the use of an independent third party arbitrator.

(8) A coordinated care organization may not unreasonably refuse to contract with a licensed health care provider.

(9) The authority shall:

(a) Monitor and enforce consumer rights and protections within the Oregon Integrated and Coordinated Health Care Delivery System and ensure a consistent response to complaints of violations of consumer rights or protections.

(b) Monitor and report on the statewide health care expenditures and recommend actions appropriate and necessary to contain the growth in health care costs incurred by all sectors of the system.
