SB191 with -1 Amendment: External Medical Reviews for Medicaid

Testimony to Senate Committee on Health Care by

Paul Terdal

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Introduction – Paul Terdal

- Resident of Northwest Portland, Senate District 17 / House District 33
- Volunteer health consumer advocate assisting families with insurance appeals related to autism and related medical / mental health coverage
  - Assisted more than 100 families with insurance denials, coverage issues
  - Consulted on multiple class action lawsuits over insurance denials
- Led consumer advocacy for OHP 1115 Medicaid Waiver reform in 2016, 2021-22
  - More than 60 state, national advocacy organizations joined successful call for end to "EPSDT" clause in waiver in 2022
- Lead consumer advocate on key health legislation since 2011
  - SB365 (2013) – Autism Health Insurance Reform
  - SB414 (2013) – Insurance Commissioner's restitution authority
  - SB696 (2015) – Behavior Analysis Regulatory Board
  - HB2931 (2017) – Behavior Analysis Interventionist Educational Requirements
  - HB2839 (2017) – Prohibits discrimination in organ transplantation
  - SB358 (2021) – Extended sunset on SB365
- Business Management and Public Policy Consultant
  - Research for National Council on Disability on State's Use of QALYs in Medicaid (2021-22)
  - MBA, Yale School of Management

SB191 with -1 Amendment: Medicaid External Medical Review

- Originally filed in 2017 as SB917
  - Co-Sponsored by Sen. Kruse, Rep. Kennemer
- "External Medical Review" allows a consumer to appeal a denial of coverage based on medical judgment to an independent medical expert appointed by the State
  - Example: is the prescribed treatment medically necessary?
- Oregon provides "External Medical Review" through DCBS for consumers with commercial insurance plans – but not 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 completed within 30 days – 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
  - 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

Federal Law authorizes State Medicaid Agencies to provide External Medical Review

42 CFR 438.402 - General requirements

(c)(1)(i)

- **(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.

Reference: https://www.law.cornell.edu/cfr/text/42/438.402

Oregon's new Section 1115 Medicaid Waiver drops "EPSDT" provision

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requires:

- "All medically necessary diagnostic and treatment services within the federal definition of Medicaid medical assistance must be covered, *regardless of whether or not such services are otherwise covered* under the state Medicaid plan for adults ages 21 and older." (*emphasis* added) (http://mchb.hrsa.gov/epsdt/overview.html#1)

Since 1992, Oregon has been exempt from EPSDT:

- Oregon has reserved the right to withhold medically necessary care from children under 21 based on the "prioritized list"

New OHP 1115 Waiver drops "EPSDT" clause:

- "This most recent OHP demonstration makes a significant change, in that the state is not seeking a renewal of its EPSDT waiver. This change will be effective on January 1, 2023. As of that date, the state will follow all Title XIX requirements with respect to coverage of services for individuals under age 21 and *provide all medically necessary services to children consistent with EPSDT* requirements. This will have a significant operational impact on the Prioritized List, which was previously lacking some EPSDT services for children."
  - Department of Health and Human Services letter to Oregon Health Authority, 9/28/2022

Adults may also need to appeal denials based on medical judgment – some examples:

STATEMENT OF INTENT 4: ROLE OF THE PRIORITIZED LIST IN COVERAGE:

- "The Commission recognizes that a condition and treatment pairing above the funding line does not necessarily mean that the service will be covered by the Oregon Health Plan (OHP). *There may be other restrictions that apply, such as the service not being medically necessary* or appropriate for an individual member."

GUIDELINE NOTE 32, CATARACT:

- "There are rare instances where cataract removal is *medically necessary* even if visual improvement is not the primary goal…."

GUIDELINE NOTE 6, REHABILITATIVE AND HABILITATIVE THERAPIES:

- "The quantitative limits in this guideline note do not apply to mental health or substance abuse conditions."
- The lack of hard limits for mental health means that coverage decisions for intensive therapy require medical judgment

Reference: 2023 List of Prioritized Health Services. https://www.oregon.gov/oha/HPA/DSI-HERC/PrioritizedList/1-1-2023%20Prioritized%20List%20of%20Health%20Services.pdf

Example: Growth Hormones for Prader Willi Syndrome

- Pediatric patient with Prader Willi Syndrome was prescribed growth hormones by OHSU Endocrinology clinic
  - Coverage was terminated at age 17 because of Prioritized List criteria related to bone growth
  - Prescribing physician said ongoing care was still medically necessary for other indications, including energy level and cognition
  - Because this was "below the line" patient had no meaningful opportunity to appeal denial
- End of EPSDT waiver means he would have the right to appeal on "medical necessity"
- New provision in "GUIDELINE NOTE 74, GROWTH HORMONE TREATMENT":
  - "Treatment of children and adolescents with growth hormone (for any indication) *must be evaluated for* medical appropriateness and *medical necessity* on a case-by-case basis. Therapy must be initiated by and continued in consultation with a pediatric endocrinologist."

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Oregon Faces Scrutiny Over One-Of-A-Kind Hurdles to Children's Health Care

By: Ben Botkin

Cainan Molzer (far right), 17, of Medford, poses with his family./Photo courtesy Joe Molzer

Cainan Molzer of Medford was born with a rare genetic disorder that can thwart the growth of children's bodies and slow the development of their minds.

Now 17, he first started taking growth hormones to combat the condition, called Prader Willi Syndrome, when he was 2 years old. The federally-funded Oregon Health Plan, however, cut off Molzer's coverage for the treatment when he was 16. It did so despite the recommendation of Molzer's doctor, as well as studies attesting to the therapy's benefit. The treatment costs $20,000 a year, and his family, which has belonged to the low-income state program all his life, is in no position to pay it.

The Molzer family's experience illustrates how a cost-cutting measure in the Oregon Health Plan — once a darling of national health reformers — has, for some, become a case study in how states can evade their obligations under federal law.

https://www.thelundreport.org/content/oregon-faces-scrutiny-over-one-kind-hurdles-children%E2%80%99s-health-care

Partial list of the External Medical Review Cases I have worked on

Case #	Patient Description:	Insurer:	Denial Type:	IRO:	Decision:	Date:
ER11104	Male, age 4, autistic disorder	Kaiser	Medical Necessity	Lumetra	Upheld	11/22/2011
ER11105	Male, age 6, autistic disorder	Kaiser	Medical Necessity	IPRO	Overturn	12/2/2011
ER11127	Male, age 3 yrs 11 months, autism spectrum disorder	Kaiser	Medical Necessity	IPRO	Overturn	1/27/2012
ER11137	Female, age 3, Fragile X and autism	Kaiser	Medical Necessity	IPRO	Overturn	1/20/2012
ER11140	Male, age 5, autistic disorder	Kaiser	Medical Necessity	Permedion	Overturn	1/13/2012
ER12005	Male, age 3, autism spectrum disorder	Providence	Experimental / Investigational	Permedion	Overturn	2/2/2012
ER12025	Male, age 6, autistic disorder	Kaiser	Medical Necessity	Medwork	Overturn	3/16/2012
ER12052	Male, age 4, autistic disorder	Kaiser	Medical Necessity / Licensure	Medwork	Overturn	5/18/2012
ER12053	Male, age 6, autistic disorder	Kaiser	Licensure	Permedion	Declined	5/11/2012
ER12054	Male, age 4, autistic disorder	Kaiser	Medical Necessity	IPRO	Overturn	5/21/2012
ER12077	Male, age 6, autistic disorder	Kaiser PEBB	Medical Necessity	IPRO	Overturn	6/22/2012
ER12085	Male, age 7, autistic disorder	Kaiser	Medical Necessity	Permedion	Overturn	7/6/2012
ER12095	Male, age 5, Asperger's	Kaiser PEBB	Medical Necessity	AMR	Overturn	7/30/2012
ER12102	Male, age 3 yrs 9 months, autistic disorder	Kaiser	Medical Necessity	IPRO	Overturn	8/16/2012
ER12112	Male, age 5, autism	Kaiser	Medical Necessity	Medwork	Overturn	8/31/2012

Statistics from DCBS about External Medical Reviews for non-Medicaid health insurance consumers

Number of External Reviews by Year (through Q3 2022)

Received Year	Standard	Expedited
2019	405	6
2020	358	10
2021	319	4
2022	235	7

Decision Outcomes (through Q3 2022)

Received Year	2022	2021	2020	Grand Total
Overturned Denial	39.3%	29.6%	33.5%	33.5%
Partial Overturn	1.2%	2.1%	1.5%	1.6%
Upheld Denial	59.5%	68.3%	65.1%	64.9%

Note: provided by Department of Consumer and Business Services on 1/16/2023 in response to a public records request

Feedback from DCBS about cost of External Medical Reviews

Cost to the Division of supporting External Medical Reviews

"Division of Financial Regulation staff time to implement the external review program is recouped through the DCBS annual insurer assessment. Whoever works on the program includes the time spent in the annual time study. The time would fall under the health insurance/company category. There isn't a separate program cost account for the program.

Estimated 0.6 FTE." (*emphasis* added)

Cost to insurers for review

- Average rate for non-expedited reviews = $583
  - Non-expedited (Standard) external reviews for 2022 (through Q3) = 383
  - 383 x $583 = $223,289
- Average rate for expedited reviews = $669
  - Expedited external reviews for 2022 (through Q3) = 12
  - 12 x $669 = $8,025
- Average rate for cases deemed ineligible for review = $170
  - Ineligible external review cases for 2022 (through Q3) = 117
  - 117 x $170 = $19,890
- 2022 total estimated annual cost of External Medical Reviews for insurers = $251,204

Note: provided by Department of Consumer and Business Services on 1/16/2023 in response to a public records request

Next Steps

Key Questions:

- Should OHA work with DCBS to manage this External Medical Review process – or should OHA set up its own process?
  - Current draft calls for OHA to enter into interagency agreement with DCBS to manage this – that seemed to be efficient, since DCBS already has a similar process for commercial insurance
  - If OHA prefers, we can easily change this to have OHA set up its own External Medical Review process instead
- Does OHA want more statutory guidance on process details, or more explicit authority to adopt rules?
  - Example: should consumers be required to complete internal appeals before seeking External Medical Review? What about exceptions in case of urgent medical emergencies?
    - From Staff Measure Summary: "*First, an enrollee must appeal to the insurer or medical assistance program. If the appeal is denied, an external review can be requested. In urgent situations, an external review may be requested even if the internal appeals process is not yet completed.*" – does this need to be spelled out clearly in the bill language?

I would be happy to work with any and all interested stakeholders to finalize consensus language

Appendix: Definition of "Medically Necessary" for the Oregon Health Plan

OAR 410-120-0000: Acronyms and Definitions

- (148) "**Medically Necessary**" means health services and items that are required by a client or member to address one or more of the following:

- (a) The prevention, diagnosis, or treatment of a client or member's disease, condition, or disorder that results in health impairments or a disability;

- (b) The ability for a client or member to achieve age-appropriate growth and development;

- (c) The ability for a client or member to attain, maintain, or regain independence in self-care, ability to perform activities of daily living or improve health status; or

- (d) The opportunity for a client or member receiving Long Term Services & Supports (LTSS) as defined in these rules to have access to the benefits of non-institutionalized community living, to achieve person centered care goals, and to live and work in the setting of their choice;

- (e) A medically necessary service must also be medically appropriate. All covered services must be medically necessary, but not all medically necessary services are covered services.