

SB917: CCO 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 may be pitted against a CCO attorney 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

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SB917 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.

(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. Further, unless the [enrollee](#) requests an expedited resolution, an oral [appeal](#) must be followed by a written, signed [appeal](#).