February 6, 2019

Honorable Chair Laurie Monnes-Anderson
900 Court St NE, S-211
Salem, OR, 97301

RE: SB 139 Restrictions on Utilization Management

Chair Monnes-Anderson and members of the Senate Committee on Health Care,

This letter is being submitted on behalf of several Coordinated Care Organizations (CCO) who are charged with delivering low cost, high quality health care services to more than One Million Oregon Health Plan members. We want to register our concerns with the process by which SB 139 was crafted and the impact that the proposed changes will have on health care costs and access in Oregon. Oregon's position as a national leader in health care reform will be put in jeopardy should the provisions contained in this bill pass.

Let us begin by emphasizing that utilization management tools such as prior authorization and step therapy protocols are integral elements of managing care in both public and private health plans. These tools are not intended to deny people access to the health care services and medications that are necessary to sustain the high quality of life that everyone deserves. These protocols are used in accordance with the most recent science and health care industry best practices designed to reduce the amount of unnecessary care, testing, and imaging, while recognizing that navigating patients access to cost effective health care services can be achieved without jeopardizing health outcomes. CCO's remain committed to partnering with providers to ensure that all Oregonians receive high quality, evidence based, cost effective care.

SB 139 seeks to take away the ability to use some of these tools, putting patients at risk of unnecessary medical interventions and the sustainability of the CCO model in jeopardy. This bill has the potential to significantly impact CCO's financial solvency and may ultimately limit access to health coverage in Oregon. Further, CCO's in Oregon already have extensive regulatory oversight – under OHP Medicaid statutes and rules, under Oregon's Section 1115 Waiver, and under the CCO contracts with OHA. We fail to see the rational that would warrant these additional restraints on CCO's who are charged specifically with managing cost and providing value to patients.

Of specific concern:

> ***Section 2 (1)(a). If a request for prior authorization for a prescription drug is approved, continue to provide coverage for the next consecutive 12-month period***
>
> ***(b) If a request for prior authorization for a health service other than a prescription drug is approved, continue to provide coverage for reasonable and customary length of time and not less than 90 days***

This provision is not medically appropriate and may significantly increase the cost to CCO's and health plan premiums. Many medications are now well over $100,000 annually, and a patient's clinical condition may quickly change making ongoing provision of the medication unnecessary or inappropriate over a 12-month period of time. Removing a CCO's ability to review these medications on a timely basis, may significantly impact costs, which are ultimately passed along to consumers, employers, and tax payers. A similar argument can be made for non-prescription health services.

> ***Section 3. A provider who requests prior authorization for an item or health service,***

an exception from step therapy, as defined in ORS 743B.602, or other drug protocol or any other coverage that is subject to utilization review may exercise any of the rights of the enrollee for whom the coverage is requested with respect to internal appeals and external reviews under ORS 743B.250, 743B.252, 743B.255 and 743B.256.

Currently it is appropriate that health plan members have greater appeal rights than providers - it is members who know what is important to them. While it is reasonable for a provider to assist a member in navigating the appeals process, it is inappropriate for providers to assume and commandeer the member's appeal. Providers already have appeal rights; making these more rigorous does not serve members well, and applies burdensome requirements on CCOs and health plans.

Sections 6 and 8 (8)

These requirements are to some degree redundant to what is already required for CCOs, and it is unclear what will be achieved by the administrative burden of providing the additional information.

Section 7 (3) The coordinated care organization may not require step therapy if a provider submits the information described in subsections (2) (b) and (c) of this section.

It is absolutely appropriate, as Section 7(2)(b) & (c) suggest, for an enrollee's provider to submit the documentation required under these subsections, and for a CCO to review the documentation before allowing the prescription of a certain course of drug treatments. Allowing a provider to submit the documentation and having the submission alone be the driving justification for treatment – with no allowance to review the documentation - falls short of the impartial review that is necessary to ensure that lower cost options are considered before prescribing certain medications.

Section 8, relating to appeals (e) A person involved in the consideration of the denial or internal appeal must be a clinician in the same or similar specialty as the prescribing provider.

Section 10 (2) (e) A physician licensed under ORS 677.100 to 677.228 who is a provider in the same or similar specialty as the provider requesting a service or site that is the subject of the utilization review shall be responsible for all final recommendations regarding the necessity or appropriateness of services or the site at which the services are provided and, in making the recommendations, shall consult as appropriate with medical and mental health specialists in the same or similar specialty as the provider requesting the service or site that is the subject of the utilization review.

The practicality of these two provision, and how they are used elsewhere in the bill, is lacking significantly based on the cost associated with having a contractual relationship with all of specialty providers that this would require would be financially unsustainable. In some cases those specialist to specialist conversation would be impossible to schedule in the times required by this bill. Requiring a physician in the same specialty as the ordering provider could be a challenge both financially and in terms of practical availability for smaller more rural organizations without access to millions of covered lives. This has the real potential to actually to create longer delays in trying to comply with the strict provisions of this bill that will have a negative impact on patient care.

Section 10 (2) (b), relating to insurer website

We request further clarification of the prohibition on use of "proprietary payer portals" for submission of prior authorization requests. Is the concern that CCOs and insurers must make these portals open to providers without financial charge? Or is the concern that CCO and insurers may not develop their own proprietary payer portal – even if providers are not charged for accessing the portal to make prior authorization requests? Further we suggest that if all insurers and CCOs will be required to have the website portals for prior authorization requests, that providers be required to use the portals rather than using paper and facsimile.

> ***Section 10 (2) (h) If an enrollee is stabilized on a treatment plan and the treatment is subject to utilization review, the insurer must continue to provide coverage of the treatment until utilization review is completed and all appeals are resolved.***

This provision is unreasonable and unnecessarily costly. For example, the treatment or service that is the subject of the treatment plan may not be a covered benefit under Medicaid or under the health benefit plan. If coverage of the treatment must continue until all review and appeals are resolved, the non-covered service may already be delivered and completed – thus requiring the CCO to cover a service that is not part of the benefit package. This could significantly increase costs.

Finally, the response timelines that are suggested for CCO's cause significant concerns. CMS gives providers 72 hours to review urgent requests and 14 days for all others. Ratcheting these numbers down to one day for urgent requests and 2 days in all other situations as suggested in Section 10 adds a level of regulation upon the CCO's that could potentially subject members to unnecessary testing and costly services. In addition, it may have an unintended consequence of increasing denials, since the primary reason for denials in the pharmacy department are insufficient clinical information from the provider. Limiting response time to 2 days would exacerbate this problem.

The CCO's stand ready and willing to work with the Oregon Medical Association and others on identifying workable solutions to the issues raised, but in its current form we must oppose this costly and burdensome proposal.
Sincerely,

AllCare Health
CareOregon
Coalition for a Healthy Oregon
Cascade Health Alliance
InterCommunity Health Network CCO
PacificSource Community Solutions
Trillium Community Health Plan
Umpqua Community Health.