SB191 with -1 Amendment:
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 (SB191 -1 Amendment):

- 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

SB191 -1 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.

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