CareOregon

May 13, 2025

CareOregon Support for Provider Reconsiderations

Chair Patterson, Vice-Chair Hayden, and Members of the Committee,

CareOregon is a community non-profit organization serving members of the Oregon Health Plan (OHP) for 30 years. We currently manage OHP benefits for over 500,000 Oregonians. CareOregon wholly owns two coordinated care organizations (CCOs), Jackson Care Connect and Columbia Pacific CCO. We also are a founding member of Health Share of Oregon, managing an integrated community network and the behavioral health benefit for all Health Share of Oregon members. We also serve statewide through our tribal care coordination benefit. Our mission is to inspire and partner to create quality and equity in individual and community health.

CCO members should not experience unnecessary delays or be subjected to unnecessary administrative processes to receive care a CCO and provider agree is medically necessary. CCO members also have a right to appeal a denied prior authorization request as required under 42 CFR 438.400 – 438.424. These commitments to the CCO members we serve are not mutually exclusive. We propose the language below be added to HB 3134 A to give CCOs the statutory clarity needed to conduct provider reconsiderations, so we can maximize the extent we can achieve both commitments.

> (1) A coordinated care organization may approve a previously denied prior authorization request within 60 days of issuing the denial, if:
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> > (a) the coordinated care organization consults with the requesting provider and both the coordinated care organization and provider agree the requested service is medically necessary; and
> >
> > (b) the member has not requested an appeal for the denied prior authorization request with the coordinated care organization.

Due to layers of administrative burden providers experience, it is not uncommon for a CCO to receive necessary documentation after a CCO is required to deny the request at the end of the 14-day approval window. Currently, the only option to reverse a denied prior authorization request is via the member-initiated appeal process. The best-case scenario is the member engaging in the process and requesting an appeal, resulting in a delay of needed care. The worst-case scenario is the member receiving the denial notice and disengaging due to the barrier of the appeals process, forgoing medically necessary care. Due to a CMS rule change, the 14-day prior authorization request approval window will be shortened to 7 days beginning in 2026, adding to CCO and provider administrative burden and risking further delays to care. The proposed language will address these challenges by giving CCOs and providers an administrative off-ramp to reduce unnecessary delays in getting services approved, while simultaneously protecting member appeal rights without relying on them as the only pathway to medically necessary care after an administrative denial.

Concerns have been raised about the potential for provider reconsiderations to impede a member's right to appeal as described in 42 CFR 438.400 – 438.424. While being clear on the member-initiated appeals process, by no means does the spirit or letter of 42 CFR 438.400 – 438.424 not allow for a more efficient and expeditious process to arrive at a result that ultimately benefits the Medicaid recipient. The regulation is meant to set a floor for the right of members to appeal adverse benefit determinations, not preclude all other means by which providers could advocate for reconsideration of denials. Furthermore, the proposed language intentionally preserves appeal rights and clearly prohibits provider reconsiderations from preempting them.

Provider reconsiderations are a process at least four other state Medicaid programs (IN, KS, OH, OK) explicitly allow in administrative rule.[1] Medicare has also issued clear guidance for reopening determinations based on new medical information while maintaining the right to appeal.[2]

We urge your support for including language allowing provider reconsiderations in HB 3134 A. The CCO model is meant to foster creative collaboration between providers and plans for the benefit of OHP members; provider reconsiderations are a natural and allowable product of that collaboration.

Thank you,

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CareOregon

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[1] Other states' administrative rules related to provider reconsiderations:
Indiana: https://iar.iga.in.gov/code/2026/405/5#405-5-7-2
Kansas: https://sos.ks.gov/publications/pubs_kar_Regs.aspx?KAR=129-9-6
Ohio: https://codes.ohio.gov/ohio-administrative-code/rule-5160-1-31#:~:text=(A)%20Reimbursement%20for%20certain%20items,managed%20care%20entity%20(MCE).
Oklahoma: https://oklahoma.gov/ohca/policies-and-rules/xpolicy/grievance-procedures-and-process/subchapter-three-member-grievances-and-appeals-provider-complaints-and-state-fair-hearings-in-soonerselect/provider-complaint-system.html
[2] Medicare guidance on reopening determinations (pg 102): https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/parts-c-and-d-enrollee-grievances-organization-coverage-determinations-and-appeals-guidance.pdf