

From: Lisa Pool <blueskyacu@gmail.com>

Sent: Tuesday, February 25, 2020 5:51 PM

To: SCHOPF Michael D * DCBS <Michael.D.Schopf@oregon.gov>

Subject: Re: 2022 Essential Health Benefits Committee - DRAFT Ideas for Consideration

Michael -

Here is my full proposal - I can send as attachment if that is easier. I have two proposals so far.

Proposal for Essential Benefit Task Committee:

Proposal #1:

We are charged with determining what should be considered an essential benefit. This is often based on what is an essential need from our community. Currently, our state has an essential need for acute and chronic non-opiate pain management with very little access. Our current list defines and limits "essential" benefits for the treatment of pain to Opiates and Physical Therapy. While each of these options are essential, they are limited in their scope to address the complexity of pain conditions and in the case of opiates, we should be advocating for reduction and elimination of opiates whenever possible.

The opiate crisis continues to grow throughout the country and Oregon is no exception. The opiate crisis has increased primarily as a result of a need for effective non-opiate pain management without proper access to those services. There is no doubt that opiates can provide effective pain management in many cases, but it comes at a heavy price because opiate use can often lead to significant side effects and addiction. People experiencing unmanaged acute and/or chronic pain tend to have more visits to the ER, more surgeries, increased medications and increased mental health emergencies. Unmanaged acute and chronic pain also keeps people from going to work and can interfere with their ability to care for themselves and their families financially. All of these factors further burden our communities and families and can lead to other costs for our communities with police, EMT, Fire, Judicial system, social services and more.

In order to meet the need to reduce the opiate crisis and address an essential need in our state, I am proposing an increase to non-opiate related therapies and techniques.

This would need to happen in the following ways:

1. Non-opiate therapies such as DC, LAc, LMT would need to be added as essential modalities.

2. Add 30 visits per year for patients to access a comprehensive set of non-opiate modalities and the techniques covered under their licensure.
3. I would suggest combining the requested additional 30 visits, with the already approved 30 visits for PT, for a combination of 60 visits total for non-opiate related therapies. Putting all the benefits into one bucket would then allow the patient to access the modality or modalities necessary for their case and condition. This would also help prevent the "double dipping" of benefits currently seen in many health plans. For example, if I see my Chiropractor and he performs any technique beyond spinal manipulation, my PT benefit and my DC benefits are both docked a visit even though it was one provider, one DOS and one session. Pooling the visits would ensure patients would be billed per visit, not per technique, especially since many techniques are covered under multiple scopes of practice.

This plan would mean approximately approving up to \$1350 per year (based on an average of compensation from 8 insurers), per patient and yet would drastically reduce opiate usage, reduce ER visits, reduce surgeries and other costly procedures. This would be the maximum impact as we expect most patients will not utilize the full 60 visits. For example, Medicaid/OHP allowed 90 visits for PT, LAc, DC for 2 years and during that time most pain patients were accessing 30-45 visits/yr for chronic pain management. Occasionally a patient would start with one modality and it would not be sufficient to address the issue and would need to utilize another modality. This scenario was the most common reason for utilizing 60 visits and patients with severe medical concerns would access more than 60 (extremely rare) or if there were multiple injuries in one year (also rare).

The Essential benefits list should be, at a minimum, meeting the standards set with OHP/Medicaid and Medicare. OHP allows 30 visits for non-opiate therapies (LMT excluded) for pain management and additional visits for smoking cessation. Medicare allows for unlimited PT, unlimited for DC, 20 visits for LAc and no coverage for LMT.

Proposal #2:

Add limited bariatric surgery for patients with long term morbidly obese of 40 BMI or more w/ co-morbidities of diabetes or HBP or other complications from obesity.

From: Vern Saboe <vern@drvernsaboe.com>
Sent: Wednesday, February 26, 2020 8:55 AM
To: SCHOPF Michael D * DCBS <Michael.D.Schopf@oregon.gov>
Cc: Vern Saboe <vern@drvernsaboe.com>
Subject: RE: 2022 Essential Health Benefits Committee - DRAFT Ideas for Consideration

Hi Michael,

Thank you for this draft items for consideration. In box three “Remove exclusion of ‘chiropractic care’ to ensure compliance with provider non-discrimination.” I respectfully suggest that “acupuncture” which is listed on the bottom of that same page of the 2017 CMS document also applies. Meaning of course acupuncture is also a profession with acupuncturists performing more than acupuncture under their licenses. I think it was Lisa Pool who referred to “physical medicine” interventions and the “30-60 visit bucket” deal.

Additionally, I think it appropriate to cite statute ORS 743B.505 and rule OAR 836-053-0012(6-8) so insurers and health plans don’t assume we are pulling this out of our “backsides” but that provider non-discrimination provisions are in Oregon statute and rule...

Box 4, “Increase limit on physical therapy visits...” should this not read “physical medicine” visits? Just leaving it as physical therapy connotes visits only to a licensed physical therapist?? Yes? No?

Box 5, “Include coverage of spinal manipulation.” Would like something referring to the inappropriate activity of some insurers e.g., Moda and I think David Nessler-Cass confirmed this, at least I think I heard him mention this. Some insurers having the policy that they will pay for an osteopath to perform spinal manipulation but not a chiropractor.

Cheers, Vern

From: Vern Saboe <vern@drvernsaboe.com>
Sent: Wednesday, February 26, 2020 12:03 PM
To: SCHOPF Michael D * DCBS <Michael.D.Schopf@oregon.gov>
Cc: Vern Saboe <vern@drvernsaboe.com>
Subject: RE: 2022 Essential Health Benefits Committee - DRAFT Ideas for Consideration

Me again Michael,

I wish to add this item. It also as it pertains to ORS 743B.505 important to note the legislative intent and meaning of, “(2)(c) This subsection does not prevent an insurer from establishing **varying reimbursement** rates based on **quality or performance measures.**”

The legislative intent for this language was the same as for the PPACA’s Section 2706a and for Governor Kitzhaber’s Senate Bill 1580 CCO bill that was rolled into Senate Bill 1509 both passed in 2015. I can provide both the congressional record and Oregon State legislative record that validates this, if needed.

The legislative intent of this language was to prohibit insurers, health plans and CCOs from paying certain providers less for the same covered service that is within in their scope to provide than other providers, simply based type of provider. For example, an insurer, health plan, or CCO paying an osteopathic physician \$200.00 for E/M Code 99202 but only \$100.00 for the same covered service to a chiropractic physician, simply because he/she has a DC after their name and not DO or MD or FNP or filling the blank.

In short the legislative intent of this language was that insurers, health plans and CCOs can vary reimbursement levels only based on quality of performance measure and not by type of provider.....thanks, Vern

From: Dr. Jeff Clark <drjeffclark@truehealthmedicine.com>
Sent: Friday, February 28, 2020 9:22 AM
To: SCHOPF Michael D * DCBS <Michael.D.Schopf@oregon.gov>
Cc: Nicholina Terzieff <Niki@leadingedgepublicaffairs.com>; Beth Martin <beth@oanp.org>;
Maeghan Culver <mculver@nwim.org>
Subject: INPUTS Re: 2022 Essential Health Benefits Committee - DRAFT Ideas for Consideration

Hi Michael,

Looking forward to being in attendance at the next meeting. Thank you for choosing to include me/us in the RAC.

I understand there was spirited discussion that wandered from the committee's focus on EHB. Here are some inputs from me that are on-topic for the ongoing discussion.

1. Non-drug pain management and therapies. I really want to make sure that we fully air out this topic to remove restrictions as much as possible for patient access to non-drug pain treatments. I know our insurance friends are going to complain. My insistence is that they tally up the financial and human costs of opiod addiction and treatments along with major surgeries that might be avoided when they go to balance the relative costs of these services to their plans.

a) Accupuncture often needs to be administered 2x a week for a period of time and then weekly for up to a year to resolve and manage chronic pain syndromes without relying on analgesics that are either addictive or pose a health risk to liver and/or kidney from chronic usage. Unlimited should be the standard allowing the practitioner and patient to individualize treatment plans. If there must be a limiting number, then I propose acupuncure up to 60 visits independent of other pain modality benefits.

b) Chiropractic, Osteopathic, occupational and physical therapy treatments. To be effective in resolving chronic pain syndrome, these manipulation and related therapies need to be available to the patient up to weekly, with initial visits 2x per week. So if there needs to be an annual cap, then 60 visits independent of limits on any other type pain therapy.

c) Non-surgical physio-therapies. Everything legal and within an Oregon licensed practitioner's scope of practice to perform in-office should be covered in a pain code. Botox injections and implanted neuro-stim devices are relatively big ticket and debatable as EHB. In office therapeutic ultra sound, external neuro-stim, hydrotherapy, and other low force physio-therapy interventions should be covered as EHB when billed under a pain ICD-10. Independent limit of up to 60.

d) Licensed therapeutic massage treatments. Independent limit of up to 52 treatments per year when prescribed under a pain ICD-10.

2. Behavioral Health and Addiction therapies. Out patient counseling, MAT, other modalities. There needs to be coverage for up to weekly out-patient visits per year, with more in the beginning so up to 60/year.

3. Telemedicine. Must be covered by all plans for followup to in-office visits. Increases effective workforce size in rural and under served communities. Facilitates more access to behavioral health services in particular.

Jeff Clark, ND
OANP Legislative Chair

From: Tony Kopki <Tony.Kopki@pacificsource.com>
Sent: Friday, February 28, 2020 2:17 PM
To: SCHOPF Michael D * DCBS <Michael.D.Schopf@oregon.gov>
Cc: Richard Blackwell <Richard.Blackwell@pacificsource.com>; Tony Kopki <Tony.Kopki@pacificsource.com>
Subject: EHB 2022 Advisory

Good afternoon Michael:

As a follow up to our EHB 2022 advisory meeting, PacificSource would like to offer the following comments and suggestions:

1. PacificSource is supportive of introducing the evidence based solutions to address the opioid epidemic that could include the solutions outlined in the Illinois benchmark plan.
2. Coverage solutions to keep insulin affordable through formulary development strategies.
3. Do not embed Pediatric Dental in medical plans as this would create complexities to the tiered rating structures in small group.

Looking forward to additional discussion on March 10th.

Please let me know if you have any immediate questions.

Tony Kopki, CHFE

Vice President, Commercial

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From: Cortney Rouse <cortney@pdxpertmedicalbilling.com>
Sent: Friday, February 28, 2020 4:21 PM
To: SCHOPF Michael D * DCBS <Michael.D.Schopf@oregon.gov>
Subject: Re: 2022 Essential Health Benefits Committee - DRAFT Ideas for Consideration

Michael,

I have been collaborating with Lisa Pool and Verne Soboe on behalf of AMTA to come up with our proposed idea to add to the EHB 2022. One of them may be submitting a similar but separate draft, due to the time limit we were down to the wire in our collaborations. I have attached our draft to this email.

Thank you! Please let me know if you have any questions.

Warmly,
Cortney Rouse
PDXPERT Medical Billing

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