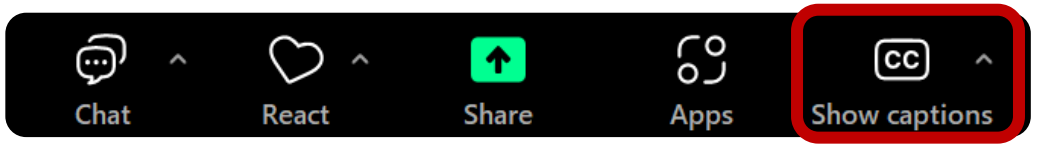
August 26, 2024

Oregon Health Plan Benefit Update Project Coordinated Care Organizations and Fee-for-Service (Open Card) Contractors Information Session #1

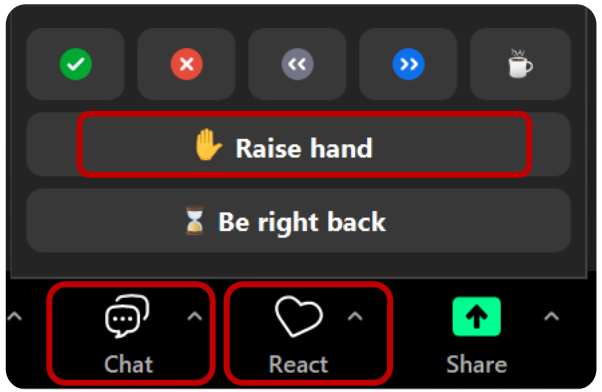
Zoom meeting instructions

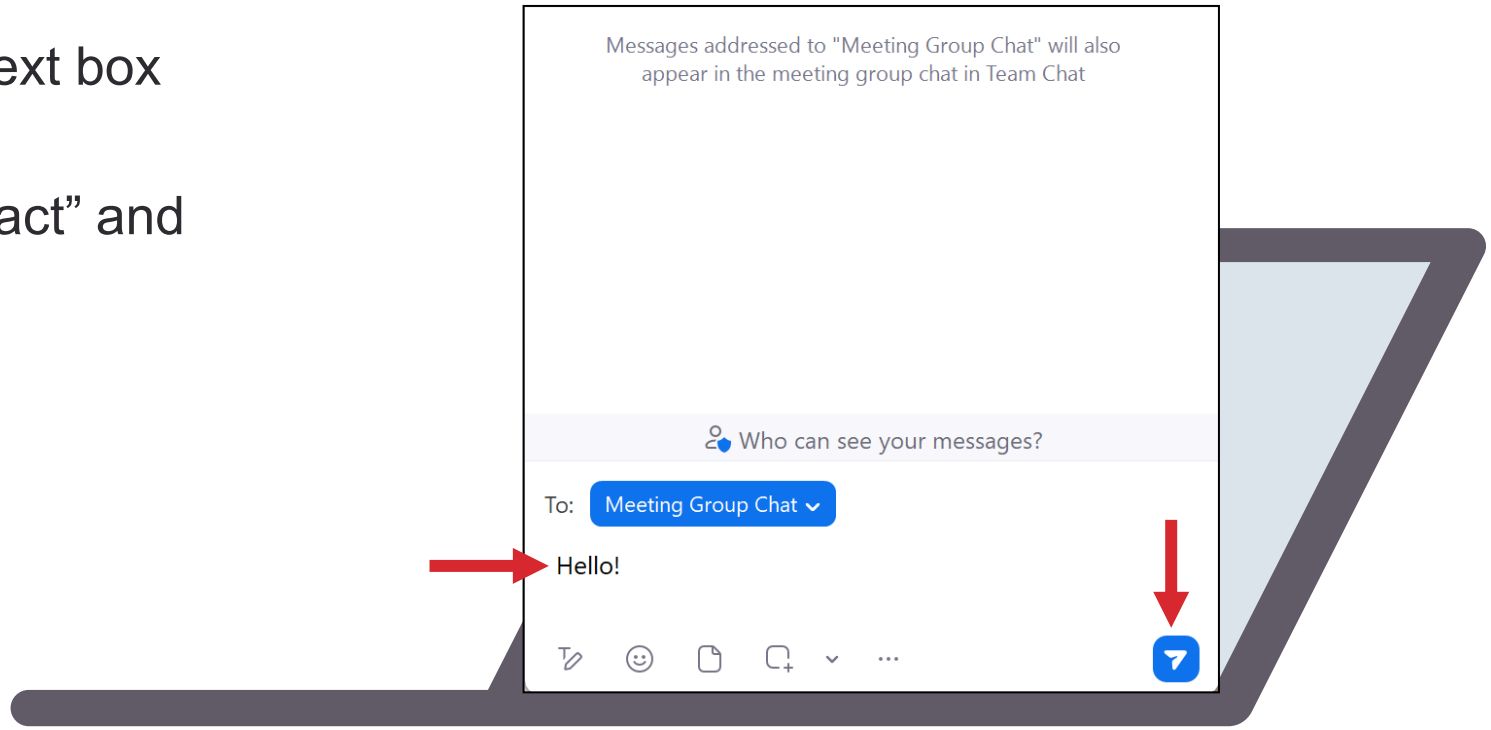
- At the bottom middle of your screen, you should see a menu of options. If you can't see the menu, hover your mouse over the bottom middle of the screen.
- Click on the "CC" icon and a separate window with captions will appear.



Zoom meeting tip: Asking questions

- Click on the “Chat” icon in your tool bar.
- The chat will open on the right-hand side of the Zoom window.
- Type your question into the text box and press “Enter” to send.
- To raise your hand, click “React” and then “Raise hand.”





Project objectives

Reorganize benefits from Prioritized List to the State Plan

Include members in benefit decision processes

Establish a compliant, accessible fee-for-service appeals process

Note: State leadership advises minimal changes for this project.

Introductions

Oregon Health Authority (OHA)

- **Lea Forsman**, Project Lead
- **Jason Gingerich**, HERC Director
- **Satyasandipani Pradhan**, Project Engagement Lead
- **Jessica Carroll**, FFS/Open Card Contracts

Kearns & West

- **Madeline Kane**, Facilitator
- **Nicole Metildi**, Facilitation and Tech Support

Poll

- Which Coordinated Care Organization or Fee-For-Service/Open Card contract do you represent?
- What region(s) of Oregon do you serve?

Session goals

1

Share information on the need and process for re-aligning OHP benefits with State Plan definitions.

2

Gather feedback on the impacts of anticipated changes on CCOs or Fee-For-Service/ Open Card care coordination contractors.

Today's agenda

1. **Opening and Introductions**
Learn who's in the room and share session goals

2. **Oregon Health Plan (OHP) Benefits Update Project (BUP)**

- Give an overview of OHP-BUP
- Discuss anticipated changes and impacts

3. **Listening Session**
Gather feedback

4. **Closing**
Next steps and upcoming sessions

Session topics

TODAY

Impacts of reorganizing the Prioritized List and the future of code pairing and guideline notes

SEPTEMBER

Project update, follow-up on feedback, and refresher on project overview and anticipated changes and impacts

OCTOBER

Updates to CCO denials and appeals

Background on the OHP benefit update project

- The federal Centers for Medicare and Medicaid Services (CMS) announced that Oregon must stop using the Prioritized List to define covered Medicaid benefits.
- Starting on January 1, 2027, Oregon must list covered benefits in its Medicaid State Plan.
- All other states use a State Plan to define health care services covered by Medicaid.

What's changing

Prioritized List

- Health conditions and their treatments are ranked by priority.
- Conditions above a funding line are approved by legislature.
- Conditions below funding line are usually not covered.

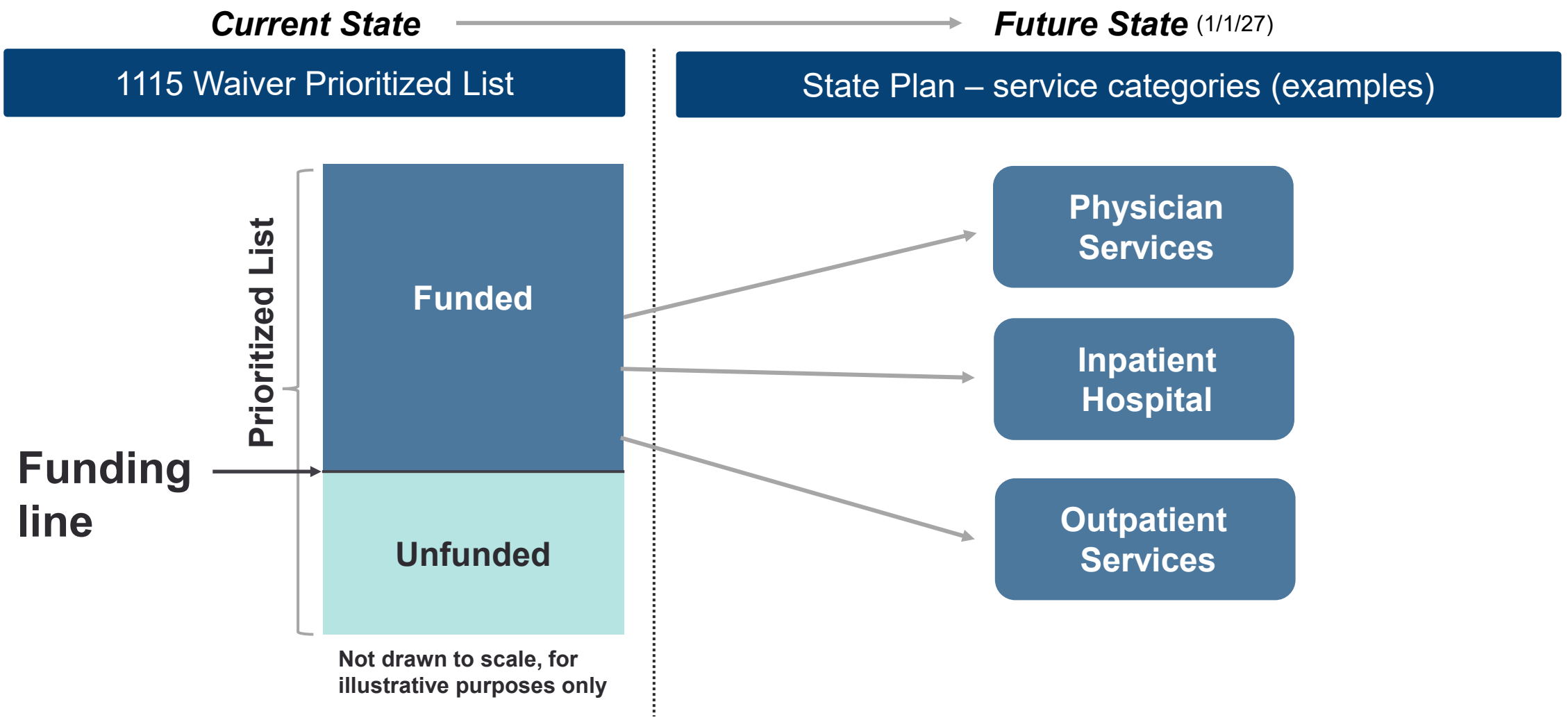
State Plan service categories

- CMS defines categories and which are Mandatory or Optional.
- Some services must be covered when medically necessary; others are Optional.
- Health Evidence Review Commission (HERC) will define which services are medically necessary.
- This change will help OHP meet the medical needs of individuals.

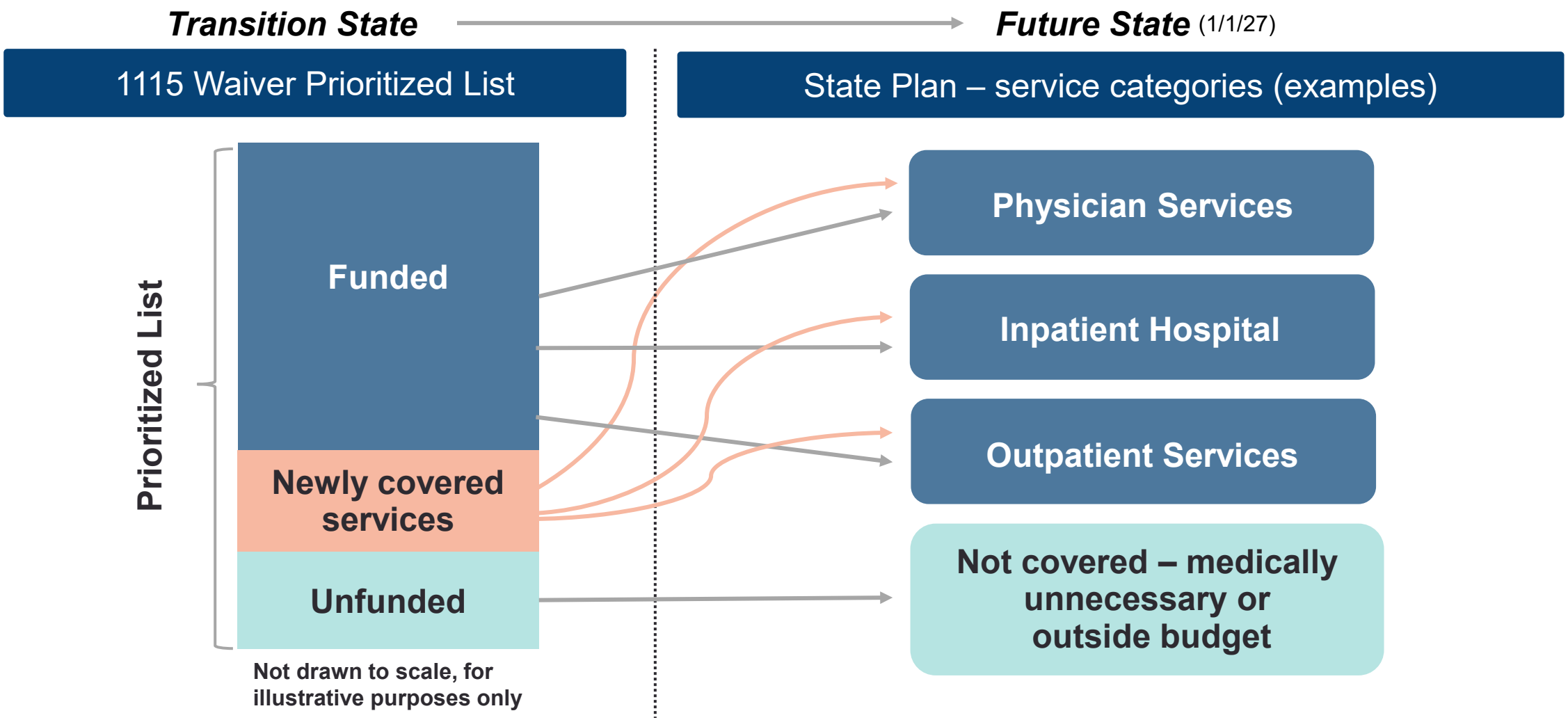
What's staying the same?

- HERC decides which services are medically necessary based on evidence and community input.
- Guideline notes with medical necessity criteria will continue to be used.
- Code pairing files will continue to be used.
- For some services, OHP-defined medical necessity criteria must be met, and sometimes other treatments have to be tried first.

Prioritized List compared to State Plan



Transition State compared to State Plan



Benefit update project: The impacts

Going from a prioritized list to a State Plan

- State plans use service categories like “physician services.” All medically necessary services (determined by HERC) within these categories must be covered.
- The diagnosis/treatment code pairings from the Prioritized List will continue with some updates.
- They show which services are medically necessary for which conditions. This will ease the transition for claims systems. Any changes to the code pairings will be vetted publicly.
- The guideline notes with medical necessity criteria also will continue with some updates.

Code pairing updates

Now

- Prioritized List consists of funded and unfunded lines of diagnoses and procedure codes with guideline notes.
- When a diagnosis and procedure appear on the same line, the service is usually covered (based on guideline notes).
- OHP provides data files for diagnoses, procedures and guideline notes. Computers systems use the data files to review claims.

Future

- OHP will use the same kinds of data files and formats in the code groups (instead of lines). There will no longer be unfunded lines.
- There will likely be fewer groups (formerly known as lines) to simplify processes.
- All decisions about the groups will be reviewed by HERC with opportunities for public comment.

Updates to the guideline notes

Guideline notes will largely remain the same.

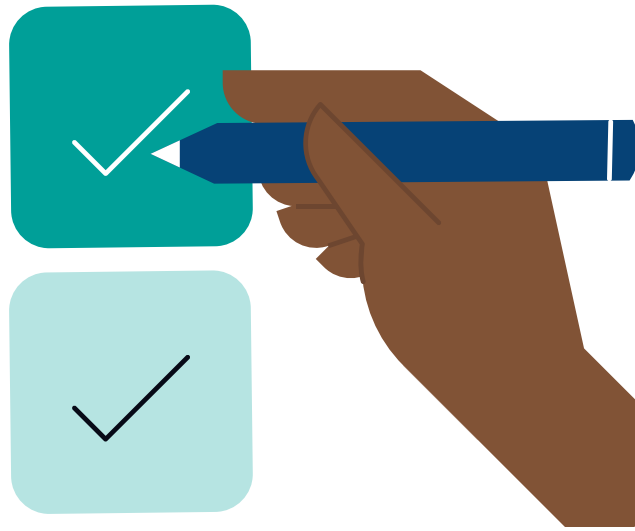
- Parts that would change:
  - Name may change to “Medical Necessity Policies”
  - References to lines replaced with references to code groups or specific codes
  - References in the unfunded region replaced with statements that the services aren’t covered or medically necessary (when that is the case)
  - Unfunded services will be covered if HERC decides they’re medically necessary and in scope of the benefit package

Email 1115Waiver.Renewal@odhsoha.oregon.gov if you have ideas or concerns about these updates.

What CCOs said about their priorities

We're considering if we can apply the following CCO feedback about the Benefit Update Project.

- **Evidence-based coverage decisions also need to be equity informed:** Consider the benefits and harms of each service, provider and patient experiences and overutilization.
- **Balance standardization and flexibility:** Give CCOs medical necessity criteria but also allow for some coverage flexibility.
- **Newly-covered services (previously below-the-line):** Address concerns about whether there are resources to cover them.
- **Benefit consistency:** Use medical necessity criteria (guideline notes) and code pairings as a reliable baseline to deny services that aren't medically necessary.



Poll

Of the presented changes, which change will have the most impact on your organization?

- Impact of increased covered services for the community you service
- Impacts to claim management systems
- Impacts to internal processes and materials like member handbooks

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Listening Session

Gathering feedback

Prompts

How will your claims management systems be impacted by the removal of the Prioritized List?

How will the removal of the Prioritized List impact your organization's operations and processes?

What kind of training will your staff or the people you serve need to navigate this transition?

Anticipated timeline

HERC listening sessions and public meetings will continue as usual.

Phase 1: Prepare Program Changes	Phase 2: Obtain Legislative Approval	Phase 3: Plan Implementation	Phase 4: Implement

Key Activities

1/1/2027: OHP Benefit Update Go-Live

Summer – Fall 2024

- Collect feedback from member proxies, CCOs, and Open Card contractors on impacts of anticipated changes
- Develop Legislative Concept for introduction in 2025 Legislative Session

Summer 2024
Get OHA internal approvals for program changes

Fall 2024 – Beginning of 2027
OHA shares updates and discusses operational decisions and implementation planning with member proxies and CCOs through standing tables.
OHA will consult with providers as needed and start providing updates after legislation for program changes is passed

Fall 2024 – End of 2025
Develop Transition Plan

Summer 2025
Pass legislation for program changes where needed

Fall – End of 2025
Public comment on State Plan Amendment

End of 2025
Submit State Plan Amendment to CMS

Spring 2026
Public comment on Transition Plan

June 30, 2026
Submit Transition Plan to CMS

Summer 2026
Rules Advisory Committees on Oregon Administrative Rules (OAR) changes

Spring – End of 2026
Implement modified CCO contracts, program changes, modified OARs, and system changes

Go-Live | OHA Activity | Impacted Party Outreach | Public Comment

Opportunities for CCO input

- OHA will hold two more virtual meetings this summer/early fall for CCO. You'll learn more about upcoming changes and get a chance to provide feedback.
- Information will also be made available online: https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/Benefit-Update.aspx
- OHA will hold regular meetings with CCOs in the fall. They'll offer regular updates and opportunities to discuss of operational decisions.
- As more information is known, OHA will share it with CCOs through Quality and Health Outcomes Committee (QHOC) meetings.
- HERC meetings are open to public and CCO comment. Meeting schedule at: https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Meetings-Public.aspx

Thank you and next steps

How will this be used? Input from these sessions will be shared with the project team. They'll use it to identify outreach needs and shape transition plans.

Upcoming Sessions

- **Late September and Late October:** Discuss feedback from CCOs and Open Card contractors and provide project updates

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Questions or Comments?

- Email: 1115Waiver.Renewal@odhsoha.oregon.gov
- Visit the OHP Benefit Update Project web page https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/Benefit-Update.aspx