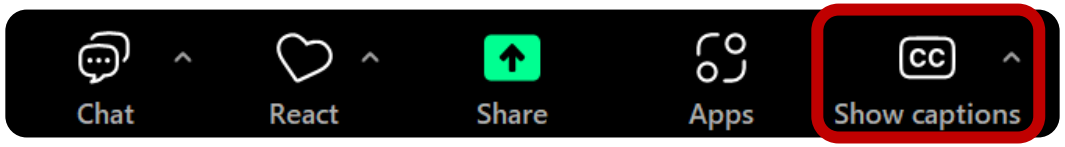
OREGON HEALTH AUTHORITY

September 27, 2024

Oregon Health Plan Benefit Update Project Information Session #2

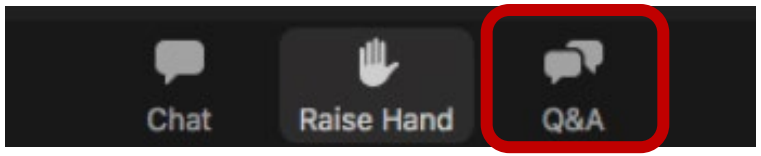
Zoom meeting instructions

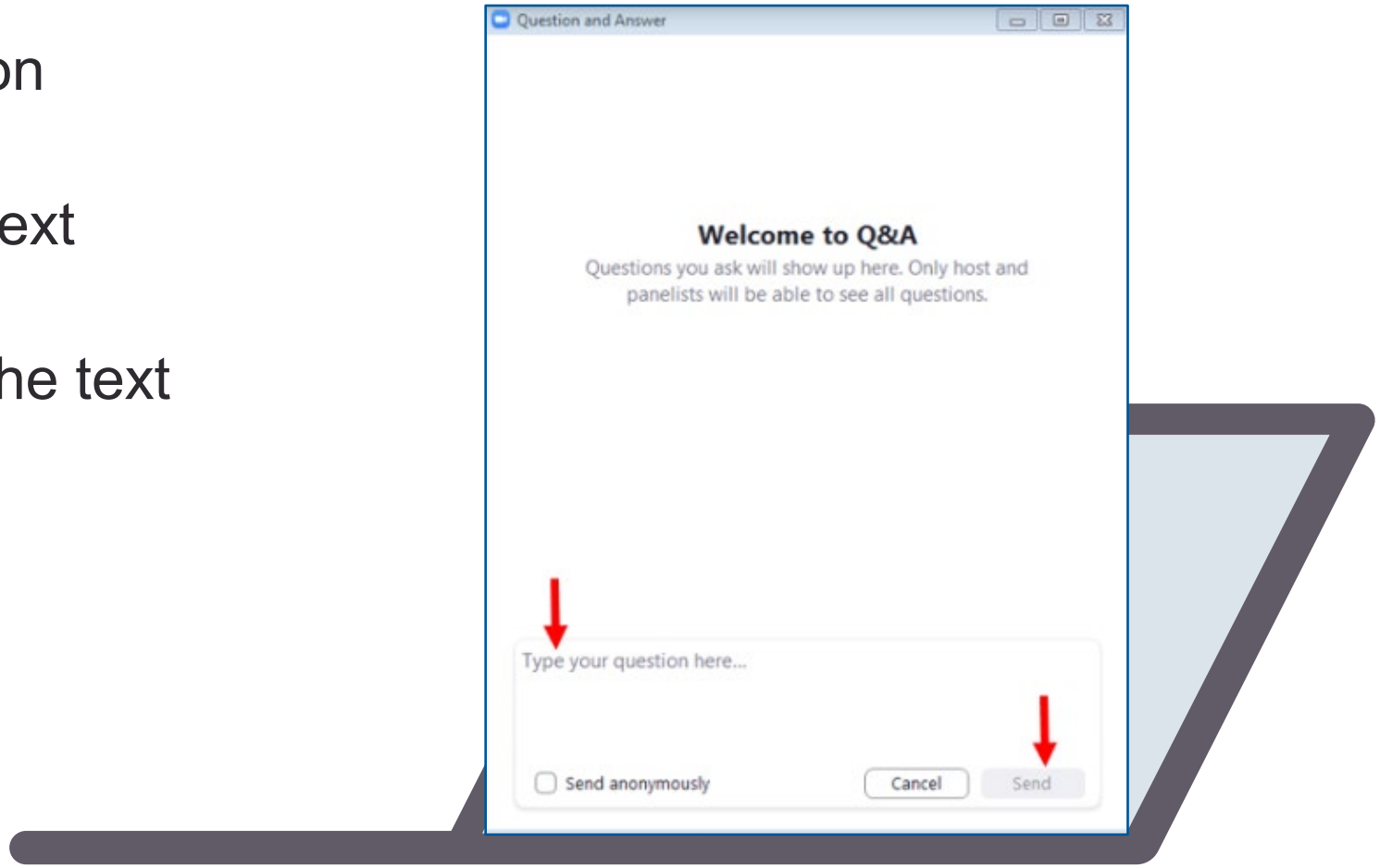
- At the bottom middle of your screen, you should see a menu of options. If you can't see the menu, hover your mouse over the bottom middle of the screen.
- Click on the "CC" icon and a separate window with captions will appear.



Zoom meeting tip: Asking questions

- Q&A Pod Instructions:
  - Click on the “Q&A” icon on your tool bar.
  - A box will pop up with a text box.
  - Type your question into the text box, and then hit “send”.





Project objectives

Align with CMS requirements due to the end of the 1115 Waiver

Continue to include members in benefit decision processes

Establish a member-facing, accessible fee-for-service appeals process

Note: State leadership advises minimal changes for this project.

Session goals

1

- Discuss the need and background for the Oregon Health Plan Benefit Update Project, including how benefits will be reorganized.

2

- Share the feedback we've heard to date
- Answer common questions
- Provide some responses.

3

- Hear from you

Introductions

Oregon Health Authority (OHA)

- **Lea Forsman**, Project Lead
- **Jason Gingerich**, Health Evidence Review Commission (HERC) Director
- **Satyasandipani Pradhan**, Project Engagement Lead

Kearns & West

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

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)**

- Project legal/cost framework
- HERC planning update
- Benefit decision making - CCO/FFS

3. **Listening Session**
Gather feedback

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

Poll

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

Session topics

AUGUST

Impacts of restructuring OHP benefits and the future of code pairing and guideline notes

TODAY

Follow-up on feedback, and refresher on project overview and anticipated changes and impacts

NOVEMBER

Additional details on the project and discussion of feedback

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Background Review

Bottom line

Beginning January 1, 2027

- OHA's current 1115 waiver is ending. This is the waiver that allows OHA to use the Prioritized List.
- Will use state plan, medical necessity policy, and utilization management

What this means for OHP

- State plan will define benefits at a high level
- HERC & OARs will provide medical necessity policies – like they do today
- Others will come from CCOs – like they do today
- Medically necessary State Plan services must be covered
- Some services will still not be covered
- We expect a relatively small increase in the scope of services

Centers for Medicare and Medicaid Services (CMS) mandate for change

- CMS ended Oregon’s waiver that allows Oregon to define OHP benefits based on the Prioritized List, starting January 1, 2027.
- Although the structure is transitioning, operational elements of the Prioritized List structure will continue.
  - Evidence review, code pairs, and medical necessity guidance (guideline notes) will continue.
  - HERC's public processes will continue.
- Get ready for a brief journey into Federal Medicaid requirements to understand Oregon's mandate.

Legal background (part 1)

- Each state has a state plan.
- The Oregon State Plan:
  - Documents the agreement between Oregon and CMS
  - Organizes benefits into high-level categories like Physician Services and Lab and X-Ray Services.
  - Defines some high-level limitations on both Mandatory and Optional services

Legal background (part 2)

- Two key federal rules for benefits:
  - **42 CFR 440.230(c)** says the state may not "arbitrarily deny or reduce the amount, duration or scope of a required service because of the diagnosis, type of illness or condition.
  - **42 CFR 440.230(d)** says the state may place "appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures."

Legal background (part 3)

- Current waiver 4.2.d:

  "OHP Plus benefits are based on the Prioritized List… which ranks condition and treatment pairs by priority, from the most important to the least important, representing the comparative benefits to the entire population to be served. The prioritization of the list is based on the clinical and cost-effectiveness of services. The waiver of amount, duration, and scope as related to the Prioritized List will end by January 1, 2027."

- After January 1, 2027, OHA can't prioritize (or de-prioritize) in the form of a list.
  - OHA *can* continue to place limits on benefits based on medical necessity and can manage utilization.
  - The HERC will continue to determine which OHP services are medically necessary and provide medical necessity criteria and policy for some services.
  - CCO can continue to manage benefits, subject to State Plan, medical necessity and CCO contract

Services addressed by Prioritized List (and BUP)*

Mandatory

- Physician services
- Inpatient/Outpatient hospital services
- Laboratory and X-ray services
- Family planning services
- Tobacco cessation counseling for pregnant women
- Home Health
- Nurse Midwife, Nurse Practitioner
- Birth center services
- Medication-Assisted Treatment (MAT)

Optional

- Other licensed practitioner (e.g., chiropractor, acupuncturist)
- Dental Services
- Prescription Drugs
- Dentures
- Physical and Occupational Therapy (PT/OT), Speech Therapy
- Prosthetics
- Eyeglasses
- Hospice

*Some service categories overlap and some are not listed here. For a full list visit Medicaid.gov

Change… and continuity

Results of Transition

The following goes away:

- Legislative funding line
- Ranking
- Denials based on funding line
- Comorbidity rule

Continued Processes

- Coverage decisions and denials based on medical necessity and benefit limits
- Code pairings, guideline notes continue to support medical necessity decisions
- Public, transparent, evidence-based process for decisions about medical necessity

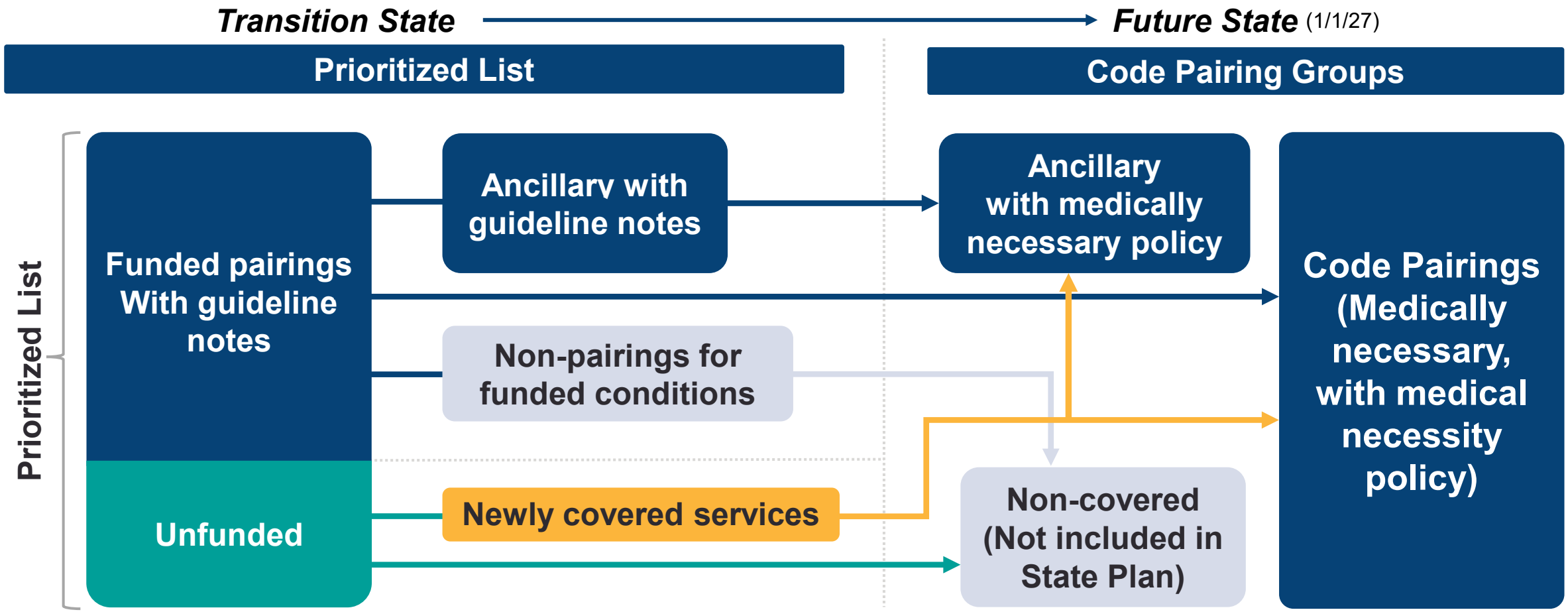
What to cover? How much will it cost?

- Staff are reviewing the unfunded region:
  - Some conditions need only office visits, medication, emergency services — no change needed.
  - Some below the line conditions already have guideline notes.
  - Others require analysis: Which treatments are medically necessary for these conditions?
  - For prescription drugs, criteria related to “unfunded conditions” or categories excluded because of the funding line will need to be reviewed and often replaced with medical necessity criteria.
- We do expect a budget impact. Rates will be actuarially sound and will follow the usual rate making process.

HERC work plan

- **Jan. – Dec. 2024:** Staff planning/analysis
  - Examine below-the-line services for medical necessity
  - Meet with experts in various specialties
  - Look for opportunities to simplify without sacrificing important detail
  - Ensure equity is centered in the process
- **Jan. – Nov. 2025:** HERC Public meetings and decisions
  - Public can suggest additional services for consideration
- **2026:** Refinement, budgeting and incorporating changes made to the 2026 Prioritized List into the Code Pairing Files and Medical Necessity Policies

Transition to Code Pairing Groups



Not drawn to scale, for illustrative purposes only

Simplification

- Combining lines into smaller sets of code groups
  - With only office visits
  - With similar treatments
  - Services without need for Prior Authorization/Utilization Management

How decisions will be made

- HERC level
  - Similar process to today
  - Names of bodies may evolve but scope of services reviewed will continue

Poll

What systems changes will require the most education/guidance or will be the most challenging to implement?

- Prior authorization processes
- Claims processing systems
- Internal policy and procedure updates
- Updates to public-facing materials
- Member/provider supports - communication

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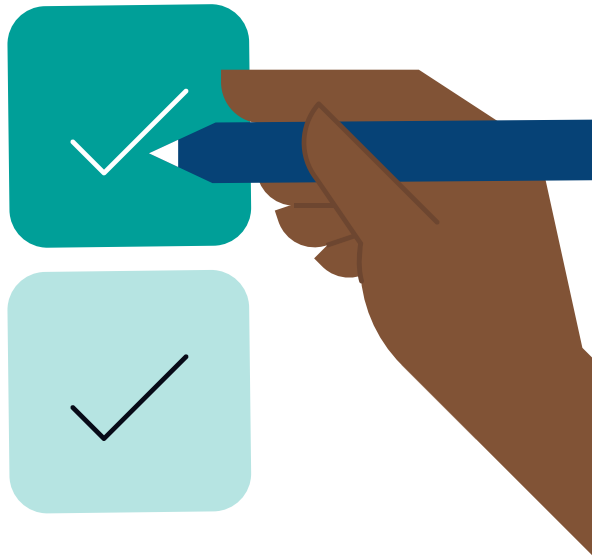
What We've Heard

Refresher: What CCOs have said about their priorities

We are considering 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 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.



What we've heard

Concerns about the cost of newly-covered benefits

Questions about how policy will work without the unfunded region

Questions about whether HERC may make decisions differently

Defining "medically necessary"

Responding to feedback

- **Costs:** Assessment of budget implications is in process.
- **Rates:** Rates will be actuarially sound and set through the usual process.
- **Changes to HERC Decision-Making:** Any changes to HERC decision making processes will be vetted publicly, with opportunities for meaningful input.
- **Goals** include preserving HERC's public, evidence-based decision process, providing consistency across the OHP benefit and ensuring good stewardship.
- **Medical necessity:** More information on application of "medical necessity" to members and to determination of OHP benefits will be provided at the November session.

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 Care Coordination contractors on impacts of anticipated changes
- Develop Legislative Concept for introduction in 2025 Legislative Session

Summer – Fall 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 Legislative Concept is approved.

Fall 2024 – End of 2025
Develop Transition Plan
HERC public meetings to review unfunded region

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

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Listening Session

Gathering feedback

Prompts

How will this transition impact your organization's ability to deliver the care members need?

OHA will form a CCO workgroup for regular updates and discussion of operational decisions starting later this fall. What topics would CCO staff find most useful?

Opportunities for CCO and Open Card contractor input

- OHA will hold another meeting with CCOs and Open Card contractors to share information on the project and discuss feedback in November
- A workgroup for CCOs will be starting up late Fall 2024
- Updates will be continually provided through the Quality and Health Outcomes Committee (QHOC) and Health Evidence Review Commission (HERC) public meetings.
- OHA anticipates holding a public meeting late Fall
- More information on the project website: https://www.oregon.gov/oha/hsd/medicaid-policy/pages/benefit-update.aspx

Thank you

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

- **November:** Additional details on project and discussion of feedback

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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