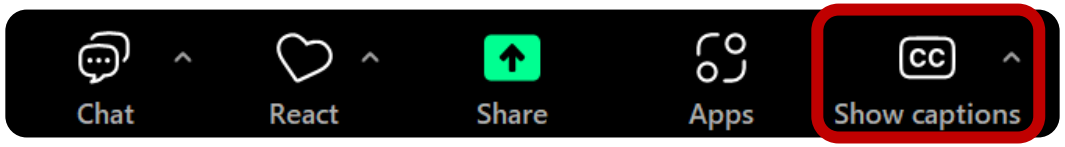
OREGON HEALTH AUTHORITY

November 6, 2024

Oregon Health Plan Benefit Update Project Information Session #3

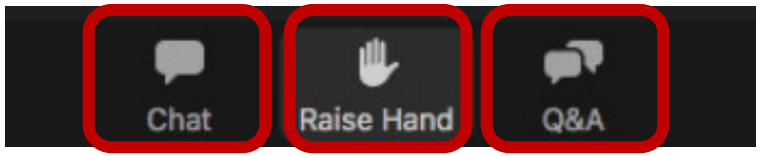
Zoom meeting instructions

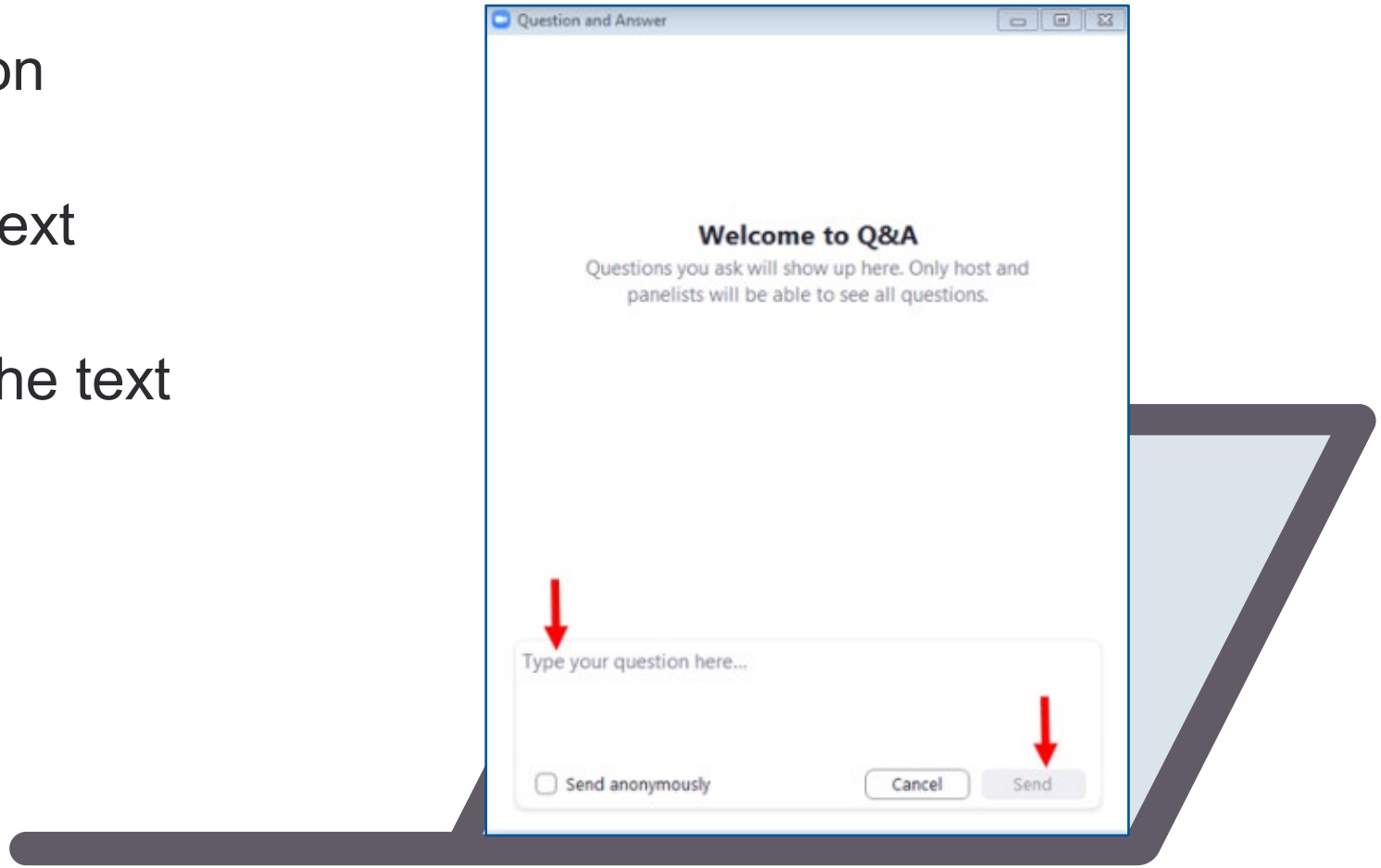
- At the bottom middle of your screen, you should see a menu of options. If you can’t see the menu, hover your mouse over the bottom middle of the screen.
- Click on the “CC” icon and a separate window with captions will appear.



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 resulting from 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

Refresher on the Oregon Health Plan Benefit Update Project

2

Share the feedback we've heard to date

- Answer common questions
- Address concerns

3

Discuss the process for:

- Determining medical necessity
- How HERC deliverables might evolve

4

Hear from you

Introductions

Oregon Health Authority (OHA)

- **Jason Gingerich**, Health Evidence Review Commission (HERC) Director
- **Dawn Mautner**, Medicaid Medical Director
- **Lisa Bui**, OHA Quality Improvement Director & Interim HPA Equity Director

Kearns & West

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

Today's agenda

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

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

Refresher on the BUP	Medical Necessity/Appropriateness	Picturing the future (and transition)	Review feedback to date

3. **Listening Session**
Gather feedback

4. **Closing**
What we are doing with your feedback and upcoming activities

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 Oregon Health Plan (OHP) benefits and the future of code pairing and guideline notes

SEPTEMBER

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

TODAY

Additional details on medical necessity, Health Evidence Review Commission HERC deliverables, and discussion of feedback

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Background Review

Background on OHP Benefit Update

- Starting 1/1/2027, Oregon will no longer have access to the waiver that permitted the use of the Prioritized List.
- The original intent of the Prioritized List was to maximize the number of people covered by being strategic about the services covered. However:
  - The Prioritized List is no longer used as a budget tool. The funding line has not moved since 2012.
  - 97% of people in Oregon now have health coverage, which is a record high.
- Under the Prioritized List, not all mandatory benefits were covered. This transition is an opportunity to expand coverage to include some additional medically necessary services.
- HERC will continue to provide guidance on which services are considered medically necessary and under which conditions, through their public, evidence-based processes.
- HERC mechanisms to prevent undue influence by interested parties will remain in place.

Refresher

- Centers of Medicare and Medicaid Services (CMS) ended Oregon's waiver that allows Oregon to define Oregon Health Plan (OHP) benefits based on the funding line of the Prioritized List, starting January 1, 2027.
- Although the waiver will end, operational elements of the Prioritized List structure and the Health Evidence Review Commission (HERC) process will continue.
  - Evidence review, code pairing files, and medical necessity guidance (guideline notes) will continue.
  - HERC's public processes will continue.
- Values of transparency, stewardship, equity and evidence will continue to guide decisions.
- Federal law allows limitations based on medical necessity and utilization management.
- Some benefit/cost increase expected. No reduction in population or benefits.

Background to Centers of Medicare and Medicaid Services (CMS) decision

- CMS concerns with Prioritized List waiver:
  - Risk that not all mandatory services are being covered.
  - Risk that members may not have access to full appeal rights due to below-the-line denials.
- Oregon's funding line hasn't moved since 2012.
- Oregon's uninsured rate is at 3 percent; with the expansion population there is less reason to limit coverage in order to fund expansion populations.
- This project is an opportunity to expand coverage for some additional medically necessary services members are requesting.

Bottom line

Beginning January 1, 2027

- The current 1115 Waiver authority that allows OHA to use the Prioritized List is ending.
- State Plan, medical necessity policy, and utilization management will continue to be used to manage the benefit

What this means for OHP

- State Plan will define benefits at a high level
- HERC & Program Rules (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 some increase in the scope of services

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What We've Heard

What we've heard

Concerns about the cost of newly-covered benefits and financial impact of removing unfunded services

How medical necessity is defined or determined, and potential for industry influence

Dental coverage, pharmacy services, and prescription coverage

How HERC will make decisions about which services are covered

Changes to HERC work products, including to guideline notes and code-pairings. How to process non-medically necessary claims

Impacts to CCO system configurations

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.
- **Pharmacy and dental coverage**: Some medications currently denied based on funding level will become covered, though clinical prior authorization criteria may be applied to ensure appropriate use. Dental coverage is unlikely to change.
- The more **operational questions** are potential topics for discussion during the upcoming BUP CCO workgroup.

What people want to learn more about

- Newly covered services
- New guideline notes
- Prescription coverage and pharmacy services
- Dental coverage
- Financial analysis
- Billing system changes

Upcoming CCO Workgroup

- OHA aims to launch a workgroup for CCO representatives to discuss BUP **operational topics** in December or January.
- OHA will ask each CCO to identify **two representatives** to attend the workgroup meetings: one decision-maker and one Operations representative. Depending on the topic for a given meeting, CCOs might be asked to send an additional person.
- Dates will be set by polling CCO representatives on their availability.
- OHA will identify topics for workgroup meetings and sequence out topics in collaboration with CCOs.
- During an initial planning meeting, OHA will confirm and build on the list of topics and questions we've collected from prior sessions with CCOs and prioritize topics together with CCOs.
- Following the planning meeting, OHA will develop and share a tentative timeline with CCOs showing when OHA anticipates being able to discuss each topic and share decisions.

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Medical Necessity and Appropriateness

Key concept: Medical Necessity

OAR 410-120-0000 (191) Excerpts:

(a) Required to address one or more of the following:

- Prevention, diagnosis or treatment of the client or member's disease, condition or disorder that may result in health impairments or a disability
- …ability to achieve age-appropriate growth and development
- …ability to attain, maintain or regain independence in self-care, ability to perform activities of daily living or improve health status
- …access to the benefits of non-institutionalized community living, to achieve person centered care goals, and to live and work in the setting of their choice…when receiving Long Term Services or Supports

(b) …Medically necessary services must also be medically appropriate. Not all medically necessary services are covered services

(c) For EPSDT see Chapter 410 Division 151

Key concept: Medical Appropriateness

OAR 410-120-0000 (190) Medically Appropriate. Excerpts:

(a) …Health services, items or supplies..

(B) Safe, effective and appropriate for the patient based on standards of good health practice by the relevant scientific or professional community based on the best available evidence.

(C) Not solely for the convenience or preferences of an OHP client, member, or a provider….

(D) The most cost effective of the alternative levels or types of health services … that can be safely and effectively provided...

(b) All covered services must be medically appropriate…but not all medically appropriate services are covered services

Application of medical necessity/appropriateness

- HERC's decision-making and standards will not change because of this project
- HERC will continue to value safety, wellness for members, and good stewardship
- As a reminder, HERC policy would be reflected in:
  - Code pairing files
  - Coverage guidelines
  - Statements of intent
- Program rules (OAR) will continue to apply as well

These rules need consistent interpretation, so…

- CCOs ***must*** cover medically necessary and appropriate services as defined by HERC, as they apply to the member's circumstances
- CCOs ***can*** deny services HERC has said are not medically necessary/appropriate. Specifically:
- Where HERC has made clear policy, CCOs ***can*** rely on it to support denials and uphold appeals
- CCOs ***have discretion*** to make exceptions if appropriate based on individual circumstances as they do with the Prioritized List today.

  Examples: Unique patient circumstances, comorbidities, contraindications, late breaking evidence
- Where HERC is ambiguous or silent, CCOs ***can use medical judgment and external resources*** (and can suggest HERC provide clear policy)

Change… and continuity

Results of Transition

The following goes away:

- Legislative funding line
- Ranking
- Denials based on funding line
- Comorbidity rule as it currently exists

Continued Processes

- Reliance on HERC for consistent baseline coverage
- Reliance on HERC decisions to support denials of care that's not medically necessary
- CCO discretion to use external supplemental resources
- CCO discretion to make exceptions where appropriate

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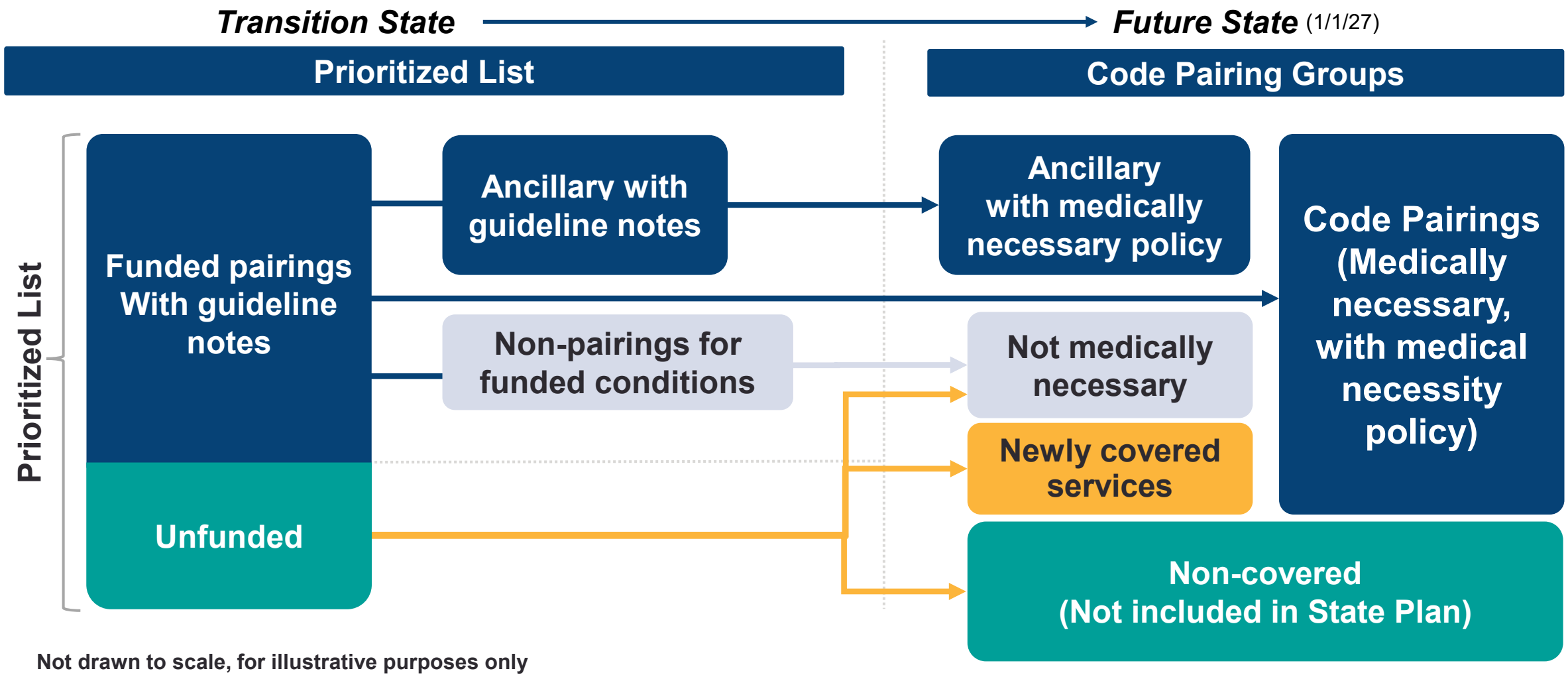
Picturing Future HERC Policy

Transition to Code Groups



Not drawn to scale, for illustrative purposes only

Picturing the future state

Code Group: 10005

Condition:	TOBACCO DEPENDENCE (See Coverage Guideline ~~Notes~~ 4 and 92)
Treatment:	MEDICAL THERAPY/BEHAVIORAL COUNSELING
ICD-10:	F17.200-F17.228,F17.290-F17.299,Z71.6,Z72.0
CPT:	96156-96159,96164-96171,97810-97814,98966-98972,99051,99060,99202-99215,99341-99350,99366,99406, 99407,99415-99417,99421-99427,99437-99449,99451,99452,99487-99491,99495-99498,99605-99607
HCPCS:	G0019-G0024,G0068,G0071,G0088,G0090,G0140,G0146,G0248-G0250,G0318,G0323,G0459,G0463,G0466, G0467,G0469,G0470,G0511,G2012,G2211,G2214,G2251-G3003,G9016-G9038,H0038,S9453,S9563,D1320

COVERAGE GUIDELINE ~~NOTE~~ 4, TOBACCO DEPENDENCE, INCLUDING DURING PREGNANCY

Code groups **10001, 10005**

Pharmacotherapy (including varenicline, bupropion and all five FDA-approved forms of nicotine-replacement therapy) and behavioral counseling are medically necessary, alone or in combination, for at least two quit attempts per year. At least two quit attempts per year must be provided without prior authorization, and each attempt can include both pharmacotherapy and behavioral counseling. Combination drug therapy (i.e., two forms of NRT or NRT plus bupropion) is also included with each quit attempt without prior authorization. However, nicotine inhalers and sprays may be subject to prior authorization.

A minimum of four counseling sessions of at least 10 minutes each (group or individual, telephonic or in person) are included for each quit attempt. More intensive interventions and group therapy are likely to be the most effective behavioral interventions. During pregnancy, additional intensive behavioral counseling is strongly encouraged. All tobacco cessation interventions during pregnancy are not subject to quantity or duration limits.

Sample HERC recommendation (1)

HERC staff recommendations:

This topic summary is informational only.

Discuss the draft recommendations regarding the below the line allergy diagnoses, and the general approach HERC staff are taking in addressing the benefits update project. HERC staff are interested in member questions, concerns, and input and the general approach and details of this proposal.

Effective 1/1/2027

1) Create a new code group 10001 for conditions requiring allergy testing
2) Create a new code group 10002 for conditions requiring allergy testing and treatment
3) Create a new code group 10003 for conditions requiring food allergy testing and treatment
4) Note: these new code groups will also need the usual outpatient office visit CPT/HCPCS codes
5) Create new coverage guidelines for each code group modeled after Prioritized List GN156 as shown below

Sample HERC recommendation (2)

COVERAGE GUIDELINE XXX, ALLERGY TESTING

Code group: Allergy testing 10001

Allergy testing is only medically necessary when:

A) Testing correlates specifically to the member's history, risk of exposure and physical findings; AND

B) Test technique and/or allergens tested must have proven efficacy demonstrated through scientifically valid medical studies published in the peer-reviewed literature.

The following limits apply to allergy testing:

1) Percutaneous allergy testing (CPT 95004) is only allowed up to 60 times per year.
2) Intradermal testing (CPT 95024) is only allowed up to 40 times per year.
3) Allergic IgE testing (CPT 86003) is only allowed up to 80 times per year.

Allergy testing is not medically necessary for any ICD-10-CM code not appearing in this code group.

Date of last review: 9/20/2024

Sample HERC recommendation (3)

COVERAGE GUIDELINE YYY, ALLERGY TREATMENT

Code group: Allergy treatment 10002

Allergen desensitization is only medically necessary when:

A) The patient has a properly performed skin test and/or serologic evidence of IgE-mediated antibody to a potent extract of the allergen, AND

B) Hypersensitivity to allergen cannot be adequately managed by appropriate medication therapy and/or allergen avoidance.

Allergen desensitization is not medically necessary for any ICD-10-CM code not appearing in this code group.

Date of last review: 9/20/2024

Sample HERC recommendation (4)

COVERAGE GUIDELINE ZZZ, FOOD ALLERGY TESTING AND TREATMENT

Code group: Food allergy testing and treatment 10003

Food allergy testing is medically necessary only when

A) Testing correlates specifically to the member's history, risk of exposure and physical findings; AND

B) Test technique and/or allergens tested must have proven efficacy demonstrated through scientifically valid medical studies published in the peer-reviewed literature.

The following limits apply to allergy testing:

1) Percutaneous allergy testing (CPT 95004) is only allowed up to 60 times per year.
2) Allergic IgE testing (CPT 86003) is only allowed up to 80 times per year.

Pharmaceutical treatment with medications intended to reduce the severity of the food allergy only medically necessary when ALL of the following criteria are met:

1) The patient has a clinical history of serious food allergy and/or anaphylaxis, AND
2) The diagnosis of food allergy has been confirmed with an IgE or skin-prick test, AND
3) The pharmaceutical treatment is prescribed by, or in consultation with, an allergist or immunologist

Treatment of food allergies does not include use of subcutaneous immunotherapy.

Testing and treatment for food allergies is not medically necessary for any ICD-10-CM code not appearing in this code group.

Sample HERC recommendation (5)

ICD-10-CM Code	Code description	Current Placement	Code group(s)
H10.401-H10.439	Chronic conjunctivitis	494 CHRONIC CONJUNCTIVITIS, BLEPHAROCONJUNCTIVITIS	10001 Allergy testing 10002 Allergy treatment
H10.45	Other chronic allergic conjunctivitis	555 ALLERGIC RHINITIS AND CONJUNCTIVITIS, CHRONIC RHINITIS	10001 Allergy testing 10002 Allergy treatment
J30.1-J30.9	Allergic rhinitis	555	10001 Allergy testing 10002 Allergy treatment
J31.0	Chronic rhinitis	555	10001 Allergy testing 10002 Allergy treatment
J38.4	Edema of larynx	123 ANAPHYLACTIC SHOCK; EDEMA OF LARYNX	10001 Allergy testing 10002 Allergy treatment
J45.20-J45.998	Asthma	9 ASTHMA	10001 Allergy testing 10002 Allergy treatment
J67 family	hypersensitivity pneumonitis	221 OCCUPATIONAL LUNG DISEASES 239 CONDITIONS REQUIRING HEART-LUNG AND LUNG TRANSPLANTATION	10001 Allergy testing 10002 Allergy treatment
K50.0	Eosinophilic esophagitis	123 ANAPHYLACTIC SHOCK; EDEMA OF LARYNX 377 ESOPHAGITIS: GERD	10003 Food allergy testing and treatment

Additional diagnoses will be recommended but are not shown here
Similar tables would be produced for procedures
Prescription medication criteria for medications for these conditions would be updated to remove references to the List/funding line

Oregon Data file (example)

HERC Code Group Procedures

Health Evidence Review Commission files; HERC; OHA

Last Updated
September 11, 2024

Data Provided By
HERC Staff of OHA

Columns (4)

Column Name	Description	API Field Name	Data Type
CodeGroup	Code Group Number	CodeGroupNumber	Number
Code		code	Text
EffectiveDate	Code Group Effective Date	CodeGroupEffectiveDate	stamp
FileDate		filedate	Floating Timestamp

Services that are not medically necessary/not in benefit

- Not medically necessary:
  - Platelet rich plasma for knee pain
  - Epidural steroid injections for low back pain
  - Excision of lingual (lip) frenum for tongue tie
  - Spinal fusion for a person without nerve impairment
- Not in benefit (outside scope of state plan)
  - Infertility services
  - GLP-1 for weight loss
  - Dental crowns/root canals
  - Eyeglasses for adults

Poll 2

How should HERC indicate that HERC has reviewed a service and determined it not to be medically necessary?

A. Excluded file (if not medically necessary for any diagnosis)

B. Omission from all code groups that contain the relevant diagnoses (analogous to a current non-pairing in the funded region)

C. Non-medically necessary (or Excluded) code group including pairings reviewed and determined not medically necessary (for more common requests)

D. Coverage guidelines saying a service is not medically necessary under certain circumstances (like today's guideline notes)

Key takeaways

- Medical necessity and appropriateness rules are not changing
- There will be no changes to the following:
  - CCOs must cover services HERC decides are medically necessary
  - CCOs can deny services HERC has decided are not medically necessary
  - CCOs can rely on external resources for medical necessity where HERC has not made policy
  - CCOs can make exceptions for individual circumstances

Key takeaways (2)

- In the transition process and going forward:
  - HERC will continue to be an independent, governor-appointed Commission, confirmed by the Senate
  - HERC will continue to use its evidence-based, transparent process, balancing participation between members, CCOs, providers and other parties
  - HERC will continue to consider equity in decision making
  - HERC deliverables will evolve with only necessary format/language changes

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How Decisions are Being Made about Covered Services

HERC work plan

- Hiring additional medical director
- Meeting/outreach to specialists as of Nov. 1, 2024
  - So far: Ophthalmologists, Allergists, Behavioral Health Panel, Oral Health Panel, Genetics Panel, Dermatology, Breast Surgery, Urology, Colorectal
  - Planned: Orthopedics/Spine, general surgery, vascular surgery, sports medicine, ENT, GYN, GI surgery/GI
  - Others we should meet with?
- Staff will prepare proposals and bring to the CCO workgroup and HERC at 2025 meetings
- Staff will coordinate with actuaries and budget to ensure they have accurate information to plan necessary funding

HERC work plan continued

- Plan to periodically release review tracker in 2025 and update periodically
- Goal: All significant decisions about current below the line services complete by December 1, 2025
- Meeting materials will include detailed code pairings and guideline text; decisions in minutes
- Will start releasing “Previews” of draft policy deliverables by late 2025;
- Dual maintenance of List and new deliverables throughout 2026
- Final version to be published December 1, 2026 (to include new CPT codes)

Consolidation

- Identifying lines that can be combined (for example, multiple unfunded lines with the exact same procedures can be combined)
- Focus guideline development on procedures with potential for waste or overuse
- As we review, some items that are non-controversial and that don’t have significant cost will be moved sooner
- Consolidations will be vetted through the HERC process and in CCO workgroups
- Final decisions will be confirmed at the HERC

Fee-For-Service Pharmacy Preparations for the Transition

- **2025:** Staff analysis/planning
  - Evaluate current prior authorization criteria which reference funding line
  - Evaluate utilization of common medications with indications for unfunded diagnoses

- **2025-2026:** Pharmacy & Therapeutics Committee public meetings
  - Conduct evidence reviews to establish definitions for medically necessary treatment as needed
  - Conduct drug use evaluations to evaluate medically appropriate utilization
  - Collaboration with stakeholders including CCO pharmacy directors and HERC

- **2027:** Evaluation and policy refinement
  - Evaluation of drug trends after prioritized list and prior authorization changes are implemented

Poll 3

Which option represents your sense of how well the planned HERC deliverables will work for your organization:

1) This should work
2) Looks promising, need more detail
3) I'm worried this won't work for administrative/technical reasons
4) I'm worried that the policy won't be clear enough to implement

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

What questions do you have about the updated HERC deliverables and work plan?
How will they impact your organization?

What questions do you have about how medical necessity will work after 1/1/2027?
How will it affect members and your operations?

Opportunities for CCO and Open Card contractor input

- OHA aims to launch a workgroup for CCOs in December or January.
- 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 in early 2025 (let your members know).
- 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.

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

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