Oregon Health Plan Benefit Update Project: FAQs

Oregon is transitioning how covered services are defined for the state's Medicaid program, known as Oregon Health Plan (OHP). By January 1, 2027, the state will transition from using the Prioritized List of Health Services to define covered services to using categories of services described in the Medicaid State Plan. Below are a series of frequently asked questions (FAQs) on this project.

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Organizing Medicaid Benefits

How does Oregon currently organize benefits?

- Since 1994, Oregon has used the Prioritized List of Health Services to help determine what the Oregon Health Plan (OHP) covers. Oregon Health Plan (OHP) is our state's version of Medicaid.
- This list ranks health conditions and their treatments.
- Services that are most effective or most important for the Medicaid population in Oregon rank higher.
- Services that are less effective rank lower.
- The Oregon Legislature sets a funding line in the Prioritized List. Services above the line are covered. Services below the line are usually not covered.
- The funding line has not moved since 2012. The federal Centers for Medicare & Medicaid Services (CMS) stopped allowing the state to move the funding line if the change would reduce benefits.
- Oregon is the only state that uses a Prioritized List.

What is changing?

- In 2022, the federal Centers for Medicare & Medicaid Services (CMS) told Oregon Health Authority that the state will need to transition away from the

Prioritized List by January 1, 2027. By then, OHA must group OHP services into categories defined by CMS. These categories will be described in Oregon's Medicaid State Plan.

- The federal government sets these categories, including which categories of services are Mandatory or Optional.
- OHP will cover all medically necessary services in covered categories, with some exceptions.
  - Oregon will define which services are medically necessary.
  - Optional categories will clearly list covered and non-covered benefits.
- Oregon will decide which new Optional benefits to cover.
- This matches how other states define Medicaid-covered services.

What's next?

- OHA will be developing a transition plan in partnership with CCOs, providers and members. This plan will be sent to CMS by June 30, 2026.

1115 Medicaid Demonstration Waiver

What is the 1115 waiver?

- Oregon Health Plan (OHP) is our state's version of Medicaid.
- Medicaid is a state and federal program. To make changes that are different than federal guidelines, states must apply for a Medicaid waiver.
- Medicaid waivers give states the flexibility to test new ways to deliver and pay for benefits and must be approved by the federal Centers for Medicare and Medicaid (CMS).
- Oregon's current Medicaid waiver started in 2022 and goes until 2027. For more information visit the Waiver web page.

How is the waiver connected to the Prioritized List?

- Oregon received permission to use the Prioritized List as part of the Medicaid waiver in 1994. Since then, Oregon continued to include the Prioritized List in

each Medicaid waiver request. CMS approved the Prioritized List as part of the Medicaid waiver until recently.

- In 2022, CMS told Oregon Health Authority that the state will need to transition away from the Prioritized List by January 1, 2027.

Health Evidence Review Committee

What is HERC's role now?

- The Health Evidence Review Commission (HERC) manages the Prioritized List. The commission is an independent body that:
  - Looks at the science behind treatments
  - Decides what treatments are medically necessary
  - Gets feedback from members on which services OHP should cover

What will HERC's role be after January 1, 2027?

- HERC will continue to supply diagnosis/treatment paired codes, Guideline Notes and the other files it supports. And it will continue to:
  - Review evidence and community input on clinical services
- Support their public, transparent processes
  - Seek opportunities for community engagement
  - Produce guidance on the medical necessity of some services
- Document conditions and their covered treatments via code pairings

Oregon Health Plan (OHP) Members

What is staying the same for members?

- Members won't lose benefits because of this change. All services covered today will still be covered on and after Jan. 1, 2027.
- OHP still won't cover treatments that are cosmetic or medically unnecessary.
- OHA or the member's coordinated care organization (CCO) may still need to approve some services to ensure they meet medical necessity criteria.

What will be changing for members?

- Starting in January 2027, OHP will cover medically necessary treatments for a small number of additional health conditions, such as treatments for fibromyalgia.

How can members get involved?

- Members can request to have coverage for specific benefits reviewed by HERC. Suggestions can be emailed to: 1115Waiver.Renewal@odhsoha.oregon.gov
- OHA is holding information sessions for community partners through November 2024 to gather feedback.
- OHA will share updates with groups that support members, including the Community Partner Outreach Program (CPOP) and Medicaid Advisory Committee
- OHA will consider member input during transition planning through public comment periods
- HERC will continue holding community listening sessions. Visit this webpage for more information: https://www.oregon.gov/oha/hpa/dsi-herc/pages/listening-sessions.aspx

Coordinated Care Organizations (CCOs)

What is staying the same for CCOs?

- Coverage decisions and denials will be based on medical necessity and benefit limits.
- OHA will continue providing code pairings and guideline notes, with some updates, to support medical necessity decisions.

What is changing for CCOs?

- Starting January 1, 2027, CCOs will no longer be able to deny services based on their position below-the-line on the Prioritized List.

- This means that CCOs may need to update their appeals processes to remove references to the Prioritized List and “below-the-line,” and retrain staff.
- The addition of some newly covered services means CCOs may need to add new staff dedicated to the review of prior authorizations and appeals.
- There will also be some IT system updates to support claims management for the newly added services.

How can CCOs get involved?

- OHA is holding information sessions for CCOs and Open Card/FFS contractors through November 2024 to gather feedback.
- A workgroup for CCOs will be starting up late Fall 2024, and updates will be continually provided through the Quality and Health Outcomes Committee (QHOC) and Health Evidence Review Commission (HERC) public meetings.

Note: The OHP Benefit Update Project FAQs document will continue to be updated as operational decisions and implementation planning are finalized in collaboration with coordinated care organizations (CCOs), Open Card contractors and community partners.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the Benefit Update Project at 1115Waiver.Renewal@odhsoha.oregon.gov.

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