1115 MEDICAID WAIVER
IMPLEMENTATION PROJECT | OREGON

OREGON HEALTH AUTHORITY

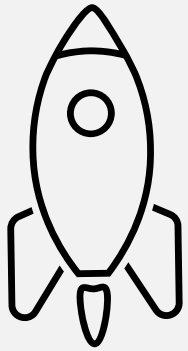
August 13, 2025

Benefit Update Project (BUP) Workgroup Kick Off

Today in Two Parts

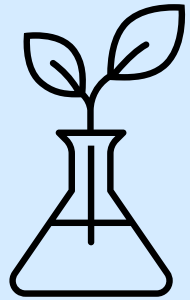
Workgroup Kick Off Meeting

8:05 AM – 9:05 AM PT



“BUP 101” Meeting

9:05 AM – 10:30 AM PT



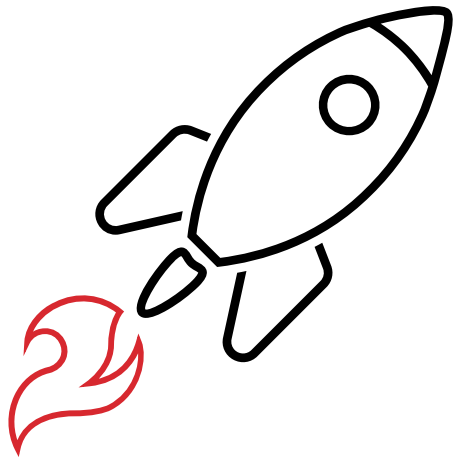
Kick Off Meeting Agenda & Goals

Agenda

- Welcoming remarks
- Introductions
- Review Workgroup charter and scope
- Preview upcoming meeting agenda topics

Goals

- Gain a shared understanding on BUP Workgroup scope



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Introductions

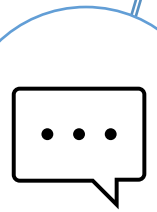
Level-Setting: Zero to Five Voting Method

No way.	Not a good idea.	I have reservations.	I'm ok, but not completely comfortable.	I understand, and this sounds good.	I champion this.

Icebreaker

Zero to Five: I feel concerned about the BUP transition.

In Chat: Name, pronouns, what organization or group you are representing



In Chat: Why did you join the BUP Workgroup?

Workgroup Members

- **Disability Rights Community:** Ben Gurewitz, Disability Rights Oregon
- **Tribal Representative:** TBD
- **Dental Care Organization**: Dr. Gary Allen, Advantage Dental
- **Statewide Behavioral Health Association**: Heather Jefferis, Oregon Council for Behavioral Health
- **Community-Based Provider**: Briana Axline, Community Health Centers of Lane County
- **Health System**: Art Mathisen, Good Shepherd Health Care System
- **Legal Aid**: Bridget Budbill, Oregon Law Center
- **Health Evidence Review Commission (HERC):** Dr. Adriane Irwin
- **Coordinated Care Organizations:**
  - Erin Fair Taylor, PacificSource
  - Dr. Amy Burns, AllCare
  - Dr. Cat Livingston, Health Share
  - Dr. Jeanne Savage, Trillium Community Health Plan
  - Dr. Mary Engrav, CareOregon

Review Workgroup Charter

- **Authority:**
  - The OHA BUP Workgroup is established by OHA in collaboration with the Governor's Office and the State Legislature. The workgroup is advisory in nature and does not have decision-making authority.
- **Purpose:**
  - The workgoup will consider the implications of and ways to streamline the transition away from the PL with the goal of minimizing disruption to care, advancing health equity, and supporting the delivery of appropriate, high-value health services under OHP.
- **Output:**
  - The workgroup will align on final recommendations that will be presented at the final meeting of the workgroup prior to the end of 2025, be made publicly available, and inform OHA's workplan toward the January 1, 2027, deadline.
- **Consensus-Building Process:**
  - OHA will use "Zero to Five" polling throughout workgroup meetings to gauge consensus and understanding.
  - The Workgroup members will vote "yes", "no" or "I'd like more discussion" during the iteration process for final recommendations. Recommendations will only move forward if a majority of votes are yes.

BUP Workgroup's Proposed Purpose & Scope

The purpose of the BUP Workgroup is to provide input on the implementation and potential impacts of phasing out the Prioritized List (PL) of Health Services.

Topics that <u>are</u> in the Workgroup's scope for discussion:

- Processes that determine the State's benefit package, including medical necessity policy or clinical practice guidelines
- Claims adjudication and provider processes, including denial reasons
- Opportunities to promote Coordinated Care Organization (CCO) model sustainability in alignment with BUP
- Appeals, notices of adverse benefit determinations, and grievances processes
- Best practices to support and educate members regarding the transition
- Other operational considerations identified by the Workgroup that require further exploration to inform final recommendations for implementation

BUP Workgroup Purpose & Scope

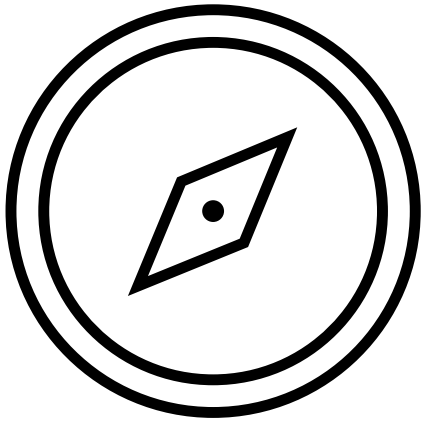
The purpose of the BUP Workgroup is to provide input on the implementation and potential impacts of phasing out the PL of Health Services.

Topics that are <u>not</u> in the Workgroup scope:

- Revisiting engagement with CMS related to the Prioritized List.
- Immediate impacts of recent federal action on the overall State Medicaid budget.
- Rate-setting details, systems changes and testing.

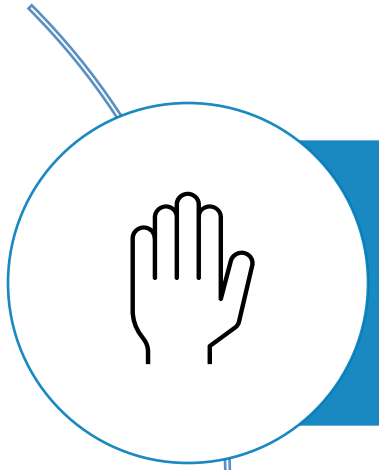
OHA aims to have discussions about these topics with partners in other settings.

Guiding Principles

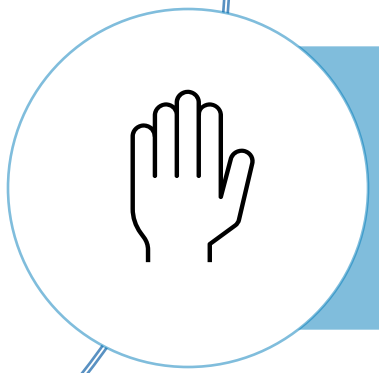


- Oregon's strategic goal to end health inequities by 2030
- Continued use of evidence-based medical necessity policy
- Using existing partner input as a starting point
- Centering those most impacted – seeing lived experience and community wisdom as valid and valued sources of data

Discussion Questions



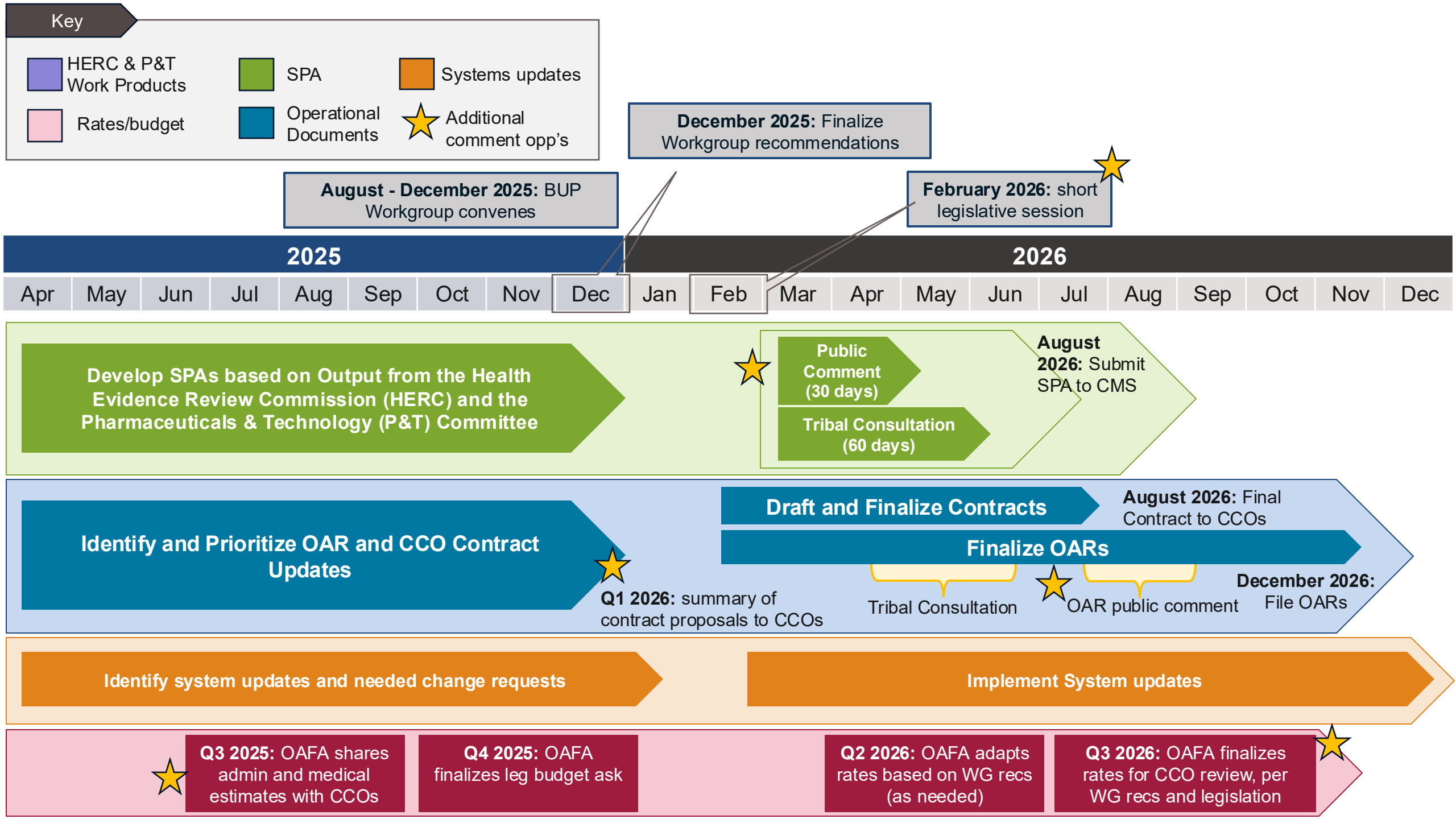
Zero to Five: I agree with the scope the workgroup.



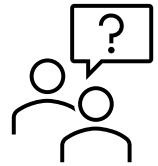
Zero to Five: I feel comfortable with the workgroup's guiding principles.

Overview of Proposed Upcoming Meetings

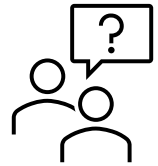
Meeting Date	BUP Workgroup Agenda Topics
Week of August 11	**Workgroup Kickoff:** OHA will cover the priorities and proposed agenda of the Workgroup overall, review the workgroup charter, and solicit additional feedback on the agenda and direction of the Workgroup. **BUP 101 – Introduction to Benefits Update Project:** Align on basic parameters of the BUP and learn about what is changing and not changing in the transition away from the PL.
Week of September 1	**BUP 102 - Deeper Dive into HERC Roles and Responsibilities:** Deeper dive into the past, present, and future role of HERC.
Week of September 22	**Specific topics may depend on Workgroup feedback.** The goal of these meetings may be to address – at minimum – considerations for members, providers, and CCOs and how to streamline the transition for these key partners.
Week of October 13	
Week of November 3	
Week of November 17	**Recap of Prior Topics and Look to the Future:** Recap questions from the prior sessions, discuss what OHP looks like after the phase out of the PL, and define directions for developing a set of draft recommendations.
Week of December 1	**Review Draft Recommendations:** Review draft recommendations and address any outstanding questions. Final review will occur offline.
Week of December 15	***Optional Meeting:*** Finalize recommendations, as needed.


Key
HERC & P&T Work Products
SPA
Systems updates
Rates/budget
Operational Documents
Additional comment opp's
December 2025: Finalize Workgroup recommendations
August - December 2025: BUP Workgroup convenes
February 2026: short legislative session
2025
2026
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec
Develop SPAs based on Output from the Health Evidence Review Commission (HERC) and the Pharmaceuticals & Technology (P&T) Committee
Public Comment (30 days)
Tribal Consultation (60 days)
August 2026: Submit SPA to CMS
Identify and Prioritize OAR and CCO Contract Updates
Q1 2026: summary of contract proposals to CCOs
Draft and Finalize Contracts
August 2026: Final Contract to CCOs
Finalize OARs
Tribal Consultation
OAR public comment
December 2026: File OARs
Identify system updates and needed change requests
Implement System updates
Q3 2025: OAFA shares admin and medical estimates with CCOs
Q4 2025: OAFA finalizes leg budget ask
Q2 2026: OAFA adapts rates based on WG recs (as needed)
Q3 2026: OAFA finalizes rates for CCO review, per WG recs and legislation

Discussion Questions



In Chat or Unmute: Do you have remaining questions about the scope of the Workgroup or the topics we will cover?



In Chat or Unmute: Do you have questions about the work needed or the timeline for the BUP transition?

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August X, 2025

Benefit Update Project (BUP) Workgroup: BUP 101

BUP 101 Meeting Agenda & Goals

Agenda:

- Welcome
- Level set on current Prioritized List (PL) background and requirement to phase out
- Discuss phase out of PL and possible implications
- Workgroup Questions and Answers

Goals:

- Recap understanding on BUP Workgroup scope
- Establish shared understanding of the PL phase out
- Confirm what is changing and what is staying the same

Preview: Next Meeting Agenda

The next BUP Workgroup meeting [INSERT DATE] will go deeper into the current, future, and transition roles and processes of the Health Evidence Review Commission (HERC).

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Background on BUP and the PL

Oregon Has Historically Used a "Prioritized List of Health Services" to Determine Coverage

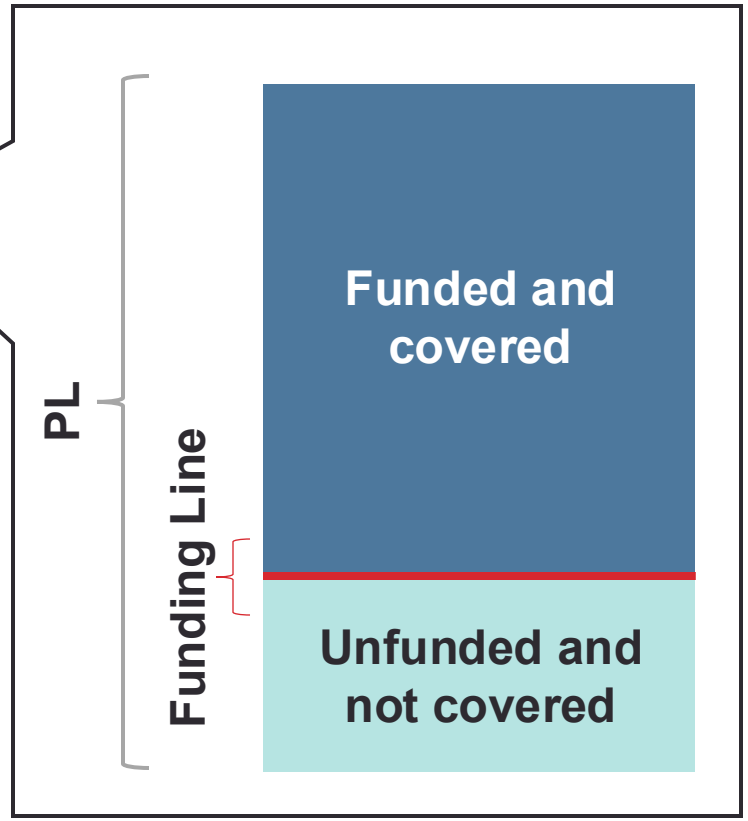
History of the PL

- Since 1994, Oregon has used the "Prioritized List of Health Services" (PL) to help determine the medical services that the Oregon Health Plan (OHP) will cover.
- The original goal was to expand coverage by only covering the most important services for the broadest population.
  - Oregon prioritized covering effective services with significant impacts on overall health over services for more minor conditions or smaller health benefits for the individual or population.
- Since 2012, CMS required Oregon to *not* adjust the funding line upwards (reducing benefits), to increase or generate savings.

The PL Contains Three Main Components Used to Determine Coverage

The three main components of the PL:

- **RANKED LIST OF SERVICES:** the HERC ranks treatment-condition pairings based on population benefit.
- **GUIDELINE NOTES:** Clarify specific criteria to guide coverage decision and utilization management policies.
- **FUNDING LINE:** The *Oregon Legislature* sets a funding line – treatment-condition pairings ranked above the line are covered (when medically necessary as defined in OAR). Pairings below the line can be denied.



HERC decides the best treatment for complex conditions that require in-depth study but does not review all medical services. We will discuss the HERC's process in more detail in future meetings.

Oregon's 1115 Waiver Authorizes the PL

The PL is authorized via the State's 1115 waiver. However, CMS is requiring Oregon to phase out the use of the PL by 1/1/27.

1115 Waiver waives 42 CFR 440.230(c), allowing the State to modify the benefit package based on diagnosis (i.e., denials based on the ranking of treatment-condition pairs).

42 CFR 440.230(c)

"(c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or condition."

Oregon decided to phase out the PL, and the requirements to do so are outlined in the terms and conditions of the current 1115 waiver.

OR 1115 Waiver – STC 12.9

"The state's waiver of amount, duration, and scope related to the Prioritized List, authorized in the original 1994 approval, will be phased out of the OHP demonstration by January 1, 2027. Use of this waiver authority will continue until January 1, 2027 while the state coordinates with CMS and its Legislature to authorize and implement its termination."

Check-In Questions

In Chat or Unmute: What questions do you have about the history or current state of the PL? What do you want to explore in more detail?

Zero to Five: I feel like I understand the PL history enough to discuss the transition away from the PL.

What Will Likely Change and What Will Remain the Same

Overview: Transitioning Away from the PL will Lead to Targeted Changes

What is Not Changing?

Roles of HERC, OHA and Legislature to define coverage policy and implement OHP.

Use of medical necessity to make coverage decisions will remain.*

HERC's work products will remain largely the same.

What is Changing?

"Prioritized List" will be replaced by **"Clinical Coverage Policies"**

Services will be organized in **unranked code groups** – services will no longer be denied solely because of the funding line.

OHP benefits structure will transition to **Mandatory and Optional benefits.****

OHA will implement a new FFS Appeals option.

* Not including "below the line" denials for adults today.

**A small number of additional services will be covered in the transition.

Roles of HERC, Legislature, and OHA Remain the Same

	 OR Legislature	 OHA	 HERC
	Will continue to provide funding and statutory direction	Will continue to define and implement the benefit, through policy and OARs	Will develop Clinical Coverage Policies based on medical evidence, member and expert input

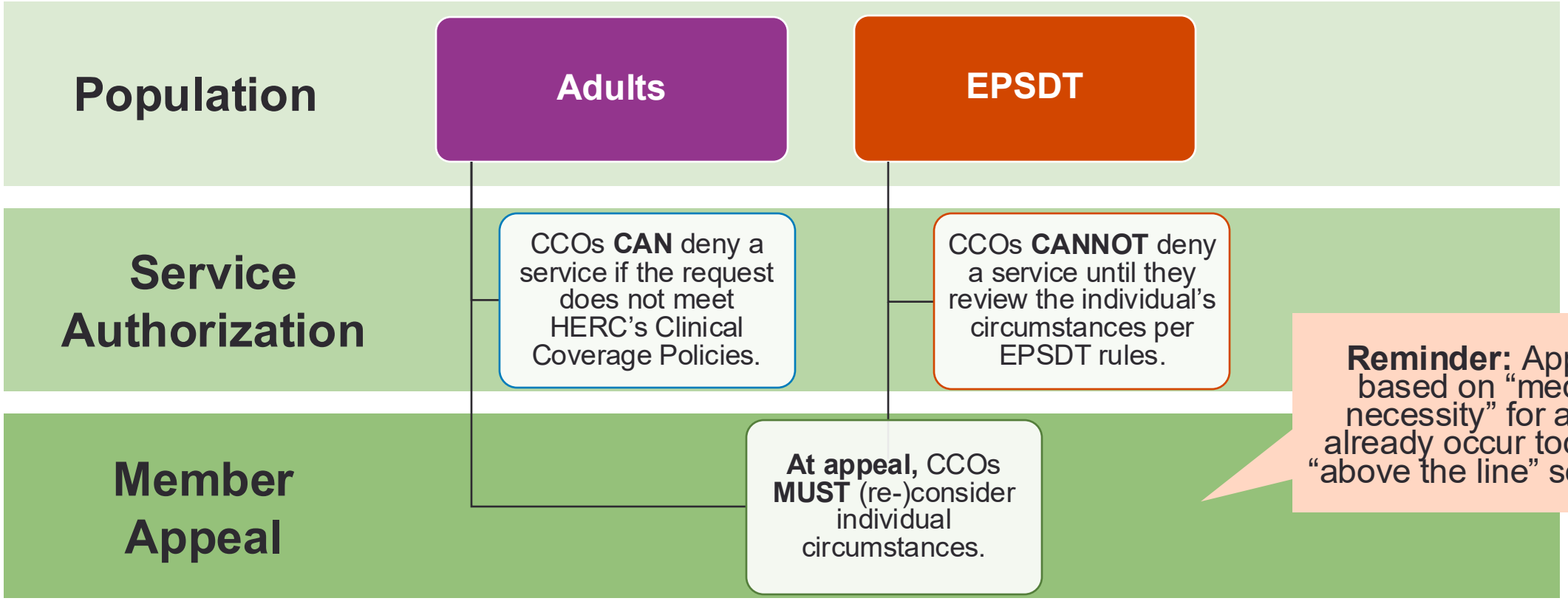
Use of Medical Necessity to Make Coverage Decisions will Largely Remain the Same

- Oregon rules and statute will continue to define the OHP benefit package.
- For OHP covered services, **Oregon will continue to use a definition of medically apprpriate and medically necessary** in rule (for adults, currently OARs 410-120-0000 (193) and (194)) for individual determinations.
- **HERC will continue to create evidence-informed medical necessity policy** to support effective, consistent utilization management across OHP, at the population.

HERC policies do not apply to *all* OHP-covered benefits, such as Home- and Community-Based Services.

Note: there may be changes to OAR as a result of the BUP Project to conform with changes.

What about EPSDT?



The phase out of the PL does not change these differences between adult and EPSDT service authorization and appeals.

HERC's Work Products Will Remain Largely the Same

- HERC will continue to produce guidance, code pairings, and statements of intent to elaborate on decisions.
- No change to diagnostic files.

Note: there may be changes to OAR as a result of the BUP Project to conform with changes.

"Prioritized List" will be replaced by "Clinical Coverage Policies"

Current: HERC deliverables (lines, guideline notes, statements of intent) currently constitute the "Prioritized List of Health Services"

Future:

- The substance of HERC **work products** will remain the same but no longer constitute the "Prioritized List of Health Services"
- HERC policies will likely be called **"HERC Clinical Coverage Policies"**
- Guideline notes will likely be called **"Coverage Guidelines"**

Services Will Be Organized In Unranked Code Groups

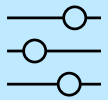
Current : The PL pairs treatments and conditions and then places them in **ranked lines** by importance to the population served.

Future: HERC Clinical Coverage Policies will largely mirror the content (e.g., coverage policies, guidelines, and notes) of the PL but will be **unranked code groups.**

Like the ranked lines today, each coding group will contain a set of diagnosis codes and procedure codes.

Role of HERC's Deliverables Will Change

Current : The PL pairs treatments and conditions and then places them in **ranked lines;** pairs below the funding line are not covered. PL has a hybrid role in defining scope and medical necessity policy.



Future: HERC Clinical Coverage Policies will define medical necessity within State-determined **scope, duration, and amount** of services covered under the State Plan.

State Plans Generally Share a Similar Structure

The state plan is an agreement between a state and federal government describing how that state administers its Medicaid program and what expenses will be matched (42 CFR 431.10).

Mandatory Benefits

Include, but are not limited to:

- Inpatient and outpatient hospital services
- Physician services
- Laboratory and X-ray services
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services
- Certain clinic and health center services

Optional Benefits

Include, but are not limited to:

- Prescription drugs
- Dental services
- Physical, occupational, speech, and/or hearing therapy
- Case management services
- Home and community-based services

Under federal law, states are required to provide a set of mandatory benefits but may provide optional benefits in the state plan. Some benefits may be state-funded only.

Services May Fall Into New Categories

MANDATORY

Services that HERC considers **medically necessary** and will be **newly covered** 1/1/27:

- Some allergy testing and treatment for nasal allergies without asthma.
- Facial nerve grafts and surgeries for certain eyelid conditions

OPTIONAL

Services that HERC considers **medically necessary** under certain conditions, for example:

- Physical therapy for certain conditions like sprains and strains
- Psychotherapy for somatization disorder and somatoform disorder,
- Acupuncture for tension headaches and cervicogenic headaches

OPTIONAL

Services that HERC considers **NOT medically necessary** under certain conditions:

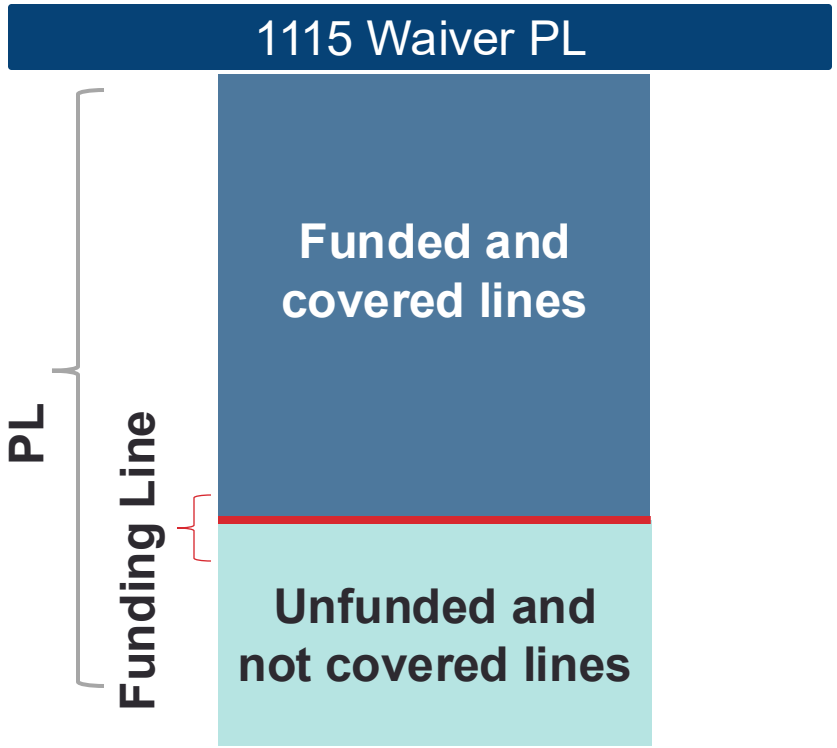
- Physical therapy for fibromyalgia
- Contact lenses for dry eyes
- Removal of skin growths (lipomas)

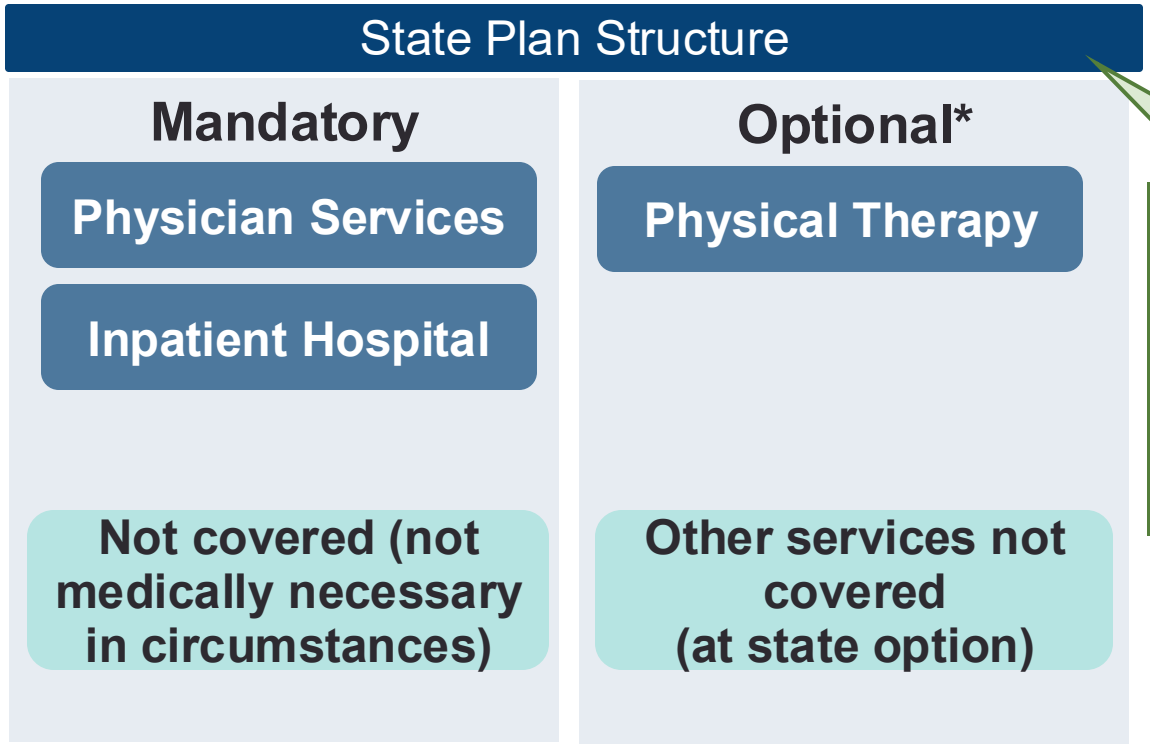
Note: Some examples above may still be under deliberation.

Summary: the RANKED LIST and the FUNDING LINE Will No Longer Exist

LEGEND
- COVERED
- NOT COVERED

Current → ***Future State***





HERC will continue to develop **guideline notes** for mandatory and relevant optional services in the State Plan.

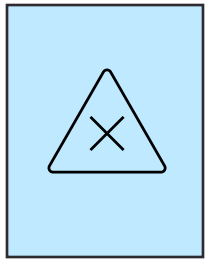
Note: Not drawn to scale, for illustrative purposes only

*CMS-defined optional services include a wide range of common services including retail drugs, adult vision and dental, and physical therapy.

OHA will Implement a New FFS Appeal Option

OHA aims to create a member-driven appeals process in FFS, mirroring the expedited process that is available for those covered under managed care.

Current: For FFS members, all "appeals" go to state fair hearing.

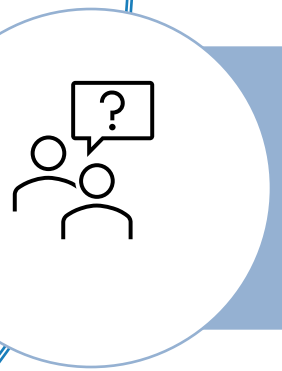


Future: FFS members will have the option to pursue an appeal simultaneously with a hearing. Hearings will also be modified to be based on medical necessity and not the PL funding line.

Note: the option to seek an appeal does not preclude any member from their right to a state fair hearing

Polling: To what extent do you agree with the following statements? (0-5)

In Chat or Unmute: Where do you have concerns or need more information? Where do you want more detailed discussion, now or at a future meeting?



In Chat or Unmute: For what *is* changing, what barriers do you see for implementation? What are strategies you think would make the transition go smoothly?

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Q&A

Overview of Proposed Upcoming Meetings

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Appendix

Example of Clinical Coverage Guideline

Appendix C: Benefit Update Project Guideline Changes

Note: As a result of the Benefit Update Project, references to Prioritized List Guideline Notes have been changed to "Clinical Guideline." Where a Clinical Guideline is based on an existing Guideline Note, the same number is retained. Revisions shown in red and blue are changes from current Prioritized List Guideline Notes.

CLINICAL GUIDELINE 3, PROPHYLACTIC SURGICAL TREATMENT FOR PREVENTION OF CANCER IN HIGH-RISK WOMEN

Code group 100YY Breast cancer and high risk for breast cancer:

Bilateral prophylactic breast removal and/or salpingo-oophorectomy are ~~included on Line 190~~ medically necessary for women without a personal history of invasive breast cancer who meet the criteria in the NCCN Clinical Practice Guidelines in Oncology (Genetic/Familial High-Risk Assessment: Breast, Ovarian and Pancreatic V2.2025 (11/7/24) www.nccn.org). Prior to surgery, women without a personal history of breast cancer must have a genetics consultation as defined in section B of the DIAGNOSTIC GUIDELINE D1, NON-PRENATAL GENETIC TESTING GUIDELINE.

Contralateral prophylactic mastectomy is medically necessary ~~included on Line 190~~ for women with a personal history of breast cancer.

Prophylactic hysterectomy is only medically necessary ~~included on Line 190~~ for women meeting NCCN criteria as above who undergo the procedure at the time of risk reducing salpingo-oophorectomy.

Date of last review: January 2025