1115 MEDICAID WAIVER
IMPLEMENTATION PROJECT | OREGON

OREGON HEALTH AUTHORITY

September 2, 2025

Benefit Update Project (BUP) Workgroup: BUP 102

BUP 102 Meeting Agenda & Goals

Agenda:

- Recap Previous Workgroup Meeting
- Address Key Points of Discussion from Prior Meeting, Today and Future
  - Benefit Package
  - Coverage Decisions
- Review the HERC's Role in Supporting the Transition Away from the Prioritized List

Goals:

- Further clarify scope and purpose of the workgroup
- Align thinking on the current and future state of OHP "benefits" and how coverage decisions are made
- Establish shared understanding of HERC-related transition processes

Preview: Next Meeting Agenda

The next BUP Workgroup meeting on September 24 will focus on topics based on today's discussion and direction from the workgroup steering committee.

Note: *Today's meeting is the last history/contextual meeting in the workgroup series. All future meetings will focus on recommendations development and discussions on future state.*

Reminder: 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.

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Recap Previous Workgroup Meeting

Recap: BUP 101 Meeting

The last BUP workgroup meeting focused on:

- Scope of the workgroup and key topics for discussion during workgroup meetings
- The history of the Prioritized List (PL)
- CMS requirement to phase out the use of the PL from the state's 1115 waiver
- Discussing the possible implications of the phase out of the PL

Reminder: Scope and Purpose of Workgroup

Reminder of Workgroup Charter

Authority:
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 workgroup 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 delivering appropriate, high-value health care

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.

Steering Committee Feedback After Session 1:

- Ensure future discussions are centered on answering questions related to OHP-system impacts and developing responsive recommendations
- Set discussion guardrails to focus time together efficiently
- Ensure meeting goals specify where workgroup should exercise its advisory role and develop recommendations

Overview: Transitioning Away from the PL will Lead to Select 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.

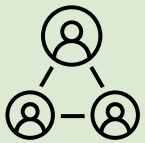
OHP benefits structure will transition to **Mandatory and Optional benefits.****

OHA will implement a new FFS Appeals option, if this initiative is funded.

* 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



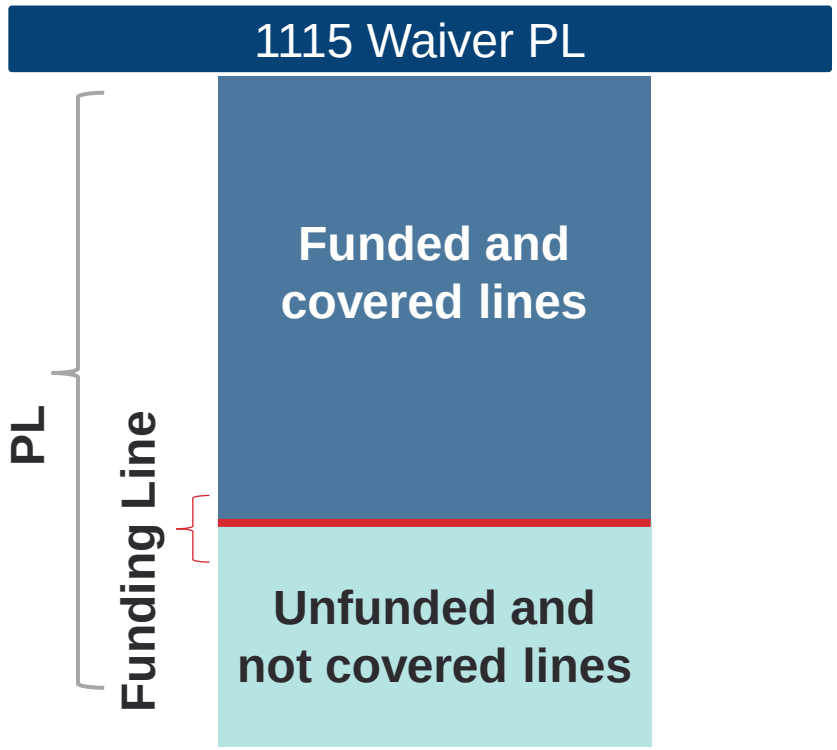
OR Legislature	OHA	HERC
Will continue to provide funding, responsible for ORS changes, including related to the benefit package.	Will continue to define and implement the benefit, through policy and OARs	Will develop Clinical Coverage Policies based on medical evidence, member and expert input, to guide coverage decisions

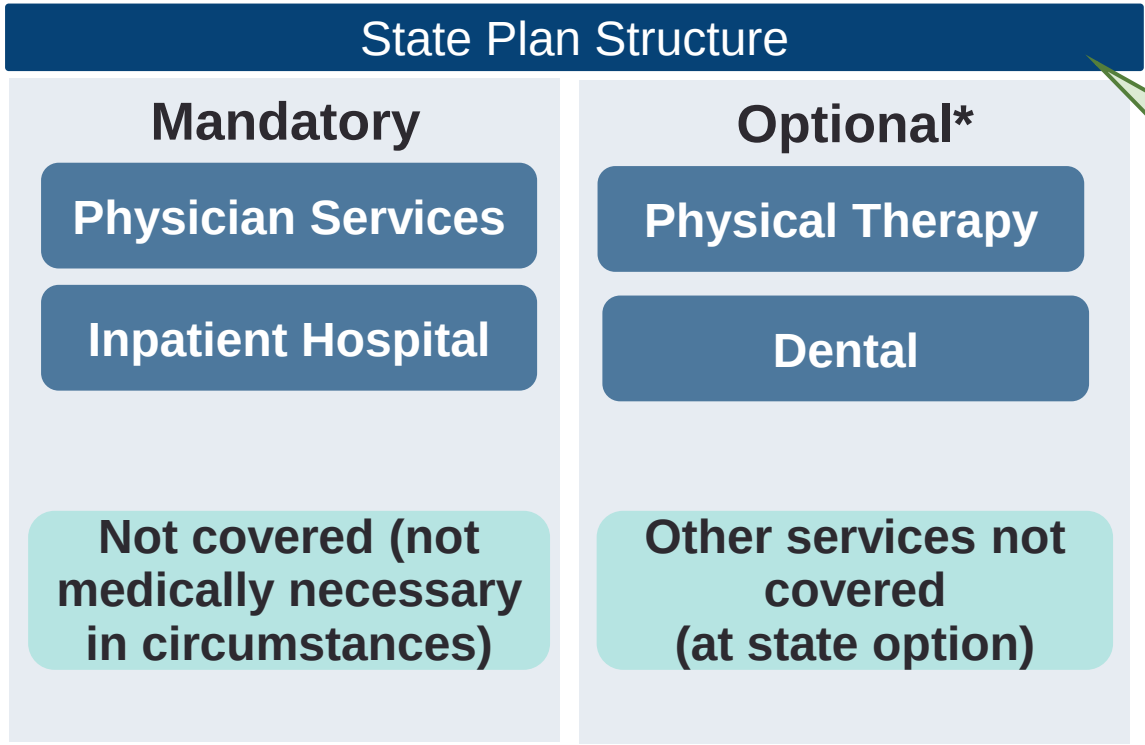
Dynamic relationship between Leg, OHA, and HERC to determine benefits.

Recap: 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.

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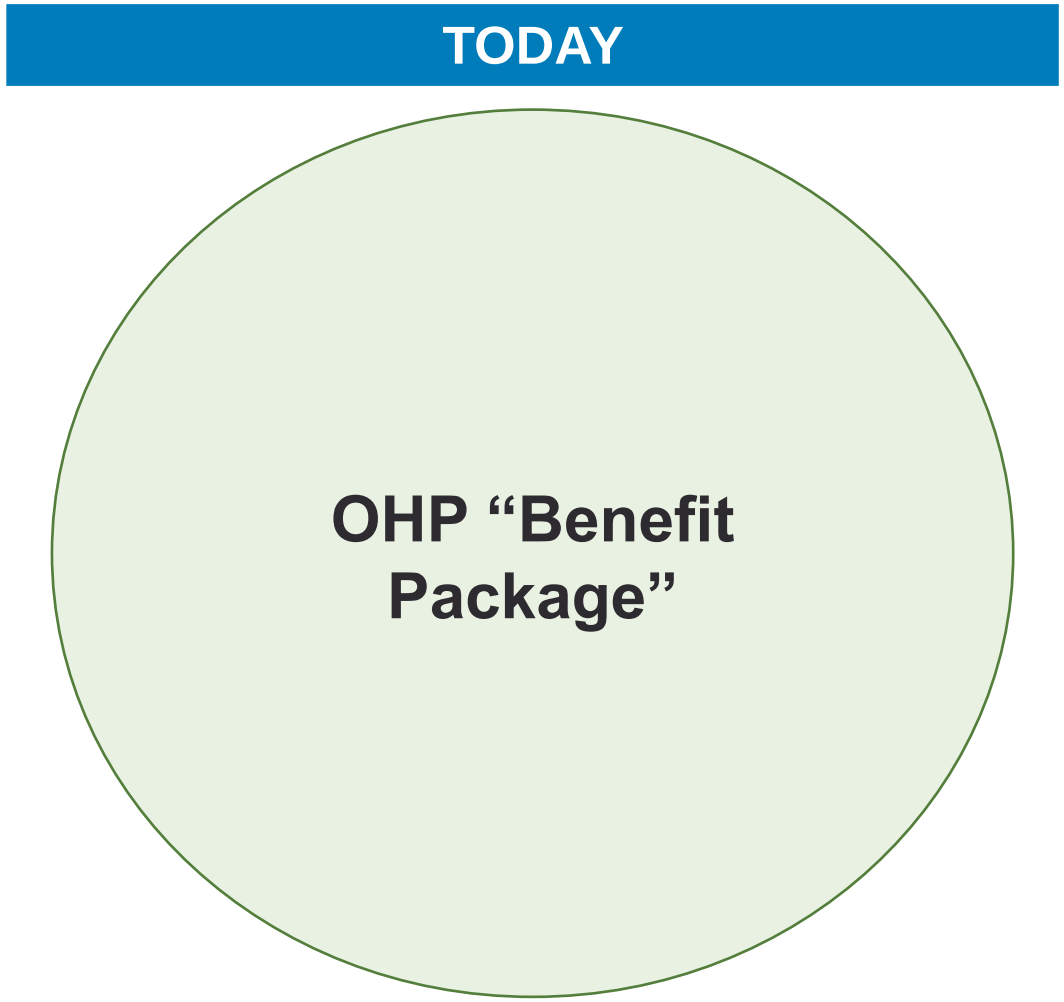
What do we mean by “OHP Benefits”?

Note: not including Rx

What Do We Mean by “OHP Benefits”?

- **Green circle =** the total “Benefit Package” at the highest level – defined in OAR and ORS
- Captures the universe of services that ***could*** be covered by the State through OHP to any enrollee.
  - *Example of something **outside** green circle: infertility treatments*
  - **Reminder:** PL exists within, but does not cover the entirety of the OHP Benefit Package (e.g., waiver services)

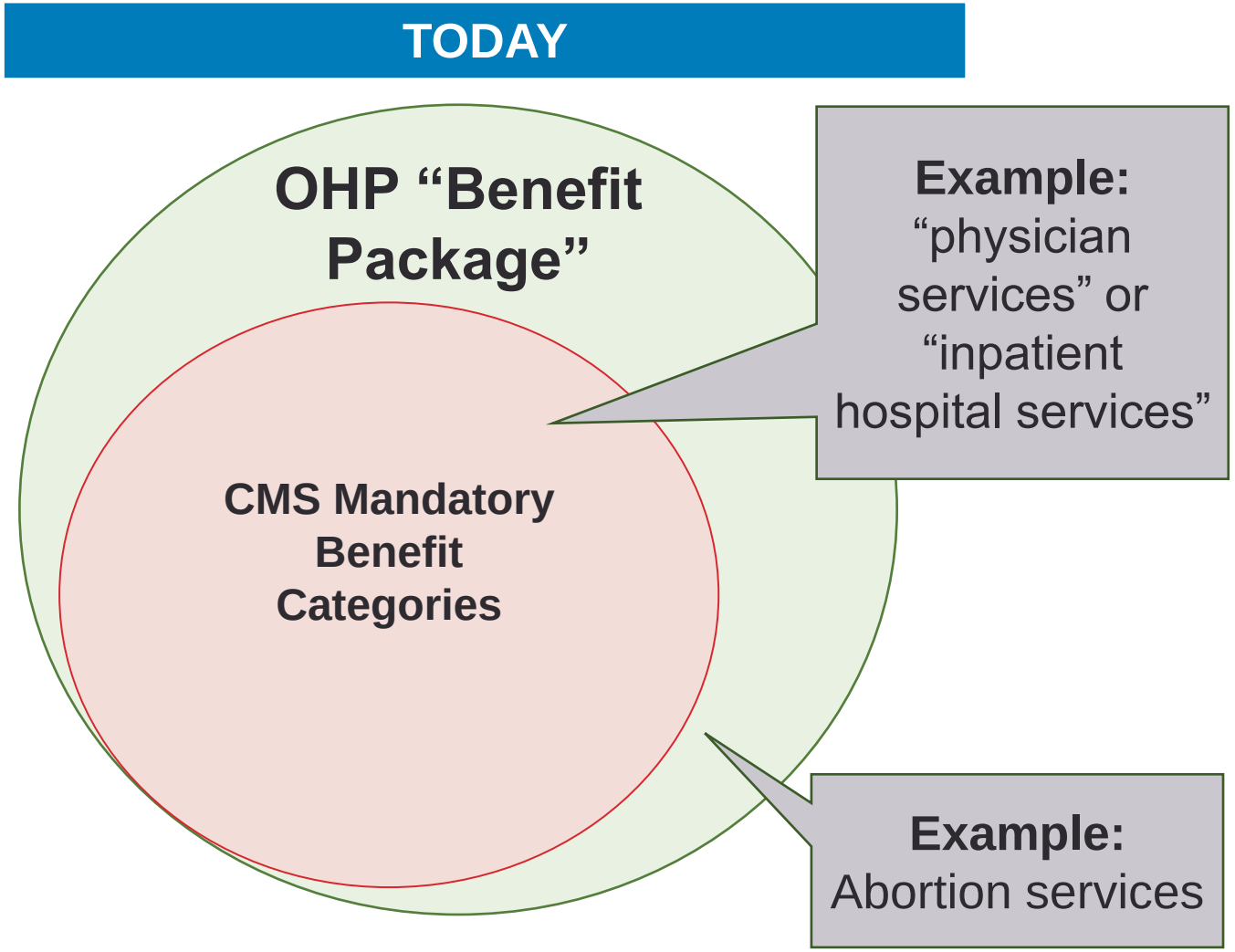


Note: not including Rx

What Do We Mean by "OHP Benefits"

- **Red circle =** Mandatory ***categories*** of services, that must be included in the State Plan

- Note: a small % of services (such as abortion) are outside the State Plan but covered through state-only funding

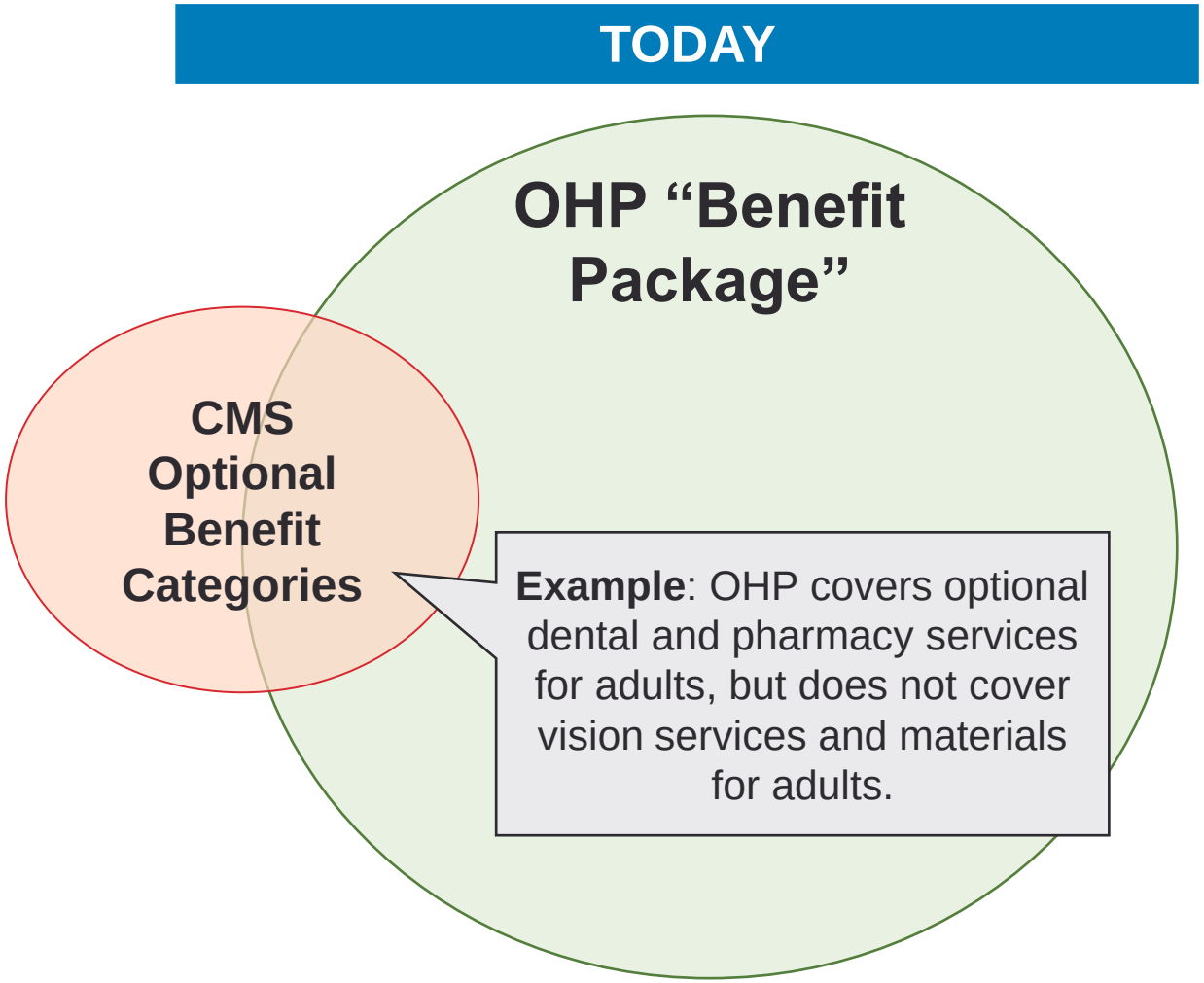


Note: does not include Rx

What Do We Mean by "OHP Benefits"

- **Orange Circle =** Optional ***categories*** of services, such as vision services for adults.

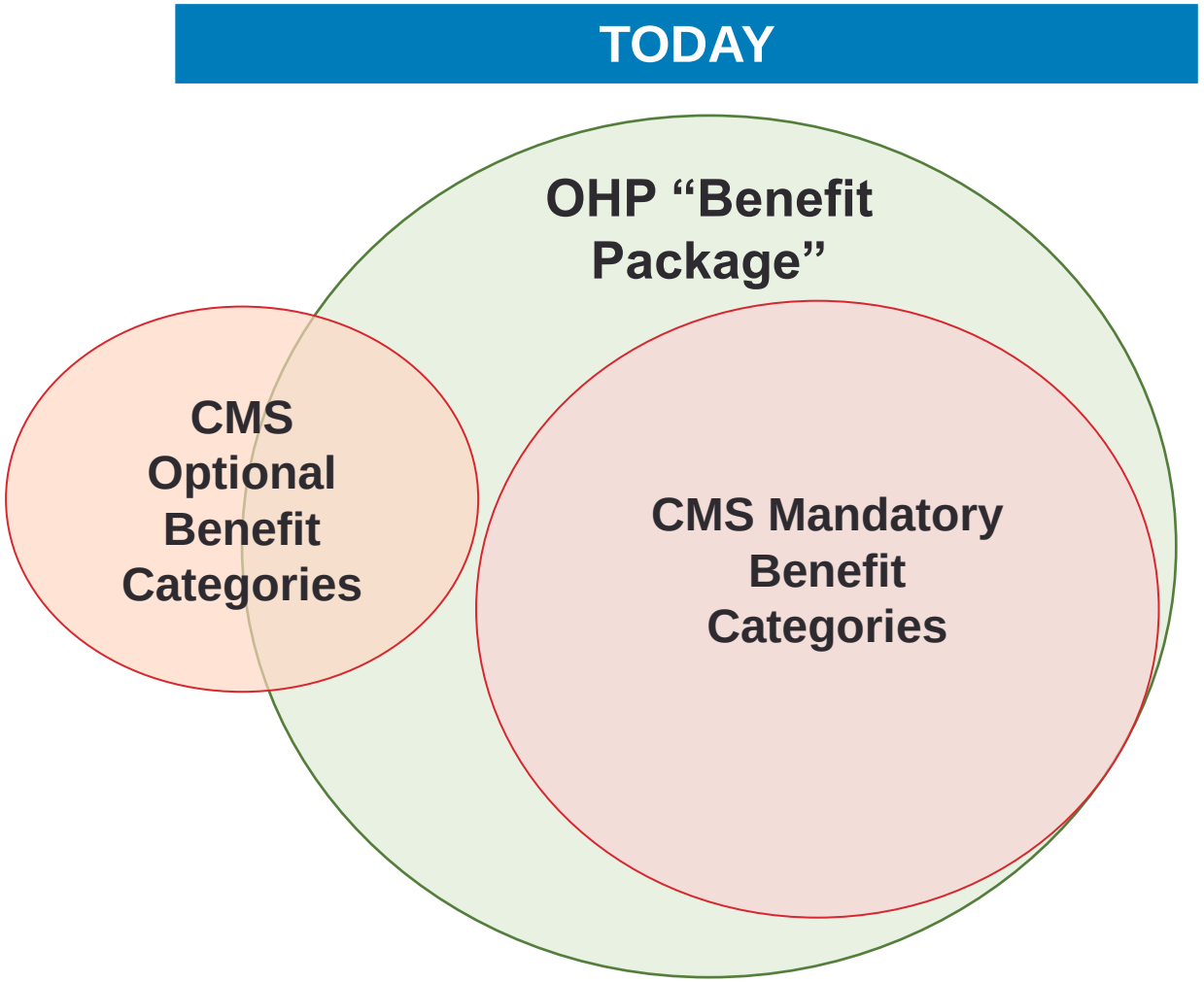
- OHP covers some but not all optional benefit categories



Note: not including Rx

What Do We Mean by "OHP Benefits"

- The **orange circle** plus the **red circle** constitute the State Plan agreement and capture most services covered by OHP (and capture all the services where OHA receives federal match).



Note: not including Rx

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

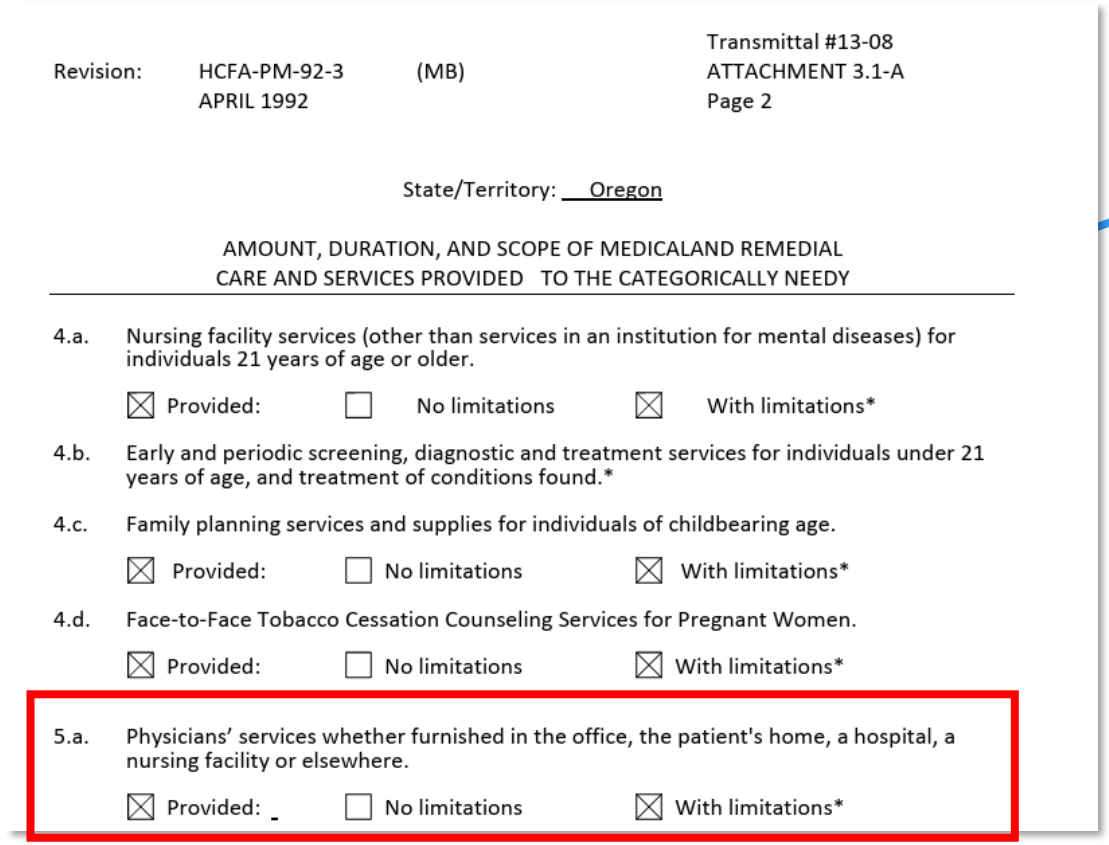
Include, but are not limited to:

- 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 articulated in the state plan. States may include optional benefits in their state plan. Other benefits may be state-funded only.

State Plans Generally Share a Similar Structure

State plans typically capture "amount, duration, and scope" of services at a high level.



Revision: HCFA-PM-92-3 (MB)
APRIL 1992

Transmittal #13-08
ATTACHMENT 3.1-A
Page 2

State/Territory: Oregon

AMOUNT, DURATION, AND SCOPE OF MEDICALAND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
☒ Provided: ☐ No limitations ☒ With limitations*

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

4.c. Family planning services and supplies for individuals of childbearing age.
☒ Provided: ☐ No limitations ☒ With limitations*

4.d. Face-to-Face Tobacco Cessation Counseling Services for Pregnant Women.
☒ Provided: ☐ No limitations ☒ With limitations*

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.
☒ Provided: ☐ No limitations ☒ With limitations*

Example: Physicians' services

Scope: provided with limitations

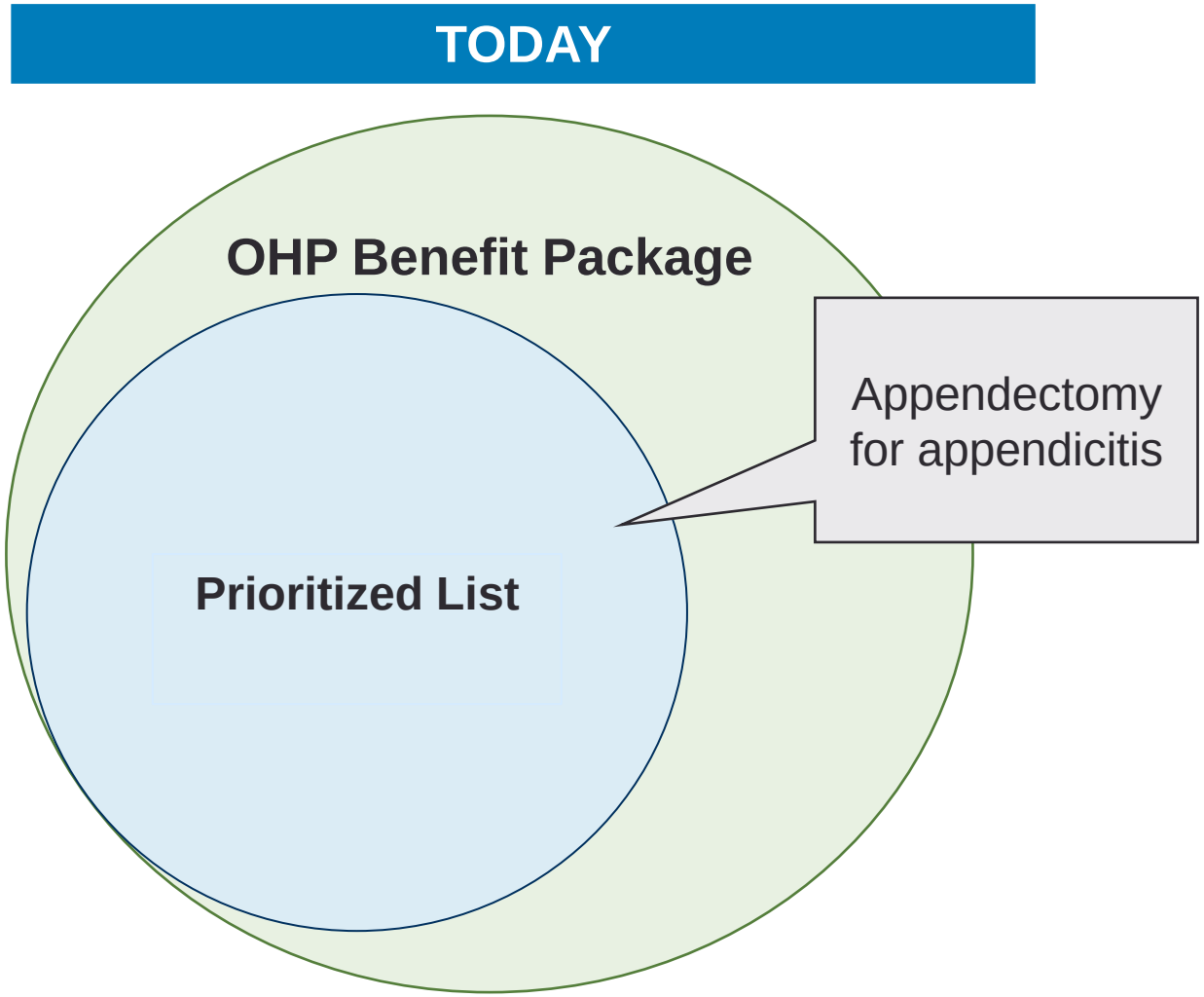
Limitations: Some services require prior authorization. Exceptions for non-covered services or services with limitations are allowed when medically necessary and prior authorized by the Division.

Source: https://www.oregon.gov/oha/HSD/Medicaid-Policy/StatePlans/Medicaid-State-Plan.pdf

Note: not including Rx

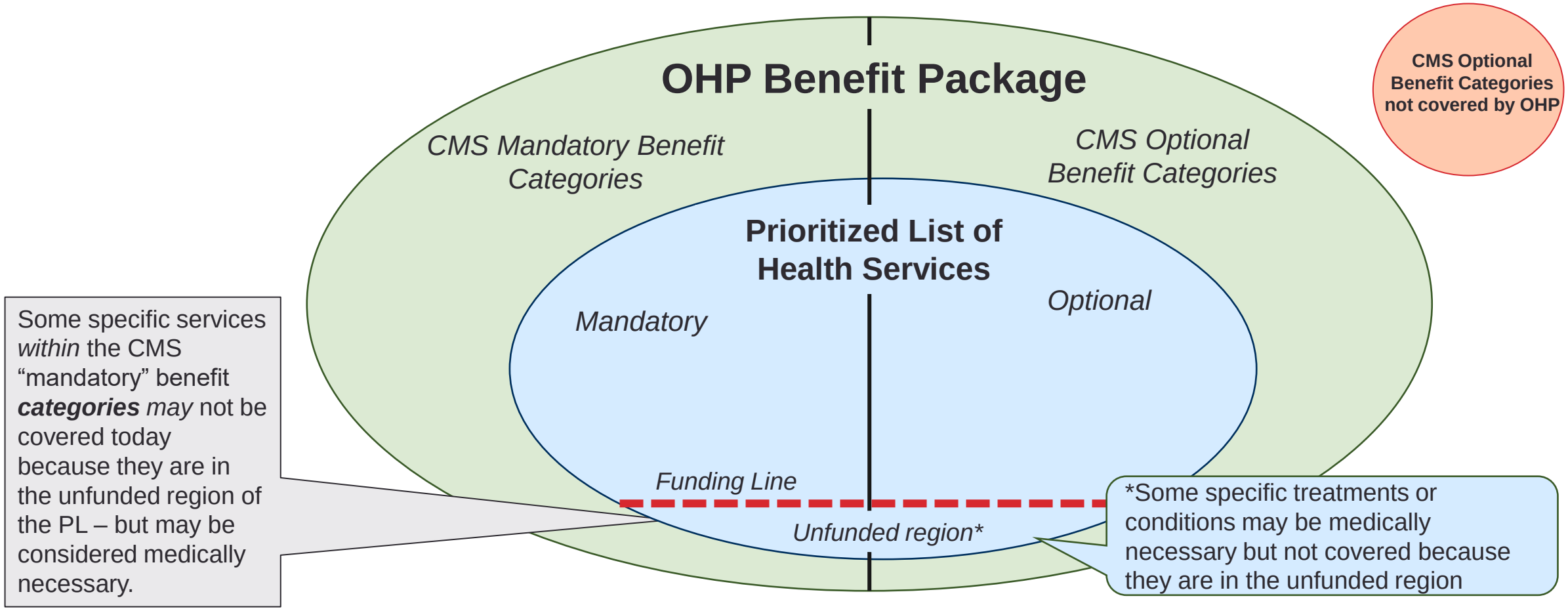
What Do We Mean by "OHP Benefits"

- **Blue Circle =** the prioritized list of treatment-condition code pairs, ranked by HERC by population benefit
  - PL exists within, but does not cover the entirety of the OHP Benefit Package (e.g., waiver services)
  - PL is **granular** – capturing specific lines of treatment-condition pairs within broad categories of service



What Do We Mean by OHP Benefits?

TODAY



Note: For illustration only; not drawn to scale. Also, diagram does not include Rx – to be discussed in a future slide.

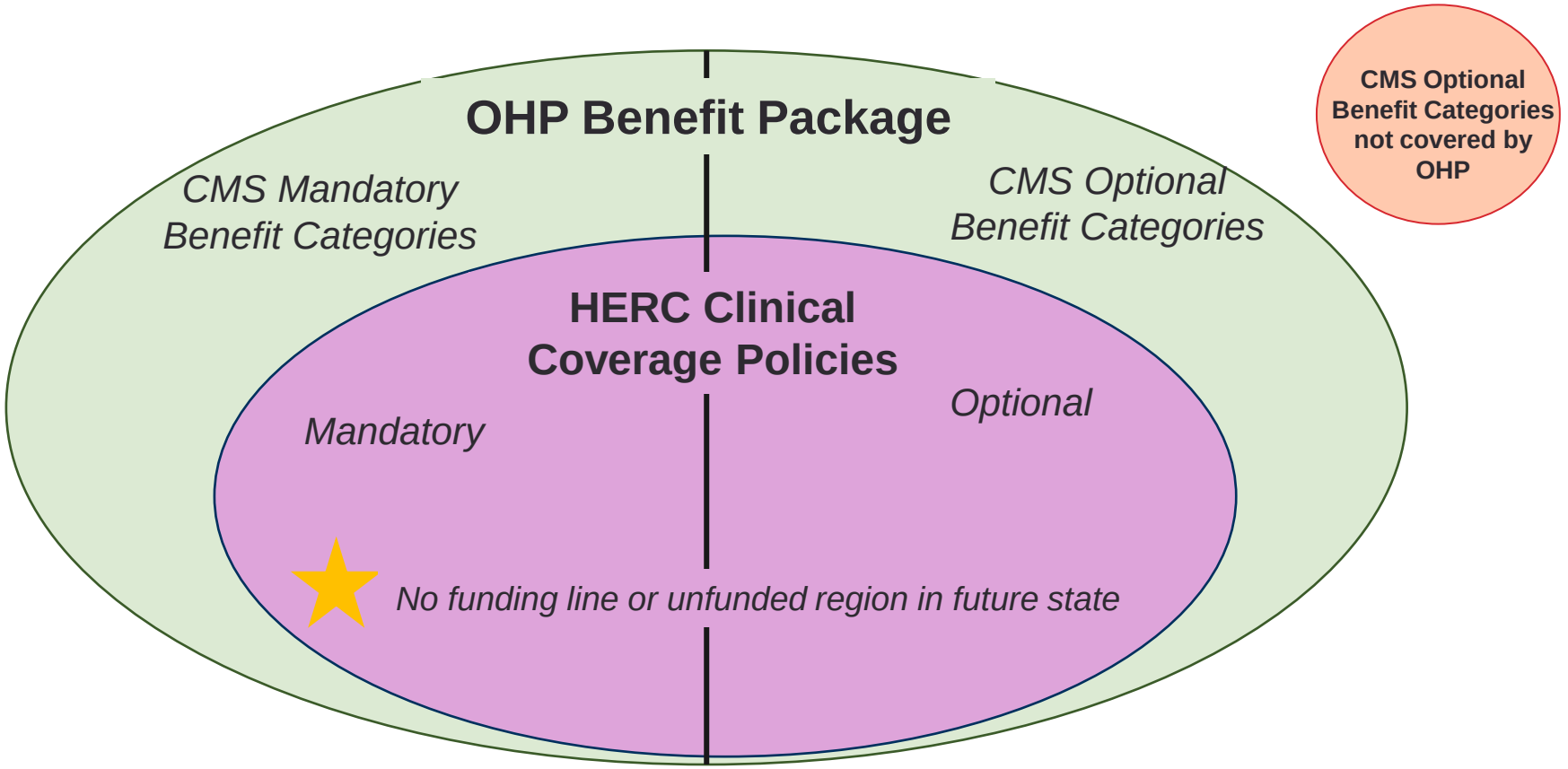
Discussion Questions—
For Workgroup Members Only

1. Why does HERC rank services on the Prioritized List Today?
2. How do you use the ranking in your work today?
3. Since there will be no funding line in the future state, is there a still a need for ranking of services? Why or why not?

Transition Away from PL May Lead to More Covered Benefits but Not Fewer

Future State

- The PL becomes **"HERC Clinical Coverage Policies" that define medical necessity**
- Clinical Coverage Policies still include treatment-condition code pairs and guideline notes, in unranked groups
- Clinical Coverage Policies are **granular** – capturing specific treatment-condition pairs within broad categories of service.
- There will be no reduction in services covered, including optional services, due to the transition away from the PL



Note: For illustration only; not drawn to scale. Also diagram does not include Rx – to be discussed in a future slide.

Coverage for Prescription Drugs Will Increase

- The transition away from the PL will lead to coverage for medically necessary medications for unfunded conditions
  - Prescription drugs will constitute majority of additional coverage
- HERC does not review all drugs—a separate committee (Pharmaceuticals & Therapeutics or “P&T”) addresses those needs
- In transition, P&T is determining which drugs will be medically necessary for these conditions *(and CCO P&Ts should be taking similar actions)*

Discussion Questions –
For Workgroup Members Only

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?

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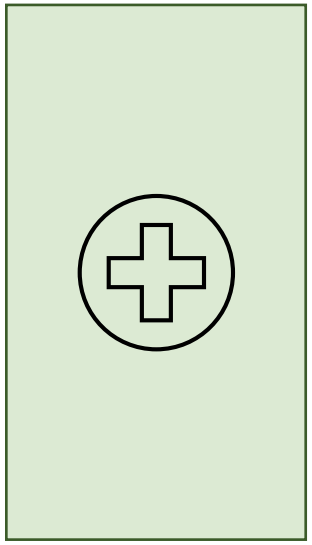
How Are Coverage Decisions Made?

Definition of Medical Necessity to Make Coverage Decisions will Remain the Same



- **Oregon will continue to use a definition of medically appropriate and medically necessary** in rule for individual determinations (for adults, see OARs 410-120-0000 (193) and (194)).
- **HERC will continue to create evidence-informed medical necessity policy** to support effective, consistent utilization management across OHP, at the population level.

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

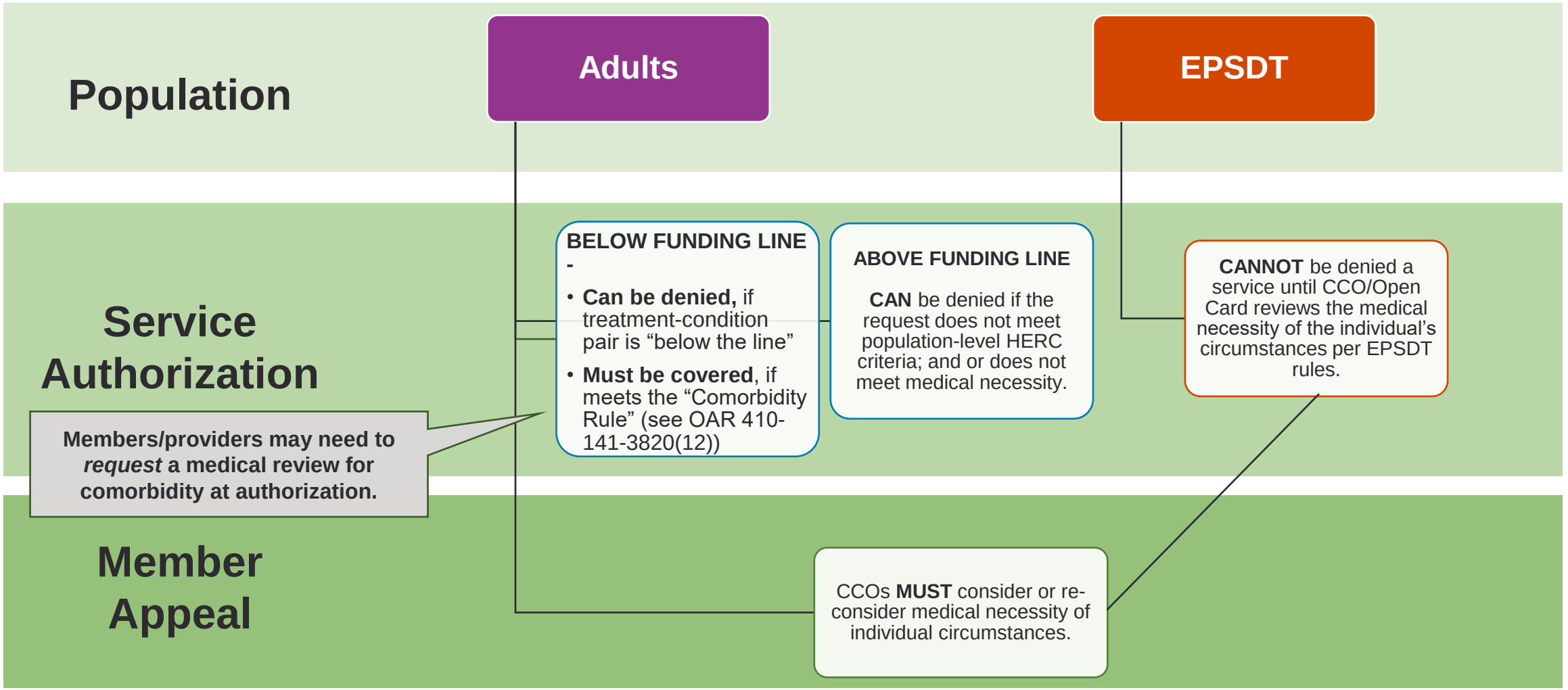
Note: there may be changes to OAR as a result of the BUP Project to conform with changes.

HERC's Work Products that Guide Coverage Decisions Today Will Remain Largely the Same

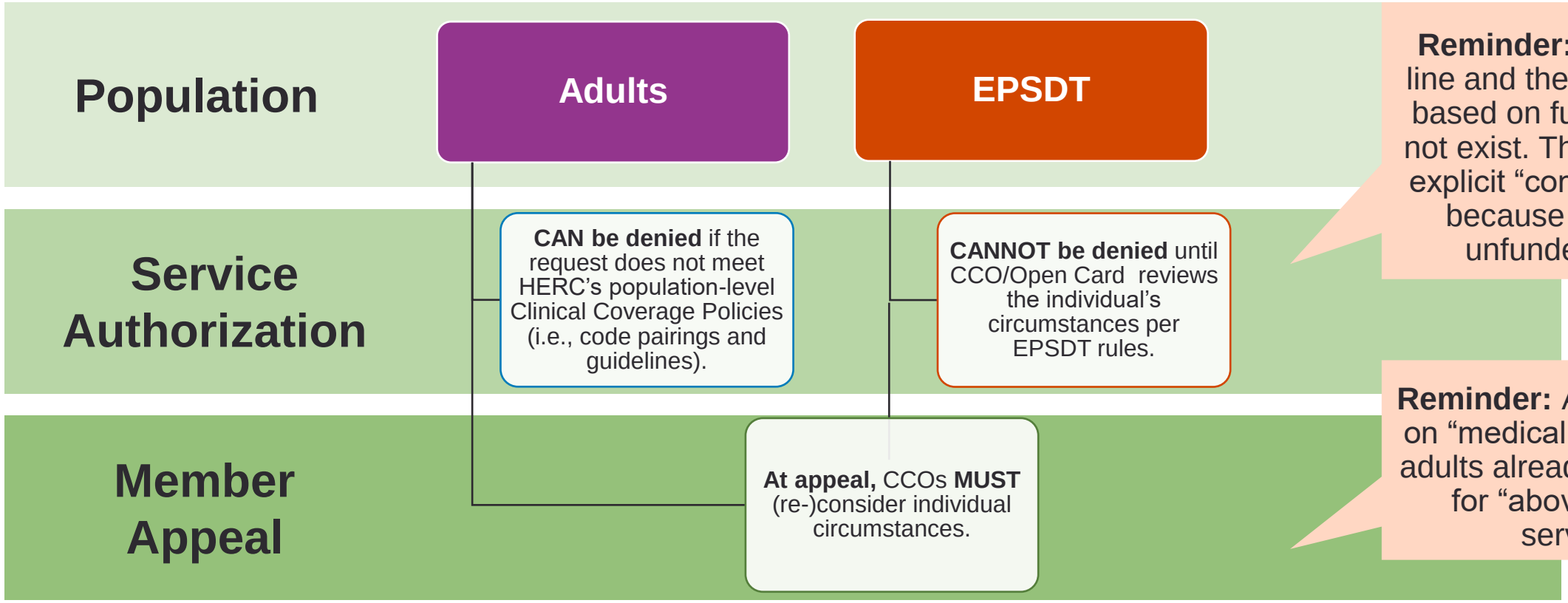
- HERC will continue to produce guidelines, code pairings, and statements of intent to elaborate on decisions.
- HERC will recommend services for other files, such as
  - Non-medically necessary
  - Diagnostic
  - Excluded
  - Ancillary

Reminder: We will delve further into this transition later in the presentation.

Service Coverage Decisions Today



Service Coverage Decisions in Future



Reminder: The funding line and therefore denials based on funding line do not exist. There is also no explicit "comorbidity rule" because there is no unfunded region.

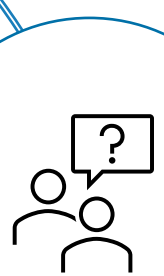
Reminder: Appeals based on "medical necessity" for adults already occur today for "above the line" services.

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

Some Coverage Decisions will Change, Many Will Remain the Same

Examples	Changing denial reason	Newly covered after transition	Outside benefit package
Service	Hysterectomy for chronic pelvic pain	Acupuncture for tension headaches	Infertility
Today	Denied because the condition treatment pair is below the funding line	Denied because the treatment-condition pair is below the funding line.	Denied because outside the OHP Benefit Package
Future	Denied because not medically necessary (because it doesn't pair)	Covered and medically necessary	Denied because outside the OHP benefit package (no change)

Discussion Questions –
For Workgroup Members Only



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?

Zero to Five: I feel comfortable with the changes that may occur to coverage decisions (e.g., no unfunded region)?

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10 Minute Break

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Deeper Dive on HERC Activities in Transition and in Future

Reminder: What is the HERC?

HERC was **established in a 2011 legislative session**, as the body responsible for reviewing and making benefit coverage decisions for certain (but not all) clinical services covered by the OHP.

See ORS 414.688 to 414.704

Reminder: HERC Members Represent Different Key Partners

The HERC is a group appointed by the Governor and confirmed by the Oregon Senate and consists of 13 members, including the following:

- **5** Physicians (MD/DO)
- **1** Provider Of Complementary And Alternative Medicine
- **1** Dentist
- **1** Public Health Nurse
- **1** Behavioral Health Representative
- **2** Consumer Advocates
- **1** Retail Pharmacist
- **1** Insurance Industry Representative

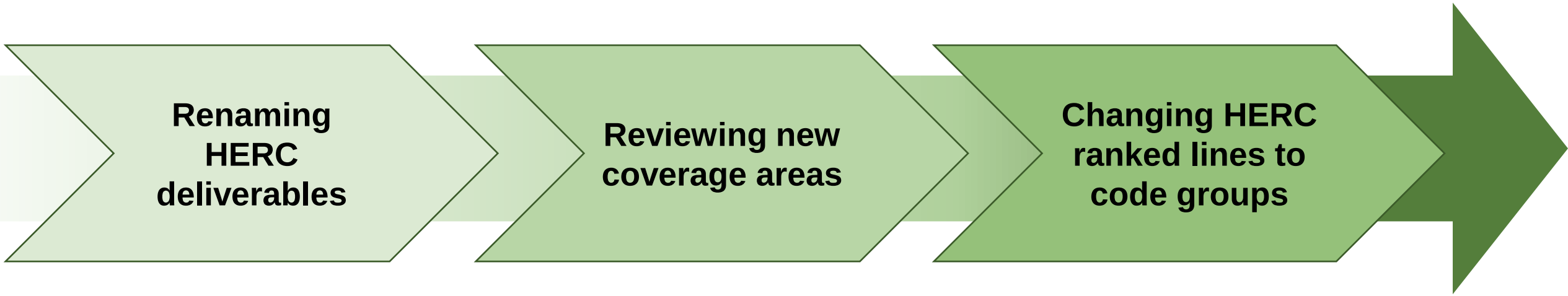
Reminder: HERC Has a Significant Role in OHP Coverage Determinations

Today: HERC is responsible for incorporating new medical advancements or evidence, routinely evaluating OHP benefits to incorporate new medical codes, and make corrections.

Process	Output
Public, transparent, evidence-based process that holds the HERC and the State accountable.	HERC ranks services in the PL and submits recommendations to the legislature every two years (biennially).

HERC is Currently Working on BUP Transition Process

Without the PL and associated funding line, certain outputs need to change and there may be newly added services that HERC needs to address.



HERC's Role and Processes Will Not Change in Future

Future: The HERC will continue to routinely evaluate medical necessity for OHP benefits to incorporate new medical codes, make corrections, and incorporate medical advancements.

Process	Output
Public, transparent, evidence-based process that solicits community feedback and holds the HERC and the State accountable for the coverage decisions made.	• Services no longer need to be ranked • HERC will develop "Clinical Coverage Policies."

Reminder: HERC's Work Products Will Remain Largely the Same, but Some With New Names

- **HERC will continue to produce evidence-based guidance,** and statements of intent to elaborate on decisions.
- HERC outputs will constitute the HERC's "Clinical Coverage Policies" rather than "Prioritized List."
- HERC will create similar treatment-condition code pairs, but in unranked groups.
- No change to diagnostic files.

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

HERC Has Reviewed Several Coverage Areas To-Date

HERC has reviewed services in several coverage areas so far to see if coverage should be added after 1/1/2027. The below are examples of areas reviewed so far.

- Behavioral health conditions
- Allergies
- Podiatry
- Oral health conditions
- Women's health/gynecology
- Dermatology

The HERC will continue reviewing currently unfunded services throughout 2025.

OHA Anticipates New OHP Services, Effective 1/1/2027

HERC is recommending coverage changes to OHP starting 1/1/2027 as part of the BUP, including the examples below.

Coverage Area	Details
Primary care office visits and medications for currently non-covered conditions	• Check-ups and reasonable testing are already covered • Many low-cost and safe medications are already covered
	• Medications and equipment: no more denials because a condition is unfunded
Allergy treatment & testing	• Newly covered conditions such as seasonal allergies and some rashes
Sports Medicine (treating injuries and illnesses related to physical activity)	• Physical & occupational therapy for more conditions
Ophthalmology (eye diseases)	• Newly covered eye and eyelid conditions

HERC Output Data Will No Longer be Ranked

HERC Outputs:

Current:

- HERC ranks services in relation to the funding line
- The resulting list is the PL as it exists today
- The final product is formatted in a PDF of a Word document

Future:

- HERC will place services into code groups
- The resulting work product will be the Clinical Coverage Policies
- The final product is formatted in the same structured Word document, with new content

HERC Evaluation and Management Codes Will Change in the Transition

HERC Evaluation and Management (E&M) Codes:

Current:

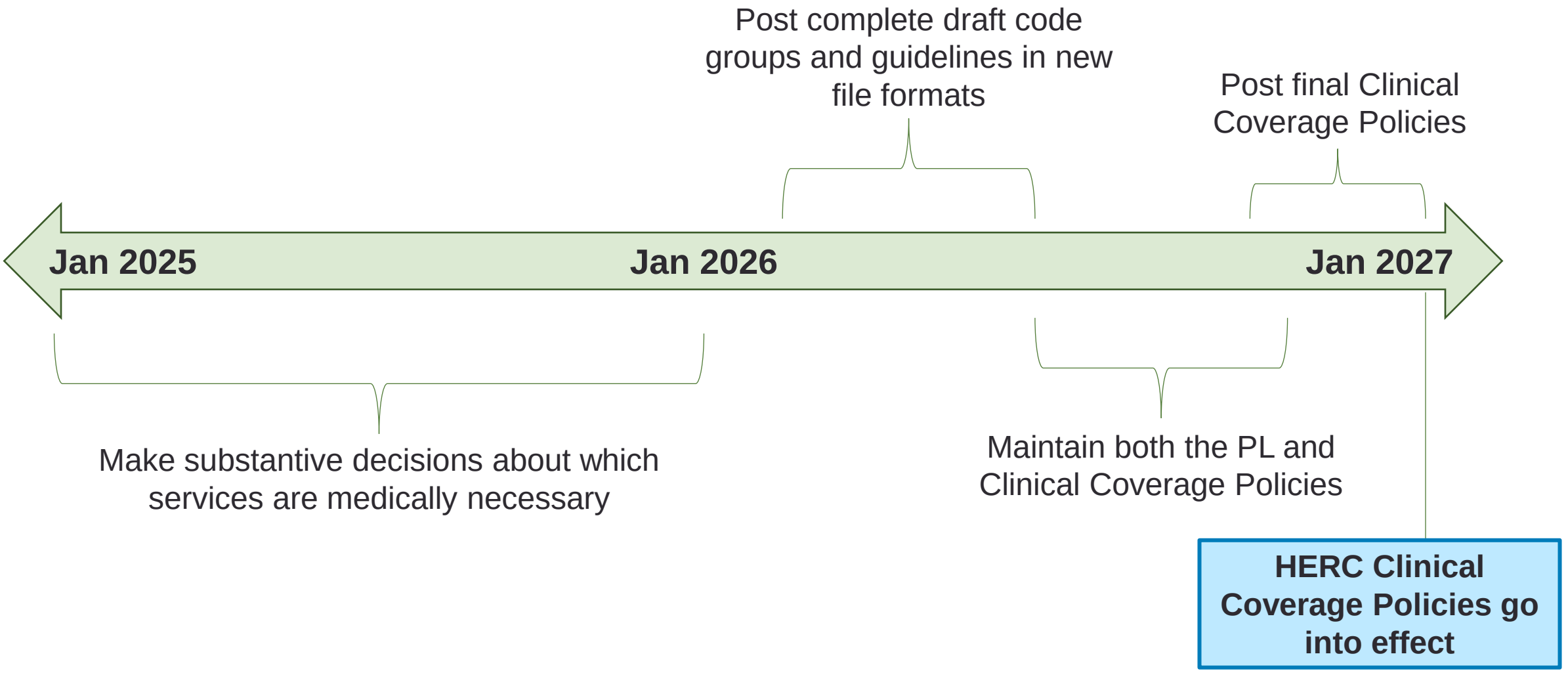
- Many diagnoses in the unfunded region are already in an E&M group
- E&M codes are on 600+ lines of the PL, and also on the Diagnostic Services file
- Other services are on the “Excluded Services” file or “Not Medically Necessary” file

Reminder: even today, for conditions in the current unfunded region, evaluation visits are already covered (as diagnostic).

Future:

- HERC will create a new “Management Procedure File” and all codes will be moved to either the Diagnostic Services file or the new file
- Services on the Not Medically Necessarily file are in the benefit but generally denied; these will be eligible for appeal based on medical necessity
- Services on the “Excluded” file will be denied as outside the benefit package

HERC Transition Timeline Leading up to 1/1/27



Key Takeaways

Changes:

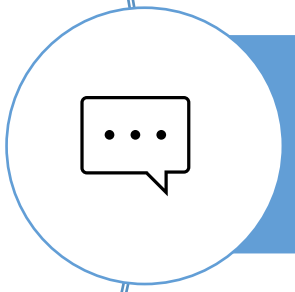
1. **No funding line and unfunded region; therefore, no denials based solely on funding line.**
2. **More denials based on medical necessity, rather than the list.**
3. **HERC's ranked lines will change to code groups.**
4. **Some new services will be covered.**

Remaining the same:

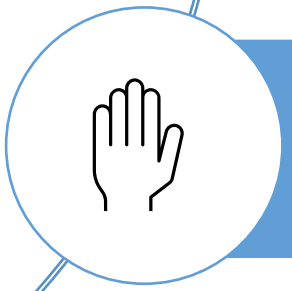
1. HERC's public and evidence-based processes.
2. Code-pairings and substance of statements of intent, guidelines notes, diagnostic and ancillary files.

Discussion

In Chat or Unmute: Are there any unaddressed questions you have about HERC?



In Chat or Unmute: What should be our focus or priorities to address in our next meeting?



Zero to Five: I am comfortable with my understanding of the HERC transition process between now and 1/1/27.

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Q&A

Reminder: Overview of Upcoming Meetings

Meeting Date	BUP Workgroup Agenda Topics
TODAY: Week of September 1	**BUP 102 - Deeper Dive into HERC Roles and Responsibilities:** The Workgroup will dive deeper 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:** The Workgroup will review draft recommendations and address any outstanding questions.
Week of December 15	***Optional Meeting:*** Finalize recommendations, as needed.

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Appendix

Example: Changes to current 'Guideline Notes'

COVERAGE GUIDELINE 68, TREATMENT OF CHRONIC LOWER EXTREMITY VENOUS DISEASE

Code group CHRONIC LOWER EXTREMITY VENOUS DISEASE AND CHRONIC ULCER OF SKIN

Medical treatment of chronic lower extremity venous disease with major complications (skin ulceration, recurrent cellulitis or clinically significant bleeding) is medically necessary ~~included on Line 376~~, including medical compression garments.

Surgical treatment of chronic lower extremity venous disease is only medically necessary ~~included on Line 376~~ when

A) The patient has had an adequate 3-month trial of conservative therapy and ~~failed~~treatment did not benefit the patient or was contraindicated; AND

B) Ultrasound findings of severe axial venous reflux (>1 second in the greater or small saphenous vein or accessory saphenous vein; AND

C) The patient has one of the following:

1) Non-healing skin ulceration in the area of the varicose vein(s), OR
2) Recurrent episodes of cellulitis associated with chronic venous disease OR
3) Clinically significant bleeding from varicose vein(s).

~~Otherwise, these diagnoses are included on Lines 512 and 632.~~

Date of last review: January 2025

HERC Has Reviewed Several Coverage Areas To-Date

HERC has reviewed services in the following coverage areas so far to see if coverage should be added after 1/1/2027 – the Commission will continue reviewing services throughout 2025.

- Uncovered breast surgeries
- Preventive services not shown to benefit people
- Behavioral health conditions
- Fibromyalgia and chronic pain syndrome
- Conditions requiring only evaluation, medical management, equipment and supplies
- Diseases of the veins and arteries
- General surgery
- Gastrointestinal conditions
- General headaches
- Sports medicine and orthopedic surgeries (other than back or spine)
- Procedures ad surgeries of the back and spine
- Noninvasive back pain treatments
- Ophthalmology
- Allergies
- Podiatry
- Oral health conditions
- Urologic conditions
- Women’s health/gynecology
- Conditions of the rectum and colon
- Temporomandibular joint disorders (TMJ)
- Chiropractic and osteopathic manipulative treatment
- Dermatology
- Otorhinolaryngology

"Prioritized List" Will Likely 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

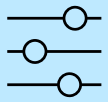
Current: The PL pairs treatments and conditions and then places them in **ranked lines** by importance to the population served.

Future: HERC Clinical Coverage Policies will largely mirror the content (e.g., pairings, 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.

Output 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 generally 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 – as shown by non-pairing or guideline criteria.

OHA Aims to Implement a New FFS Appeal Option

A member-driven appeals process in FFS would mirror the expedited process that is available for those covered under managed care, as a BUP-adjacent initiative.

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

Future: FFS members could have the option to pursue an appeal simultaneously with a hearing, if staffing for this initiative is funded. Hearings will also be modified to be based on medical necessity and not the PL funding line.

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

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 (and covered)

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 (not covered)

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.

HERC May Establish Subcommittees

These committees use peer-reviewed studies, consumer experiences, and evidence-based resources when making their coverage recommendations on key areas of expertise to the full HERC committee.

Committees today:

- Evidence-based Guidelines Committee
- Value-Based Benefits Subcommittee

The HERC and P&T Committee are Separate Entities that Interact to Finalize Certain Coverage Decisions

HERC

- HERC currently determines which health care services to put on the state's Prioritized List and where, including coverage guidance.
- Beginning 1/1/2027, HERC will develop "Clinical Coverage Policies" to help inform categorization and utilization management of mandatory and optional benefits under the State plan (as discussed in BUP 101).

P&T

- The P&T Committee is an 11-member advisory committee of physicians, pharmacists and consumer representatives.
- P&T conducts **drug use reviews** and advises the OHA on which prescription drugs should be included on any preferred drug list (PDL) established by OHA.
- P&T establishes clinical/PA criteria for FFS system; CCOs have their own P&T and formularies.
- All states have P&T Committees, but sometimes share roles with the state's Drug Utilization Review (DUR) or Medicaid agency.[1]

[1] For more on roles across states, see here: https://www.kff.org/other/state-indicator/medicaid-drug-review-responsibilities/