1115 MEDICAID WAIVER
IMPLEMENTATION PROJECT | OREGON

OREGON HEALTH AUTHORITY

October 28, 2025

Benefit Update Project (BUP) Workgroup: Appeals/Hearings and HERC's Role in Optional Benefits

BUP Workgroup Meeting Agenda & Goals

Agenda:

- Recap Previous Workgroup Meetings: Key Takeaways, Action Items, Draft Recommendations
- **Discuss Future State Coverage Decisions, Appeals and Hearings**
- **Discuss a Future Role for HERC in Prioritizing Optional Benefits**
- Additional Questions & Answers

Goals:

- Outline preliminary recommendations for Appeals and Hearings in the future state
- Align on preliminary approach for HERC's role in prioritizing optional benefits
- Vote on key legislative recommendations (e.g., HERC's future role and appeals/hearings)

Recap Previous Workgroup Meetings

Roadmap for Discussion in this Section

Goal: Gain a shared understanding of workgroup discussions to date, and areas of preliminary alignment for recommendations.

10/14 Meeting: Takeaways and Action Items

Key Takeaways	Corresponding Action Items
Workgroup supported direction of preliminary rough draft recommendations and the desire to preserve the spirit of the PL.	*More details on next slides*
Workgroup requested further discussion on: • Clarifying and communicating the differences between "medical necessity" at population and individual levels • Clarifying how Fair Hearings will work in the future state • Legislative recommendations to clarify and standardize the use of HERC Clinical Coverage Policies for coverage decisions, appeals, and hearings • Requirements for CCO and FFS to conduct a physician-level review of denials	**Today,** we will focus on: ❑ Clarifying the role of HERC Clinical Coverage Policies regarding medical necessity and medical appropriateness ❑ Discussing future state of appeals and hearings ❑ Voting on recommendations for: • Future state of appeals and hearings – *continued from 10/14 discussions* • Future role of HERC in prioritizing *optional benefits – spillover from 10/14 materials*
Workgroup also requested further discussion on: • Pharmacy-related impacts of BUP (e.g., costs and administrative burden), and HERC's potential role in "low-value" medications • Provider reconsiderations of appeals • Importance of advisory panels in the transition to the future state	**At future meetings**, we will discuss: ❑ Pharmacy-related impacts and costs (11/5) ❑ Provider reconsideration and implications of BUP efforts ❑ Communications plan and leveraging advisory panels ❑ Other OHA-led recommendations that do not require legislation

Summary of Recommendations from Workgroup Meetings

Topic	#	Recommendation	Action	Status
Role of HERC	1	The Legislature and OHA should **revise statute and OARs to maintain key HERC roles and the spirit of the Prioritized List**. The Clinical Coverage Policies should replace the Prioritized List and, to the extent possible, maintain HERC's current: • Evidence-based, transparent, population health approach • Independence from agency and Legislature • Membership • Role in specifying which services (code pairings, coverage guidelines, statements of intent) that should and should not be covered as a general rule	Statutory	• Preliminary alignment. • **Vote on 10/28.**
	2	HERC should have a role in making evidence-based decisions regarding **prioritizing optional services** for the purposes of resource allocation decisions.	Statutory	• On today's agenda. • **Vote on 10/28.**
Clarity on Coverage	3	HERC **should develop a "not medically necessary or appropriate" code groups** within the HERC Clinical Coverage Policies, like the existing "unfunded region," with key differences (e.g., different denial reasons, no comorbidity rule)	Statutory	• Preliminary alignment. • **Vote on 10/28.**
	4	OHA should conduct rulemaking to **define the intended hierarchy by which CCOs and FFS make coverage decisions** (e.g., review HERC policy first, specific OARs second, clinical judgement/third party evidence last).	Statutory	• Preliminary alignment. • **Vote on 10/28.**
	5	HERC should ensure all HERC-related outputs (including code groups, ancillary files, etc.) continue to be easily and **readily accessible on the HERC website** and on the same page.	Sub-regulatory	• Preliminary alignment. • **Vote on 10/28.**
	6	OHA should develop **communications and technical assistance** materials for members and community partners to ensure streamlined transition and understanding.	Sub-regulatory	• Preliminary alignment. • **Vote on 10/28.**
Clarity on Appeals, Hearings	7	OHA should conduct rulemaking to **clarify the role of HERC Clinical Coverage Policies in OAR**, to ensure they are relied upon in a similar fashion to how its policies (e.g., PL) are applied today for appeals and hearings.	Statutory	• On today's agenda. • **Vote on 10/28.**

Roadmap for Future Workgroup Discussions

Sessions in November and December will wrap up topic-specific discussions to build towards legislative recommendations.

Nov 5: Appeals and Hearings (follow-up), Rates	**Nov 18:** Focus on Additional OHA Recommendations	**December:** Focus on Additional OHA Recommendations
• Finalize (as needed) recommendations from 10/28 meeting • Deeper dive on pharmacy-related impacts of BUP and recommendations • Draft capitation rate impact presentation	• Spillover topics from Nov 5 • Revisit OHA-led activities to support changes without legislative action	• Revisit OHA-led activities to support changes without legislative action

Update: Clarifying FFS and CCO Obligations on Medical Review

OHA is working with internal and external experts to clarify comments regarding FFS and CCO requirements related to individual medical review of authorization requests and claims.

The team plans to include a clarification vetted by internal/external experts in the future.

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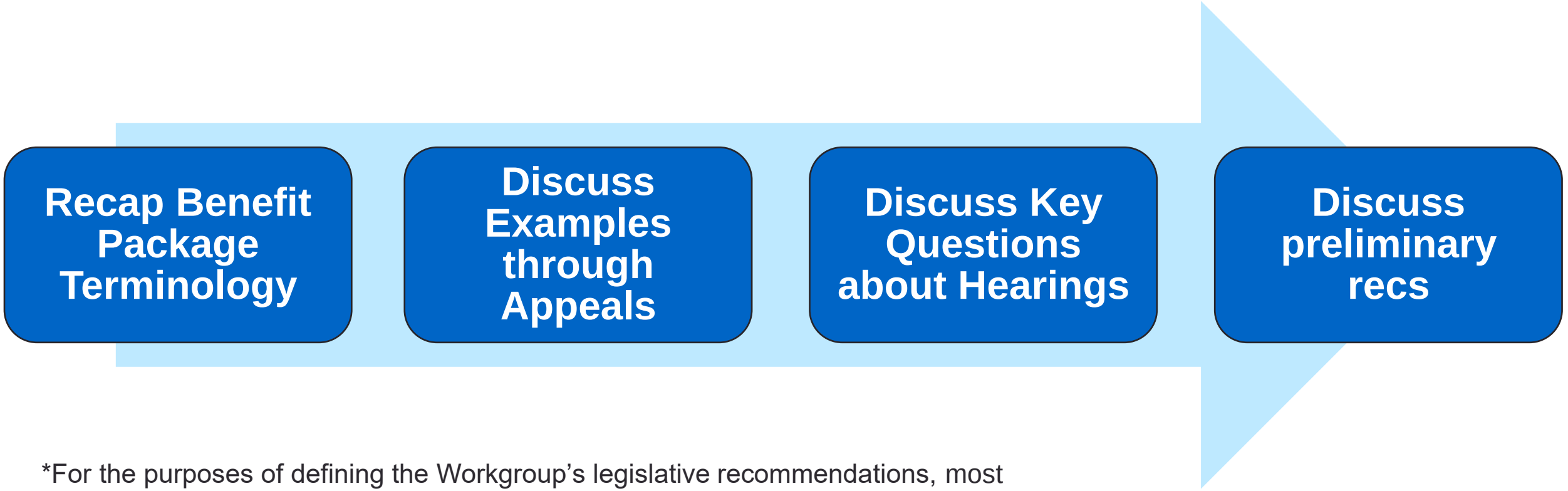
Discuss Future State Coverage Decisions, Appeals and Hearings

Discussion Roadmap for this Section

Goal: Explore how HERC Clinical Coverage Policies apply at the population and individual levels for adults, and how these work at appeal and hearings.*



*For the purposes of defining the Workgroup's legislative recommendations, most discussions will focus on the CCO process.

High Level Overview of Coverage for Adults

HERC Clinical Coverage Policies (CCPs) will specify what is "presumptively" medically necessary and appropriate (i.e., covered) within the OHP benefit package.

Benefit Package

- The benefit package is the universe of potentially covered services.
- OHA has the authority to define **what is in and what is out**, to place limits on the benefit package.*
- **Services not in the benefit package are <u>never</u> covered for adult OHP member (e.g., infertility).**

Covered Services

- Within benefit package, OAR says "covered services" for adult OHP members must be **both** medically appropriate and necessary. (*OAR 410-120-0000 (78)*)
- **HERC CCPs will define the circumstances in which a service would be "presumptively covered", for most situations and people.**

Individual Circumstances

- CCOs can use HERC CCPs to make coverage decisions (like the PL today)
- But when provided additional information, CCOs must account for individual circumstances before denial.
- Members and providers can appeal denials.

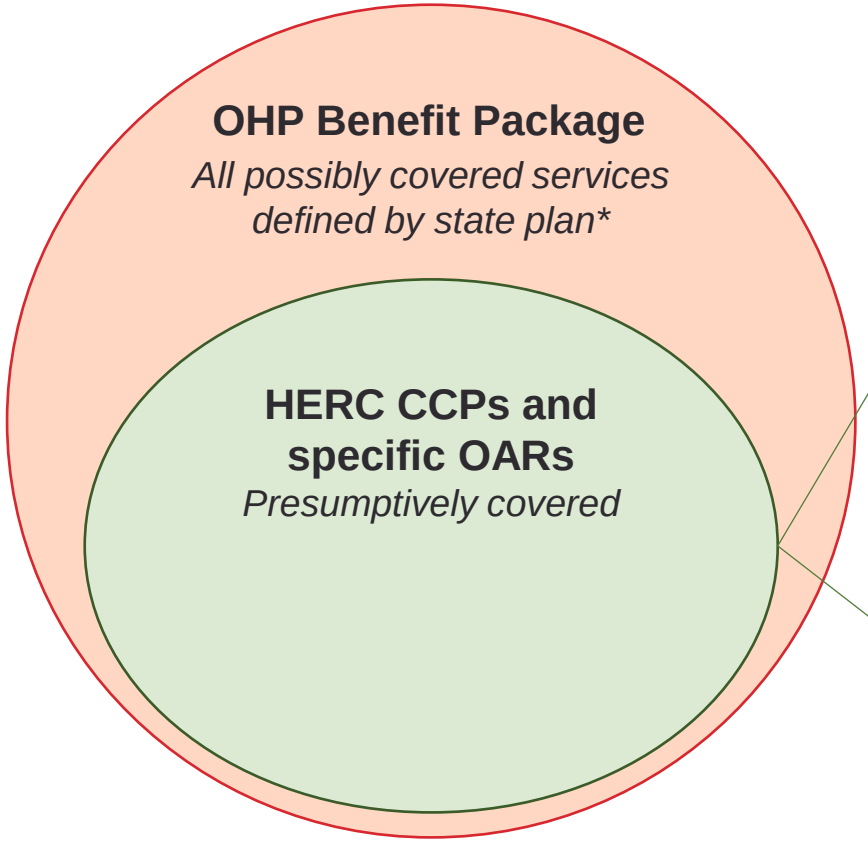
* CMS requires mandatory categories (and optional services, if included at all) to be meaningfully covered, not include *all possible services* under that category.

Overview of Future State Coverage for Adults

HERC CCPs will specify what is "presumptively" medically necessary and appropriate (i.e., covered) within the OHP benefit package.

Services outside the benefit package
Never covered

Examples:
eyeglasses or infertility treatment.
OAR 410-120-0000 (206)
OAR 410-141-3825



- "Covered services" within package must be both medically necessary and appropriate
- HERC CCPs will define the circumstances in which a service would be "presumptively covered", for *most situations and people*.

OAR 410-120-0000 (78), (193), (194)
OAR 410-141-3820

- HERC and OAR may not address all possible treatments within benefit package.
- If not, CCOs and FFS can use other sources to guide their coverage decisions (e.g., InterQual or Milliman).

* CMS requires mandatory categories (and optional categories, if included at all in SPA) to be *meaningfully* covered, not include *all possible services* under that category.

Overview of Future State Coverage for Adults*

HERC CCPs would define what is "presumptively" medically necessary and appropriate *for most people and circumstances* – but individual circumstances may need consideration.

- CCO and OHA coverage decisions must also be informed by members' circumstances, if requested.
- If a CCO denies a service within the OHP Benefit Package, members and providers can appeal the decision based on individual circumstances.

FFS "appeals" go straight to Fair Hearings – *future options to be discussed at the end of this section.*

*Note: The following slides are for adults. For people under age 21 and eligible for YSHCN, there are some differences.

Future State Scenario (Not in Benefit Package)

Jane has been dealing with infertility. Jane's provider submits a prior authorization request for IVF treatment, which is not a service in the OHP Benefits Package.

CCO Coverage Authorization Decision-Making Process

Is the service in the benefit package? → No → **Deny**

Member Appeal Options

Member (or provider on their behalf) **may** appeal decision

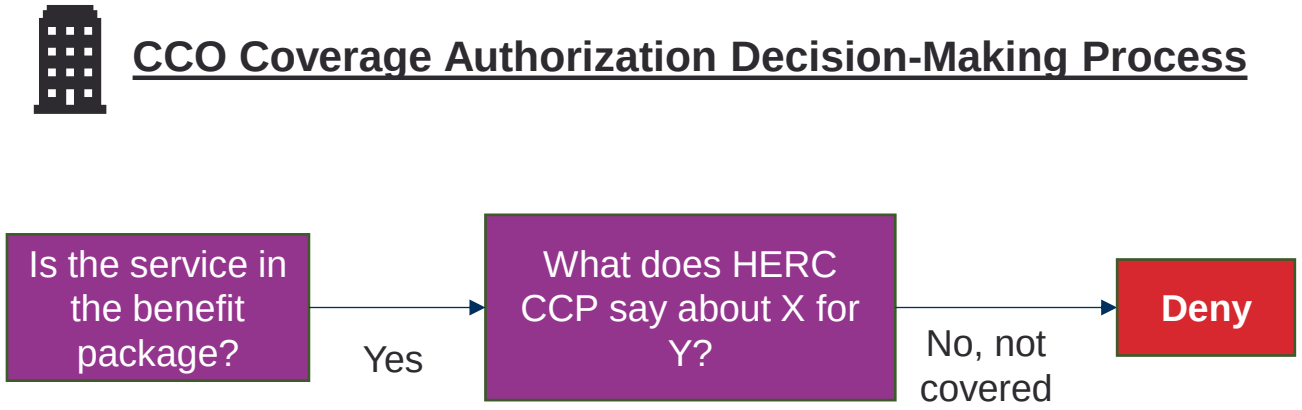
An adult appeal is unlikely to be successful. EPSDT exists to allow children access to services outside benefit package – this does not apply to adults.

Note: these scenarios assume a PA request is required

Future State Adult Scenario (HERC Says Not Covered)

Jake has had back pain for several years. His provider submits a prior authorization request for an epidural steroid injection. Per the HERC CCPs, this treatment is not a covered service.

CCO Coverage Authorization Decision-Making Process



Member Appeal Options

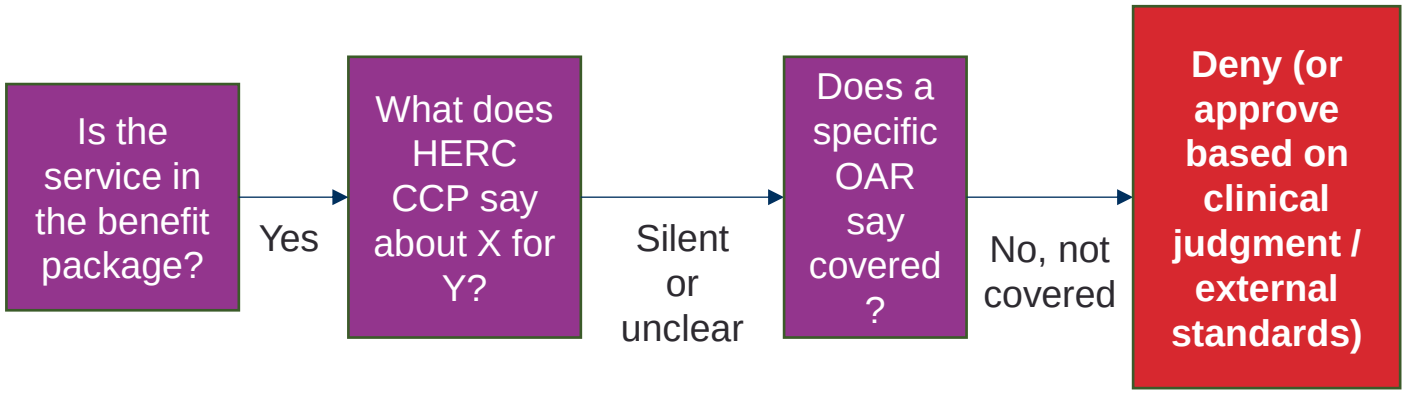
Member (or provider on their behalf) **MAY** appeal decision

Note: these scenarios assume a PA request is required

Future State Adult Scenario (HERC is Silent)

Jo has diabetes. Their provider submits a prior authorization for a quantity of diabetes test strips that exceeds the limits established in the OAR.

CCO Coverage Authorization Decision-Making Process



Member Appeal Options

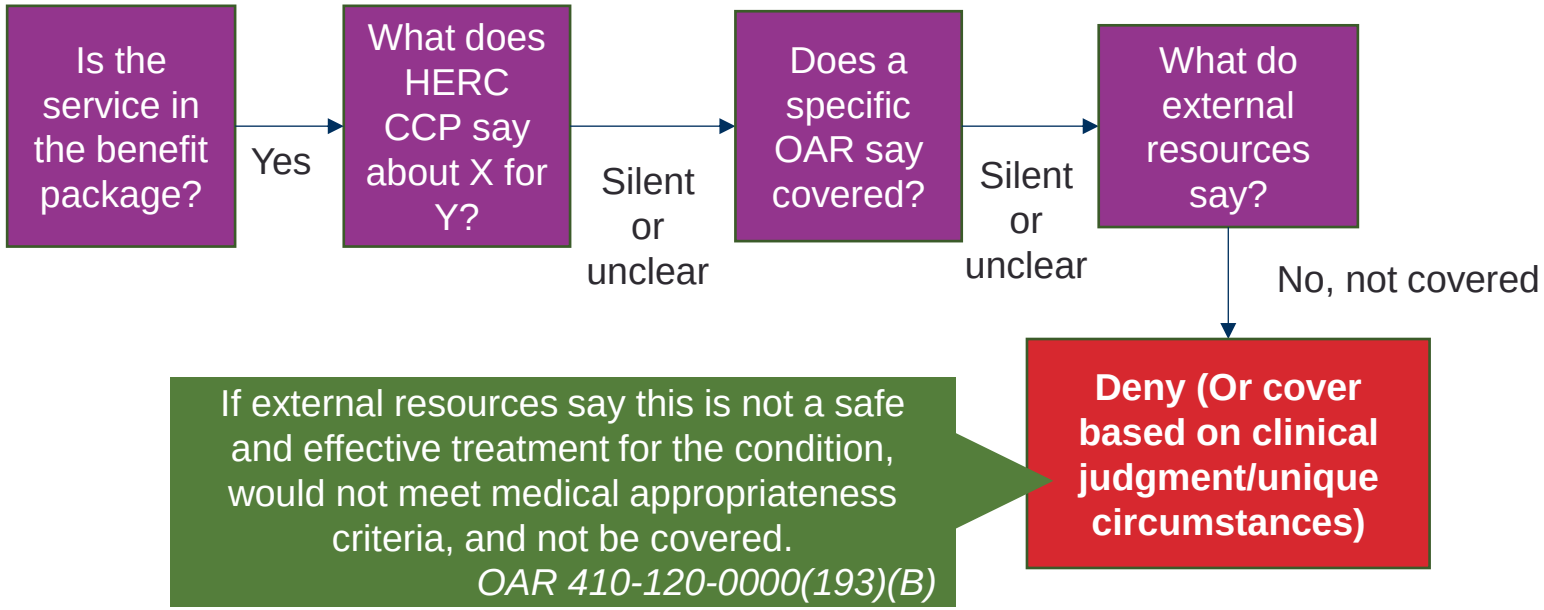
Member (or provider on their behalf) may appeal decision

Note: these scenarios assume a PA request is required

Future State Adult Scenario (HERC and OARs Silent)

Kim has sleep apnea. Their provider submits a prior authorization for TMJ surgery. There is no HERC or OAR guidance on coverage of TMJ surgery for sleep apnea.

CCO Coverage Authorization Decision-Making Process



Member Appeal Options

Member (or provider on their behalf) may appeal decision

Note: these scenarios assume a PA request is required

Key Takeaways for Future State Adult Coverage Decisions Through Appeal

FUTURE STATE

- Adult OHP members are only covered for services in the OHP benefit package.
- CCOs will continue to use “population-level” policy to make coverage decisions for services within the OHP benefit package (e.g., Prioritized List -> HERC Clinical Coverage Policies).
- CCOs will continue to consider individual circumstances (e.g., medical information provided with PA request), *if requested.*
- Adult members can continue to appeal coverage decisions based on their individual circumstances, *but only for services within the OHP benefit package.*

Future Scenario Through Hearing

Jake is a 30-year old Member with a 34 BMI and no known comorbidities. Jake's providers believe that his weight is negatively impacting his health and severely limiting his mobility.

1. PA Request

Jake's medical provider places a PA request for bariatric surgery.

2. CCO Decision

Jake's CCO denies the PA request.

Medical documents show his BMI is <35 and he does not have diabetes.

See HERC Guideline Note 8, page 33.

3. Appeal

Jake's provider appeals his CCO's denial on his behalf.

Jake's CCO upholds the appeal, indicating that the clinician did not document that the patient met the HERC's criteria of BMI >35

4. Fair Hearing

Jake requests a medical hearing.

Future Scenario Through Hearing

The Hearings process, including roles and responsibilities, will not change under BUP.

Hearings Coordinator

Gathers casefile (e.g., Jake's denial notice and PA request documentation)

Hearings Representative

Reviews the casefile and requests additional information

- May request ad hoc determination (OAR 410-141-3820(15)), as needed.
- May work with partners to understand OAR and HERC intent (e.g., is there a statement of intent with the bariatric surgery guideline note?)
- Represents the state in a contested case hearing – identifying CCO reason(s) for denial and what rules were used to make the denial (e.g., HERC guidance under OAR 410-141-3830).

Administrative Law Judge (ALJ)

Reviews materials brought by the Hearings Representative and makes decision that upholds the Jake's CCO's decision.

- ALJ bases decision on proper use of OAR (e.g., HERC guidance at 3830, guidelines say bariatric surgery only for >35 BMI; provider did not indicate otherwise).
- Treating provider can testify to describe how different circumstances apply.

Key Takeaways for Hearings

Questions and Concerns from Workgroup	Responses
What are key OARs?	• OARs 410-141-3820 ("Covered Services") and 410-141-3830 ("Prioritized List of Health Services"), • OARs 410-10-1860 (“Contested Case Hearing Procedures”)
How does the Oregon Administrative Law Judge (ALJ) make decisions?	ALJs at Fair Hearing are not medical experts and will deliberate based on the **proper application of OARs including** Prioritized List (today) or CCPs (in future) and written FFS/CCO policies.
What happens when there are differing interpretations of “medical necessity”?	CCOs and/or the Authority are responsible for providing documentation and testimony to prove that the OARs defining medical necessity and appropriateness criteria have been followed appropriately.

Rules need to be modified for the future state (more on this in recommendations)

Summary of New Recommendations to Improve Clarity at Hearings and Appeals

Topic	#	Recommendation	Action	Status
Clarity on Appeals, Hearings	7	OHA should conduct rulemaking to **clarify the role of HERC Clinical Coverage Policies in OAR**, to ensure they are relied upon in a similar fashion to how its policies (e.g., PL) are applied today for appeals and hearings	Statutory	• On today's agenda. • **Vote on 10/28.**

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Voting on Recommendations

Summary of Recommendations from Workgroup Meetings

Topic	#	Recommendation	Action	Status
Role of HERC	1	The Legislature and OHA should **revise statute and OARs to maintain key HERC roles and the spirit of the Prioritized List**. The Clinical Coverage Policies should replace the Prioritized List, and, to the extent possible, maintain HERC's current: • Evidence-based, transparent, population health approach • Independence from agency and Legislature • Membership • Role in specifying which services (code pairings, coverage guidelines, statements of intent) that should and should not be covered as a general rule	Statutory	• Preliminary alignment. • **Vote on 10/28.**
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Voting on Recommendations from Workgroup Meetings

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Voting on Recommendations from Workgroup Meetings

Topic	#	Recommendation	Action	Status
Clarity on Coverage	3	HERC **should develop a "not medically necessary or appropriate" code groups** within the HERC Clinical Coverage Policies, like the existing "unfunded region," with key differences (different denial reasons, no comorbidity rule)	Statutory	• Preliminary alignment. • **Vote on 10/28.**

Voting on Recommendations from Workgroup Meetings

Topic	#	Recommendation	Action	Status
Clarity on Coverage	4	OHA should conduct rulemaking to **define the intended hierarchy by which CCOs and FFS make coverage decisions** (e.g., review HERC policy first, specific OARs second, clinical judgement/third party evidence last).	Statutory	• Preliminary alignment. • **Vote on 10/28.**

Voting on Recommendations from Workgroup Meetings

Topic	#	Recommendation	Action	Status
Clarity on Coverage	5	HERC should ensure all HERC-related outputs (including code groups, ancillary files, etc.) continue to be easily and **readily accessible on the HERC website** and on the same page.	Sub-regulatory	• Preliminary alignment. • **Vote on 10/28.**

Voting on Recommendations from Workgroup Meetings

Topic	#	Recommendation	Action	Status
Clarity on Coverage	6	OHA should develop **communications and technical assistance** materials for members, providers, CCOs, and community partners to ensure streamlined transition and understanding.	Sub-regulatory	• Preliminary alignment. • **Vote on 10/28.**

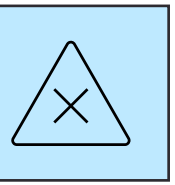
Voting on Recommendations from Workgroup Meetings

Topic	#	Recommendation	Action	Status
Clarity on Appeals, Hearings	7	OHA should conduct rulemaking to **clarify the role of HERC Clinical Coverage Policies in OAR**, to ensure they are relied upon in a similar fashion to how its policies (e.g., PL) are applied today for appeals and hearings	Statutory	• On today's agenda. • **Vote on 10/28.**

OHA Aims to Implement a New FFS Appeal Option

A member-driven appeals process in FFS similar to the 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.

Preliminary recommendation <u>for future vote</u>: Legislature should fund OHA for 2 State FTEs to implement a new FFS appeals option.

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

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Discuss Future Role for HERC in Prioritizing Optional Benefits

Discussion Roadmap for this Section

Goal: explore whether the HERC should play a role in defining the package or clinical policy restrictions on optional services with future budget constraints.

Align on the scope of optional benefits

Discuss federal rules and considerations for HERC's role

Review rough draft recommendation for the workgroup's consideration

Reminder: How Do We Define Optional Services?

In Scope

Optional medical services already in HERC purview, including:

- Dental (subject to budget limitations)
- PT/OT
- Speech therapy
- Prosthetics
- Eyeglasses (not implemented due to budget cuts)
- “Other licensed providers” other than those listed as mandatory

Not Currently in Scope

- Most mental health modalities and practitioners (to avoid mental health parity issues)
- Pharmacy (Pharmacy & Therapeutics Committees)
- Health-related social needs (separate conversation, would expand HERC's current role)
- Waiver services like HCBS

Federal Rules Do Not Allow a Funding Line Without a Waiver

42 CFR 440.230, which applies to both mandatory and optional benefits defined in the state plan, prohibits the use of a funding line. Currently, the 1115 Waiver waives 42 CFR 440.230.

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.**"*

- **42 CFR 440.230 (including (c)) applies to all benefits the state includes in the benefit package** subject to amount, duration, scope.
- **Absent a waiver, the State's interpretation is that "arbitrarily deny or reduce the amount" prohibits the function of a "funding line,"** whereby certain conditions are in the "unfunded region."

Looking Deeper – Ranking Relative Value of Optional Benefit Modalities

Scenario: OHA would decide to modify benefit limits (with federal approval) based on available funds, **leveraging pre-defined benefit changes** established by HERC per medical evidence of population health benefit.

For example, HERC ***could*** consider the following "ranking" (*these bullets have not been reviewed at HERC*):

- 15 visits per year of PT/OT (30 covered today after evaluation)
- Additional 15 visits per year of PT/OT
- Eyeglasses for adults (not covered today)
- Crowns and root canals for adults (largely not covered today)
- TMJ (not covered today except comorbidities)
- Podiatry (including foot care for patients with high-risk conditions)
- Infertility services (not covered today)

Pros	Cons
• Proactive approach, rather than after facing budget issues	• Difficulty of establishing relative value • Politically sensitive decisions

Process:

- If funds are restricted, OHA would use the relative rankings as input to reduce benefit limits (e.g., 30 visits of PT/OT to 15)
- Likewise, if funding becomes available, a higher value benefit might be added.

To discuss: How should HERC do the ranking if they pursued this approach?

What We're Hearing from Workgroup Discussions: What Legislative Recommendations Could Look Like

What Could Legislative Recommendations Look Like?

Brainstorming: Preliminary Recommendation for Consideration

Define the role of HERC to **additionally and specifically** evaluate optional services based on medical evidence, for the purposes of resource allocation decisions.

Ideas on how this could be implemented:

- When feasible, OHA will present planned reductions to HERC along with estimated cost savings before OHA acts to reduce or expand an optional benefit
- When feasible, OHA, OHPB, and Legislature would seek input from HERC on other benefits changes that might achieve the same savings with less impact to member health
- HERC to include recommended benefit changes in its biennial report

Recommendations from Workgroup Meetings

Topic	#	Recommendation	Action	Status
Role of HERC	2	HERC should have a role in making evidence-based decisions regarding **prioritizing optional services** for the purposes of resource allocation decisions.	Statutory	• On today's agenda. • **Vote on 10/28.**

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Appendix

Purpose of "Medical Necessity"

Federal regulations allow states to "place appropriate limits on a service on the basis of criteria applied under the State plan, such as Medical Necessity" (42 CFR 438.210). **Oregon defines OHP covered services based on both medical necessity and medical appropriateness.**

Oregon Coverage Criteria

"Covered Services" means medically necessary and appropriate health services and items described in ORS chapter 414 and applicable administrative rules. Covered services include:

(a) Services described in the Prioritized List of Health Services above the funding line set by the legislature;

(b) Ancillary Services OAR 410-120-0000 (22);

(c) Diagnostic Services OAR 410-120-0000 (82);

(d) Services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in Code of Federal Regulations (CFR) 42 CFR part 438, subpart k; and

(e) Services necessary for compliance with the requirements for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) as described in chapter 410 division 151.

OAR 410-120-0000(78)

OHA does not intend to change the definition of "covered services" as both medically appropriate and necessary, but will remove references to the Prioritized List.

Definition of "Medical Necessity"

Absent a federal definition, Oregon defines both "Medically Necessary" and "Medically Appropriate" in State rules.

"Medically Appropriate" (for Adults)

a) Means health services, items, or medical supplies that are:
   - **A. Recommended by a licensed health provider practicing within the scope of their license;** and
   - B. Safe, effective, and appropriate for the patient based on standards of good health practice and generally recognized by the relevant scientific or professional community based on the best available evidence; and
   - C. Not solely for the convenience or preference of an OHP client, member, or a provider of the service item or medical supply; and
   - D. The most cost effective of the alternative levels or types of health services, items, or medical supplies that are covered services that can be safely and effectively provided to a Division client or member in the Division or MCE's judgment.

b) All covered services must be medically appropriate for the member or client, but not all medically appropriate services are covered services.

"Medically Necessary" (for Adults)

a) Health services and items that are required to address one or more of the following:
   - A. The prevention, diagnosis, or treatment of a client or member's disease, condition, or disorder that could result in health impairments or a disability; or
   - B. The client's or member's ability to achieve age-appropriate growth and development; or
   - C. The client's or member's ability to attain, maintain, or regain independence in self-care, ability to perform activities of daily living or improve health status; or
   - D. The client's or member's ability to have 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 they are receiving Long Term Services or Supports (as defined in these rules);

b) A medically necessary service must also be medically appropriate. All covered services must be medically necessary, but not all medically necessary services are covered services.

We recognize the Workgroup has previously noted that "Medical Necessity" is ambiguous and may have different meanings in different settings, and its application without the Prioritized List may be more challenging – Workgroup recommendations can support clarification.

Sources: *OAR 410-120-0000 (193) and (194)*

Overview of OHP Hearings/Appeals Options for CCO Members

Members have two pathways to challenge CCOs' denial of services.

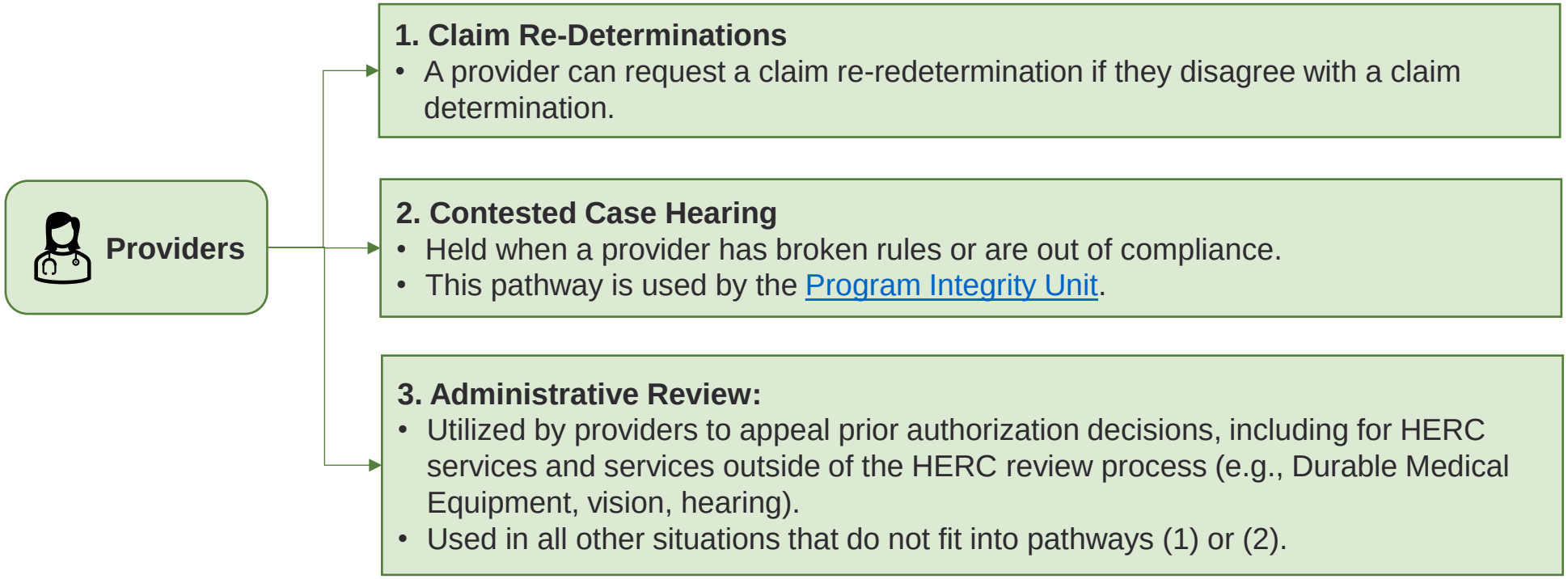
Members

1. Appeals:
- OHP Members, or a provider on their behalf, can request an appeal.
- The first step when asking for a re-consideration of a prior authorization or claim denial.
- An appeal must be made before a hearing.

2. Medical hearing process:
- OHP Members, or a provider on their behalf, can request a medical hearing, if an appeal is denied.
- During a Hearing, the OHA Hearing representatives review the denial to ensure legal sufficiency, including:
  - Working with Hearing partners to understand Agency rule intent, HERC intent, etc.
  - Presenting testimony laying out the case, identifying the CCOs' reason for the denial and what rules were used to make the denial.

Overview of OHP Hearings/Appeals Options for CCO Providers

CCO providers have three pathways to challenge CCOs' denial of services.



Overview of the Future Scenario Logic