1115 MEDICAID WAIVER
IMPLEMENTATION PROJECT | OREGON

OREGON HEALTH AUTHORITY

November 5, 2025

Benefit Update Project (BUP) Workgroup: Appeals and Hearings & Rates

BUP Workgroup Meeting Agenda & Goals

Agenda:

- **Recap Previous Workgroup Meetings**
  - Key Takeaways and Action Items
  - Voting on revised recommendations
- **Future Role for HERC in Prioritizing Optional Benefits**
- **Discuss FFS appeals option**
- **Deeper-dive into pharmacy impacts**
- **Draft capitation rate impact presentation**

Goals:

- Finalize votes on recommendations from 10/28 meeting
- Vote on preliminary recommendations for HERC's role in prioritizing optional benefits
- Align on potential direction for future FFS appeals work
- Define potential pharmacy-related recommendations
- Outline BUP-related rate impacts

Preview: 11/18 Workgroup Meeting Agenda

Discuss OHA-led activities to support changes without legislative action, including details on communications and technical assistance

Recap Previous Workgroup Meeting

Roadmap for Discussion in this Section

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

Review key takeaways and action items from prior meetings

Review roadmap for future workgroup discussions

Vote on revised recommendations from prior meeting

10/28 Meeting: Takeaways and Action Items (1/2)

Key Takeaways	Corresponding Action Items
• FFS and CCOs differ in their appeal processes and confirmed that CCO members may appeal an initial coverage determination (NOABD) even for services outside the benefit package. ○ **High importance:** Maintaining appeal rights for services not covered in the benefit package and ensuring clarity in the rules.	• ***Action item:*** OHA to revise slide 15 to clarify that members will maintain their right to appeal. • ***Action item:*** OHA to bring back the FFS appeals concept to 11/5 workgroup meeting.
• Concerns about maintaining consistency in coverage decisions across CCOs and FFS, particularly due to the differences in review processes and interpretations of existing clinical criteria (especially third-party sources). ○ **High importance:** Robust rulemaking that includes relevant experts and community partners, and for rules to explicitly address exceptions based on comorbidities and individual circumstances.	• ***Action item:*** OHA to develop recommendation regarding the use of HERC Clinical Coverage Policies that includes specific partners and considerations for individual circumstances.

10/28 Meeting: Takeaways and Action Items (2/2)

Key Takeaways	Corresponding Action Items
• When recommendations are sent to legislative colleagues, there should be adequate context regarding the scope of the workgroup to accompany the recommendations. ○ **High importance:** Ensuring context and assumptions are clear, especially regarding the decision not to pursue putting the Prioritized List directly into the state plan amendment.	• ***Action item:*** OHA to develop executive summary or preamble for the workgroup recommendations and share with workgroup members for feedback and review.
• There could be more done to connect already-reported CCO data on denials and appeals (e.g., Exhibit I data) to HERC's role in creating standardized policy (i.e., a feedback system so that HERC may review treatment condition pairs that have a lot of appeals, for example).	• ***Action item:*** OHA and HERC staff will take this back to consider options for future action outside the Workgroup.

Roadmap for Future Workgroup Discussions

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

Nov 18: Focus on Additional OHA Recommendations	**Dec 2:** Focus on Additional OHA Recommendations
• Discuss spillover topics from 11/5, as needed • Discuss OHA-led activities to support changes without legislative action, including details on communications and technical assistance	• Revisit OHA-led activities to support changes without legislative action • Finalize recommendations that do not require legislative action

Summary of Approved Recommendations

Topic	#	Recommendation	Action	Workgroup Vote
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	• **Yes:** Heather, Bridget, Cat, Gary, Adriane, Ben, Mike, Jeanne • **No:** Amy • **Abstain:** Erin • **Not Present:** Briana, Art, Mary
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	• **Yes:** Heather, Bridget, Gary, Adriane, Amy, Cat, Mike, Erin, Jeanne, Ben • **No:** None • **Abstain:** None • **Not Present:** Briana, Art, Mary
	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	• **Yes:** Mike, Erin, Gary, Bridget, Cat, Adriane, Amy, Ben, Heather • **No:** None • **Abstain:** None • **Not Present:** Briana, Art, Mary
	6	OHA should **develop communications and technical assistance** materials for members, providers, and community partners to ensure streamlined transition and understanding.	Sub-regulatory	• **Yes:** Erin, Ben, Bridget, Mike, Cat, Adriane, Heather, Amy, Gary • **No:** None • **Abstain:** None • **Not Present:** Briana, Art, Mary

Summary of Revised Workgroup Recommendations for Voting *(reflects feedback provided at 10/28 meeting and offline)*

Topic	#	Recommendation	Action	Workgroup Vote
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) ***Note: We propose to keep this specific recommendation the same and implement the feedback in revisions to #7 – see below. This recommendation is intended to reflect "option B" which received broad support from workgroup members at 10/14 meeting.***	Statutory	• NO as previously written - More specific recommendation regarding comorbidity rule requested.
Clarity on Appeals, Hearings	7	OHA shall conduct rulemaking to further define the role of HERC Clinical Coverage Policies in OAR, to ensure they: • are relied upon in a similar fashion to how its policies are applied today (e.g., the Prioritized List) for appeals and hearings, • Allow for individual medical review, where appropriate, including but not limited to considerations of comorbidities Prior to giving notice of intent to amend an administrative rule regarding the role of HERC Clinical Coverage Policies, OHA shall seek interested persons' (e.g., CCOs, providers, members and member advocates) input. ***Note: Proposed revisions in red.***	Statutory	• NO as previously written (split vote) - More specific recommendation on "affected parties" requested for discussion on 11/5.

Note: WG was asked to provide offline feedback on these revised recommendations last week.

Draft Preamble to Provide Context to Workgroup Recommendations

- The Oregon Health Authority (OHA) Benefit Update Project (BUP) Workgroup was chartered to provide recommendations on the phase-out of the Oregon Health Plan's (OHP's) Prioritized List of Health Services, which is currently authorized through the State's 1115 Medicaid waiver authority, which will expire at the end of 2026. The BUP Workgroup set out to develop recommendations that consider policy, operational and clinical impacts to help ensure a successful transition for members, Coordinated Care Organizations (CCOs), health care providers, and other partners. This document contains the Workgroup's recommendations to inform legislative language in the 2026 short session.
- **Membership:** The BUP Workgroup is a 13-member workgroup with representation from the following sectors:
  - Disability rights community
  - Tribal representative
  - Dental care organization
  - Statewide behavioral health association
  - Federally Qualified Health Center (FQHC) or other community-based clinical provider
  - Hospital or health system
  - Legal aid organization
  - Health Evidence Review Commission (HERC)
  - Coordinated Care Organizations
- **Recommendations:** The Workgroup operated under the assumption that the Prioritized List in its current form requires a federal waiver. The Workgroup did not make recommendations related to engagement with CMS regarding continuation of the waiver. Therefore, the Workgroup proposes the following recommendations to minimize disruptions to care, advance health equity, and support the delivery of appropriate, high-value health services under OHP after the transition from the use of the Prioritized List by 1/1/27.

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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 Legislative Recommendations Could Look Like

Brainstorming: Preliminary Recommendation for Consideration

Legislature should define the role of HERC to include evaluation of 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

FFS “Appeals” Option

OHA Aims to Implement a New FFS Appeal Option

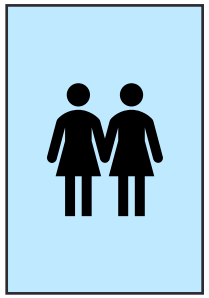
A member-driven appeals process in FFS similar to the process available for those covered under managed care, as a BUP-adjacent initiative.

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

Future: For FFS members, create a process for individuals to appeal coverage decisions with OHA in addition to fair hearing process

Note: the option to seek an appeal would not preclude any member from their right to a state fair hearing, as required by federal law.

OHA Aims to Implement a New FFS Appeal Option



Preliminary Workgroup recommendation:
OHA should continue to explore a FFS appeals option.

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Discuss Potential Changes to the Pharmacy Benefit

Discussion Roadmap for this Section

Goal: develop preliminary recommendations to update the pharmacy benefit to align with the transition from the Prioritized List to the Clinical Coverage Policies.

Align on the scope of pharmacy benefits & applicable rules and regulations

Identify opportunities to address challenges in the future state

Develop preliminary recommendations for future state

Brief Overview of Federal Rebate Law and Implications for OHP

- **The federal Medicaid Drug Rebate Program (MDRP) requires drug manufacturers to pay rebates to states in exchange for coverage of their products**, once they enter into a national drug rebate agreement (NDRA).
- **States must provide a pathway to coverage for all FDA-approved drugs from manufacturers participating in the MDRP**, with limited exceptions (e.g., over-the-counter medications).
- However, states may use formularies, supplemental rebates, other utilization management mechanisms **to manage utilization**.

Overview of Current Versus Future State

The future state will require additional coverage pathways for drugs that may currently be in the unfunded region, but OHA/FFS and CCOs can still leverage existing utilization management tools.

Current State

- Drugs in the unfunded region can be denied for being below the line.

Future State

- All drugs must have a pathway to coverage.
- Existing utilization management tools are still allowed.
- Oregon will continue to not have a Preferred Drug List

Existing tools include:

- Formularies
- Step therapy
- Prior authorization
- Generics substitution

CCOs may use P&T committee work as a guide for their own work, more on next slides

Future State Impact on Pharmacy

Per the Workgroup, the transition away from the PL will have a significant impact on the pharmacy benefit.

- OHA anticipates that more drugs will be covered under the future state than today

- P&T has been working to establish FFS criteria to mitigate the use of low-value drugs (https://pharmacy.oregonstate.edu/research/pharmacy-practice/drug-use-research-management/benefit-update-project) – *see next slide*

Recap: Pharmacy Examples

Context: Per federal rebate law, the State is required to allow *a pathway* for all drugs with a rebate agreement to be covered. However, managed care plans and states are still allowed to establish utilization management controls (e.g., PDL, step therapy, prior authorization).

Pharmacy Examples			
	Medications for constipation	**Topical medication for warts (e.g. Compound W)**	**Medications for dry eye disease**
Today	FFS covers prescription and non-prescription (OTC) agents. More costly agents have step therapy. CCOs could deny for below the line unless comorbidity rule applies. CCOs can require documentation of medical necessity and use step therapy where comorbidity rule applies.	OHA P&T has not reviewed OTC medications for warts, not covered today. Legend drugs are denied for rebate status or below the line unless comorbidity rule applies. CCOs are not obligated to cover non-rebatable drugs, and can deny all products for below the line unless the comorbidity rule applies.	FFS covers OTC agents (e.g., artificial tears). Legend products are denied for below the line unless the comorbidity rule applies. More costly agents have step therapy. CCOs could deny for below the line unless comorbidity rule applies. CCOs can require documentation of medical necessity and step therapy where comorbidity rule applies.
Future	There must be a pathway to coverage for FDA-indicated agents or those supported by compendia; step therapy and documentation of medical necessity would be allowed to encourage use of least costly option. Least costly option could be nonpharmacologic or OTC treatment.	No obligation to cover non-rebatable drugs. CCOs could develop PA criteria for medical necessity and/or evidence-based step therapy including low-cost generics, OTCs, or non-pharmacologic treatments.	Same as constipation. Cannot deny for below the line but can require documentation of medical necessity, step therapy, using lifestyle changes and low-cost agents before expensive agents can be covered.

For Discussion: Preliminary Recommendation

OHA should ensure guidance is clear that CCOs will continue to have in the future state the same utilization management tools available to them today.

Benefit Update Project
OAFA Cost Estimates

BUP Cost Estimates

The OAFA team is sharing draft BUP capitation rate impacts at the following forums:

Complete:

- 10/23 CCO Rates Workgroup – Financial Focus
  - No widespread concerns expressed during meeting
  - General CCO feedback requested by 10/31
  - Additional time offered for further CCO modeling

Upcoming:

- 11/5 BUP Workgroup – High-level summary of OAFA work, context for workgroup recommendations
- 11/10 QHOC – High-level summary of OAFA work

BUP Cost Estimates (2/6)

Budget considerations:

- OHA plans to request additional budget beyond Current Service Level
  - OAFA estimates expected to be the basis of additional budget request
- Following slide shows updated budgetary estimate with a Medicaid focus
  - Expressed as a percentage of CCO-A/B Medicaid CY24 medical spend ($6.2b)
- Primary changes from last year's estimates
  - Reduction in scope of new benefits approved during HERC / P&T review
  - Updated CY24 MMIS and CY23 APAC data
  - ~20-30 additional topics evaluated by OAFA; non-evaluated topics loading reduced
- HERC / BUP teams planning rule revisions to ensure clinical coverage policies can be used to support denials
  - Similar to how Prioritized List is used today for existing covered benefits

BUP Cost Estimates (3/6)

DRAFT cost estimates:

- Reflects CY24 CCO base medical/prescription drug treatment costs
- CY23 APAC data considered for other payer utilization information and condition prevalence
- Offset applied in cost estimates to reflect existing utilization (CCO exceptions, comorbidity, EPSDT)
- % increase is compared to total base CCO medical spend
- **$60m-$70m CY27 cost ($17m-$23m SF) for Medicaid + HOP**

BUP Topics	% of CCO Spend
Chronic Pain Syndrome	0.17%
Inflammatory Skin Conditions	0.16%
Septoplasty/Rhinoplasty	0.06%
Allergy Testing & Treatment	0.05%
Gastrointestinal Medications	0.05%
Sports Medicine and Orthopedic Surgeries	0.03%
Medications for Eye Conditions	0.03%
PE Tubes/Adenoidectomy/Tympanoplasty	0.02%
Chronic Pelvic Pain	0.02%
Adenotonsillectomy	0.02%
Orthotics	0.01%
Tension/Cervicogenic Headaches	0.01%
Other topics priced	0.04%
Topics not priced (limited cost impact)	0.03%
Total	**0.70%**

BUP Cost Estimates (4/6)

- Distribution of cost estimates
  - Medical vs. prescription drugs
  - Age group
- Based on topics listed in prior table with material cost impact
- CY24 CCO base spend, Medicaid only

Medical	Prescription Drugs
61%	39%

Adults	Children
75%	25%

BUP Cost Estimates (5/6)

OHA undertook an initial valuation of the following topics and found them likely to have < $1m annual impact systemwide. Combination of the initial valuations used to develop 0.04% load.

- Actinic Keratosis
- Allergy Testing for Eczema
- Bartholin Gland Cysts
- Benign Neoplasms of Digestive System
- Bunions/Hammertoes
- Chronic Anal Fissures
- Closed Reductions of Lesser Toe Fractures
- Corneal/Eyelid Conditions
- Ear Conditions
- Fecal Incontinence
- Fibromyalgia
- Finger Nerve Graft
- Gastroparesis
- Hyperhidrosis
- Lacrimal Duct Obstruction
- Lipodystrophy
- Post Endometrial Ablation Syndrome
- Pseudofolliculitis Barbae
- Salivary Glands
- Somatization/Somatoform Disorder
- Vulvar Dysplasia
- Warts

BUP Cost Estimates (6/6)

Next steps for budget / rates:

- OAFA used these estimates to present an initial request to Budget team
  - Emphasized draft nature and potential to change
- OAFA estimates expected to be basis for CY27 capitation rates
  - Trailing HERC/P&T changes and other new information may impact pricings
  - Trending and loading assumptions to be evaluated with Mercer

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Appendix

CMS-Designated Optional Benefits

Optional Benefits

- Other licensed practitioner services (1905(a)(6), 42 CFR 440.60)
- Private duty nursing services (1905(a)(8), 42 CFR 440.80)
- Clinic services (1905(a)(9), 42 CFR 440.90)
- Dental services (1905(a)(10), 42 CFR 440.100)
- Physical therapy (1905(a)(11), 42 CFR 440.110(a))
- Occupational therapy (1905(a)(11), 42 CFR 440.110(b))
- Speech, hearing and language disorder services (1905(a)(11), 42 CFR 440.110(c))
- Prescription drugs (1905(a)(12), 42 CFR 440.120(a) and 42 CFR 441.25)
- Dentures (1905(a)(12), 42 CFR 440.120(b))
- Prosthetics (1905(a)(12), 42 CFR 440.120(c))
- Eyeglasses (1905(a)(12), 42 CFR 440.120(d))
- Other diagnostic, screening, preventive, and rehabilitative services (1905(a)(13), 42 CFR 440.130)
- Services for individuals age 65 or older in an Institution for Mental Disease (IMD) (1905(a)(14), 42 CFR 440.140)
- Services in an intermediate care facility for Individuals with intellectual disability (1905(a)(15), 42 CFR 440.150)
- Inpatient psychiatric services for individuals under age 21 (1905(a)(16), 42 CFR 440.160 and 441 Subpart D)
- Hospice (1905(a)(18))
- Case management (1905(a)(19), 42 CFR 440.169 and 42 CFR 441.18)
- TB-related services (1905(a)(19))
- Respiratory care for ventilator-dependent individuals (1905(a)(20), 42 CFR 440.185)
- Personal care (1905(a)(24), 42 CFR 440.167)
- Primary care case management (1905(a)(25), 42 CFR 440.168)
- Primary and secondary medical strategies, treatment, and services for individuals with sickle cell disease (1905(a)(27))
- Certified community behavioral health clinic (CCBHC) services (1905(a)(31) and 1905(jj))
- State plan home and community based services (1915(i), 42 CFR 440.182)
- Self-directed personal assistance services (1915(j), 42 CFR 441.450-441.484)
- Community First Choice Option (CFC) (1915(k), 42 CFR 441.500-590)
- Medical Assistance For Eligible Individuals Who Are Patients In Eligible Institutions for Mental Diseases (1915(l))
- Alternative Benefit Plan (ABP)* (1937, 42 CFR 440.300)
- Health homes for enrollees with chronic conditions (1945)
- Other services approved by the Secretary**

Source: Mandatory & Optional Medicaid Benefits | Medicaid

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.