1115 MEDICAID WAIVER
IMPLEMENTATION PROJECT | OREGON

OREGON HEALTH AUTHORITY

September 24, 2025

Benefit Update Project (BUP) Workgroup: HERC and Medical Necessity

Reflect Back: Workgroup Feedback to Date

Workgroup members would like to <u>maintain</u>:

- **A transparent and evidence-based process – including HERC's role –** by which benefit package decisions are made today, especially in a resource-constrained environment
- Clarity about **what is covered and what is not** (i.e., how do we ensure providers and members know what is covered, their rights to appeal and fair hearings, and how "comorbidity" exceptions work)
- The current **slate of benefits**, with a focus on preserving advances in access to **behavioral health** and optional services like **dental**

Area of alignment: critical parts of the current system will continue (e.g., HERC's role and outputs)

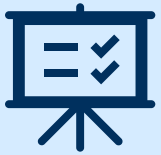
Workgroup members would like to <u>consider</u>:

- A **transparent and public process for making benefit package determinations for optional services,** if the state needs to cut benefits to manage budget pressures (in lieu of larger cuts)
- A role for HERC in resource allocation to manage budget pressures
- Promoting relative **uniformity and consistency of coverage decision-making** across CCOs

Preview: Next Meeting Agenda

Note: The next BUP Workgroup meeting on October 14 will focus on continued use of evidence-based processes to make coverage determinations and decisions regarding benefit package, including but not limited to a potential process for prioritizing optional benefits.

BUP Workgroup Meeting Agenda & Goals



Agenda:

- Reflecting on Previous Workgroup Meetings
- Recommendations for HERC's Role
- Recommendations for Medical Necessity Policy
- Additional Questions & Answers

Goals:

- Understand HERC's continued role
- Consider applications of medical necessity policy in the future state
- Begin discussing potential recommendations on topics discussed

Reminder: Workgroup Purpose

The BUP Workgroup Charter states:

The OHA BUP Workgroup will consider the potential implications of and ways to streamline the transition away from the PL – as currently authorized through the State's 1115 waiver – with the goal of minimizing disruption to care, advancing health equity, and supporting the delivery of appropriate, high-value health services under OHP.

Additional goal based on discussions to date: Where possible under federal law, **maintain critical components of the existing PL process and identify areas for improvement.**

Reminder: Zero to Five

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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Reflecting on Previous Workgroup Meetings

Recap: Previous Workgroup Meeting Agenda

The last BUP workgroup meeting focused on:

- Clarifying the scope and purpose of the BUP Workgroup
- Definition of the OHP Benefit Package
- Coverage decisions in the current and future state
- Reviewing the HERC's continued, foundational role in the future state

Recap: What is not changing and what is changing

What is Not Changing?

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

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

HERC's work products (including guideline notes, code pairings, ancillary files); these will remain largely the same and used in the same way as today.

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

What is Changing?

"Prioritized List" will now be called **"Clinical Coverage Policies"** (but include many of the same components as today)

Services will be organized in **unranked code groups** – there will be no funding line and services will no longer be denied solely because of their ranking on the list.

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

Note: we intend to discuss FFS "appeals" in more detail in November

Ongoing activities to prepare for future meetings

With the chairs' guidance, OHA is considering key areas of focus for the workgroup to make recommendations, based on the conversations to date and steering committee feedback.

Future of Optional Benefits

Digging into HERC's role with respect to resource allocation and amount, duration, and scope of optional benefits:

- Are there opportunities to expand HERC's role in allocating resources?
- What are regulatory or operational barriers? I.e., what are the federal rules with which the state must comply?
- What could this look like in practice (i.e., workflows)?

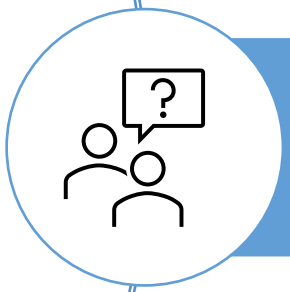
Optimizing the Future State

Discussing how to apply lessons from prior benefit package changes to streamlining the transition:

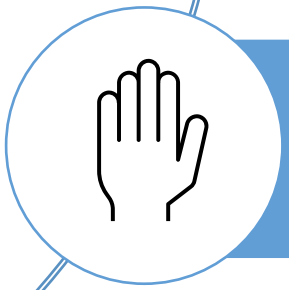
- What do members, CCOs, providers need to know and when?
- What do we think the role of OHA, advocates, CCOs, providers are to ensure proper communication?

General Discussion Questions

Are there are any other reflections or workgroup feedback you think should be captured above?



What else should OHA be preparing between meetings to ensure productive workgroup meetings?



At a high level, I am comfortable with my understanding about what is changing and what is not from the previous slide.

Today: Possible Areas of Focus for Recommendations

Role of HERC

1. Opportunities to maintain, expand or change the role of HERC (other than ranking optional services, to be discussed in October)
2. Ensuring HERC clinical coverage policies are clear, transparent, and accessible

Medical Necessity and Coverage Decisions

3. Processes and standards CCOs must use related to requests and appeals, to promote consistent application of HERC policy

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Recommendations Regarding the Role of HERC

Overview: 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 will create similar treatment-condition code pairs, but in unranked groups, along with guideline notes and other ancillary files. No change to diagnostic files
- Guidance will continue to be based on **public, transparent, evidence-based process** that solicits community feedback and holds the HERC and the State accountable for the coverage decisions made
- HERC outputs will constitute the HERC's "Clinical Coverage Policies," rather than "Prioritized List," that partners can use to understand what is covered or not
- **The intention is for HERC outputs to be used in the same way as they are today to guide decisions about service requests or appeals.**

Note: HERC is actively reviewing new coverage areas that may be allowable under mandatory benefits (more on this in the Appendix)

HERC-related Recommendations Based on Workgroup Feedback to Date

1

In what areas can HERC sustain, grow, or alter its current role? *(Excluding ranking optional services)*

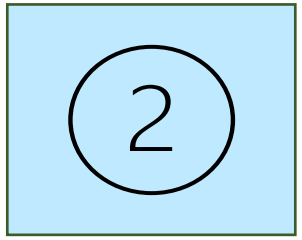
Example Workgroup Recommendations based on Workgroup Feedback:

- OHA should continue to leverage HERC's approach for future decisions about relevant coverage (e.g., most medical services), to ensure the most evidence-based population health approach possible, given resource-constrained environment.

- HERC (and P&T) should continue to review services and medications that may be marginal benefit, low cost-effectiveness, or harmful and ensure they are not covered.

Note: We intend to discuss P&T and pharmacy-related recommendations in more detail at a future meeting.

Questions and Proposed Recommendations based on Workgroup Feedback to Date



How can interested parties ensure that HERC clinical coverage policies are clear, transparent, and accessible enough to implement consistently?

Example Workgroup Recommendation based on Workgroup Feedback:

- All HERC outputs (including code groups and ancillary files, Not Medically Necessary file, etc.) should be easily **accessible on the HERC website**.

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Recommendations Regarding Medical Necessity and Coverage Decisions

Definitions of Medical Necessity and Appropriate will Remain the Same

- **Oregon will continue to use definitions of <u>medically appropriate</u> and <u>medically necessary</u>** in rule for individual determination. (For adults, see OARs 410-120-0000 (193) and (194)).
- All covered services must be medically appropriate and medically necessary, but not all medically appropriate/necessary services are covered services.
- **HERC will continue to create evidence-informed medical necessity policy** to support effective, consistent utilization management across OHP, at the population level.

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

Defining Medical Necessity

In accordance with federal regulations, OHA is permitted to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

See 42 CFR 440.230 for details.

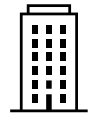
OHA / OR Legislature

Define medical necessity broadly and specifically for services like DME within OARs

(e.g., 410-122-0080)

HERC

Defines medical necessity through Clinical Coverage Policies for many medical benefits, based on medical evidence, member and expert input, to guide coverage decisions



CCOs

Can use clinical judgement or third party or external medical review (EMR), especially when there is no relevant OAR or Clinical Coverage Policy or when applying clinical coverage policy

How Oregon Compares to Other States

Takeaway: While there are some differences in states' definitions of medical necessity, to reflect state preferences, they are all quite broad, including in states with a two-tier process for independent policy review.

New York

- The New York State Medicaid Evidence Based Benefit Review Advisory Committee (EBBRAC) reviews coverage requests for technologies or services with a focus on efficacy, safety, generalizable clinical outcomes and relevancy to the population served by the New York State Medicaid Program.
- New York defines medically necessary services as:

health care and services necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity or threaten some significant handicap.

New York has a two-tier process like Oregon--an evidence review process (EBBRAC) for specific topics, and a general rule that applies elsewhere. Massachusetts just has the general rule.

Massachusetts

- The Massachusetts Health Policy Commission (HPC) is an independent state agency tasked with administering independent external reviews of insurer medical necessity denials.
- Massachusetts law defines services as medically necessary if:
  1) *It is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and*
  2) *There is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to the MassHealth agency*.

OARs define medically necessary services as ones that *address prevention, diagnosis, or treatment of a member's health condition; age-appropriate growth and development; independence in daily living; improved health status; access to the benefits of non-institutionalized community living.*

Adult Coverage Decisions in Future

Service Authorization

REQUEST CAN BE DENIED IF:

- service is not in the OHP benefit package (e.g., infertility treatments) **OR**
- the request does not meet other medical appropriateness or medical necessity criteria defined in OAR (e.g., for DME) **OR**
- request does not meet HERC's population-level Clinical Coverage Policies (i.e., code pairings and guidelines)

Member Appeal

MUST consider the individual circumstances of medical necessity

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

Key takeaways:

- Denials based on funding line do not exist in the future.
- Because there is no unfunded region, there is also no explicit "comorbidity rule"; members can still request individual review.
- CCOs have the *option* to deny services to adults at authorization, based solely on medical necessity without individual human review (e.g., based on OARs or HERC pairings and guidelines).
- *Some* pairs previously below the line (i.e., not covered) could now be considered *not* medically necessary (i.e., still not covered but for new reason) – this impacts the nature of some appeals.

Note: specific to medical services, not including pharmacy – to be discussed in future

Lack of a Funding Line Changes the “Comorbidity Rule”

Concept:
Determinations for services currently below the funding line will be considered based on the medical necessity of the service itself for the purpose it was ordered, rather than having to justify that it would help a funded condition (i.e., above the line) using the comorbidity rule.

Example:

- Patient has **actinic keratoses**. These rarely develop into cancer (a treatable form). Patients also desire treatment for cosmetic reasons. Today, this is unfunded and a comorbidity claim is unlikely to be approved.
- Under BUP, treatment is medically necessary for a defined group of high-risk patients including those with autoimmune conditions.

Lack of a Funding Line Changes the “Comorbidity Rule”

Concept:
Determinations for services currently below the funding line will be considered based on the medical necessity of the service itself for the purpose it was ordered, rather than having to justify that it would help a funded condition (i.e., above the line) using the comorbidity rule.

Example:

- Patient has **TMJ and sleep apnea**. TMJ surgery is currently in unfunded region. If someone asks for TMJ surgery today but has sleep apnea and the medical records indicate that the surgery might help sleep apnea, it might be approved due to comorbidity rule.
- Under BUP, TMJ surgery will be considered "not medically necessary" based on HERC policy, but the surgeon could submit records saying the TMJ surgery is needed to address the patient's sleep apnea and that could be considered without referencing the comorbidity rule.

Medical Necessity Recommendations based on Workgroup Feedback to Date

3

Processes and standards CCOs must use related to requests and appeals, to promote consistent application of HERC policy.

Questions for Discussion:

- How can the workgroup and interested parties promote consistent application of clinical coverage policies (i.e., medical necessity policy) across CCOs? How could we achieve that?
- How do we make pathways for coverage "exceptions" clear and accessible to providers and members? *In other words, how do we translate the* ***comorbidity rule*** *in a new world with a broader application of medical necessity?*

Recommendation:

- TBD based on conversation

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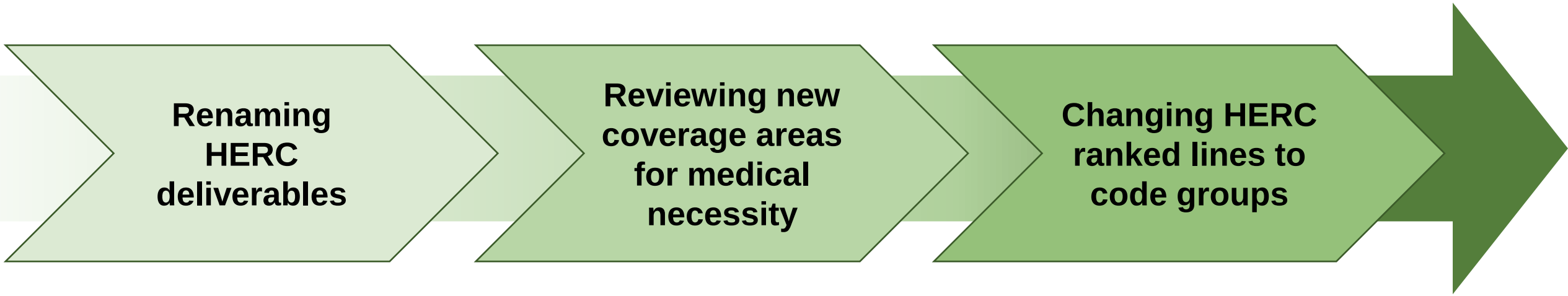
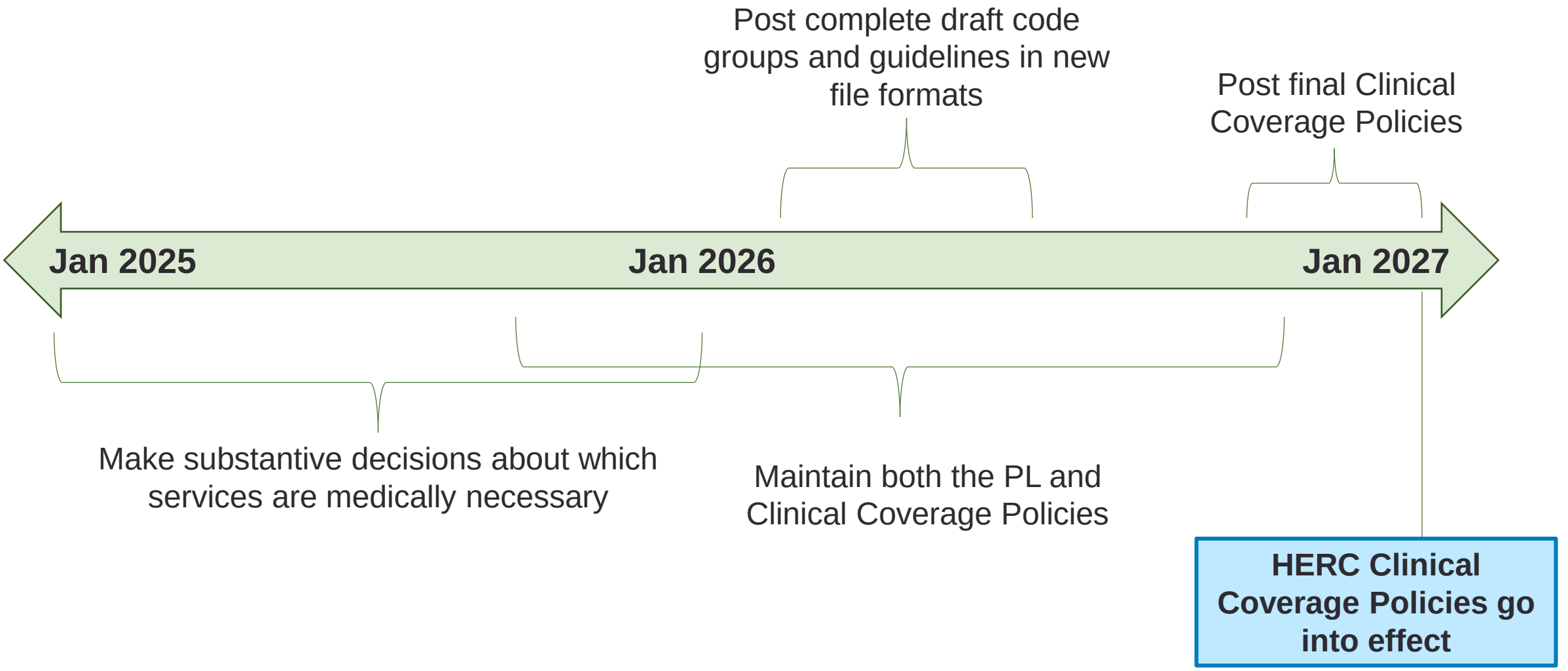
Appendix

HERC is Currently Working on BUP Transition Process

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



HERC Transition Timeline Leading up to 1/1/27



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

Live view of HERC Workplan: https://www.oregon.gov/oha/hpa/dsi-herc/pages/bup-workplan.aspx

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 has identified additional services that will be added and others they wish could be added if funds were available – no services lost entirely as a result of this process.

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	• Physical & occupational therapy for more conditions
Ophthalmology	• Newly covered eye and eyelid conditions

The HERC has not recommended any service covered today no longer be covered in the future, as a result of this process, but will continue to evaluate medical evidence in the future.

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

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.~~

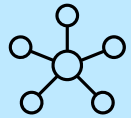
Date of last review: January 2025

HERC 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

Key Takeaways

Changes:

- No funding line and unfunded region; therefore, no denials based solely on funding line.
- HERC's ranked lines will change to code groups.
- Some new services will be covered.

Remaining the same:

- **Process:** HERC's public and evidence-based processes.
- **Outputs:** Code-pairings and substance of statements of intent, guidelines notes, diagnostic and ancillary files (without ranking).

"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

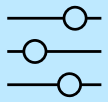
Current: The PL pairs treatments and conditions and then places them in **ranked lines** by importance to the population served.

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.

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/

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)

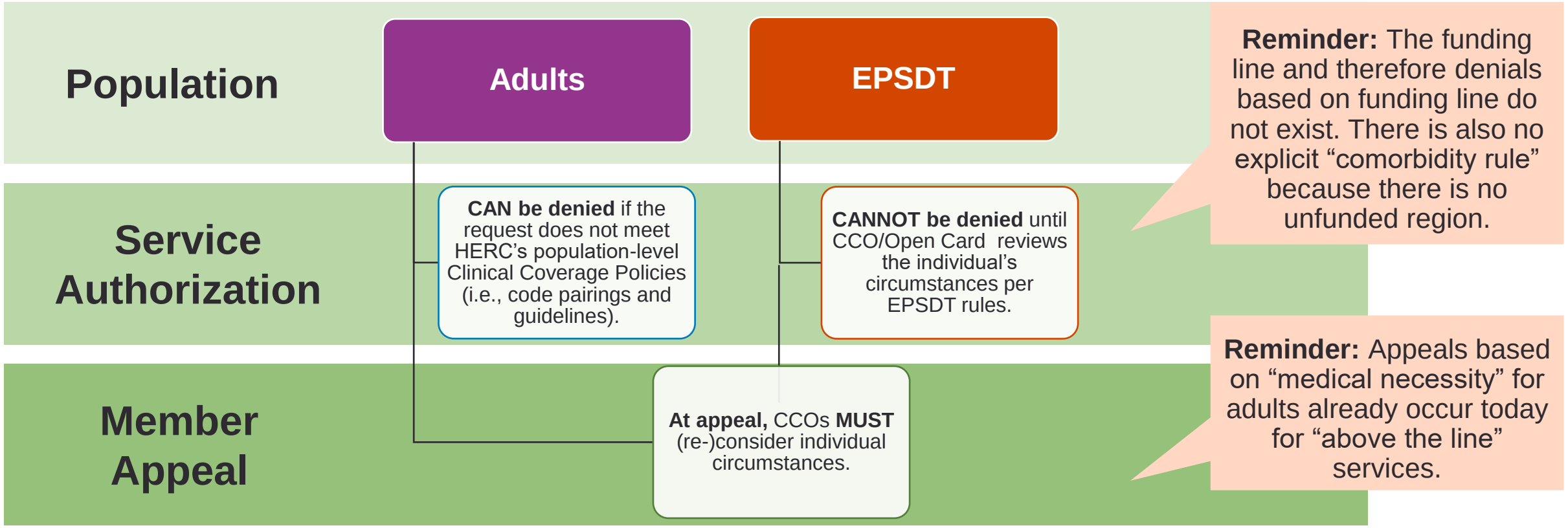
Services that HERC considers **NOT medically necessary** under certain conditions:

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

Note: Some examples above may still be under deliberation.

* psychotherapy is mandatory when provided by a psychiatrist (MD) but optional when provided by a psychologist or other licensed counselor

Service Coverage Decisions in Future



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

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