Oregon's 1115 Medicaid Waiver

All Come Webinar

January 8, 2025

OREGON HEALTH AUTHORITY

Oregon HEALTH PLAN

1115 MEDICAID WAIVER IMPLEMENTATION PROJECT | OREGON

Zoom Meeting Tips

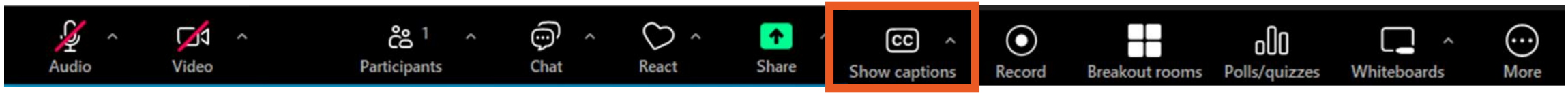
Use chat to ask questions.

- We'd like this session to be interactive, so we'll be saving the chat.
- If you want to ask a question verbally, feel free to raise your hand.

This webinar is being recorded.

- We'll share it with participants after the presentation.

For live captioning, please click on the "cc" button at the bottom of your screen.



Today’s Agenda

1. 1115 Medicaid Waiver Background
2. Benefit Update Project (BUP)
3. Community Capacity Building Funds (CCBF)
4. Question & Answer

1115 Medicaid Waiver Background

What is the Oregon Health Plan?

Medicaid

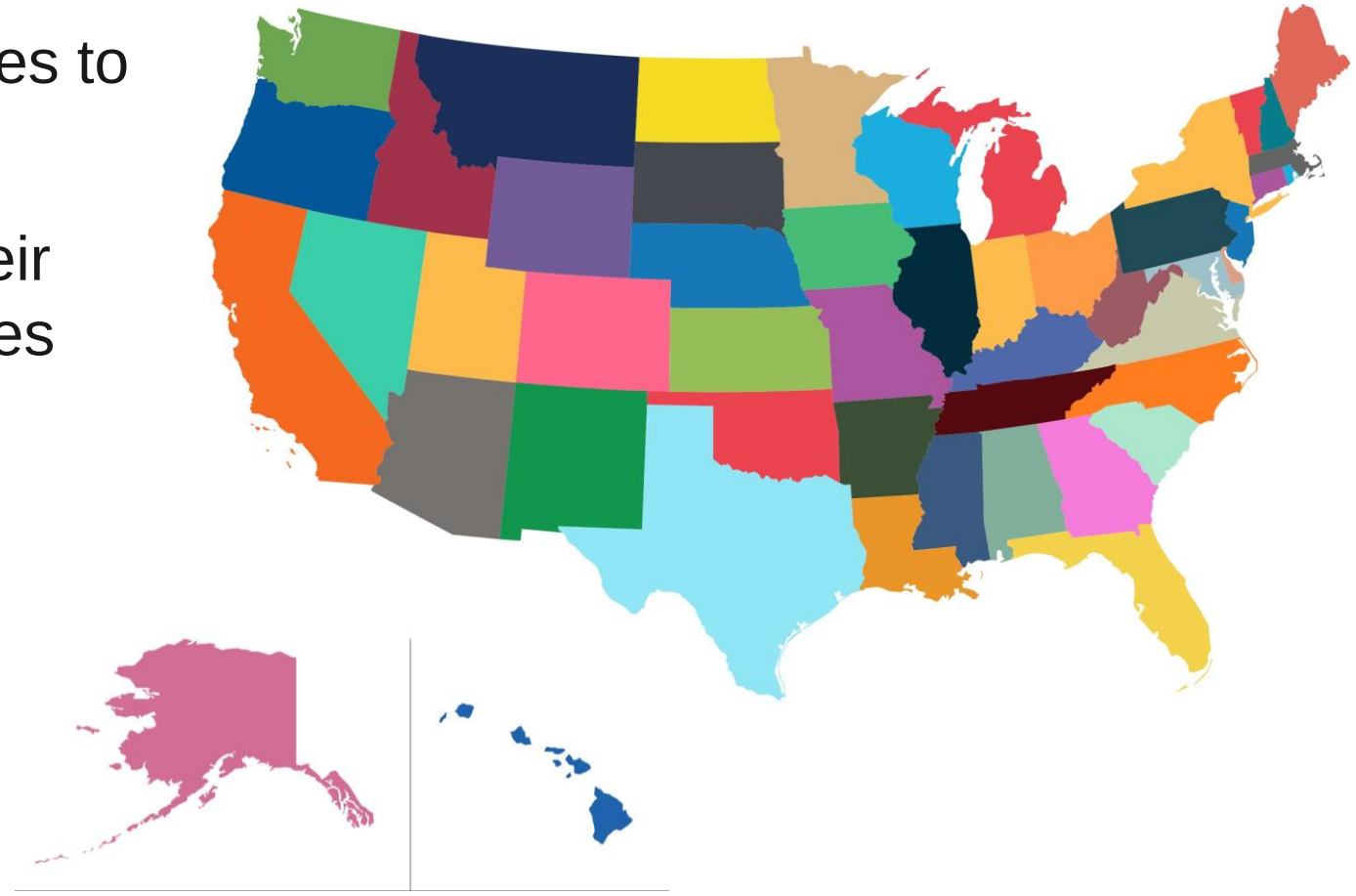
Medicaid is the nation's public health care program.
In Oregon we call it the Oregon Health Plan (OHP).

Oregon Health Plan

The Oregon Health Plan (OHP) is free health care coverage for low-income children, teens, and adults who live in Oregon. You can apply for OHP at any time during the year.

What is a Medicaid Waiver?

- States must follow federal rules to get Medicaid funding.
- States can ask **to change** their Medicaid rules. These changes are called a Medicaid waiver.



Oregon 1115 Waiver Key Changes

Extended Oregon Health Plan (OHP) Eligibility and Benefits

1) Expanded Medicaid coverage (more people enrolled for longer):

- Continuous OHP eligibility and enrollment for children up to age six*†
- Two years of continuous enrollment for OHP members ages six and older*†
- Coverage for young adults with special health care needs up to age 26*

2) Expanded Medicaid benefits and services include:

- Health-related social needs (HRSN) supports including housing, nutrition, climate supports and outreach and engagement services*
- A limited set of services for people in a carceral setting 90-days prior to release
- Tribal Traditional Healing practices
- New appeals system for OHP Open Card/FFS members (by Jan 1, 2027)
- Few currently uncovered OHP services will become covered (starting Jan 1, 2027)

* Indicates an approved change that is first-in-the-nation

† These benefits are in effect and began in July 2023

Benefit Update Project

Oregon Health Plan (OHP) - Benefit Update Project (BUP): Most Important Take-Aways

- A project to update the organization of OHP benefits so that all medically necessary and appropriate services are covered.
- This change is mostly administrative rather than a change to **how** OHP services are delivered.
- No members will lose services as a result of this transition.
- Some services not covered today will be added to the benefit package.

How Medicaid works in Oregon currently

Oregon Health Plan (OHP):

Oregon's Medicaid program; free health coverage for people in Oregon who meet eligibility criteria.

Medicaid covers things like:

Doctor visits, hospital care, mental health services, labs and x-rays, dental care, routine vision care, physical therapy, prescription drugs.

Oregon's Health Evidence Review Commission (HERC) and Prioritized List:

Health Evidence Review Commission (HERC) provides evidence-based reviews of services and ranks them on the List; Legislature funds only a portion of the Prioritized List; services above the funding line are funded and those below the funding line are not covered.

Oregon has a special waiver that allows it to use the List. That ends 12/31/2026.

OHP Benefits current state

HERC = Health Evidence Review Commission

Health Evidence Review Commission (HERC)

Public process for deciding which health care services are medically necessary and should be covered.

The commission chooses services most likely to:

- Help prevent disease
- Treat illnesses and injuries
- Manage chronic conditions
- Improve members' ability to function

13 appointed members.

Encourages public comment & participation

Ranks health conditions and their treatments in the Prioritized List of Health Services

Background on Prioritized List – why was it used?

- OHA has had approval to use the Prioritized List since 1994.

- The original goal of the Prioritized List was to maximize the number of people covered by being strategic about the services covered. However:
  - The Prioritized List is no longer used as a budget tool. The funding line has not moved since 2012.
  - 97% of people in Oregon now have health coverage, which is a record high.

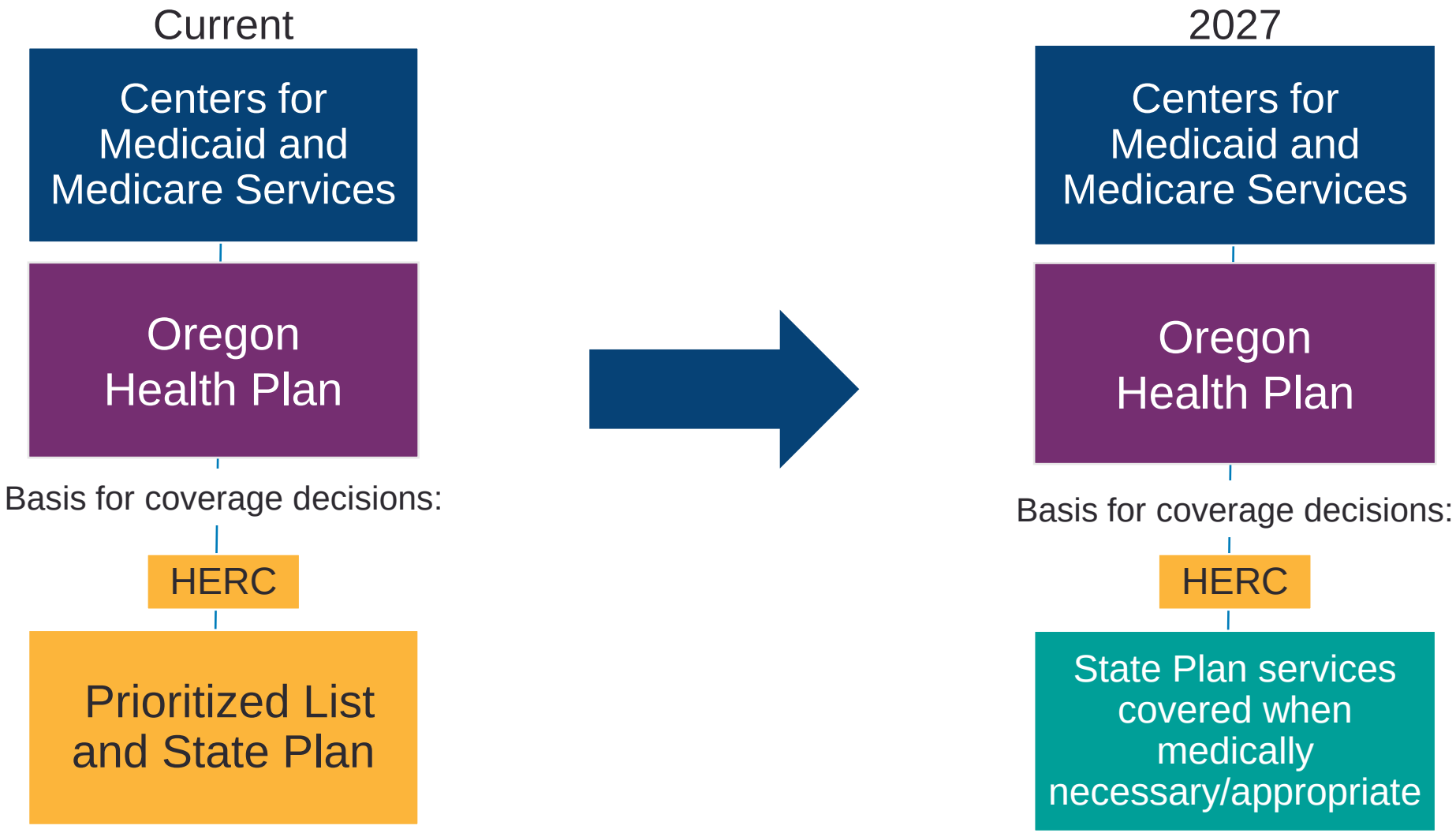
- Under the Prioritized List, not all mandatory benefits were covered.

- This transition provides us with an opportunity to realign our benefit package with the federal requirements.

Why is this project needed?

- Oregon has a special federal waiver that allowed the use of the Prioritized List.
- The waiver is ending on 12/21/2026 and will not be renewed.
- This means that by January 1, 2027 Oregon will no longer be able to organize its benefits into a Prioritized List, with a funding line indicating which areas are covered (above the line) and not covered (below the line).
- Instead, Oregon will move to the typical organization of Medicaid benefits that all other states use.

OHP Benefits current state and future state



HERC = Health Evidence Review Commission

Structure of typical State Plan (future state for Oregon)

- State Plan is an agreement between any state and the federal government.

- It includes Mandatory and Optional benefits:
  - **Mandatory** services like physician services, lab and x-ray, family planning, hospital care.
    - States must cover these... when the state determines them medically necessary.

  - **Optional** services like dental services, chiropractic, physical therapy, occupational and speech therapy, prosthetics and other practitioner services.
    - Federal law allows states to limit optional benefits for budget reasons.
    - **Examples:** In Oregon, eyeglasses and some dental services for adults are not covered.

Benefit limitations

- Federal law allows states to limit Mandatory benefits in a few ways, including for:
  - Medical necessity.
  - Utilization management.

- Each state defines its own medical necessity policy.

- In Oregon, most of the medical necessity policy is currently a part of the Prioritized List (via funded and unfunded regions and in guideline notes).

- The Health Evidence Review Commission develops these policies by:
  - Deciding which specific codes to cover,
  - Deciding which diagnosis codes pair with which treatment codes,
  - Creating 'guideline notes.'

What is staying the same for members?

- Members won’t lose benefits because of this change.
- All services covered today will still be covered on and after Jan. 1, 2027, unless new evidence shows they are harmful or not effective.
- OHP still won’t cover treatments that are cosmetic or that are not medically necessary and appropriate.
- OHA or the member's coordinated care organization (CCO) may still need to approve some services.

What is changing for members?

- Starting in January 2027, OHP will cover medically necessary treatments for a small number of additional health conditions, like fibromyalgia and nasal allergies, when treatments are medically necessary and appropriate.

- There will be no more denials based solely on the funding line – denials will need to be based on lack of medical necessity.

- There will be a new process for member-initiated appeals for Fee-For-Service/Open Card.

Transition planning

- **HERC will review the region below the funding line on the prioritized list and develop medical necessity policy for those conditions.**
  - HERC is meeting with specialist providers to discuss medical necessity of services below the funding line.
  - HERC will rely on the OHP medical necessity and medical appropriateness rules to make this policy.

- **HERC does not make case by case decisions about services.**

- **HERC makes medical necessity and clinical coverage policies to guide CCO and FFS/ Open Card decisions.**

Recap: Transition away from the Prioritized List

Prioritized List

- Priority ranking for conditions and treatments.
- Conditions above a funding line are approved by legislature.
- Conditions below funding line are usually not covered.
- Medical necessity is defined by code pairs and Guideline Notes.

State Plan and Medical Necessity

- No more denials for "below the line" or "unfunded region."
- State plan organizes benefits into broad categories of services using CMS definitions.
- Within these, HERC will continue to define which services are medically necessary with code pairs and Guideline Notes.

CMS = Centers for Medicare and Medicaid Services, **HERC =** Health Evidence Review Commission

Opportunities for community input

- You can request to have coverage for specific benefits reviewed by HERC. Suggestions can be emailed to: 1115Waiver.Renewal@odhsoha.oregon.gov.
- You can also email other comments or questions to: 1115Waiver.Renewal@odhsoha.oregon.gov
- OHA anticipates sharing quarterly updates at:
  - All Come and Para Todos meetings
  - Medicaid Advisory Committee (MAC)/Advancing Consumer Experience (ACE) subcommittee meetings.
- HERC will continue holding community listening sessions.
- OHA will consider member input and public comments during transition planning.

Opportunities for provider & CCO input

- **Listening session for providers -** OHA will share information on the Benefit Update Project on January 29, 2025 from 9:05-11am.
  - Registration Link

- **BUP Operations Workgroup for CCOs** - An operational workgroup will start in January. The workgroup will occasionally invite providers to attend, depending on the scheduled topics.

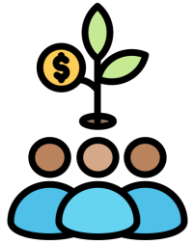
Resources: Websites

- **How to participate in HERC**
  - https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/public-input-opportunities.aspx
- **Searchable Prioritized List, Guideline Notes, Multisector Interventions and Services Recommended for Non-Coverage**
  - https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Searchable-List.aspx
- **Benefit Update Project page, fact sheet, and FAQs:**
  - https://www.oregon.gov/oha/hsd/medicaid-policy/pages/benefit-update.aspx
  - https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/BUP-Fact-Sheet-EN.pdf
  - https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/Benefit-Update-Project-Frequently-Asked-Questions.pdf

Community Capacity Building Funds (CCBF)

What are Community Capacity Building Funds?

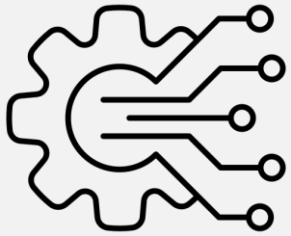
The Oregon Health Authority (OHA) is providing resources, called Community Capacity Building Funds (CCBF), to health-related social needs (HRSN) providers (e.g., community-based organizations, social service agencies, others).



These funds support organizations that intend to become HRSN providers to develop what they need to participate in the Medicaid delivery system and deliver HRSN services to eligible OHP members.

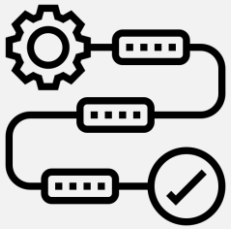
Coordinated care organizations (CCOs) administer the CCBF Grant Program and **applications can be submitted between April – May 30, 2025.** More information is available on OHA's CCBF web page

Community Capacity Building Funds: Allowable Uses



Technology
(e.g., new billing systems)

Workforce Development
(e.g., staff salary and fringe benefits for up to 18 months)



Development of Business Practices
(e.g., designing new workflows)

Outreach and Education
(e.g., launching a new learning collaborative)

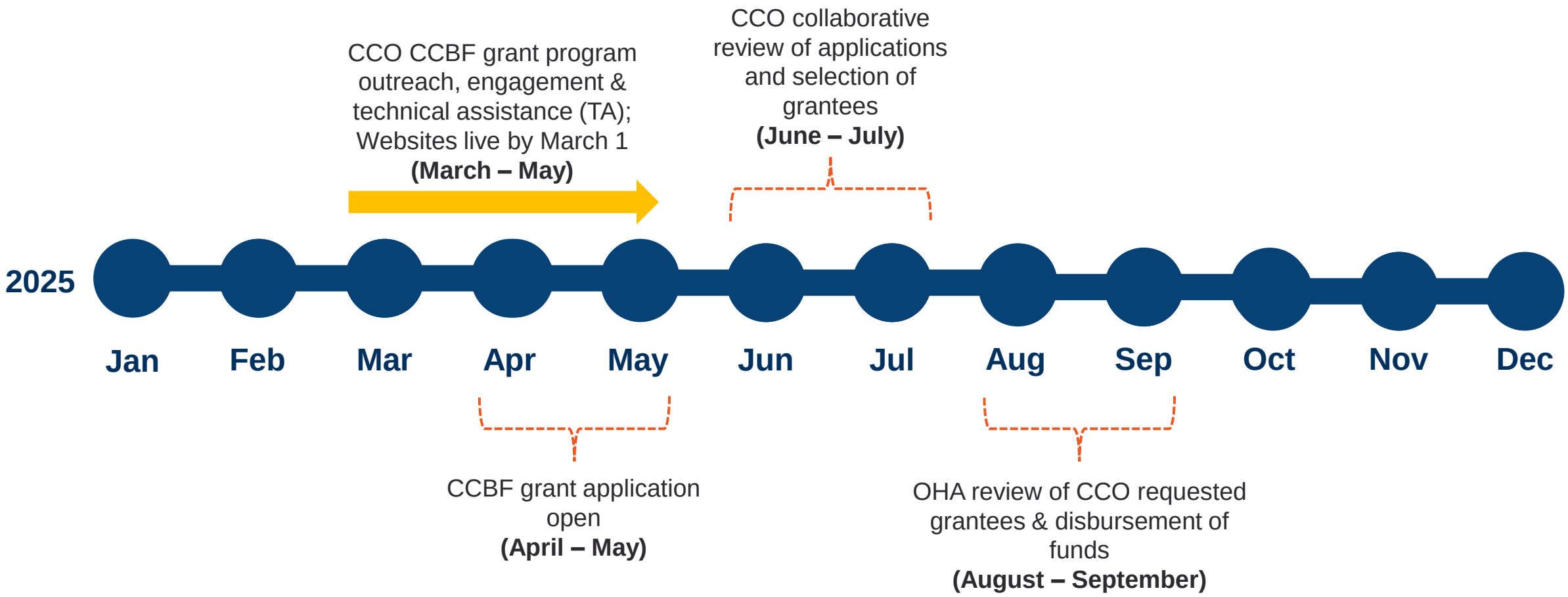
Eligible Entities for Community Capacity Building Funds

The following entities are eligible to apply for and receive CCBF (examples are not exhaustive)*:

- Community-based organizations (e.g., housing agencies and food and nutrition providers)
- Organizations that provide or coordinate HRSN benefits (e.g., case management providers or local governmental agencies)
- Organizations that will support the development of the HRSN network (e.g., an entity that provides administrative, billing, training supports or other supports)

*For more information on eligible entities for CCBF, please see the HRSN Infrastructure Protocol here

Timeline for 2025 CCBF Grant Program



CCBF = Community Capacity Building Funds, **CCO =** Coordinated Care Organization**, OHA =** Oregon Health Authority

Question & Answer

What questions do you have?

Upcoming 2025 Sessions

Topics TBD

Dates:

- ★ April 9
- ★ July 9
- ★ October 8

Stay Connected!

For questions related to today's presentation, please contact us: 1115waiver.renewal@odhsoha.oregon.gov

For additional updates and information, check our website: www.oregon.gov/1115waiverrenewal

Subscribe to updates that will be sent out in the coming months: https://public.govdelivery.com/accounts/ORHA/signup/37696

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Thank you for your collaboration and ongoing partnership!

Eligible Entities for Community Capacity Building Funds

The following entities are eligible to apply for and receive CCBF:

- Community-based organizations, including:
  - Social Services Agencies
  - Housing Agencies and Providers
  - Food and Nutrition Providers
  - Climate Service Providers
  - Outreach and Engagement Providers
- Organizations that provide or coordinate HRSN benefits, including:
  - Case Management Providers
  - Traditional Health Workers
  - Child Welfare Providers
  - City, County, and Local Governmental Agencies
- Organizations that will support the development of the HRSN network, including:
  - Organizations who will be **convening** current and potential HRSN partners
  - Organizations who plan to act in the 'hub' role (i.e., partnering with HRSN providers to coordinate benefits, provide administrative, billing, training supports or other supports)
- Tribal governments and providers