1115 MEDICAID WAIVER
IMPLEMENTATION PROJECT | OREGON

OREGON HEALTH AUTHORITY

October 14, 2025

Benefit Update Project (BUP) Workgroup: HERC and Optional Benefits

BUP Workgroup Meeting Agenda & Goals

Agenda:

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

Goals:

- Gain a shared understanding of how the state plan structure works and what is permissible
- Align on preliminary approach for HERC in prioritizing optional benefits
- Align on draft recommendations related to content covered today

Preview: Next Meeting Agenda

The next scheduled BUP Workgroup meeting on October 28 will focus on the application of medical necessity at appeals and fair hearings.

Note: *Additional meeting (10/28) added to support additional time for discussion and recommendation-making*

Recap Previous Workgroup Meetings

Roadmap for Discussion

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

1. Review key takeaways and action items from prior meetings
2. Confirm alignment with 9/24 preliminary recommendations
3. Next steps on clarifying CCO medical review / denials

9/24 Meeting: Takeaways and Action Items

Key Takeaways	Corresponding Action Items
Further discussion needed: - How OHA decides about changes to the OHP benefit package - How determinations of medical necessity will happen in the future - Clarity on what documents (HERC policies, OAR, statute) are used (in what order) when determining medical necessity	 **Today, discuss** preliminary recommendations, with a focus on: • Future state medical necessity decisions, including pharmacy • Future role of HERC in changes to *optional benefits* Additional October session on appeals and fair hearings
Concerns re: enforceability of HERC policies at appeal	
Additional need for TA and communications that can be understood by all	OHA will develop TA/communications recommendations in Oct/Nov for feedback

Roadmap for Future Meeting Discussions

Sessions in October and November will focus on topics necessary to build towards legislative recommendations

10/28: Appeals and Hearings

Specific topics:

- Clarifying CCO obligations on medical review
- Burden of proof at fair hearing
- Discrepancies on Medical Necessity
- Recommendations clarifying state fair hearing processes

11/5: Appeals and Hearings (follow-up), Rates

Specific topics:

- "Spillover" topics from 10/28 meeting on Appeals and Hearings
- Draft capitation rate impact presentation

11/18: Finalize Legislative Recommendations

Specific topics:

- Finalize recommendations for transmittal to Rep. Nosse

December: Focus on recommendations for actions OHA can take to support key changes (e.g., information sharing and comms)

Rough Draft Recommendations from the Workgroup from 9/24 Meeting

- HERC should continue to play the same role as today by using a transparent, evidence-based, population health approach to benefit determination.
- All HERC-related outputs (including code groups, ancillary files, etc.) should be easily **accessible on the HERC website**.

Workgroup members should submit further input offline prior to 10/28, to help streamline and refine this language.

Update: Clarifying CCO Obligations on Medical Review

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

The team plans to include a clarification vetted by internal/external experts to the 10/28 meeting.

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Discuss State Plan Structure and Coverage Decisions in Future State

Discussion Roadmap for this Section

Section Goals:

- Gain a shared understanding of how the State Plan works and how it relates to benefits and medical necessity criteria in the future state.
- Refine recommendations related to medical necessity determinations and HERC's role.

Overview of state plans and their functions, including Oregon's State Plan

Application of Medical Necessity in the future state of adult service authorizations and appeals, with examples

Rough draft recommendation for the workgroup's consideration

Reminder: State Plans are Similar Across States

The state plan is an agreement between a state and federal government describing how that state administers its Medicaid program and what expenses will be matched (42 CFR 431.10).

Mandatory Benefits

Include, but are not limited to:

- Inpatient and outpatient hospital services
- Physician services
- Laboratory and X-ray services
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services
- Certain clinic and health center services

Optional Benefits

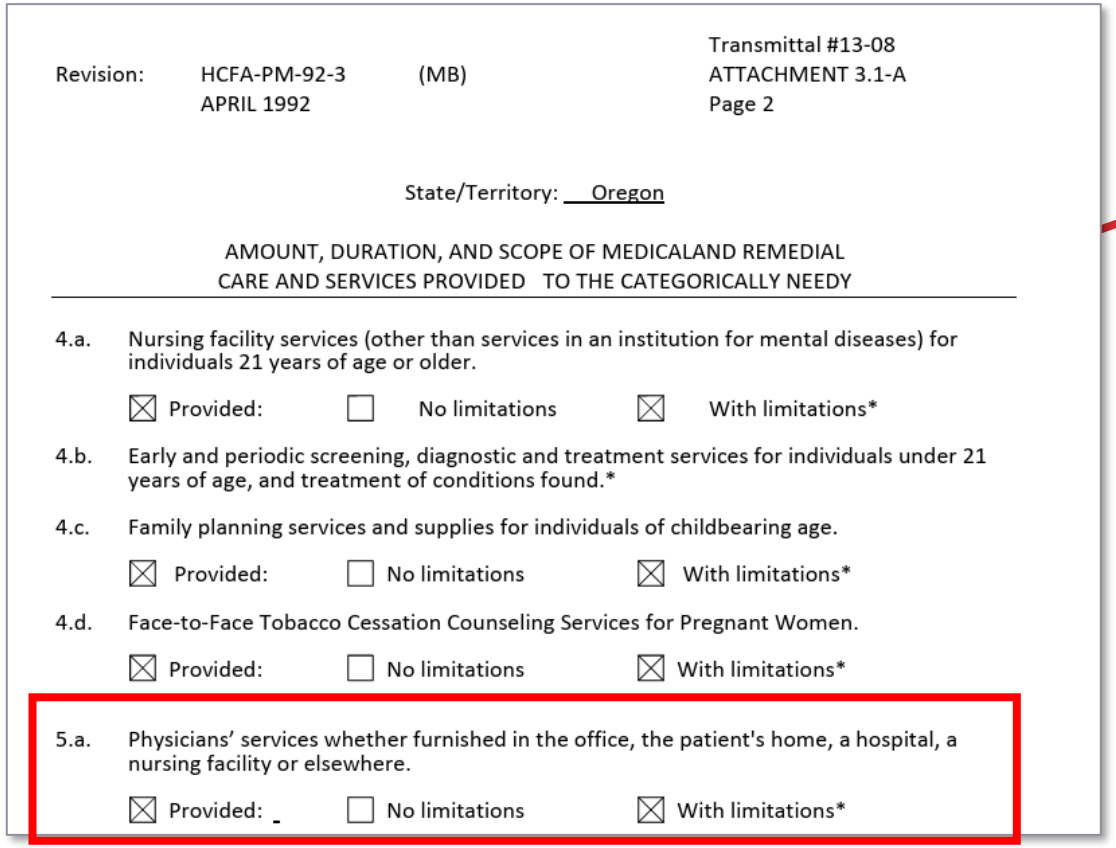
Include, but are not limited to:

- Prescription drugs
- Dental services
- Physical, occupational, speech, and/or hearing therapy
- Case management services
- Home and community-based services

Under federal law, states are required to provide mandatory benefits articulated in the state plan. States may include optional benefits in their state plan. Other benefits may be state-funded only.

The State Plan Outlines Covered Services, Including Limitations

Oregon's state plan outlines amount, duration, and scope for covered mandatory and optional benefits and sometimes references the Prioritized List



Revision: HCFA-PM-92-3 (MB) Transmittal #13-08
APRIL 1992 ATTACHMENT 3.1-A
Page 2

State/Territory: Oregon

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

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

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

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

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

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

Example: Physicians' services (mandatory)

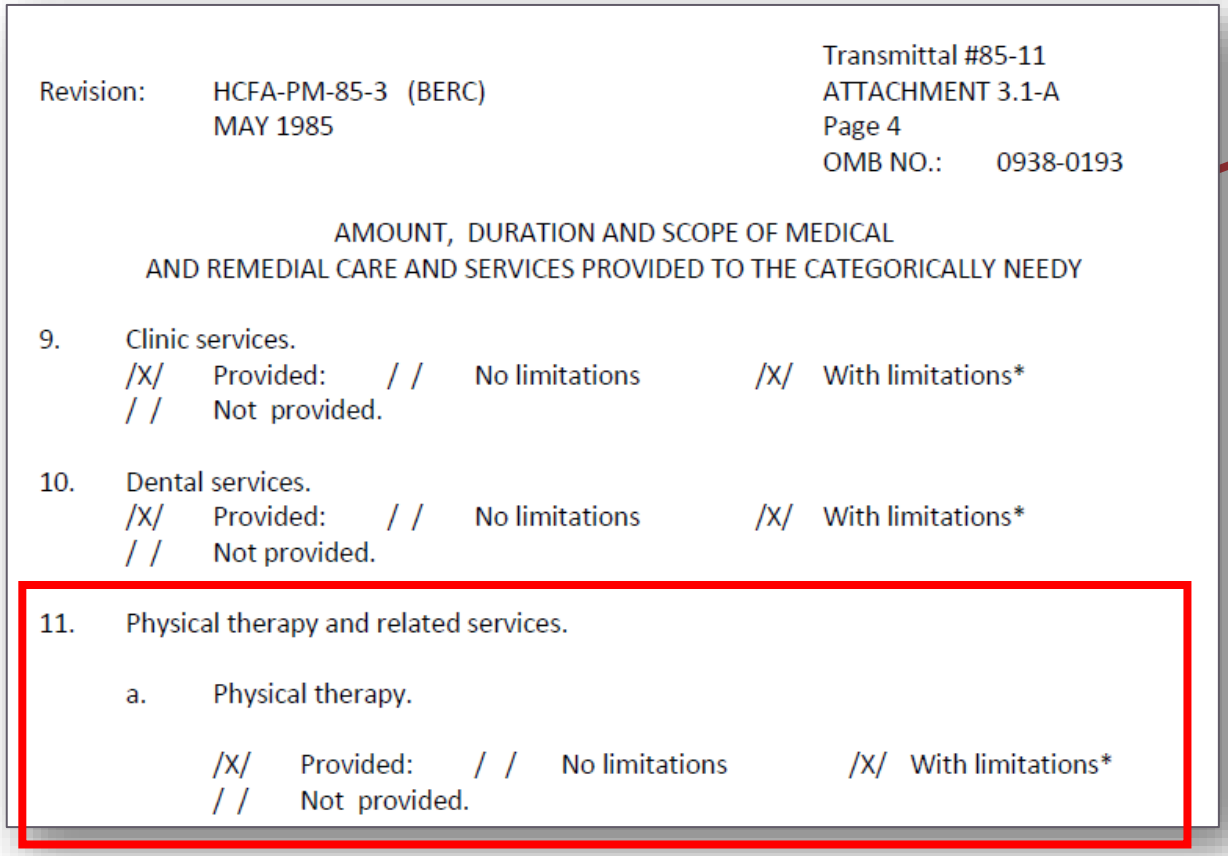
Scope: provided with limitations

Limitations: "Payment for physicians and oral surgeon services is subject to Health Evidence Review Commission, Prioritized List of Health Services as authorized under the 1115 waiver"… Some services require prior authorization… "Exceptions for non-covered services or services with limitations are allowed when medically necessary and prior authorized by the Division…"

Only references to the Prioritized List will need to change

Source: https://www.oregon.gov/oha/HSD/Medicaid-Policy/StatePlans/Medicaid-State-Plan.pdf (PDF page 358-359)

Current State Example: Optional Services



Revision: HCFA-PM-85-3 (BERC)
MAY 1985

Transmittal #85-11
ATTACHMENT 3.1-A
Page 4
OMB NO.: 0938-0193

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

9. Clinic services.
/X/ Provided: / / No limitations /X/ With limitations*
/ / Not provided.

10. Dental services.
/X/ Provided: / / No limitations /X/ With limitations*
/ / Not provided.

11. Physical therapy and related services.

a. Physical therapy.

/X/ Provided: / / No limitations /X/ With limitations*
/ / Not provided.

Example: Physical therapy (optional)

Scope: provided with limitations

Limitations (*no mention of PL*)**:**

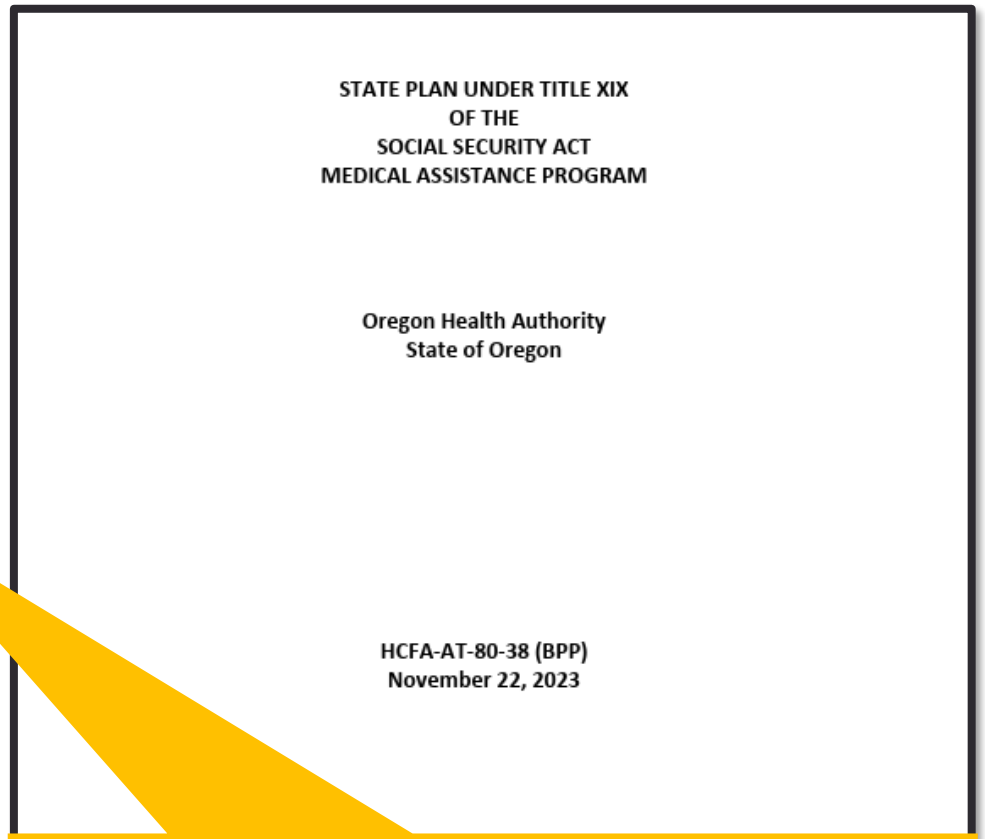
- Defines allowed providers and PA requirements
- Initial evaluation: 2 in any 12-month period, no PA required
- Re-evaluations: 4 in any 12-month period, no PA required
- After evaluation: requires plan of care, up to 30 rehab and 30 habilitative visits
- Additional visits based on medical necessity.
- Not covered: maintenance therapy, back school classes, others

Specific limits would be removed here so benefits can be managed in OAR and by HERC policy

Source: https://www.oregon.gov/oha/HSD/Medicaid-Policy/StatePlans/Medicaid-State-Plan.pdf (PDF page 358-359)

Future State Requires Limited State Plan Changes

- After the transition, the **State Plan can look similar to how it does today**.
- CMS can request specific changes and question any page Oregon asks to change
- OHA intends to continue outlining State Plan services at a high level to meet CMS' requirements while **providing flexibility for implementation.**
- Minor language changes to remove reference to the Prioritized List are needed.
  - Ideally, no major changes needed.



STATE PLAN UNDER TITLE XIX
OF THE
SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

Oregon Health Authority
State of Oregon

HCFA-AT-80-38 (BPP)
November 22, 2023

Putting too much detail in the state plan will require engagement with CMS every time a change is needed, no matter how minor.

Federal and State Rules Permit Additional Limits on Services

42 CFR 438.210

Permit an MCO, PIHP, or PAHP to place appropriate limits on a service—

i. On the basis of criteria applied under the State plan, such as medical necessity; or

ii. For the purpose of utilization control, provided that—

A. The services furnished can reasonably achieve their purpose, as required in paragraph (a)(3)(i) of this section;

B. The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the enrollee's ongoing need for such services and supports; and

C. Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with § 441.20 of this chapter.

42 CFR 438.210 -- Coverage and authorization of services.

OAR 410-141-3835: *MCE Service Authorization*

(9) MCEs may place appropriate limits on a service authorization for Covered Services based on Medical Necessity and Medical Appropriateness as defined in OAR 410-120-0000, or for utilization control provided that the MCE:

a) Ensures the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished;

b) Authorizes the services supporting individuals with ongoing or chronic conditions or those conditions requiring long-term services and supports in a manner that reflects the member's ongoing need for the services and supports […]

Oregon Secretary of State Administrative Rules

NOTE: **OAR 410-141-3830: Prioritized List of Health Services**

Currently describes the role of the prioritized list and will be updated to reflect "HERC Clinical Coverage Policies" to ensure these policies define medical necessity criteria in the future.

Note: 42 CFR 438.210 and OAR 410-141-3835 will remain unchanged in the future state based on this project, beyond making changes to Prioritized List references.

Applying Limits Based on Medical Necessity

Key Question for Discussion: How do CCOs and FFS determine what is medically necessary in the future state?

- **Oregon will continue to have a definition of medically appropriate and medically necessary** in rule for individual determinations (for adults, see OARs 410-120-0000 (193) and (194)).
- **HERC will continue to create evidence-informed medical necessity policy** to support effective, consistent utilization management across OHP, at the population level, including by updating **OAR 410-141-3830: Prioritized List of Health Services**

Applying Limits Based on Medical Necessity (cont'd)

Key Question for Discussion: How do CCOs and FFS determine what is medically necessary in the future state? OAR 410-141-3820

- **410-141-3820, Covered Services.** "(1) General standard. The OHP Benefit Package includes treatments and health services which pair together with a condition on the same line of the Health Evidence Review Commission (HERC) Prioritized List of Health Services adopted under OAR 410-141-3830...."
- Defines diagnostic and ancillary services, the role of HERC guidelines, ad hoc determinations and comorbidity rule
- OAR will need to be updated in 2026 based on any changes to statute.
- OHA's intent is to amend the rule to support HERC decisions being used very much as they are today as medical necessity policy

Key Takeaways So Far

Key Takeaways

- Minor changes are needed to Oregon's State Plan
- OHA and CCOs can still limit service utilization, based on medical necessity (e.g., as defined by HERC Clinical Coverage Policies and in rule)
- **No requirement that all services must be offered to all members**

What about pharmacy?
Limits can also be applied to pharmacy – CCOs and the State must allow a pathway to coverage for all drugs under federal rebate agreement, *but* they can establish utilization management controls (e.g., step therapy, prior authorization)

Applying Medical Necessity Policy

Key question: how will HERC create medical necessity policy In the future?

Current: The Prioritized List 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., coverage policies, guidelines, and notes) of the Prioritized List but will be **unranked code groups.**

Similar to today's ranking, each coding group will contain a set of diagnosis codes and procedure codes.

Examples	Denials				Newly covered after transition	
	Denials where only the denial reason is changing			Denials that will continue		
Condition /Service	**Cryotherapy (freezing) for warts**	**Hysterectomy for chronic pelvic pain**	**TMJ surgery**	**Infertility**	**Actinic keratoses for people at high risk of complications**	**Acupuncture for tension headaches**
Today	Denied because the condition treatment pair is below the line.	Denied because the condition treatment pair is below the funding line	Denied because the TMJ surgery pairs in the unfunded region, but may be approved per comorbidity rule (e.g., TMJ surgery would help with sleep apnea)	Denied because outside the OHP Benefit Package	Denied because condition is in the unfunded region and treatment for a comorbidity claim is unlikely to be approved Medications can be denied because the condition is unfunded.	Denied because the treatment-condition pair is below the funding line.
Future **Key takeaway**: no more denials because below the line, but in most cases can be denied for not medically necessary	Option A: Not medically necessary (does not pair) Option B: Pairs in not-medically-necessary code group	Option A: Not medically n ecessary (does not pair) Option B: Pairs in not-medically-necessary code group	Option A or Option B. Either way, surgery could be approved on appeal or request based on medical necessity and appropriateness/ad hoc coverage determinations	No change: Denied because outside the OHP Benefit Package (excluded)	Cryotherapy will pair as medically necessary, with a guideline, which specifies high risk populations for which removal procedures and medications are medically necessary. Medications can have step therapy/preferred agents & PA criteria aligned with the HERC guideline	Covered and medically necessary

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.

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BREAK

For Workgroup Discussion: Future State Claims Processing

OHA sent examples of how claims are processed today vs future state, focusing on services previously below the line. The team received helpful preliminary feedback from CCO medical directors on how to approach these scenarios in the future state, and seeks workgroup feedback.

For Discussion

- Do the processes described accurately reflect how you do things today? Any differences to highlight?
- In the future state, would you prefer “Plan A” or “Plan B”?
  - **Plan A**: No distinction between things HERC had or had not reviewed, ad hoc coverage determinations rule applies to both
  - **Plan B:** Developing a “not medically necessary” region of HERC Clinical Coverage Policies, like the existing “unfunded region” with key differences (different denial reasons, no comorbidity rule)
- Are there additional examples of services or medications you’d like OHA to think through?

Key Takeaways

See next slide for preliminary recommendations

1. State plan allows for utilization management – not all services will be covered for all members

2. Future state decisions must be made based on medical necessity – at claims processing, PA review, appeals and hearings.

3. CCOs can determine medical necessity using:
   - HERC clinical coverage policy (incorporated into OARs)
   - Other relevant administrative rules, including definitions of medical necessity and appropriateness
   - Third party compendia, medical evidence

4. Denial reasons may change for many “below the line” services today
   - “Below the line” denial reasons do not exist in the future.
   - *Most* pairs previously below the line (i.e., not covered) will now be considered *not* medically necessary (i.e., still not covered but for new reason), based on the reviews that HERC is currently undertaking

5. No explicit “comorbidity rule” but members can still request “exceptions,” i.e., individual review for medical necessity for covered services

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

What Could Legislative Recommendations Look Like?

Brainstorming: *Preliminary Recommendations for Consideration*

- **Revise statute to support HERC's continued role in reviewing evidence base to update medical necessity policy** as they do today for both mandatory and optional services in the HERC's purview, replacing the List with HERC Clinical Coverage policy.
- **Direct HERC to create "not medically necessary code groups"**
  - Non-pairing would *imply* not medically necessary
  - HERC could create not medically necessary pairings
  - Similar to "unfunded region," denials would be for 'not medical necessary' rather than 'below the line'
  - Members could still appeal based on medical necessity

Example: Explicitly pair Botox for TMJ as not medically necessary

Other Areas of Workgroup Feedback for Discussion in December

Other Non-Legislative Topics Being Tracked for Future Discussion

The workgroup also discussed several areas of activity that do not require legislative action, but that OHA could consider in the future. Below is the running list for further discussion after the finalization of legislative recommendations.

- **Consider establishing a workflow similar to today's process by which CCOs must make coverage decisions** *(e.g., HERC clinical coverage policies, then OARs, etc.)*

- **Consider opportunities to update definition of medical necessity**

- **Consider options (e.g., rulemaking, guidance or other approach) to create a standardized process for providers to submit medical necessity review requests to FFS and CCOs**

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Discuss Potential 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

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 Will Not Allow a Funding Line

42 CFR 440.230 applies to both mandatory and optional benefits defined in the state plan.

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" and *can* be denied without review of medical necessity.

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-made relative values established by HERC per medical evidence of population health benefit. For example, HERC ***could*** consider (*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

Additional Considerations:

- If funds are restricted further, OHA would use the relative rankings as input to reduce benefit limits (e.g., 30 visits of PT/OT to 15)
- For example, 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** prioritize 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 reduction 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

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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

Picturing the Future Code Group

Code Group: 10005

Condition:	TOBACCO DEPENDENCE (See Coverage Guideline ~~Notes~~ 4 and 92)
Treatment:	MEDICAL THERAPY/BEHAVIORAL COUNSELING
ICD-10:	F17.200-F17.228,F17.290-F17.299,Z71.6,Z72.0
CPT:	96156-96159,96164-96171,97810-97814,98966-98972,99051,99060,99202-99215,99341-99350,99366,99406, 99407,99415-99417,99421-99427,99437-99449,99451,99452,99487-99491,99495-99498,99605-99607
HCPCS:	G0019-G0024,G0068,G0071,G0088,G0090,G0140,G0146,G0248-G0250,G0318,G0323,G0459,G0463,G0466, G0467,G0469,G0470,G0511,G2012,G2211,G2214,G2251-G3003,G9016-G9038,H0038,S9453,S9563,D1320

COVERAGE GUIDELINE ~~NOTE~~ 4, TOBACCO DEPENDENCE, INCLUDING DURING PREGNANCY

Code groups **10001, 10005**

Pharmacotherapy (including varenicline, bupropion and all five FDA-approved forms of nicotine-replacement therapy) and behavioral counseling are medically necessary, alone or in combination, for at least two quit attempts per year. At least two quit attempts per year must be provided without prior authorization, and each attempt can include both pharmacotherapy and behavioral counseling. Combination drug therapy (i.e., two forms of NRT or NRT plus bupropion) is also included with each quit attempt without prior authorization. However, nicotine inhalers and sprays may be subject to prior authorization.

A minimum of four counseling sessions of at least 10 minutes each (group or individual, telephonic or in person) are included for each quit attempt. More intensive interventions and group therapy are likely to be the most effective behavioral interventions. During pregnancy, additional intensive behavioral counseling is strongly encouraged. All tobacco cessation interventions during pregnancy are not subject to quantity or duration limits.

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.

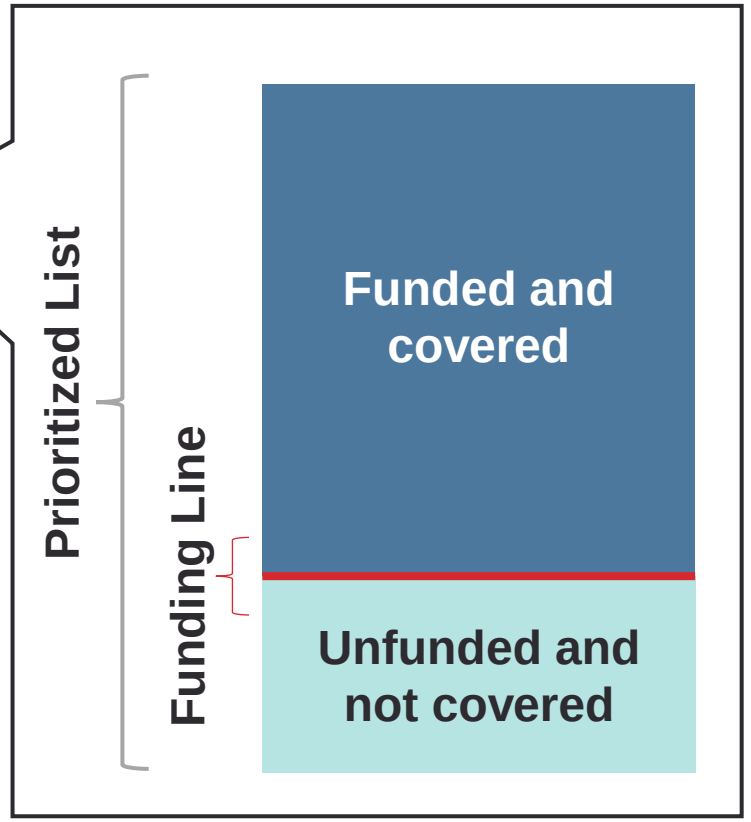
OHA will implement a new FFS Appeals option, if this initiative is funded.

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

The PL Contains Three Main Components Used to Determine Coverage

The three main components of the Prioritized List:

- **RANKED LIST OF SERVICES:** The *Health Evidence Review Commission (HERC)* ranks treatment-condition pairings based on population benefit.
- **GUIDELINE NOTES:** HERC notes to help clarify coverage of services on the PL and convey nuances of the evidence and HERC's determinations, to guide coverage decisions.
- **FUNDING LINE:** The *Oregon Legislature* sets a funding line – treatment-condition pairings ranked above the line are covered (when medically necessary as defined in OAR) and pairings ranked below the line can be denied (but appealed).



HERC decides the best treatment for complex conditions that require in-depth study but does not review all medical services. We will discuss the HERC's process in more detail in future meetings.