2/3/26

House Committee on Health Care

Sejal Hathi, MD MBA – Director

Emma Sandoe, PhD – Medicaid Director

The Prioritized List of Health Services and the Benefit Update Project (BUP)

Bill # 4003

Medicaid Division

OHA's 1115 Medicaid Waiver Authority for the Prioritized List

- **Oregon has had special approval from CMS to "waive" certain federal rules.** A waiver was needed because certain aspects of the Prioritized List do not comply with all federal Medicaid rules that govern state Medicaid plans.
- **Oregon's waiver authority to use the Prioritized List as it exists today will be phased out by January 1, 2027.**
- Without the waiver, Oregon must evolve the Prioritized List and **adopt an approach that fully meets federal rules**.

CMS Direction in OHA's 1115 Medicaid Waiver for the Prioritized List

CMS Requirements

- The state's waiver of amount, duration, and scope that **allows the Prioritized List as currently structured must be phased out** by January 1, 2027.
- OHA must submit a **phase-out plan** to CMS by June 30th, 2026, that outlines the state's approach to transitioning to state plan authority for coverage and denial decisions.

Special Terms and Conditions (STCs)* Related to "Phasing Out the Prioritized List"

13.9. **Phase-out of Waiver Authority Related to the Prioritized List.** The state's waiver of amount, duration, and scope related to the Prioritized List, authorized in the original 1994 approval, will be phased out of the OHP demonstration by January 1, 2027. Use of this waiver authority will continue until January 1, 2027 while the state coordinates with CMS and its Legislature to authorize and implement its termination. Oregon will also be required to submit a phase-out plan that will assure all mandatory state plan benefits are available to eligible OHP beneficiaries. The plan must include activities the state will perform, during the demonstration period, that will effectuate the phase-out, including timelines for submission of any necessary state plan amendments, as described in STC 3.9.

a. **Phase-out Plan.** The state must submit a phase-out plan to CMS, no less than six months prior to the expiration of the relevant waiver of amount, duration, and scope on December 31, 2026. Prior to submission of the plan to CMS, the state must publish on its website, the draft phase-out plan for a thirty-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the thirty-day public comment period has ended, the state must provide a summary of the comments received and any state changes to the phase out plan based on those comments. This Prioritized List Phase-Out Plan will be appended to these STCs as Attachment N.

*STC 4.2(c) and (d), pg. 19-20 also refer to phase out of waiver authority

CMS January 2026 Guidance

- **CMS guidance confirmed that Oregon cannot use the Prioritized List in its current form to make coverage and denial decisions** in its state plan.
- **CMS guidance was clear that Oregon can continue its innovative model.** CMS confirmed the federal rules do allow Oregon to continue to use the clinical criteria outlined in the Prioritized List to guide medical necessity criteria.
- **The update bill simplifies implementation** to keep the name of the Prioritized List and simply remove the funding line and the ranking system to comply with federal requirements.
- We have an **obligation to our federal partners** to ensure that state statute is clear and aligns with updated requirements

Preserving Oregon's Evidence-based OHP Benefit Package

- OHA will maintain a **defined, evidence-based OHP benefit package**
- Coverage decisions will be based on medical necessity as informed by the HERC
- **HERC's transparent, evidence-based process will continue** to provide medical necessity criteria for OHA and CCOs through the Prioritized List
- **CCOs will be able to continue to manage the medical needs of their members** and use HERC's policies to do so

For adults, services outside of the benefit package can be denied.

OHA is Preserving Key Elements of the Prioritized List

Most of what makes up the Prioritized List today will continue.

What is not changing

- **The Health Evidence Review Commission's (HERC) role and robust public process** to review medical evidence and create clinical criteria that guides coverage decisions.
- **HERC's list of treatment-condition code pairs to guide decisions based on medical necessity will continue to be found on the Prioritized List.**
- **OHA's and the Legislature's role** to define coverage and implement OHP.
- **State's authority to limit benefits or manage budget** in other ways.

What is changing

- **No funding line** to determine what is covered and what is not.
- HERC's list of treatment-condition pairs to guide decisions based on medical necessity will still appear in the Prioritized List but **will not be ranked**.

What Does it Mean to No Longer Have Rankings or a Funding Line?

- **HERC will no longer list treatment-condition pairs in a ranked order.** HERC will continue its robust public process to review medical evidence and create clinical criteria that OHA and CCOs can use to guide coverage decisions.

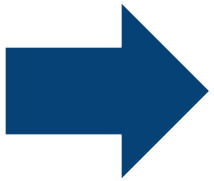
- **The ranked list is divided by a funding line set by the Oregon Legislature, which CMS has not allowed Oregon to move upwards to generate savings since 2012**. Treatment-condition pairs ranked above the funding line are generally "covered" and treatment-condition pairings below the line are not.
  - OHA and CCOs will no longer be able to deny services based on where a treatment-condition pair is relative to the funding line. Coverage decisions will need to be made based on medical necessity, which OHA and CCOs will need to assess using HERC policy as guidance.

HERC's Role in Future

The HERC will continue to routinely evaluate medical necessity for OHP benefits to incorporate new medical codes, make corrections, and incorporate medical advancements.

Process

Public, transparent, evidence-based process that solicits community feedback and holds the HERC and the State accountable for the coverage decisions made.



Output

- Services will no longer be ranked
- HERC will develop the Prioritized List that will serve as statewide clinical criteria

What Does This Change Mean for Members, Providers, and CCOs?

What Does This Change Mean for Members?

- **Children and youth under age 21** are not impacted because of this transition.
  - Since 2023, OHA and CCOs have been required to cover all medically necessary and medically appropriate services for OHP members under age 21, regardless of placement on the Prioritized List.
- **Members will not lose benefits because of this change**.
- **OHP members will have access to additional medically necessary treatments** that are already available to Medicaid members in other states, including:
  - Allergy testing & treatment for allergic rhinitis, dermatitis and related conditions
  - Physical therapy for chronic pelvic pain
  - Surgery for foot ulcers in diabetic patients
- **OHP will still not cover treatments that are cosmetic or medically unnecessary, or that are excluded from coverage** (e.g., infertility treatments).

What Does This Change Mean for Providers?

- **Most of the changes affect systems and processes rather than change how OHP services are delivered.**
  - For example, claims management systems will need to include newly covered services and remove references to “below the line.”
- **The Prioritized List will continue to include code pairings and coverage guidelines**.
- **Provider should be aware** that some additional mandatory services will be covered for some conditions as HERC reviews current policies

What Does This Change Mean for CCOs?

- **CCOs will need to make coverage decisions based on clinical criteria**, rather than a position above or below the funding line
  - CCOs will need to update member handbooks to remove language about above and below the line, and coverage based on position relative to the line.
- **CCOs will be able to rely on the Prioritized List for medical necessity criteria**
- The **same definitions of medical necessity and appropriateness in OAR will apply** to all CCOs as they do today
- CCOs will be required to **cover some additional services that are federally mandated**
  - Costs for these treatments are included in OHA's budget rebalance to ensure CCOs do not have absorb these necessary costs

Proposed Legislation

What Does Bill #4003 Do?

- **Amends Oregon statute to**:
  - Implement the transition to defining covered services based on medical necessity as informed by HERC, instead of ranking relative to the funding line
  - Require OHA to consult with HERC prior to any significant reductions in Medicaid benefits (*BUP Workgroup recommendation*)
- **At the recommendation of the BUP workgroup, the bill directs OHA to conduct rulemaking to**:
  - Define the role of the Prioritized List in determining the extent of OHP benefits, in appeals and hearings, and in allowing for individual medical review
- **At the recommendation of the BUP Workgroup, the bill directs HERC to:**
  - Evaluate the availability of relevant utilization data and the resources necessary to leverage existing utilization data to inform the clinical criteria laid out in the Prioritized List

What Does Bill # 4003 Do?

- **Following the BUP Workgroup recommendation, the bill directs OHA to:**
  - **Ensure HERC policies are readily accessible** and published on a single webpage
  - **Develop tailored technical assistance and materials** for members, providers, and CCOs about the transition
  - **Consult with OHA actuaries** to review data as soon as possible after January 1, 2027, to ensure there is sufficient data for developing CCO rates for 2028

- **Guided by the BUP Workgroup recommendation, the bill directs OHA to study:**
  - How OHA and CCOs will make coverage decisions in OHP based on HERC's Prioritized List
  - Areas for **potential alignment between FFS and CCOs**
  - Along with the HERC, the implications and feasibility of developing not medically necessary diagnosis and treatment code pairings

Why Do We Need Bill #4003?

- **Oregon needs to amend state statute and rules to**:
  - Align with federal law
  - Comply with OHA's contract with CMS (1115 waiver)
- **OHA could lose federal match if it continues to use the Prioritized List in its current form to determine covered services** and not align with federal laws that govern state plans
- **Not aligning state statute and rules with federal law could also create confusion** around what benefits Oregon Medicaid covers
  - Members might be uncertain about what benefits they can receive
  - At Medicaid hearings, there may be uncertainty about where Medicaid benefits are defined

Continued Engagement

- Health Evidence Review Commission meetings
- Dedicated time at CCO Quality & Health Outcomes Committee meetings
- Rules Advisory Committee in Summer of 2026
- Public comment period before Phase-out Plan submission to CMS by June 30, 2026
- State Plan Amendment (Summer 2026)
- Ad-Hoc Technical Office Hours for CCOs and Providers
- 1115 Waiver and Medicaid Advisory Committee Meetings (quarterly discussions)

Summary

- **Some features of Prioritized List as it functions today must be phased out.** Per CMS, OHA must phase out the use of the Prioritized List's funding line and ranking system.
- **OHA will still maintain a defined, evidence-based benefits package for OHP**
  - State will maintain its ability to place limits on mandatory and optional benefits (as defined by federal law) when needed, including deciding which optional services to cover
- **HERC will maintain a robust, transparent process** to define statewide clinical criteria to guide medical necessity decisions for covered services, based on available evidence
  - HERC's Prioritized List will continue to include treatment-condition pairings and guideline notes that provide direction on the appropriate use of services in specific circumstances
- **CCOs will be able to continue to use HERC's Prioritized List and other utilization management tools**

OREGON HEALTH AUTHORITY

Thank You

Website: https://www.oregon.gov/oha/hsd/medicaid-policy/pages/benefit-update.aspx
Email: marybeth.mealue@oha.oregon.gov