1115 MEDICAID WAIVER
IMPLEMENTATION PROJECT | OREGON

OREGON HEALTH AUTHORITY

November 18, 2025

Benefit Update Project (BUP) Workgroup: Meeting #7

BUP Workgroup Meeting Agenda & Goals

Agenda:

- **Summarize next steps for legislative process and timeline**
- **Overview BUP OAFA Cost Estimates**
- **Vote on revised, initial recommendations and preamble**
- **Discuss pharmacy impacts**
- **Discuss FFS and CCO alignment**

Goals:

- Align on next steps
- Understand BUP-related rate impacts
- Finalize initial recommendations to date
- Finalize preamble language

Preview: 12/2 Workgroup Meeting Agenda

Discuss OHA-led activities to support changes without legislative action, including details on communications and technical assistance, and finalize legislative recommendations, as needed.

Summary of Legislative Next Steps

The BUP Workgroup's recommendations will be submitted to the state legislature in November and December for consideration in a BUP legislative package in 2026.

Nov 19: Submit Initial BUP Legislative Recommendations

- OHA will submit initial recommendations from the BUP workgroup to the state Legislature
- OHA will meet with Representative Nosse

Dec 2: Finalize Additional Recommendations

- Revisit additional legislative recommendations
- Discuss potential OHA-led activities to support the phase out of the Prioritized List that do not require legislative action

February 2026: Short Session

- Legislature will vote on revised statute.

Other opportunities for public comment on BUP activities:

- Rulemaking
- Phase-out plan

Benefit Update Project
OAFA Cost Estimates

BUP Cost Estimates (1/6)

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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Discussion

Vote on Recommendations

Revised Preamble (incorporating WG feedback)

The Oregon Health Authority (OHA) and the Centers for Medicare & Medicaid Services (CMS) have determined that Oregon's Prioritized List of Health Care Services (the Prioritized List) must be phased out as of January 1, 2027.

In this context, OHA, in collaboration with the Governor's Office and Legislative leaders, chartered the Benefit Update Project (BUP) Workgroup and tasked the Workgroup to make recommendations to transition away from the Prioritized List, while retaining its core components and functions. **The BUP recommendations are made within these parameters, but not all Workgroup members endorse those parameters. The BUP Workgroup has continually expressed the importance of maintaining the Health Evidence Review Commission's vital work. The BUP Workgroup has also expressed commitment to identifying opportunities to improve member experiences, and equitable health outcomes, within the Oregon Health Plan.**

The Legislature should adopt legislation based on the following recommendations.

Vote on Recommendation to Keep PL

For discussion

For Discussion: Preliminary Recommendation for FFS and CCO Alignment

For discussion

For Discussion: Preliminary Recommendation Regarding Draft Rates

OHA should conduct actuarial assessments at least every 6 months for the next budget cycle to compare projected versus actual spend changes related to Prioritized List changes, and bring this analysis to appropriate groups including HERC and clinical leadership.

For Discussion: Additional recommendations

For discussion

Revised HERC Prioritization / Budget Consideration Recommendation (incorporating feedback)

- ***Modified –*** 2a: OHA shall consult with HERC prior to making reductions in Oregon Health Plan benefits.

- ***New –*** 2b: OHA shall consult with the Medicaid Advisory Committee and the Beneficiary Advisory Council whenever reductions are proposed to Oregon Health Plan benefits

- ***Modified –*** 2c: OHA shall implement greater utilization data monitoring to inform modification of HERC Clinical Coverage Policies.

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 11/5 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)	Statutory	• **Yes:** Adriane, Gary, Cat, Jeanne, Heather, Amy, Erin, Briana, Mike • **No:** Bridget, Ben • **Abstain:** None • **Not Present:** Art, Mary
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 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.	Statutory	• **Yes:** Adriane, Gary, Cat, Bridget, Briana, Jeanne, Ben, Mike, Amy, Erin • **No:** None • **Abstain:** None • **Not Present:** Art, Mary

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

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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

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.

- 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 for examples*

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 for Pharmacy

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