Information updated November 22, 2024.

Changing how Oregon defines Medicaid benefits

Since 1994, Oregon has used the Prioritized List of Health Services to define most of what Oregon Health Plan (Medicaid) covers. This list ranks health conditions and their treatments.

- Treatments that are most effective or most important for the majority of people with Medicaid rank higher.
- Unnecessary or less effective treatments rank lower.

Oregon is the only state that uses a Prioritized List.

The funding line

The Oregon Legislature sets a funding line in the Prioritized List. Services above the line are covered. Services below the line are usually not covered.

For years, the legislature was able to adjust the funding line, moving it up or down based on state budgets. In 2012, the federal Centers for Medicare & Medicaid Services (CMS) stopped allowing the state to move the funding line if the change would reduce benefits.

What's changing?

CMS is requiring Oregon Health Authority (OHA) to stop using the Prioritized List by Jan. 1, 2027. Instead, OHA must group services into categories to decide which services to cover. These decisions will be in Oregon's Medicaid State Plan.

- The federal government sets these categories. It also sets which categories are mandatory and optional.
- OHP will cover all medically necessary services in mandatory categories.
- Optional categories will clearly list covered and non-covered benefits.

- Oregon will decide which new optional benefits to cover.

This matches how other states define Medicaid-covered services.

What this change means for OHP 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.
- Starting in January 2027, OHP will cover medically necessary treatments for more health conditions, like fibromyalgia.
- OHP still won't cover treatments that are cosmetic or medically unnecessary.
- OHA or the member's coordinated care organization (CCO) may still need to approve some services.

How will this change affect those providing health care to OHP members?

- Oregon Health Plan will continue to offer members quality health care and work toward lowering costs.
- Most of the changes affecting CCOs and providers will be administrative. They will 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" and "Prioritized List".
- Prioritized List policies like code pairings and coverage guidelines will continue.
- OHA will work with CCOs and providers to understand the potential impacts and level of effort to update systems and processes.

All treatment decisions and appeals will need to be based on medical necessity – not on the Prioritized List funding line.

The Health Evidence Review Commission

The Health Evidence Review Commission (HERC) manages the Prioritized List. The commission is an independent body that:

- Looks at the science behind treatments
- Decides what treatments are medically necessary
- Gets feedback from members on which services OHP should cover

Medically necessary means a treatment is:

- Needed to prevent, diagnose or treat a condition
- Supports growth, development and participation in school
- Backed by science

What will HERC's role be after January 2027?

HERC will continue to supply benefit/treatment paired codes and Guideline Notes to support medical necessity decisions. And it will continue to:

- Review evidence and community input on clinical services
- Support public, transparent processes
- Seek opportunities for community engagement
- Produce guidance on the medical necessity of some services
- Document conditions and their covered treatments

Seeking input on potential impacts to members and to organizations providing health care to members

OHA will hold virtual work sessions with coordinated care organizations (CCOs), Open Card contractors, providers and community partners to gather feedback. These meetings will be opportunities to understand the potential impacts and level of effort of updating systems and processes and to work through any operational challenges.

OHA also anticipates discussing operational decisions and implementation planning with CCOs beginning in early 2025 and providers in future project phases.

OHA will continue giving updates on the project to the public during HERC meetings. OHA will also share updates through Quality and Health Outcomes Committee meetings and meetings with groups that support members.

Stay informed:

Visit the Benefit Update Project web page for to learn more.

Questions?

Email 1115Waiver.Renewal@odhsoha.oregon.gov.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the Benefit Update Project at 1115Waiver.Renewal@odhsoha.oregon.gov.

Medicaid Division
1115 Waiver Strategic Operations
800 NE Oregon Street
Portland, OR 97232
1115Waiver.Renewal@odhsoha.oregon.gov
https://www.oregon.gov/oha/hsd/medicaid-policy/pages/benefit-update.aspx