

Public notice

Notice of Intent – OHA will submit Oregon’s Medicaid Phase-out Plan for the Waiver Authority Related to the Prioritized List

From: Jessi Wilson, 1115 Waiver Strategic Operations Director

Date: April 15, 2026

Comments due: 5 p.m. Friday, May 15, 2026

The Oregon Health Authority (OHA) will submit for approval a “Phase-out Plan” for the Waiver Authority Related to the Prioritized List to the Centers for Medicare & Medicaid Services (CMS) on June 30, 2026. Per the Special Terms and Conditions of the [Oregon Health Plan \(OHP\) 1115 Waiver](#), the Phase-out Plan must assure all mandatory state plan benefits are available to eligible OHP beneficiaries and include activities the state will perform, during the demonstration period (i.e., 2022-2027), that will effectuate the phase-out, including timelines for submission of any necessary state plan amendments. The draft Phase-out Plan for the Waiver Authority Related to the Prioritized List is included below.

How to comment:

OHA welcomes public review and input on Oregon’s draft Phase-out Plan for the Waiver Authority Related to the Prioritized List. Please send written comments by 5 p.m. Friday, May 15, 2026, to 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 us by email at 1115waiver.renewal@odhsoha.oregon.gov or by phone at 503-945-5772. We accept all relay calls.

Background and Overview

Oregon's section 1115(a) waiver demonstration, entitled "Oregon Health Plan (OHP)," is authorized through September 30, 2027. The demonstration outlines the terms and conditions related to the "Prioritized List of Health Services" (Prioritized List). The Prioritized List was first authorized by the Centers for Medicare & Medicaid Services (CMS) in 1994 and waives 42 CFR 440.230 related to amount, duration, and scope. Developed by the Oregon Health Authority's (OHA) Health Evidence Review Commission (HERC), the Prioritized List ranks health conditions and treatment pairs by priority, which Oregon policymakers then use to determine what benefits will be covered by Medicaid, based on available funding. However, CMS requires the state to phase out its waiver of amount, duration, and scope requirements related to the Prioritized List by January 1, 2027.

In accordance with Special Terms and Conditions (STCs) 3.9 and 13.9 of the demonstration, this phase-out plan does the following:

- Outlines the activities the state has performed to effectuate the phase out of the waiver authority related to the Prioritized List
- Assures all mandatory state plan benefits are available to eligible OHP beneficiaries
- Summarizes feedback received via a public comment and tribal consultation process
- Outlines timelines for the submission of any necessary state plan amendments

Specifically, this phase-out plan addresses the following areas:

- 1. Key Work and Partner Engagement Conducted to Date to Support the Transition**
 - a. External Workgroup to Support the Transition
 - b. HERC Support for the Transition
 - c. Collaboration with Internal Experts to Support the Transition
 - d. Member Notices Regarding the Transition
- 2. Public Comment Process**
 - a. Summary of Public Comment Approach
 - b. Feedback Received During Public Comment Period
 - c. Summary of Changes Made in Response to Feedback
- 3. Next Steps to Support Transition**
 - a. Submission of State Plan Amendments (SPAs) to CMS
 - b. Operational Planning and Next Steps

OHA and HERC have been preparing for this transition for several years, conducting engagement with interested parties and making internal plans.

OHA is committed to working with CMS on the policy and operational details necessary to phase out the 1115 Waiver authority for the Prioritized List. The state recognizes that many operational elements depend in part on CMS processes and policies and looks forward to collaboration to ensure a successful transition.

Key Partner Engagement Conducted to Date to Support Transition

Since the approval of the 2022-2027 waiver in September 2022, OHA has conducted extensive internal and external work to support the phase out of the 1115 Waiver authority related to the Prioritized List. The state has engaged in research and supported engagement initiatives with key partners and subject matter experts over the past three years.

External Workgroup to Support Transition

In late 2023, OHA chartered a cross-divisional team to make policy recommendations and develop an internal plan for the transition and began a series of public engagement sessions for interested parties to lay the groundwork for the transition. The work included policy analysis, an equity assessment, financial impact analysis, and information systems impact assessment and planning.

In August 2025, OHA created an external workgroup to provide legislative and agency-specific recommendations on the phase-out of the 1115 Waiver authority related to the Prioritized List. The Workgroup was charged with considering the potential implications of, and ways to streamline, the transition of the Prioritized List, with the goal of minimizing disruption to care, advancing health equity, and supporting the delivery of appropriate, high-value health services under OHP. These considerations were discussed in a series of eight Workgroup Meetings, organized and facilitated by OHA between August and December 2025.

The workgroup provided feedback on key operational issues including member appeals, state fair hearings, medical necessity review, rate setting, and standardization of the OHP benefit package. The workgroup considered policy, operational, and clinical impacts to help ensure a successful transition for members, CCOs, the Nine Federally Recognized Tribes of Oregon and Urban Indian Health Program, health care providers, and other impacted parties (e.g., advocates, clinicians, community-based organizations).

The Workgroup consisted of thirteen members, representing the following sectors:

- CCOs
- Dental care organization

- Disability rights community
- Federally Qualified Health Center (FQHC) or other community-based clinical provider
- HERC
- Hospital or health system
- Legal aid organization
- Statewide behavioral health association
- Nine Federally Recognized Tribes of Oregon and Urban Indian Health Program

The Workgroup's final recommendations were shared with implementation partners (e.g., OHA, CCOs, providers) and other key entities, including the Governor's Office and Legislature, starting in November 2025.

Based on recommendations made by the workgroup, a revised bill was considered during the 2026 Legislative session. However, the bill did not move forward in the legislative session. Meanwhile, OHA continued preparing for the transition based on the workgroup's recommendations, including state rulemaking and clear communication with impacted parties.

Health Evidence Review Commission (HERC) Support for the Transition

HERC Overview

The Oregon Legislature established the [Health Evidence Review Commission](#) (HERC) in 2011 as the body responsible for reviewing and making benefit coverage decisions for certain clinical services covered by the OHP. Since its creation, HERC has been responsible for maintaining the Prioritized List. HERC consists of thirteen commissioners, appointed by the governor and confirmed by the state Senate. All Commissioners are volunteers, and include five members who are physicians, two consumer advocates, a public health nurse, an alternative care provider, a dentist, a pharmacist, a behavioral health representative, and a representative from the insurance industry.

HERC maintains the Prioritized List through a public, transparent, evidence-based process of reviewing health care services covered by the OHP. The HERC is responsible for routinely evaluating medical necessity for OHP benefits to incorporate new medical codes, make corrections, and incorporate medical advancements, and its decisions include changes that affect limitations in the state plan. The Prioritized List currently is divided into two parts, a funded and an unfunded region, by a funding line set by the Oregon Legislature. The list currently has 641 lines, 470 of which are funded in 2026. Each line includes specific diagnoses and procedures which are medically necessary for these diagnoses. In some cases, guideline notes provide limitations on which services are covered. In general, services identified on lines which are above the funding line are covered and services below the line are not unless certain exceptions apply.

In most cases, the clinical policy represented in the Prioritized List is similar to medical necessity policy in other state Medicaid programs. For example, the diagnoses related to back pain appear on line 343 (in the funded region), along with the procedures for spinal decompression surgery, when they meet detailed criteria established by guideline note 37. Other services appear in the unfunded region even though they meet the state's definition of medical necessity and are denied as outside the benefit package for funding reasons (with certain exceptions).

HERC Role in the Transition

In its public meetings during the waiver period, HERC has been working to update its processes and recommendations to align with the state's phase out of the waiver authority for the Prioritized List and assure all mandatory state plan benefits are available to eligible OHP beneficiaries. HERC's role in supporting the transition process primarily consists of redesigning the Prioritized List to serve its new role in guiding medical necessity policy for OHP, within the approved amount, scope, and duration as defined in the state plan:

1. Services currently covered in the current funded region will now guide medical necessity policy for OHP. Services which align with the current lines in the funded region will continue to be covered and treated as medically necessary, as they are today.
2. Services currently below the Prioritized List funding line (now "unfunded" and not covered) were reviewed in 2025 to determine which are medically necessary according to the state's definition set out in administrative rule and within the amount, duration, and scope described in the state plan. Services so identified will remain on the Prioritized List and be considered medically necessary with appropriate guidelines.
3. Language in the guideline notes on the Prioritized List will be modified to make clear that they constitute medical necessity criteria. For instance, a guideline indicating that bariatric surgery is included on line 317 will be rephrased to indicate that bariatric surgery is medically necessary for the conditions on line 317 when those same criteria are met.
4. Other administrative (non-substantive) changes will be made to clarify coverage and simplify administration based on the changing role of the Prioritized List in coverage policy. For instance, evaluation and management codes may be removed from the Prioritized List, with policy indicating that these are covered regardless of the diagnosis, except for conditions (such as infertility) which are excluded from the benefit package.
5. In consultation with clinical experts from a variety of medical disciplines, HERC completed its review of the unfunded region in 2025 and identified the services which it considers medically necessary. Services outside the scope of the benefit as defined by the state plan will continue

not to be covered (except as required by law under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program).

Collaboration with Internal Experts to Support Transition

OHA has collaborated with internal experts to address OHP changes related to the phase out of the waiver authority for the Prioritized List including:

- Appeals and Hearings Staff
- Office of Actuarial and Financial Analytics
- Health Evidence Review Commission staff and members
- CCO Operations staff
- Medicaid Policy Team
- Medical Leadership
- Medical management team
- Medicaid Management Information Systems (MMIS) team
- Claims and Encounter Data Unit
- Pharmacy and Therapeutics Committee staff

Collaboration with internal teams has focused on ensuring all mandatory state plan benefits will be available, when medically necessary, to eligible OHP beneficiaries beginning January 1, 2027, through necessary changes to MMIS, state rules and policies, and CCO contracts.

Appeals and Hearings

After the transition, OHA and CCOs will approve and deny services based on medical necessity rather than based on their historical position above or below the funding line on the Prioritized List. These determinations will, in many cases, be supported by medical necessity policy expressed in the revised Prioritized List. Any individual who is denied a covered service will have a right to appeal. Since state regulations and HERC coverage decisions have historically been tied to the position of a treatment-condition pair relative to the funding line on the Prioritized List, the transition process necessitates updates to administrative rules relied on in appeals and hearings so that policy expressed on the Prioritized List will serve only as medical necessity policy.

MMIS

Service coverage, service authorization, denial notices, and claims processing are structured on the Prioritized List, and include specific terminology (e.g., paired above the line). While much of the existing structure in MMIS will support this change, it will need some configuration. Additionally, all references to the Prioritized List need to be reviewed and updated to align with the transition to

coverage decisions based on medical necessity and ensure MMIS generated letters and notices contain compliant language.

CCO Rates

OHA has worked with its actuaries to update CCO rates to reflect the transition and the coverage of some additional services previously not covered. OHA intends to increase 2027 CCO rates to reflect the cost of these additional services. A recent estimate of the aggregate projected cost impact is a 0.7% increase in capitation rates.

Member Notices Regarding the Transition

As a result of the transition of the Prioritized List from the 1115 Waiver to the State Plan, individuals covered by OHP will not lose access to any currently covered services. Notices were not sent to members regarding this change since there is no loss of coverage. Quarterly updates have been provided at OHA's 1115 Waiver All Come/Para Todos webinars outlining the changes to members, including highlighting the additional services that will be covered as a result of this transition. OHA will amend its Member Handbook template in the 2027 CCO contract to remove references to the funded region or funded treatment/condition pairs on the Prioritized List.

Public Comment Process

Summary of Public Comment Approach

[To be filled in May]

Feedback Received During Public Comment Period

[To be filled in May]

Summary of Changes Made in Response to Feedback

[To be filled in May]

Next Steps to Support Transition

Submission of Essential State Plan Amendments (SPAs) to CMS by October 1, 2026

Oregon's State Plan defines how it administers its Medicaid program and what expenses will be matched by the federal government under 42 CFR 431.10. By January 1, 2027, the state will transition from using the Prioritized List to define covered services to using categories of services described in the state plan. The Prioritized List will be used to guide medical necessity policy.

While Oregon's state plan already captures the amount, duration, and scope of services at a high level, OHA will need to make changes to reflect the details of how mandatory and optional services will be covered. Oregon has been working with CMS staff informally to review draft SPA changes. CMS has identified 5 sections where a required change is needed, and OHA Medicaid staff have been reviewing all other areas for any necessary changes. Once CMS has completed their informal review, we have targeted official submission to CMS no later than October 1, 2026. CMS has 90 days to review the official submission, and we anticipate approvals prior to January 1, 2027.

Operational Planning and Next Steps

OHA has collaborated across internal teams to conduct intensive planning and develop next steps to support the transition. OHA has conducted a comprehensive review of all state statutes, regulations, contracts, and other agency materials that reference the Prioritized List and will need to be updated to ensure a smooth transition.

Oregon Administrative Rules (OARs)

Oregon Administrative Rules (OARs) are the regulations state agencies adopt to carry out statutes from the Legislature. OHA is in the process of revising the OARs to update references to the Prioritized List to (1) clarify that the Prioritized List will serve as clinical coverage criteria and (2) remove references to the funding line.

CCO Contract Updates

OHA contracts with CCOs to manage and deliver health care for most OHP-eligible individuals in the state. Existing CCO contracts contain references to the Prioritized List as the method for determining coverage for OHP members. To support the transition, OHA has worked with CCOs and is revising CCO contracts, including Member Handbook templates, that will be effective January 1, 2027.

Conclusion

Oregon has performed, during the demonstration period, the activities outlined above to effectuate the phase-out of the Prioritized List under the state's 1115(a) waiver. OHA will continue to work with CMS on the policy and operational details of the transition.