Governor's Advisory Group on Medicaid Sustainability Final Report

Summary

In 2025, Congress passed President Trump's House Resolution 1 (H.R. 1) known as the "Big Beautiful Bill." H.R. 1 drastically changes the state and federal partnership that has governed the Medicaid program in Oregon. When the federal proposals were being considered, Governor Kotek highlighted the impact that the policies would have by convening a roundtable of health care providers and consumer advocates, advocating against these changes directly to Oregon leaders in Washington, D.C., and highlighting how damaging these policies would be on Oregon. Now that they are being implemented, these policies will result in significant losses to Oregon's health care system in two ways:

- Projected loss in coverage due to federal policies, resulting in fewer reimbursable services for providers and an increase in the uninsured; and
- Direct limitations on federal funding and revenue policies, resulting in an immediate general fund shortfall for 2027-29 that totals $9.41 billion in general and federal funds by 2031.

These drastic federal changes undermine the state's long commitment to keeping Oregonians insured and are intended to compel states to take drastic action to balance the loss of federal funding.

In 2025, Governor Kotek convened an Advisory Group on Medicaid Sustainability ('advisory group') to seek input on how the state might address the shortfall caused by H.R.1. The advisory group developed a set of options for her to consider for the 2027-29 Governor's Recommended Budget to respond to an estimated $421 million biennial General Fund Budget gap created by the passage of H.R.1. Governor Kotek established starting principles for the work, including a directive to preserve health care coverage and eligibility for the Medicaid program, and ensure no one strategy disproportionately affects one part of Oregon's health

care system. In response, the advisory group developed a range of budget options and actionable strategies for the 2027–29 biennium. To form these options, the advisory group reviewed and commissioned analyses, including comparisons of Oregon's benefit to other states. Some of this work is reflected in the appendices of this report. The options identified by the advisory group span programmatic, operational, and financing approaches, reflecting the group's charge to balance program sustainability with continuity of coverage. Benefit design was also considered by the advisory group. Longer term guidance for the Medicaid program was also discussed by the group for the Governor's consideration in anticipation of a larger funding deficit in the 2029-31 biennium due to H.R.1. Governor's office advisors also met regularly with a bicameral, bipartisan group of legislators to discuss H.R. 1 impacts and trends within the Medicaid program, and also sought to ensure members of the legislature had access to similar information and insight into the advisory group's process. Input and impressions collected from these legislative discussions are solely advisory to the Governor and will also help inform how she considers options presented in this report.

The Governor is not obligated to adopt or otherwise pursue development of the options produced by the advisory group. The options presented in this report do not constitute decisions or opinions of the Governor.

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Background on the Advisory Group

Governor's Charge to the Group

Governor Kotek convened this advisory group to develop a set of options for her to consider when taking actions necessary to stabilize the Medicaid program due to significant funding reductions in the 2027-29 biennium and into the future due to the passage of H.R.1, the federal budget reconciliation bill. The advisory group's focus was primarily on 2027 and beyond, but included consideration of any option that could start during this biennium.

The Governor established principles, scope, and values that informed the advisory group's work. Of those, the Governor expressed a commitment to assuring that Oregonians who rely on the Oregon Health Plan (OHP) maintain access to critical health care services. The Governor also called for the group to maintain health care coverage and enrollment levels. The advisory group was developed to identify how best to meet this charge.

The Governor is not obligated to adopt or otherwise pursue development of the options produced by the advisory group. The options presented in this report do not constitute decisions or opinions of the Governor.

The overall impact of H.R.1 and corresponding budget gap to the state's Medicaid program may change over time and the advisory group's funding target was established by determining a point-in-time estimate.

Group Scope of Work

The scope of the advisory group's work was the Medicaid budget within the Oregon Health Authority (OHA), given that H.R. 1 primarily impacts the Medicaid program as administered by OHA. Long-term care and long-term services and supports (LTSS) and other Medicaid programs administered by the Oregon Department of Human Services (ODHS) were out of scope for the advisory group.

Out of Scope:

- Budgets outside of the OHA.
- Programs within the OHA or Department of Consumer and Business Services that are outside of Medicaid, Marketplace or the Reinsurance Program.
- Recommendations that affect collective bargaining agreements.

Group Roster

Member	Organization
Mindy Stadtlander	Health Share of Oregon
Sean Jessup	Eastern Oregon Coordinated Care Organization (CCO)
Max Janasik	AllCare Health
Brent Eichman	Umpqua Health Alliance
Eric Hunter	CareOregon
Felisa Hagins	Service Employees International Union
Ann Tan Piazza	Oregon Nurses Association
Sejal Hathi	Oregon Health Authority (OHA)
TK Keen	Department of Consumer and Business Services (DCBS)
Jennifer Burrows	Providence Hospitals and Health Systems
Jeremy Davis	Grande Rhonde Hospital
Becky Hultberg	Hospital Association of Oregon
Megan Haase	Mosaic Community Health
Carla McKelvey	Oregon Medical Association
Shereef Elnahal	Oregon Health and Science University
Olivia Quroz	Oregon Latino Health Coalition
Wendy Watson	Kaiser Foundation Health Plan & Hospitals of the Northwest
Teri Barichello	Delta Dental of Oregon

Process: How the Group Worked

The Governor's advisory group was convened to develop a clear, data-driven understanding of the Medicaid program's current state, how H.R. 1 will change the state's Medicaid program, and develop options for maintaining program viability amid significant fiscal pressure. The advisory group met as frequently as every two weeks beginning in November 2025 and through June 2026.

At the outset, the advisory group discussed guiding principles to anchor its work, including preserving coverage levels, protecting access to care to the extent possible, and advancing solutions that are operationally feasible within the state's delivery system. The principles helped ensure that subsequent discussions remained grounded in fiscal responsibility, Oregon's longstanding commitment to access and equity in Medicaid, and remained practical.

With that framework in place, the advisory group conducted a comprehensive review of the current Medicaid landscape. This included a detailed analysis of enrollment trends, financing mechanisms, spending patterns, and key cost drivers, as well as an assessment of benefit design and utilization. The goal was to build a common understanding of how the program is functioning today—what is driving growth, where pressures are emerging, and which components of the program are delivering the most value. This baseline analysis was critical for identifying both structural challenges and potential areas for reform.

The advisory group then turned to forward-looking pressures, including the anticipated effects of federal policy changes under H.R. 1 on the 2027–29 budget cycle. This analysis highlighted the magnitude of the fiscal gap facing the state and underscored the need for proactive planning. In response, the advisory group began developing a range of budget options, with a specific directive from the Governor to maintain enrollment levels while identifying actionable strategies for the 2027–29 biennium. These options span programmatic, operational, and financing approaches, reflecting the group's charge to balance sustainability with continuity of coverage.

Principles and Values

The principles below governed the advisory group's work:

1. Invest in Oregonians: recommendations must support Oregonians' ability to thrive.
2. Protect health care coverage to the greatest extent possible, consistent with Oregon Constitution.
3. Aspire to maintain an adequate network of health providers and front-line workforce necessary to meet community health needs.
4. Review recommendations with an equity lens, avoid deepening inequities and prioritize consumer affordability.
5. Share and coordinate commitment to the Medicaid program across the health care sector and state leadership.
6. Use data-driven insights to leverage the demonstrable strengths of the Coordinated Care Model, avoid anecdote, relying on strategies that are high-value, shown to improve quality, lower costs and maintain access to care.
7. Identify and address underlying controllable factors that drive cost trends.
8. Minimize administrative burden to ensure resources are directed to the provision of health care services.
9. Preserve quality of care and prioritize prevention-based interventions.
10. Understand system-wide impacts of recommendations, ensuring recommendations are broad-based and strive for alignment across market efforts.

Background on Current Medicaid Landscape

Oregon Health Plan Trends

As noted above, the advisory group conducted a comprehensive review of the current Medicaid landscape. This included detailed analysis of enrollment trends, financing mechanisms, spending patterns, and key cost drivers, as well as an assessment of benefit design and utilization. **Appendix 1** includes a set of charts that detail trends over the past decade.

Those trends can be summarized as follows:

- OHP enrollment has more than doubled in past 10 years.
- OHP benefits have increased over the past 10 years, and Oregon's optional benefit package is relatively rich compared to other states.
- Price was the major driver of cost growth in Medicaid and utilization was relatively controlled with notable outliers.
- CCO capitation rates have generally seen 3% - 5% increases until a major increase during this current biennium that resulted from the COVID unwinding.
- Major cost drivers have been pharmaceuticals, behavioral health, and hospital costs.
- Funding for Medicaid varies by population – the ACA expansion adults receive 90% federal match, while the Healthy Oregon Population (HOP) population is primarily general fund.
- Growth in the Medicaid program was supported by federal match opportunities (leveraging provider taxes and Intergovernmental Transfers).
- H.R. 1 changes put Oregon at significant financial risk.

H.R. 1 Budget Implications

Figure 1 summarizes the estimated Medicaid budget consequences that will result from H.R.1. The budget estimate in **Figure 1** was produced for the advisory group. Total H.R. 1 funding impacts will vary based on final implemented policies. See **Appendix 2** for additional information on H.R. 1 impacts. This section of the report will provide a narrative explanation of the budget mechanics behind the H.R. 1 driven budget shortfall and advisory group target.

Figure 1. Estimated Biennial Budget Impacts of H.R. 1

DRAFT for discussion purposes 11/24/2025			Estimated Biennial Budget Impact (in Millions)								
			2025-27			2027-29			2029-31		
Provisions that reduce OHP Caseload, leading to budget savings *	Section	Effective Date	General Funds	Other Funds	Federal Funds	General Funds	Other Funds	Federal Funds	General Funds	Other Funds	Federal Funds
Qualified non citizen definition change	71109	10/1/2026									
Work Requirements	71119	12/31/2026									
Redeterminations	71107	12/31/2026									
OHA Program Budget Savings Estimate			**5**	**-**	**(70)**	**(412)**	**-**	**(2,540)**	**(630)**	**-**	**(3,214)**
Provisions that Create Budget Challenges	**Section**	**Effective Date**	**General Funds**	**Other Funds**	**Federal Funds**	**General Funds**	**Other Funds**	**Federal Funds**	**General Funds**	**Other Funds**	**Federal Funds**
Provider Tax Changes	71115	10/1/2027	-	-	-	233	(331)	(229)	599	(856)	(600)
State Directed Payment Changes - Hospitals	71116	on passage, reductions	-	-	-	66	(96)	(70)	20	(44)	(55)
State Directed Payment Changes - IGT	71116	start 1/1/2028	106	(156)	(105)	473	(685)	(473)	814	(1,178)	(814)
Healthier Oregon Program Emergency 90% to Title XIX	71110	10/1/2026	22		(22)	61		(61)	65		(65)
OHA Program Budget Challenges Estimate **			**128**	**(156)**	**(127)**	**833**	**(1,112)**	**(833)**	**1,498**	**(2,078)**	**(1,534)**
Total Estimated Program Impacts			**133**	**(156)**	**(197)**	**421**	**(1,112)**	**(3,372)**	**868**	**(2,078)**	**(4,748)**
Total Estimated State Funds Need - OHA Program			**133**			**421**			**868**		
Percentage of 2025-27 OHA Medicaid Program State Funds Budget			**1%**			**5%**			**10%**		

*The caseload estimates are not based on the official caseload forecast. The official forecast will be updated at a later time. These estimates are for discussion and magnitude purposes only. Changes in the caseload estimates are highly variable.

**Insurer's Assessment Revenue impact has not been estimated.

Figure 1. illustrates that for the 2027-29 budget, there is an estimated net $421 million general fund gap created by H.R.1. This is the estimated amount of funds needed to continue the current OHP program. To establish a reasonable funding target the advisory group identified $421 million in general funds as the target for options.

Looking at the rest of the 2027-29 budget in the "OHA Program and Budget Savings" row, $412 million is the general fund savings from estimated decreased enrollment in the health plan due to new red tape and federal policies aimed at making it more difficult to maintain health care benefits for those eligible. $2,540 million is the federal matching funds lost due to decreased enrollment in the health plan because of work requirements and redeterminations. Together the $412 million + $2,540 million total $2.952 billion in lost revenue (reimbursable services,

coverage payments) to Oregon's health system due to loss of coverage resulting from H.R. 1 in 2027-29. This system impact grows to $6,866 million by 2031.

In the "OHA Program Budget Challenges Estimate" row, $833 million is the general fund dollars needed to make up for dollars lost from provider tax, state directed payments, and match rate changes due to H.R.1. This is a general fund shortfall. $1,112 million are the other funds no longer needed to administer provider taxes and the intergovernmental transfer programs and $833 million is the federal funds lost.

In the "Total Estimated Program Impacts" row for 2027-29, $421 million is the gap in general funds needed for the state's Medicaid program and the focus of the advisory group's work. This preliminary target is the $833 million general fund loss minus the $412 million in projected general fund "savings" from decreased caseload.

The "Total Estimated Program Impacts" row shows the total lost State and Federal Funds revenue due to H.R.1. For 2027-29 that totals $3.793 billion (421+3,372) and for 2029-31 $5.616 billion (868+4,748), a total of 9.409 billion. It is critical to understand these figures are estimates that will likely change. Caseload estimates, especially those several years out, are highly variable. The final adopted policies for H.R. 1 will also have an impact on total estimates as the federal government finalizes rules and guidance.

Summary of Medicaid Sustainability Options

Overview

A series of budget and program options were developed by the group to close the significant funding gap in 2027-29 caused by H.R.1. Options generally fit into one of the categories below (see **Figure 2**).

Figure 2. Organizing Framework for Advisory Group Options

Since Fall 2025, the advisory group has reviewed and discussed several options to improve OHP program efficiencies, review Oregon's benefits, and adjust administration of the benefit to mitigate for H.R. 1 impacts.					
CCO Structure	**Clinical Efficiency / Utilization Management**	**Provider Rates**	**Pharmacy**	**Benefit Changes**	**Across-the-Board Budget Changes**
Options related to back-end administrative efficiencies, changes to the CCO/fee-for-service delivery/financing model	Options to improve efficiency in the delivery of services and reduce unnecessary utilization	Options that change rate of payment	Options to restructure the pharmacy benefit to capture maximum savings	Options where (1) scope is reduced for optional or mandatory benefits; and (2) coverage for optional benefits is removed	Options to reduce the OHA Medicaid (managed care and fee-for-service) by a target percentage.
Examples					
Single broker for non-emergent medical transportation; improved claims processing	Additional clinical efficiency criteria; utilization management for certain services	Normalize outpatient psychotherapy rates	Review pharmacy claims for inefficient spending; establish a single Preferred Drug List	Prior authorization or other service limits for optional benefits	Reduce Medicaid budget by 1%

Figure 3 summarizes each of the potential budget and program options that could potentially address the $421 million budget gap caused by H. R. 1 for the 2027-29 biennium. Note this is a list of potential options to consider in balancing the OHP budget. The list totals more than $421 million. In addition, in some cases the options are interrelated and if an option were to be pursued, it would prevent/be in lieu of another option. Options are marked accordingly.

These options represent an initial attempt to develop strategies to mitigate the effects of H.R. 1 while preserving health care coverage and minimizing access loss. While the advisory group represents a significant portion of Oregon's health care delivery system and providers, not all impacted entities were represented in the discussion. Additional engagement with impacted providers, recipients, front line staff to better understand impacts may be necessary to fully understand the impacts of each option if pursued.

Figure 3. Summary of Budget and Program Options

Options Description		Potential Range of Biennium State Share Savings (millions)	Potential Impacts on Members	Potential Impacts on CCOs	Potential Impacts on Medicaid Delivery System
Adjust CCO Structure *These options relate to back-end administrative changes to the Coordinated Care Organization (CCO) or Medicaid fee-for-service delivery or financing model.*					
Implement a package of administrative simplification actions to reduce overall admin costs by 1% - 3%, under the current CCO model Potential levers to meet these spending reductions as discussed with the MAG include: • Continue to streamline prior authorization • Centralize claims processing • Streamline provider enrollment and credentialing processes • Use of shared administrative functions • Review/reduce reporting and deliverables requirements		$5.00-$14.80	Limited impacts to members	Improved administrative efficiency and stronger collaborations with OHA and within CCOs	Reduced administrative burden for Medicaid providers (e.g., provider enrollment process)
There were two potential options to reduce administrative costs by adjusting how the CCO model is structured	**Reduce the number of CCOs to reduce administrative costs.** This would include optimizing the number of CCOs, via consolidated membership, to achieve administrative and operational streamlining and savings. The savings opportunities identified are mainly due to economies of scale and administrative cost efficiencies. Fixed administrative costs that don't proportionally change with caseload are the ones that can be saved with fewer CCOs. The savings range an upper bound estimate of right-sizing remaining CCOs to have enough member coverage to operate as Tier 1 (7.6% administrative load) and the	$4.80-$27.00	• Possibly less localized support from remaining CCOs • Potential disruption to care if switching CCOs • Reduced complexity for members moving within the state	• Temporary increased administrative burden for remaining CCOs absorbing membership • Increased economies of scale for remaining CCOs	• Possibly less localized CCO points of contact • Reduced administrative complexity for providers who will need to contract/ coordinate with fewer CCOs. May require contracting with new CCOs • Streamlined contracting and oversight for OHA

Options Description		Potential Range of Biennium State Share Savings (millions)	Potential Impacts on Members	Potential Impacts on CCOs	Potential Impacts on Medicaid Delivery System
	lower bound estimate to right-sizing remaining CCOs to have enough member coverage to operate as Tier 1 and Tier 2. (7.6% and 8.8% administrative load).				
	OR				
	Reduce CCO administrative load to national 25th percentile (6.1%) This would update the administrative load percentages into alignment with the national benchmarks for physical health and behavioral health programs combined. The national median is 8.3% and the 25th percentile is 6.1% administrative load. This would be paired with meaningful administrative simplification actions (e.g., deliverable reform, shared administration of select services/operations).	$60.60	• Potential impact on member satisfaction from changes to CCO operations	• Potentially reduced administrative payments to meet all administrative requirements	• May increase complexity for contracted providers or FFS system if CCOs have fewer administrative resources • May require increased monitoring of CCO compliance
OHA currently contracts with CCOs, which subcontract with one or more DCOs. There are likely administrative savings from streamlining dental service	**OHA directly contract with DCO(s) to provide dental coverage.** There are potential savings from paying at-risk DCOs less administrative expense than what is currently paid to CCOs, offset by costs incurred by the State to perform additional contracting and oversight.	Multiple at-risk DCOs: Up to $2.60 Single at-risk DCO: Up to $5.20	• Potential access improvement	• Reduced administrative burden to manage dental benefit • Reduced visibility into members' dental care needs • Continued need for timely dental data to support care coordination • Need to define and standardize roles and interfaces	• Increased contracting and oversight burden for OHA • Streamlined quality and cost reporting for dental services • Need to preserve integration with physical/behavioral care via required data feeds and referral workflows (e.g., for EPSDT and high-risk populations)

Options Description		Potential Range of Biennium State Share Savings (millions)	Potential Impacts on Members	Potential Impacts on CCOs	Potential Impacts on Medicaid Delivery System
	OR				
	Carve out of Dental services: run through FFS no-risk contract Fully carve out dental benefits to FFS with a TPA for network development. Due to dental care's low-cost volatility, a TPA model may improve cost structure without significantly increasing state risk.	$21.00	• Potential statewide uniformity in coverage interpretation, payment policy, and administrative processes • Reduced care coordination across dental and other services • Access impact depends on rates and administrative burden	• Reduced administrative burden to manage dental benefit • Potential challenges related care coordination • Increased administrative burden to facilitate data exchange with FFS	• Direct visibility into utilization and spend • Standardized reporting (based on administrator contract)
Clinical Efficiency/ Utilization Management *These options are related to back-end and member-facing changes for more efficient care delivery and utilization.*					
Increase clinical efficiency under existing criteria (raising Targeted Efficiency Level [TEL] from current 50% adjustment to 75% or 100%) Currently, CY26 capitation rates have reflected the removal of 50% of claim costs associated with low-acute, non-emergent emergency department visits and potentially preventable admissions. As CCOs continue improving their clinical efficiency, the targeted efficiency level (TEL) can increase to 75% or 100%, which will result in higher savings.		Increase to 75%: $9.60 Increase to 100%: $19.20	• More efficient care delivery	• Reduced payments for underperforming CCOs	• Improved provider performance • Potential increased administrative burden for providers
Instruct the Health Evidence Review Commission (HERC) to identify additional clinical efficiency criteria As part of the advisory group process, Mercer identified a series of potential efficiencies that may be used to guide additional clinical review and		$20.00-$48.60	• More efficient care delivery • Decreased access to services deemed as	• Stronger requirements for CCOs • Reduced payments for underperforming CCOs	• Improved provider performance via increased coordination by CCOs

Options Description	Potential Range of Biennium State Share Savings (millions)	Potential Impacts on Members	Potential Impacts on CCOs	Potential Impacts on Medicaid Delivery System
interventions. This analysis included a review of high-volume services compared to other states, consistently high-cost members, and national clinical practice guidelines. Example areas identified include (but are not limited to): re-admissions within 30 days that could have been avoided, promote the reduction of medically unnecessary Cesarean deliveries, provider preventable conditions, and cellulitis treatment. *For additional information see **Appendix 3** for the Mercer report.*		inefficient (e.g., optional C-section deliveries)	• Increased costs for care management services	
Reduce avoidable neonatal intensive care unit (NICU) days, through clinical efficiencies/implementation of a Perinatal Care Overlay As part of the clinical efficiency analysis, Mercer identified an increased number of NICU admissions in Oregon compared to neighboring states (WA and ID). Savings from reduction in avoidable NICU days could be accomplished from a Perinatal Care Coordination overlay, or similar initiative. The concept is to improve outcomes and reduce avoidable cost for high-risk pregnancies and NICU infants by stabilizing care through a coordinated care overlay that keeps both birthing parent and infant in their existing CCOs but has care coordination delivered through a specialized accountable entity (regional hub or contracted administrator).	$4.60-$12.40	• Increased access to services such as care coordination	• Reduced NICU utilization and spending • Higher investments in the birthing care continuum (e.g., prenatal care, discharge planning)	• Increased state investments in the birthing care continuum (e.g., prenatal care, discharge planning)
Facilitate statewide expansion of the Health Share of Oregon (HSO) High Acuity Behavioral Health (HABH) strategy to generate an estimated 1% - 3% of savings, compared to current spending. Members in the high acuity behavioral health cohort (e.g., unhoused members with behavioral health needs) drive a significant portion of health	$3.20-$18.20	• Improved access to key behavioral health services for target member population	• High upfront investment • Improved long-term clinical outcomes and expenditures on target member population • Requires contract updates	• Stronger statewide behavioral health continuum of care • Reduced burden for ED and inpatient providers

Options Description	Potential Range of Biennium State Share Savings (millions)	Potential Impacts on Members	Potential Impacts on CCOs	Potential Impacts on Medicaid Delivery System
care utilization and spending. This recommendation contemplates uptake of the HABH strategy to reduce costs in the high-acuity behavioral health population by CCOs statewide. Additional supportive action from the state may be needed to improve impact. The model includes interventions to: • **Enhance care coordination:** Provide dedicated care management to actively coordinate services for members with complex needs. • **Support whole-person care:** Integrate physical health, behavioral health, and social needs. • **Improve risk identification:** Use data analytics and risk stratification to identify members who may benefit from additional support. • **Reduce avoidable high-cost utilization:** Improve access to timely outpatient and community-based services. • **Streamline administration:** Centralize specialized program management to reduce duplicative processes and fragmented communication. • **Improve cost predictability:** Enable more targeted management of high-cost populations.		• Reduced inappropriate utilization of ED and inpatient services		
Service adjustments and utilization management in Applied Behavior Analysis (ABA) services A utilization review identified outlier utilization trends for ABA services, a treatment for youth with Autism Spectrum Disorder (ASD). The number of members receiving ABA services more than doubled from 2023 to 2024 and prolonged high-intensity ABA services. The HERC has reviewed ABA clinical guidance and recommended the following coverage changes: covering ABA	$8.60	• Potential increased administrative complexity for members • Shift toward more appropriate care	• Reduced utilization and spending on ABA • Increased administrative burden of utilization management processes	• Attrition of Medicaid ABA providers • Potential to curb fraud, waste, and abuse

Options Description	Potential Range of Biennium State Share Savings (millions)	Potential Impacts on Members	Potential Impacts on CCOs	Potential Impacts on Medicaid Delivery System
services for children with ASD ages 1-12, including Early Intensive Behavioral Intervention (EIBI), typically 15 – 40 hours weekly. This option would make authorization changes congruent with clinical evidence and review. Other adjustments may also include: • **Strengthen program integrity through oversight and policy**: Specify expectations in OAR including rendering provider enrollment in Medicaid. • **Increase requirements for initial authorizations, progress monitoring, and continuation of service**s: ○ Increase frequency of required updates to functional assessments and treatment plan. Create more robust documentation standards. ○ Enhance ABA eligibility criteria including safety checks for medical appropriateness that it is the least restrictive option to address symptoms. ○ Provide CCOs with recommendations for reasonable service frequency based on functional impact of symptoms, age, and child & family centered goals.				
Modify psychotherapy utilization management guidance. This would reduce high-frequency, long-duration visits that do not satisfy medical necessity or provide meaningful clinical outcomes. Psychotherapy utilization in the OHP has increased significantly. This includes long-term, high-frequency utilizers. This option would review potential data and guidance to CCOs to support utilization management; focus will be	Up to $11.80	• Improved alignment of psychotherapy services with needs and outcomes • Potential for new service restrictions for some members	• Reduced utilization and spending on psychotherapy • Increased utilization and prior authorization monitoring	• More efficient and aligned utilization of psychotherapy providers

Options Description		Potential Range of Biennium State Share Savings (millions)	Potential Impacts on Members	Potential Impacts on CCOs	Potential Impacts on Medicaid Delivery System
on high-frequency, long-duration visits that do not satisfy medical necessity or provide meaningful clinical outcomes.					
Currently CCOs cover the optional non-emergency medical transport (NEMT) benefit via individual contracts. There may be opportunities for savings in benefit delivery.	**Implement NEMT efficiency adjustment in CCO model** As part of the clinical efficiency review, Mercer identified that an estimated 2%–10% of NEMT spend within the current CCO model can be avoided through strengthened oversight and monitoring of the NEMT benefit. An efficiency adjustment based on utilization review could be incorporated as early as the CY 2027 rates.	$1.00-$5.00	• Improved member experience	• Reduced administrative burden • Less flexibility managing NEMT benefit	• Improved statewide NEMT infrastructure
	OR				
	Carve out NEMT to FFS and centralize services The current NEMT benefit is administered separately between open card and CCO members. OHA contracts directly with eight regional brokers, and CCOs contract with eleven brokers (there is some overlap between broker contracts). The proposed "carve out" would result in a centralized brokerage model. A singular NEMT brokerage can de-duplicate administrative burden across the Medicaid program, creating a more straightforward consumer and provider experience. The program is expected to cost $2.3M annually to implement, these figures represent net savings.	$3.20-$9.50	• Disruptions to care during transition • May reduce access to providers that don't contract with FFS • Standardized member experience	• Reduced administrative burden • Reduced ability to coordinate care across NEMT and other services • Increased administrative burden coordinating care/data exchange with FFS	• Increased state oversight and contracting burden • Economies of scale in contracting with NEMT vendors

Options Description		Potential Range of Biennium State Share Savings (millions)	Potential Impacts on Members	Potential Impacts on CCOs	Potential Impacts on Medicaid Delivery System
Provider Rate Reductions *These options reduce provider rates for outpatient psychotherapy services, which are currently higher than commercial and Medicare rates.*					
Outpatient psychotherapy is the primary driver of rising Medicaid BH spending, driven by rapid utilization growth. While rate increases have improved access, they now exceed other programs in some cases. The MAG contemplated options to normalize rates.	**Reduce outpatient psychotherapy FFS rates by 4% where the rate is significantly higher than both Medicare and commercial rates.** Assume CCO payment rates decline in parallel by 4%. This rate normalization would: • Ensure CCOs understand their flexibility in rate setting; do not need to tie to FFS schedule • Provide guidance to CCOs to support UM for outpatient MH services, particularly focusing on long-term, high frequency therapy, that will result in additional savings • Promote telehealth services integrity with both the rate changes and UM guidance given claims data on psychotherapy codes billed	Up to $9.80	• Limited impacts to members with rates that still attract providers	• Reduced spending on psychotherapy	• Limited impacts to providers and the delivery system with rates that still attract providers
	OR				
	Reduce the same outpatient psychotherapy FFS rates by 4% <u>and</u> direct CCO psychotherapy payment rates to use the new FFS rates as a maximum. This option adds an additional requirement on CCOs to use the normalized FFS rates as maximum payment, further reducing CCO rates statewide.	Up to $23.20	• Limited impacts to members with rates that still attract providers	• Reduced spending on psychotherapy	• Limited impacts to providers and the delivery system with rates that still attract providers
Pharmacy *These options are related to discrete, back-end actions to reduce pharmacy spending in addition to more comprehensive statewide restructuring of how the pharmacy benefit is administered.*					

Options Description	Potential Range of Biennium State Share Savings (millions)	Potential Impacts on Members	Potential Impacts on CCOs	Potential Impacts on Medicaid Delivery System
Review pharmacy claims for inefficient spend and reduce capitation payments to CCOs As part of the efficiency analysis, Mercer identified opportunities to increase efficiency in pharmacy claims, including recommendations for: • Clinical edit analysis to compare CCO's utilization management to industry standards • Diagnosis to Drug Match (DxRx) analysis verifies diagnosis for high-cost and/or high-risk drug classes • Maximum Allowable Cost (MAC) analysis benchmarks generic drug unit pricing to Medicaid-specific benchmark MAC list Note: The potential saving ranges are based on saving percentage ranges from existing Mercer clients as a reference point for possible outcomes. Pharmacy efficiency adjustments are recommended for a status quo benefit or alongside a single PDL approach. Application of pharmacy efficiencies in single PBM environment is heavily dependent on the benefit design of administrative responsibility and PBM pricing structures.	$8.20-$59.00	• More efficient care delivery	• Reduced capitation • Improved efficiency in managing pharmacy benefit	• Reduced overall Medicaid pharmacy spending
Sunset "Provider Prevails" and require justification for select non-preferred drugs "Provider prevails" is a policy that allows a prescriber to override preferred drug requirements simply by indicating the non-preferred drug is necessary, without prior authorization or additional clinical justification**.** This policy would sunset the OHA practice of using provider prevails for the fee-for-service program.	$0.06 - $0.26	• Disruptions to care for FFS members prescribed a non-preferred drug	• No impact	• Increased administrative burden for providers for non-preferred drug justifications

Options Description		Potential Range of Biennium State Share Savings (millions)	Potential Impacts on Members	Potential Impacts on CCOs	Potential Impacts on Medicaid Delivery System
The advisory group explored multiple opportunities.	**Enforce a Mental Health PDL and require PA for non-preferred mental health drugs.** OHA would require prior authorization for non-preferred MH drugs and OHA could instead pursue safety edits to improve outcomes, with savings as a secondary benefit.	$1.00 - $11.80	• Consistent access to a standard formulary across CCOs • Administrative complexity accessing non-preferred mental health drugs	• Limited impact; primarily administered through FFS	• Reduced administrative burden navigating across CCOs • Increased administrative burden for providers for non-preferred drugs justifications
	OR				
	Implement a Single Preferred Drug List (PDL) Preferred Drug List (PDL) is a list of outpatient drugs that states encourage providers to prescribe over others. The concept of a single PDL aligns drug formularies uniformly across all CCOs and the fee-for-service (FFS) program. A single PDL typically produces net cost savings from increased supplemental rebates and reduces provider administrative burden. *For more information, see **Appendix 4** for in-depth Mercer and SMART-D analyses.*	Up to $24.30 *Estimate represents only 18 months in savings to account for a longer implementation timeline than other options.*	• Consistent access to a standard formulary across CCOs and FFS • Members may need to transition to preferred drugs	• Reduced administrative burden managing individual formularies • Short-term administrative complexity aligning a single PDL • Capitation adjustment to address increased CCO drug cost • May reduce efficiency for CCOs with non-OHP lines of business or who own pharmacy network • May require changes to existing formularies	• Reduced administrative burden for providers navigating multiple formularies • Stronger state negotiating power • Simplified OHA monitoring of CCO pharmacy • Analysis performed selected options that minimize 340B impacts
	OR				

Options Description		Potential Range of Biennium State Share Savings (millions)	Potential Impacts on Members	Potential Impacts on CCOs	Potential Impacts on Medicaid Delivery System
	Implement a combined single PDL/single Pharmacy Benefit Manager (PBM) A single PDL is a prerequisite for single PBM. A single PBM aligns the pharmacy benefit manager/administrator uniformly across all MCOs and the FFS program. The concept typically produces streamlined benefit administration. *Note: Cannot be implemented in addition to the "Provider Prevails" or "review pharmacy claims for inefficient spend" options.* *For more information, see **Appendix 4** for in-depth Mercer and SMART-D analyses.*	$15.20 - $25.70 *Estimate represents only 12-months in savings to account for longer implementation timeline.*	• Consistent access to drugs/pricing at across CCOs • Disruptions in care during transition	• Disruptions to existing vendor contracts	• Reduced administrative burden for providers • Stronger state negotiating power • Uniform data and reporting on pharmacy utilization • Concentrated risk if single PBM underperforms • Analysis performed selected options that minimize 340B impacts
Change/Scope Limits for Select Optional Benefits The advisory group contemplated potential optional benefit changes or scope limits. The following specific benefits were identified as part of the group's work as illustrative examples of optional benefits where Oregon may differ from peer states and/or there is ongoing consideration of benefit changes. Per Federal guidance, states are permitted to limit optional benefits, but these benefits must be sufficient in amount, duration, and scope to reasonably achieve their purpose. The exact scope limits will be deferred to the HERC for final evaluation, with a corresponding savings target. Limits on benefits were selected to minimize impact on members. The scope limits projected here are listed as a 50% reduction as an illustrative placeholder for directional advisement by the advisory group; if option(s) were ever pursued, the exact scope changes would be separately evaluated. These savings do not account for and would be offset by downstream impacts such as alternative services sought, or increased ED utilization.					
Limit BH outpatient case management		$7.09	• Reduced access to covered services, particularly in areas	• Reduced spending on covered services	• Potential shifts toward higher-cost care, including
Limit naturopath /visits		$4.72			
Limit acupuncture/ chiropractic benefit		$4.30			

Options Description	Potential Range of Biennium State Share Savings (millions)	Potential Impacts on Members	Potential Impacts on CCOs	Potential Impacts on Medicaid Delivery System
Limit licensed massage therapy	$2.80	with limited primary care • Care fragmentation and shifts to alternative providers or services • Increased utilization of higher-cost services • Greater risk of avoidable, costlier institutional care • Increased reliance on long-term care associated with certain benefit reductions • Negative impacts on member access, continuity, and health outcomes	• Increased utilization of higher-cost, higher-acuity services from reduced care management (e.g., behavioral health, institutional care) • Shifts in utilization patterns across medications, diagnostics, and other services • Potential cost offsets from increased use of alternative or downstream services • Greater reliance on long-term care for some services if member needs escalate	institutional and long-term care • Increased demand on social services to help address unmet or evolving member needs • Potential changes in provider participation in Medicaid networks, particularly if utilization patterns shift • Increased reliance on community-based and nonprofit supports (e.g., eyeglasses assistance) to fill gaps
Limit physical therapy/occupational therapy benefit	$8.00			
Limit eyeglasses for pregnant/postpartum	$0.10			
Limit prosthetics benefit	$1.50			
Limit speech therapy benefit	$0.50			
Limit adult dental benefit	$43.90	• Impacts member outcomes and avoidable utilization	• Reduced spending on eliminated services • increased utilization of costlier services due to complications	• Increased utilization of costlier care if member needs escalate • Increased burden on social services related to member health needs; • Reduced provider participating in Medicaid

Options Description	Potential Range of Biennium State Share Savings (millions)	Potential Impacts on Members	Potential Impacts on CCOs	Potential Impacts on Medicaid Delivery System
				network if utilization decreases
Removal of Select Optional Benefits *Full reduction of optional benefits was also contemplated and analyzed for projected savings.*				
No longer cover labs with no clinical value	$3.00	No potential adverse impacts identified.	No potential adverse impacts identified.	No potential adverse impacts identified.
Remove BH outpatient case management	$14.18	• Reduced access to certain services, with potential spillover effects on access to related care • Potential care fragmentation and shifts to other services or providers • Increased reliance on alternative services (e.g., other pain management approaches) • Risk of higher utilization, including avoidable or repeat services • Potential for increased dependence on long-	• Potential reductions in spending on select services, along with decreased administrative burden for managing eliminated benefits • Possible shifts toward higher-cost, higher-acuity services if member needs are not fully met (e.g., behavioral health, institutional care) • Changes in utilization patterns across medications, diagnostics, and other services • Potential for some cost offsets if utilization increases in alternative or downstream services	• Potential shifts toward higher-cost care, including behavioral health, institutional, and long-term care • Increased demand on social services to help address unmet or evolving member needs • Potential changes in provider participation, particularly in high-need or underserved areas (e.g., chiropractic providers) • Increased reliance on community-based and nonprofit resources (e.g., eyeglasses assistance) to fill gaps • Potential for increased behavioral health needs for
Remove naturopath services	$9.44			
Removal acupuncture/ chiropractic benefit	$8.60			
Remove licensed massage therapy	$5.60			
Remove physical therapy/occupational therapy benefit	$16.00			
Remove eyeglasses for pregnant/postpartum people	$0.20			
Remove prosthetics benefit	$3.00			
Remove speech therapy benefit	$1.00			

Options Description	Potential Range of Biennium State Share Savings (millions)	Potential Impacts on Members	Potential Impacts on CCOs	Potential Impacts on Medicaid Delivery System
		term care if needs escalate • Impacts to member access, continuity, and health outcomes	• Greater reliance on long-term care for some members if needs escalate	some populations (e.g., individuals with unmet pain management needs) • Risk of higher costs associated with preventable conditions
Remove adult dental benefit	$87.80	• Impacts member outcomes and avoidable utilization	• Reduced spending on eliminated services • Increased utilization of costlier services due to complications	• Increased utilization of costlier care if member needs escalate • Increased burden on social services related to member health needs • Reduced provider participating in Medicaid network if utilization decreases
Across-the-Board Budget Change *In addition, or as an alternative, to the actions discussed to date, Oregon can implement across-the-board Medicaid budget reductions, inclusive of potential provider rate cuts, to address funding shortages as deployed in other states.* Implementation considerations include: • Overall budget cuts may intersect with other options considered by the MAG. • Additional efforts are needed to refine how budget cuts would be implemented (e.g., would any services or provider types be exempt from rate cuts). • CCO rates must remain actuarially sound and many FFS rates are tied to Federal rate changes. • Savings estimate may change with caseload adjustments.				
Reduce OHA Medicaid budget by 0.5%	$42.00	*Note:* Impacts of these options depend on the		• Rate cuts may reduce the number of providers
OR				

Options Description	Potential Range of Biennium State Share Savings (millions)	Potential Impacts on Members	Potential Impacts on CCOs	Potential Impacts on Medicaid Delivery System
Reduce OHA Medicaid budget by 1%	$84.00	actions selected to reduce budget. • Reduced access to care (e.g., fewer covered services) and higher utilization of costlier, higher acuity services (e.g., ED); • Challenges accessing care due to administrative complexity and reductions in administrative funding	• Reduced administrative funding to meet administrative requirements • Challenges meeting provider network requirements with fewer providers • Higher resources needed to manage more complex patients with reduced access to care (if there are cuts to benefits)	participating in the Medicaid network • Reduced access to care may increase the need for social services and safety net care
OR				
Reduce OHA Medicaid budget by 2%	$168.00			
OR				
Reduce Medicaid budget by 3%	$252.00			
OR				
Reduce Medicaid budget by 4%	$336.00			

Summary of Budget and Program Options

Addressing the scale of H.R. 1 cuts and balancing the state's budget while preserving the integrity of the state's Medicaid program will ultimately require policy makers and budget writers to confront difficult trade-offs, competing priorities and the potential for real impacts to OHP members and providers. To inform that work, the advisory group developed a broad menu of savings options which are captured in the table above. Participants brought different perspectives to the discussion, including concerns about access to care, provider sustainability, administrative feasibility, and the long-term stability of the Medicaid program.

The options developed by the advisory group represent options with preliminary analysis for trade off considerations. The Governor is not obligated to pursue any of the options.

The structure and function of the advisory group enabled it to consider a set of several targeted policy and operational changes or to implement a single, across-the-board rate reduction. A uniform rate reduction would be simple to administer and could generate predictable savings quickly but the predominant opinion amongst the group members landed on a package of targeted savings that is more complex to implement. The latter better aligns with the advisory group's goals by focusing on clinical value, reducing low-value care, and improving operational efficiency rather than applying a broad reduction that could undermine provider participation and access. Other considerations include a multi-pronged strategy using a small across-the-board rate reduction as an alternative if additional savings are required after some targeted reductions are made, or narrowly tailoring rate reductions to preserve certain preventative services or settings.

In discussing the options, the greatest alignment consisted of:

- A preference for limiting optional benefits as opposed to eliminating them.
- A preference for maintaining adult dental services as an important part of a benefits package.
- A preference for looking at administrative efficiencies before rate or benefit reductions, including a focus on how to get better value in the state's pharmaceutical purchasing.

The group generally found alignment on the following budget and program options that are described in the accompanying chart:

- No longer cover labs with no clinical value.
- Under the current CCO Model, facilitate statewide expansion of the Health Share of Oregon High Acuity Behavioral Health (HABH) strategy to generate an estimated 1% - 3% of savings.
- Modify psychotherapy guidance to reduce visits that do not satisfy medical necessity or provide meaningful clinical outcomes.
- Normalize outpatient psychotherapy FFS rates by 4% and direct CCO psychotherapy payment rates to use the new FFS rates as a maximum.
- Under the current CCO Model, implement a package of administrative simplification actions to reduce overall admin costs by 1% - 3%.
- Preserve physical therapy/occupational therapy visits but limit benefit according to review by the Health Evidence Review Commission (HERC).
- Sunset “Provider Prevails” and require justification for non-preferred drugs.
- Applied Behavior Analysis (ABA) services adjustments and utilization management congruent with emerging best practices.
- Review pharmacy claims for inefficient spending and reduce capitation payments to CCOs.
- Additional clinical efficiency criteria to drive utilization to high value, high efficacy interventions.

Additional considerations identified by the advisory group include:

- Clinical efficiency criteria will require local implementation strategies and coordination; in lieu of effective interventions the result will be a payment reduction without a clinical outcome.
- Options represent a tension between giving local flexibility and ability for statewide economies of scale.

- The importance of using an evidence-based approach to prioritizing high value care and identifying opportunities to limit low value care that is transparent for the public, members, and providers.
- The potential that implementing efficiencies could jeopardize provider participation and access.
- Options that require contract, system, or provider experience changes will require an operational plan and may not achieve full estimated savings.

Additional Long-Term Sustainability Discussion

Overview

In addition to identifying options to address the 2027-29 funding gap due to H.R. 1, the advisory group was asked to provide thoughts on what will be necessary to sustain Oregon's Medicaid program out into future biennia. The advisory group coalesced around five priority themes outlined below. Taken together, they point toward a strategic theme: given the scale of the current gap and underlying cost pressures, Oregon will have difficulty sustaining its Medicaid program. Continued clarity about whom the program is intended to serve, what services can be afforded, what outcomes the state expects from CCOs and delivery systems will be a persistent need. Aligning, simplifying, and creating administrative and financing structures to support those goals is recommended.

1. Define a Core Medicaid Benefit

A central message from the advisory group was the need to define a core Medicaid benefit that is explicitly tied to the best outcomes and can then be used by policy makers to align with the program's fiscal limits. This reflects concerns that the current benefit structure can expand through legislative directions, customs, precedent, or diffuse decision-making without a sufficiently clear framework for distinguishing high-value services from low-value or marginally effective care and tradeoffs.

A more durable approach would identify the services that Oregon believes Medicaid must reliably cover because they produce meaningful health improvement, preventing avoidable

health decline, or reduce higher downstream costs. At the same time, the state needs a transparent process for reducing coverage of services that are high cost and low value, tightening approval criteria where evidence is weak, and revisiting benefit parameters as budget conditions change.

"Medical necessity" should remain important but should not function as the only coverage standard. Standards for medical necessity are not a tool for system-level prioritization. If we rely on it alone, we are implicitly avoiding the harder question of how to make tradeoffs within a finite program. Oregon may therefore need to review its decision framework to ensure medical necessity fully combines evidence of effectiveness, expected outcomes, cost-effectiveness, equity considerations, and consistency with the program's core purpose.

This raises the role of the Health Evidence Review Commission (HERC). The advisory group's strong suggestion is to use the HERC more deliberately as the body that helps define the Medicaid benefit over time, particularly by establishing coverage priorities, supporting disinvestment in low-value care, and creating a repeatable method for benefit adjustment when fiscal pressure intensifies.

2. Simplify Medicaid Administration

The call to simplify administration reflects a practical but often under-acknowledged reality shared across providers, plans, the state, and the federal government: a significant share of clinician and staff time is consumed by administrative requirements that may not meaningfully improve care.

Administrative simplification can be a sustainability strategy, not merely a convenience initiative. A system that is difficult to navigate generates real and compounding costs: provider time is diverted from care, payment is delayed, administrative staffing grows, compensated administrative requirements grow state and federal budgets, and smaller or resource-constrained providers are less able to participate. Over time, this makes Medicaid less attractive to providers who already experience reimbursement as inadequate and may further erode network capacity and access, particularly in areas already experiencing workforce shortages.

Efforts at administrative simplicity need to also include a formal way to get feedback from front line workers in both OHA and ODHS, as well as from clinicians. OHA's recently established Provider Engagement Unit is a good first step in doing just that. Ultimately policy makers should reset expectations for how the system functions together and view administrative simplicity as a formal objective.

OHA has been working collaboratively with CCOs to reduce administrative burden and create a culture of partnership, and this work should continue.

3. Reduce Behavioral Health Complexity

The advisory group's concern about the accumulated complexity of the behavioral health system points to a long-standing structural problem: accountability is often blurred among counties, CCOs, state agencies, community mental health providers, substance use disorder providers, and crisis system partners. When responsibilities overlap or remain unclear, members and providers face delays, hand-offs go nowhere, and gaps in the continuum of care widen driving up system costs.

Clarifying roles is therefore a governance issue as much as an operational one. Defining responsibility for financing, network adequacy, care coordination, crisis response, residential treatment access, community placement, and post-discharge follow-up for each major behavioral health service category is a goal the advisory group discussed. Clear responsibility will allow the State to set performance expectations.

The advisory group also emphasized the need for more community-based capacity to treat those with high acuity conditions, including behavioral health community beds, respite programs, and drug and alcohol step-down options. Specifically, the group recommended Oregon should continue following the recent Public Consulting Group (PCG) report and other similar tools that identify specific capacity needs and continue to invest in the necessary capacity. This is a critical point because system complexity is often treated as an administrative or coordination problem, but in many cases, it reflects a basic constraint of not having enough appropriate places for people to go. Better governance can reduce fragmentation, but it will not

by itself solve bottlenecks if the state lacks the right mix of community placements and treatment settings.

Under Governor Kotek's leadership, the state anticipates adding 1,660 licensed residential treatment beds to Oregon's continuum of care, more than a 45% increase in capacity. Of those, 1,067 are already open and serving Oregonians today, with 593 more scheduled to open within the next two and a half years. The state was the primary investor in 960 of these beds — a deliberate, targeted investment in a system that for too long has lacked the capacity to meet the scale of the need. A significant missing gap in the system is appropriate step-down options from Oregon State Hospital (OSH), residential, and acute care. Under Governor Kotek's 2026 Homelessness Emergency Declaration (EO 26-01), Medicaid is working on a mechanism such as "in lieu of services" to help fund onsite behavioral health services in housing designed for individuals with significant behavioral health concerns. This greatly increases the community-based capacity the advisory group identified as necessary.

4. Define Outcomes for CCOs

The group identified a call to more frequently review, define, and adjust the outcomes Oregon expects from its coordinated care organizations. Now is an opportunity to define a shared vision for what we want from CCOs and our Medicaid system. With fewer resources more focus may be needed. A strategy to ensure the state is maximizing its investment in the Medicaid program is to engage in explicit priority setting and more frequent review.

Key to establishing those outcomes and priorities is the need for an analysis of CCO performance to date to learn from the past decade's experience and understand what has worked and what has not.

A program that evolves through incremental policy decisions, each of which may be reasonable on their own but not clearly tied to a defined set of outcomes, may distract from core delivery elements necessary to prioritize in a resource limited environment. A shared definition of success and identification of essential and discretionary priorities will create more value within the Medicaid program.

A clearer vision for the future of CCOs would distinguish between outcomes CCOs can reasonably control and broader system conditions that require shared responsibility with providers, counties, the state, and other systems.

In that regard, the group discussed the CCO Quality Incentive Program. Where programs are driving behavior successfully, they should be preserved; as fewer dollars are available for programs, the focus and priorities of those programs should be scaled accordingly. Stability and minimizing disruption for longer-term clinical interventions and quality improvement strategies is advised.

The advisory group believes clearer outcomes for CCOs should optimize flexibility where positive results and effectiveness are observed, and changed where it does not.

5. Coordinate with Long-Term Care and Supportive Services (LTSS) to Improve Hospital Discharge

LTSS were not in scope for the advisory group. However, the impact of delayed discharge was discussed as advisory group members presented ideas and identified where inefficient care may be delivered.

Delayed discharge often occurs when a patient is medically ready to leave the hospital but cannot be placed in an appropriate home- and community-based or facility setting or cannot be safely discharged without home modifications/supports. Those delays increase hospital costs, frustrate patients and families, and tie up acute care capacity. The legislature initiated a task force that delivered a report with strategies to mitigate these challenges. The advisory group acknowledged the strong connection between LTSS and behavioral health need in Medicaid, and how the discharge challenge affects overall capacity, costs, and sustainability. The advisory group encourages a second look at recommendations from the legislature's task force's efforts.

Cross-Cutting Themes

Several themes cut across all five ideas.

- Priority setting and trade-offs must be explicit. Oregon should develop a longer-term strategy to determine what services it covers, for whom, and why, including how it weighs competing goals across coverage, cost, and outcomes.
- Accountability must match authority. CCOs should be responsible for outcomes they can realistically influence.
- Finances must align with expectations. Expectations for access, participation, and performance cannot be sustained if payment structures are not aligned with those goals.
- Simplicity is a policy lever. Administrative burden is not incidental; it affects access, provider participation, and cost.
- Capacity matters. Governance reform will not solve discharge delays or bottlenecks unless community-based supply expands.
- Technology can support, but not replace, policy discipline. AI and automation may reduce administrative costs and improve decision support within health care settings, but they cannot substitute for clear rules on eligibility, benefits, and accountability.

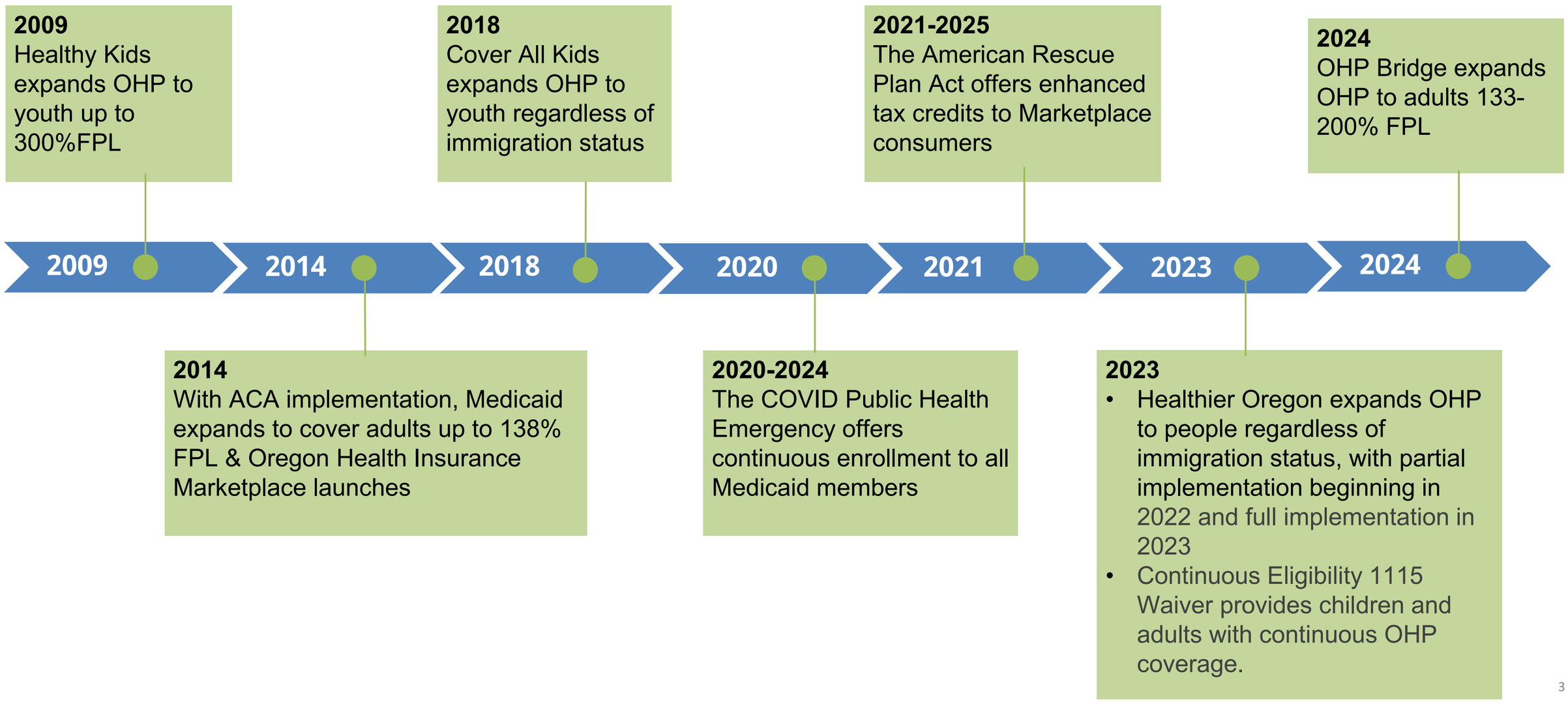
A sustainable program in the long run will require more explicit priority setting, less operational complexity, stronger accountability, and better alignment between financing and service capacity. The advisory group's feedback is that sustainability depends on clarity of purpose – being explicit about whom the program is intended to serve, what it guarantees, and how performance is measured.

Office of Governor
TINA KOTEK

Appendix 1

OHP Enrollment

Oregon Health Insurance Coverage Milestones

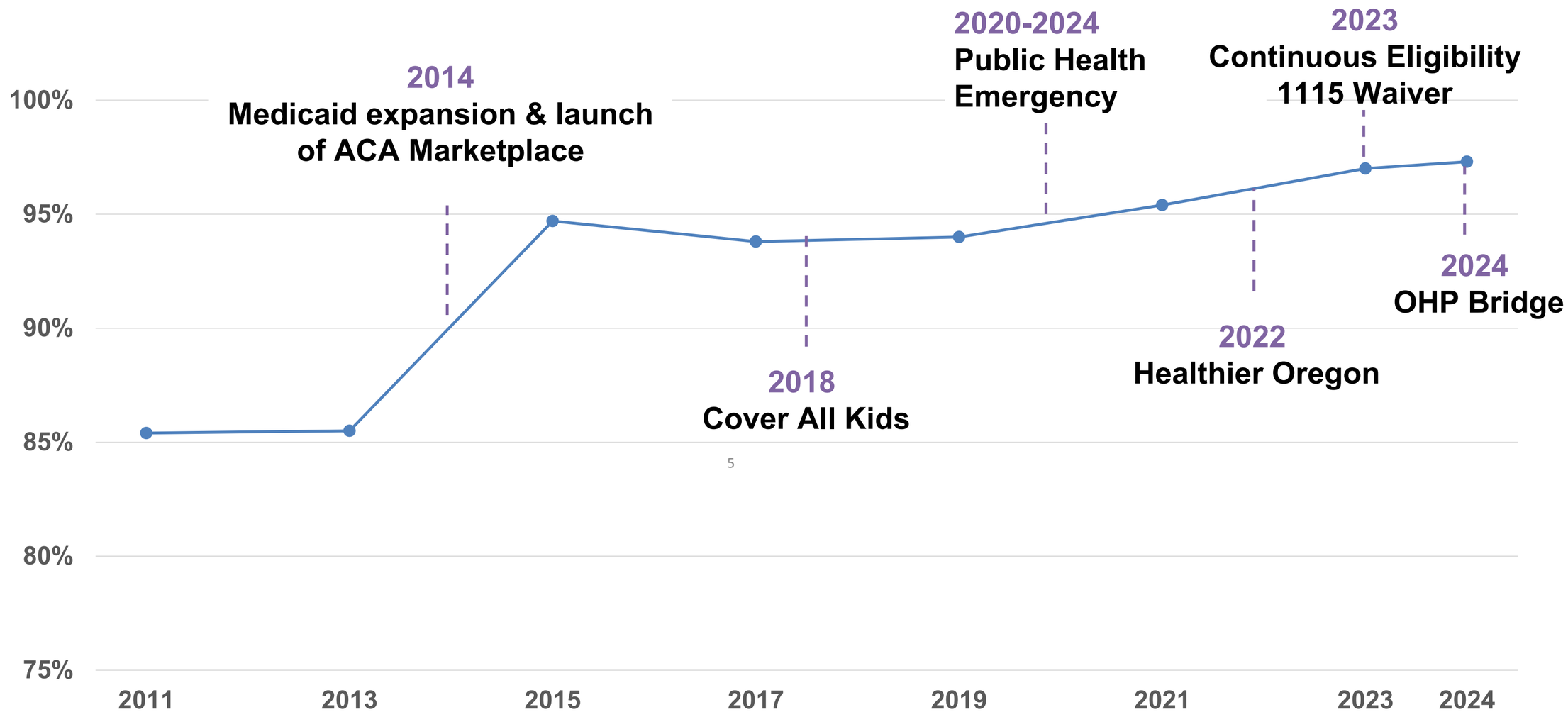


Tracking Key Milestones

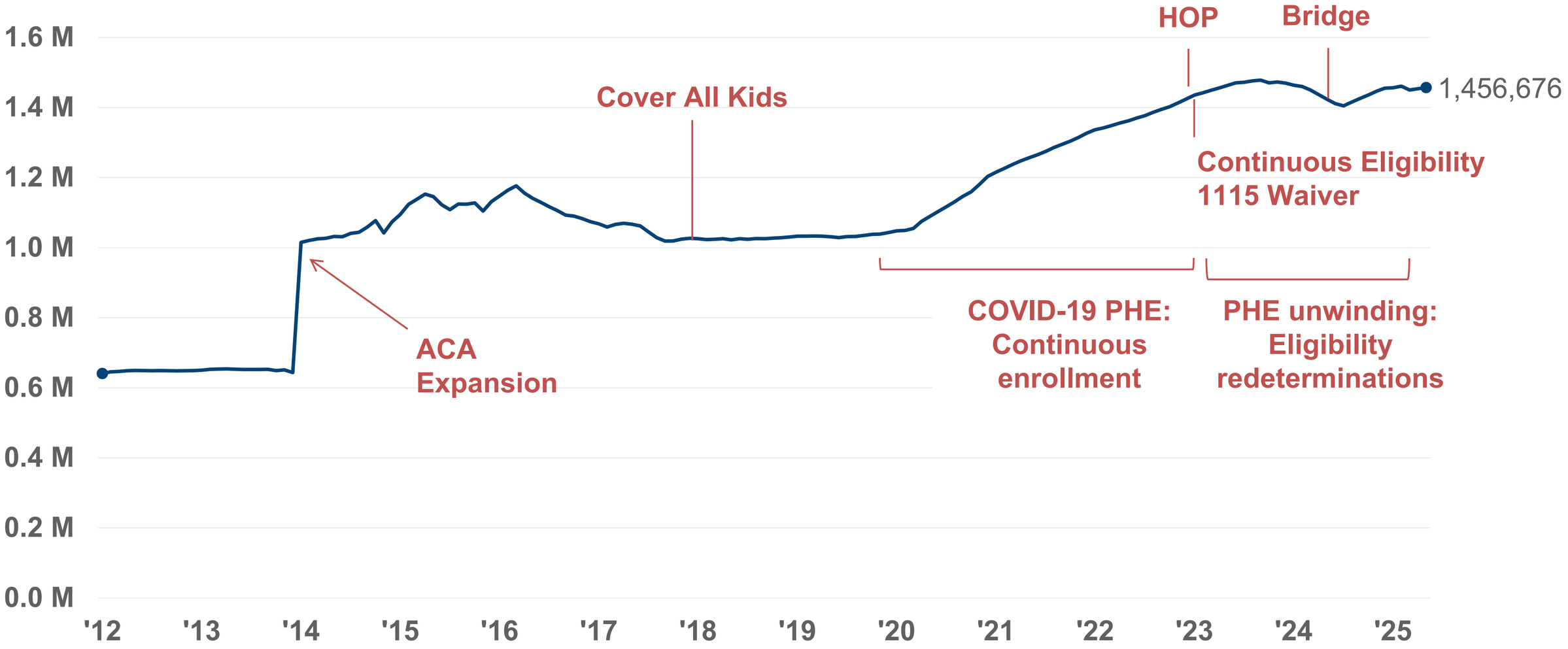
- **Healthy Kids (2009)** - Expanded OHP eligibility (300% FPL) and established 12-month continuous enrollment for children & youth
- **Medicaid expansion & launch of ACA Marketplace (2014/15)** - Expanded Medicaid eligibility up to 138% FPL for adults & created federal subsidies for private health insurance coverage
- **Cover All Kids (2018)** - Extended OHP Plus coverage to all children/youth regardless of immigration/citizenship status
- **Public Health Emergency eligibility protections (2020)** - Continuous enrollment for Medicaid members during COVID Public Health Emergency
- **ARPA enhanced federal Marketplace tax credits (2021)** - Increased federal subsidy amounts and extended eligibility for people buying private health insurance on the Marketplace
- **Healthier Oregon (2022/23)** - Extended OHP Plus to adults who meet all Medicaid eligibility criteria except for citizenship/immigration status
- **Continuous Eligibility 1115 Waiver (2023) –** Provides OHP coverage to children until age 6; provides members ages 6 and older with two full years of OHP coverage.
- **PHE-unwinding (2023/24)** - Continuous coverage protections established in 2020 come to an end
- **Temp Medicaid Expansion / OHP Bridge (2023/24)** - New coverage option for adults with annual income between 133-200% FPL & who meet federal immigration status requirements

Health Insurance Coverage Since 2011

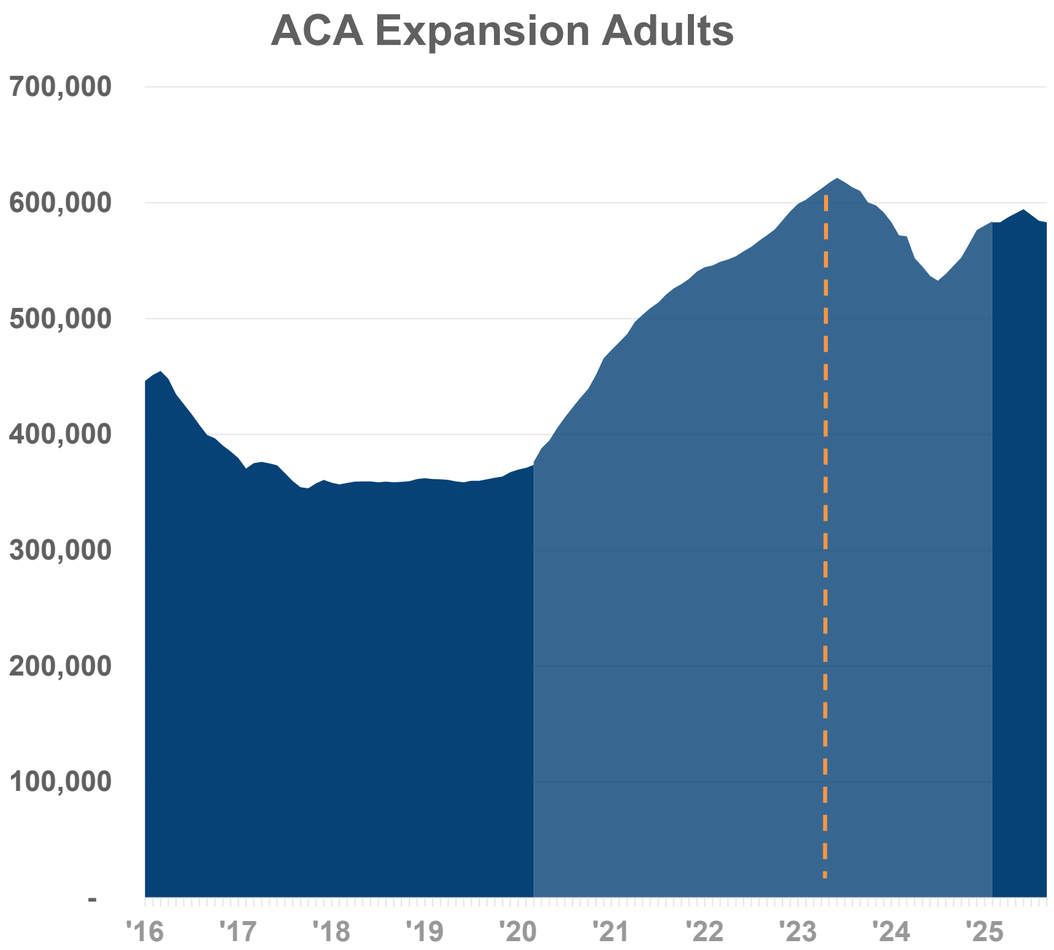
Oregon achieved an overall coverage rate of 97.3% in 2024.

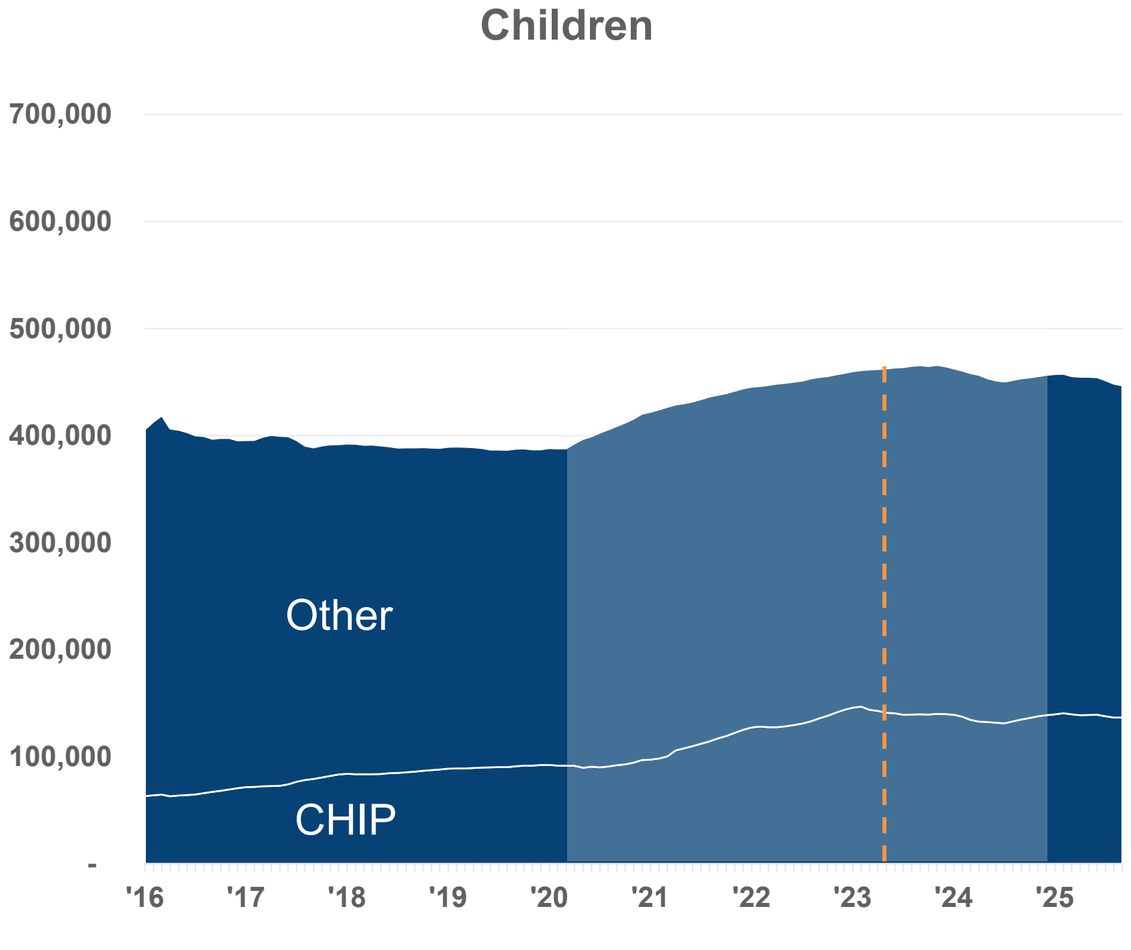


Total OHP Enrollment Has More Than Doubled Since 2012



Enrollment by OHP Eligibility Group (1 of 4)

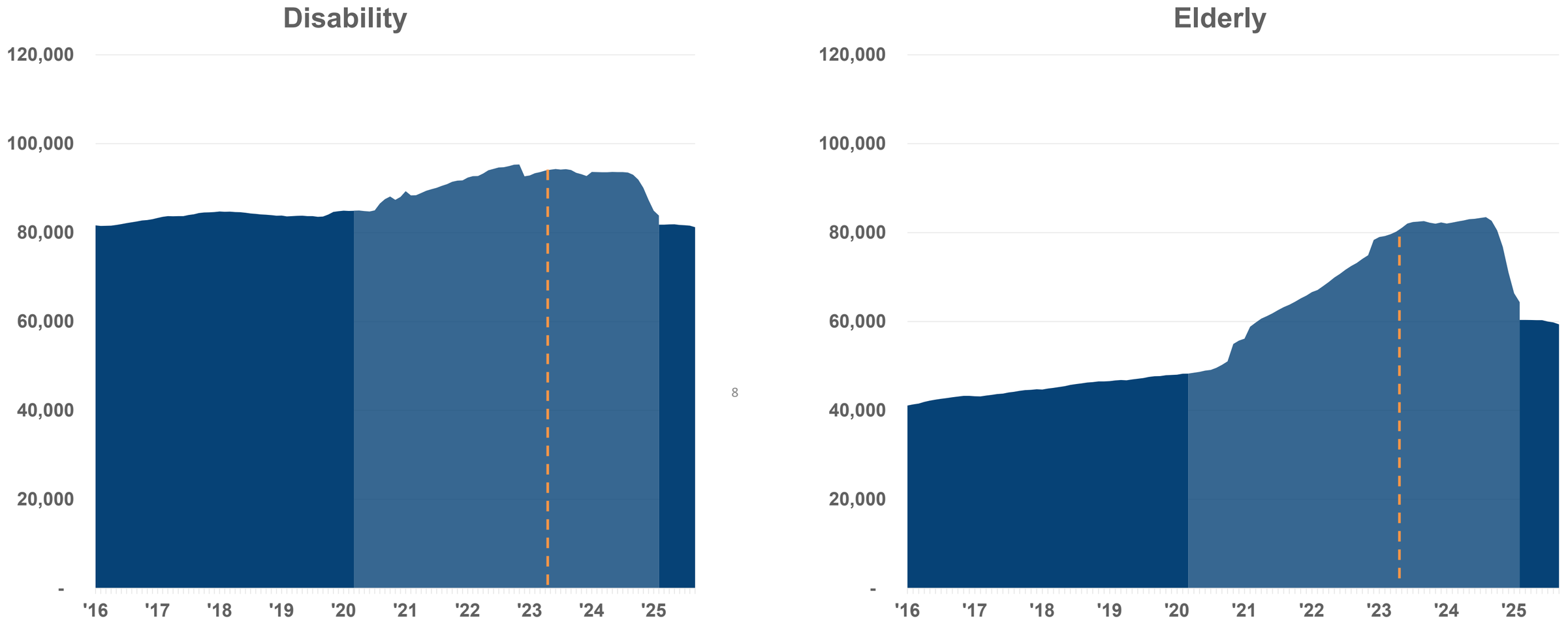




Key	COVID-19 PHE: Continuous enrollment
	PHE Unwinding: Eligibility Redeterminations

Note: Young Adults with Special Health Care Needs (YSCHN) are included in “Children – Other.”

Enrollment by OHP Eligibility Group (2 of 4)



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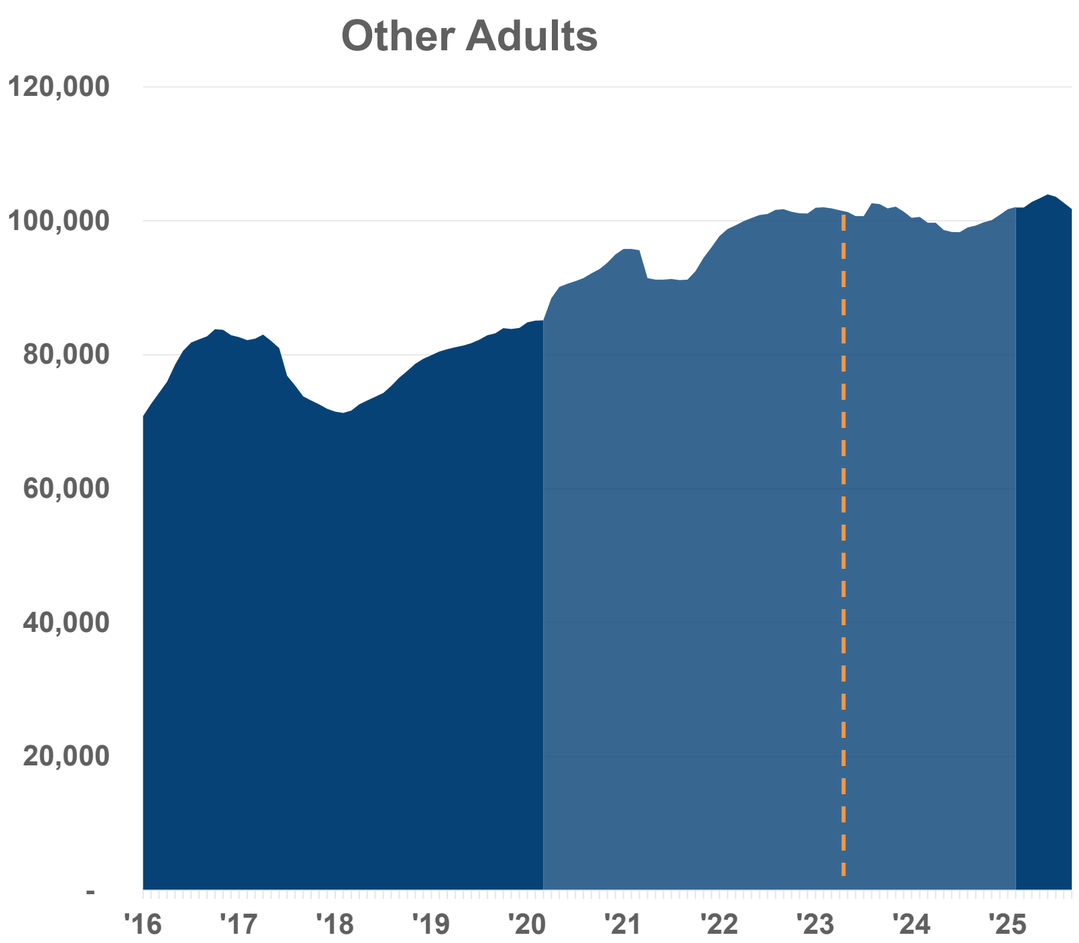
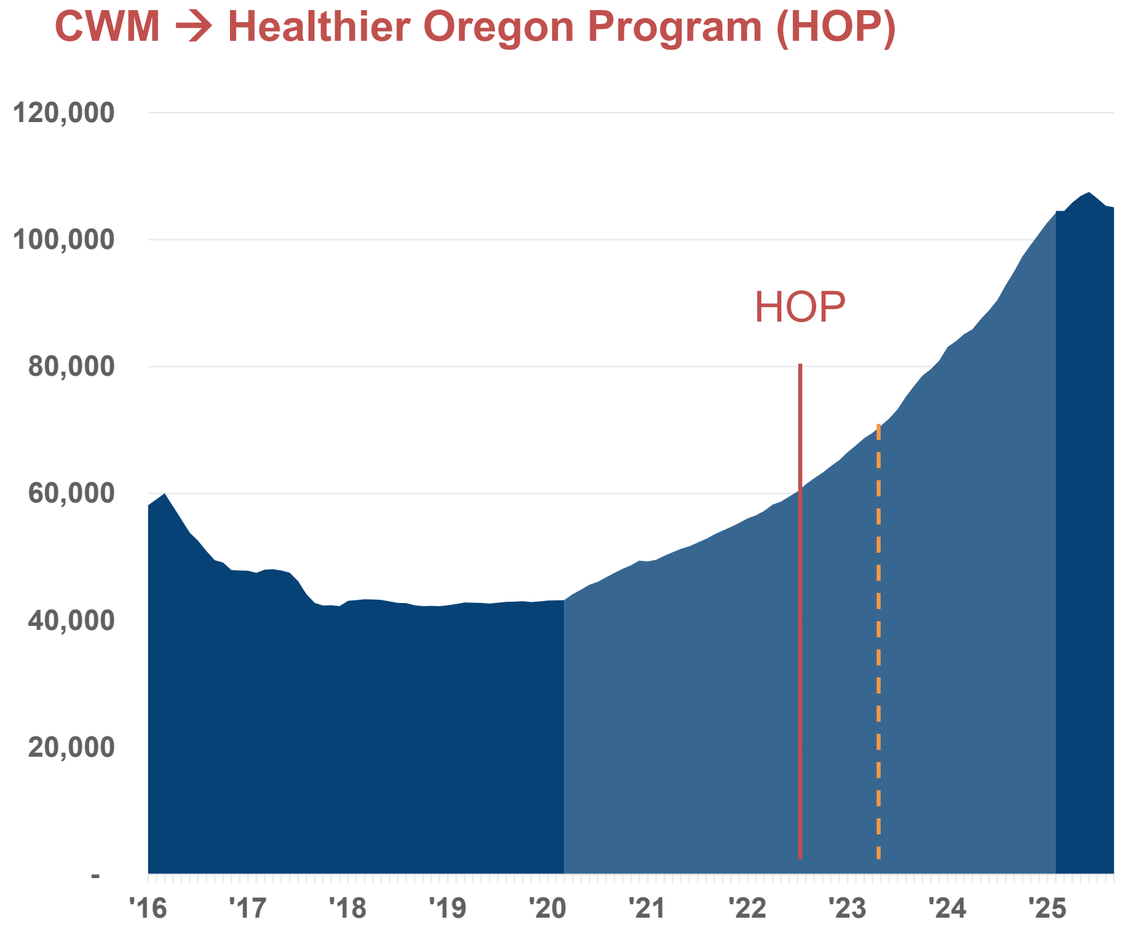
Enrollment by OHP Eligibility Group (3 of 4)

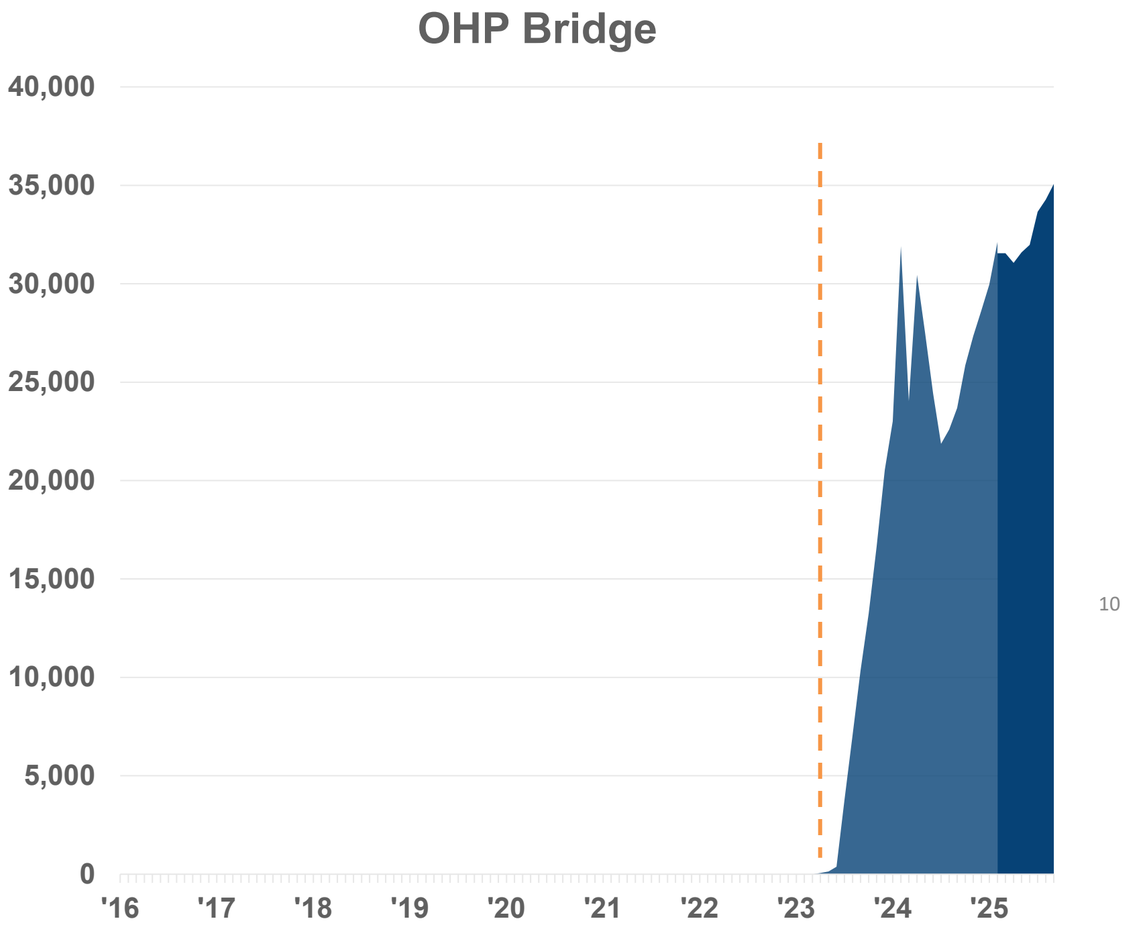


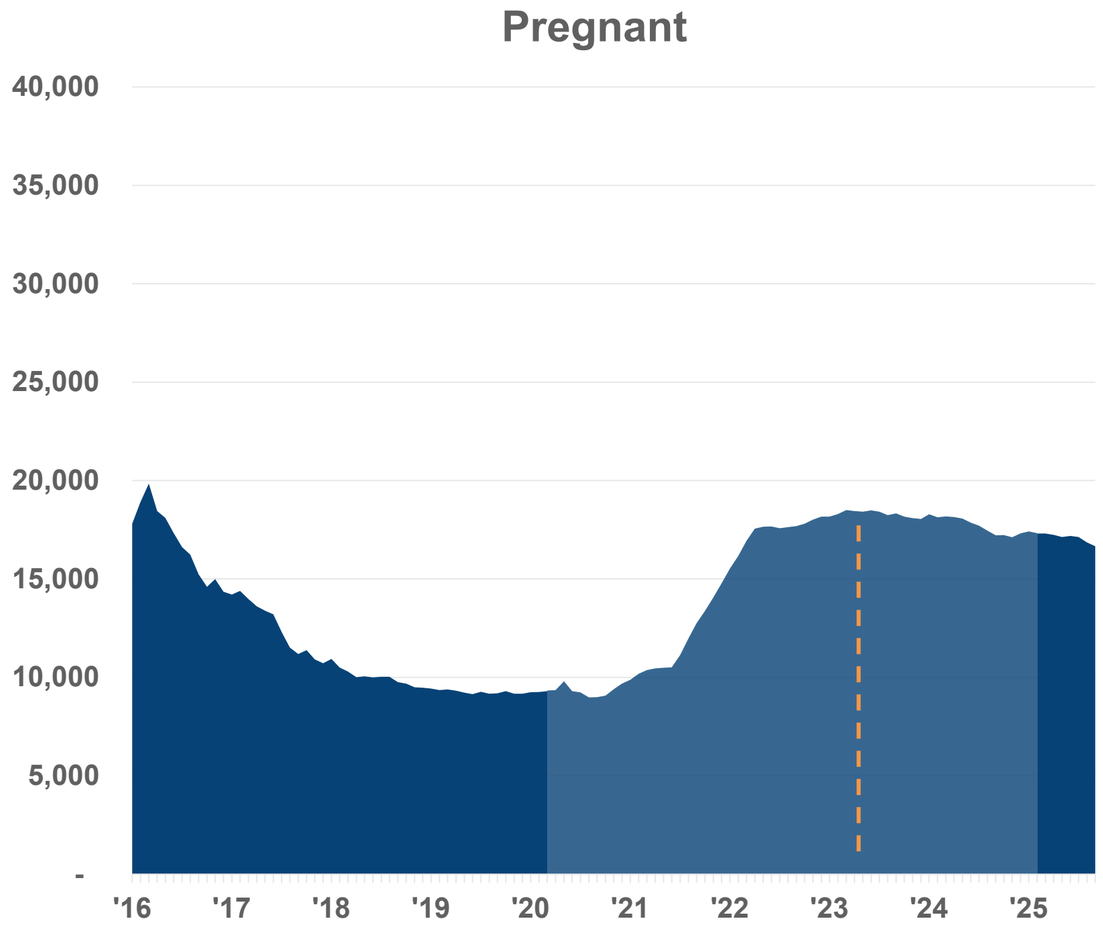
Key	COVID-19 PHE: Continuous enrollment
	PHE Unwinding: Eligibility Redeterminations



CWM: Citizen Waived Medical. HOP was launched for members ages 19-25 and 55+ in July 2022 and expanded to all ages in July 2023.

Enrollment by OHP Eligibility Group (4 of 4)



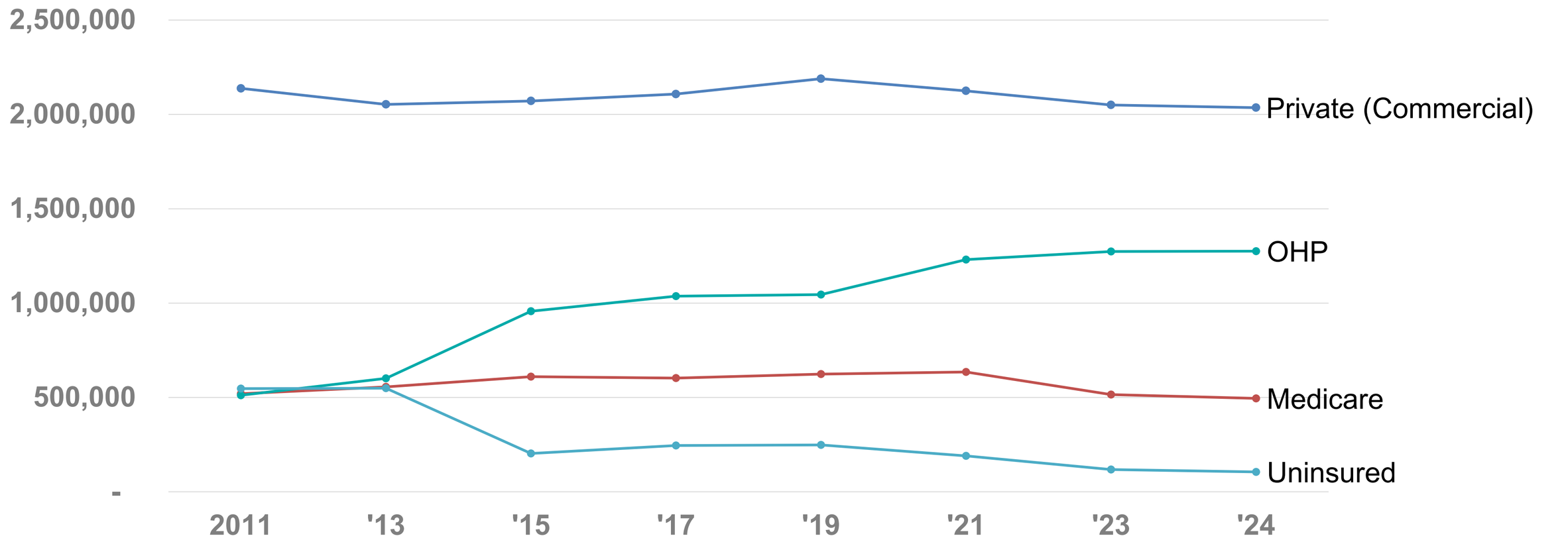


Includes “Adult Temporary Plan” members prior to the launch of the Bridge Program in July 2024

Key	COVID-19 PHE: Continuous enrollment
	PHE Unwinding: Eligibility Redeterminations

Primary Coverage Type

OHP enrollment has increased by 149% since 2011.



Not actual enrollment counts; weighted survey estimates from Oregon's non-institutionalized population. Primary coverage type used a hierarchy that selects one coverage type when a person reports more than one coverage type. If a person reported both Medicare and OHP, they are counted in OHP. In some years, a small number of people reported having insurance coverage, but the type was unknown; they are not reported in this chart (~30,000 people in 2024).

OHP Funding

Medicaid Historical Expenditures

- Includes four groupings of Oregon Health Plan eligibility:
  - **Healthier Oregon (HOP)**, including former Cover all Kids, “CWM” & “CWM Plus”
  - **Affordable Care Act (ACA)/Expansion population**
  - **Bridge**, which includes Temporary Medicaid Expansion, Permanent Medicaid Expansion/Basic Bridge Medicaid, and the Basic Health Program (which is intended to be self-funded except for OHA administrative costs).
  - **Other/Non-ACA**, which is every other eligibility group (includes Children’s Medicaid, Children’s Health Insurance Program (CHIP), Parent-Caretaker Relative, Old Age Assistance, etc.)
- **Excludes Leverage and other non-OHP expenditures not identifiable by eligibility group.**

NOTE: Due to programmatic changes and the complexity of the data, HOP expenditures in 2021-23 were not able to be removed from the separate ACA and Other/Non-ACA data. When combined together (see slide 33), there is no double-count.

OHA Medicaid Actuals in Millions, 2015 -2025

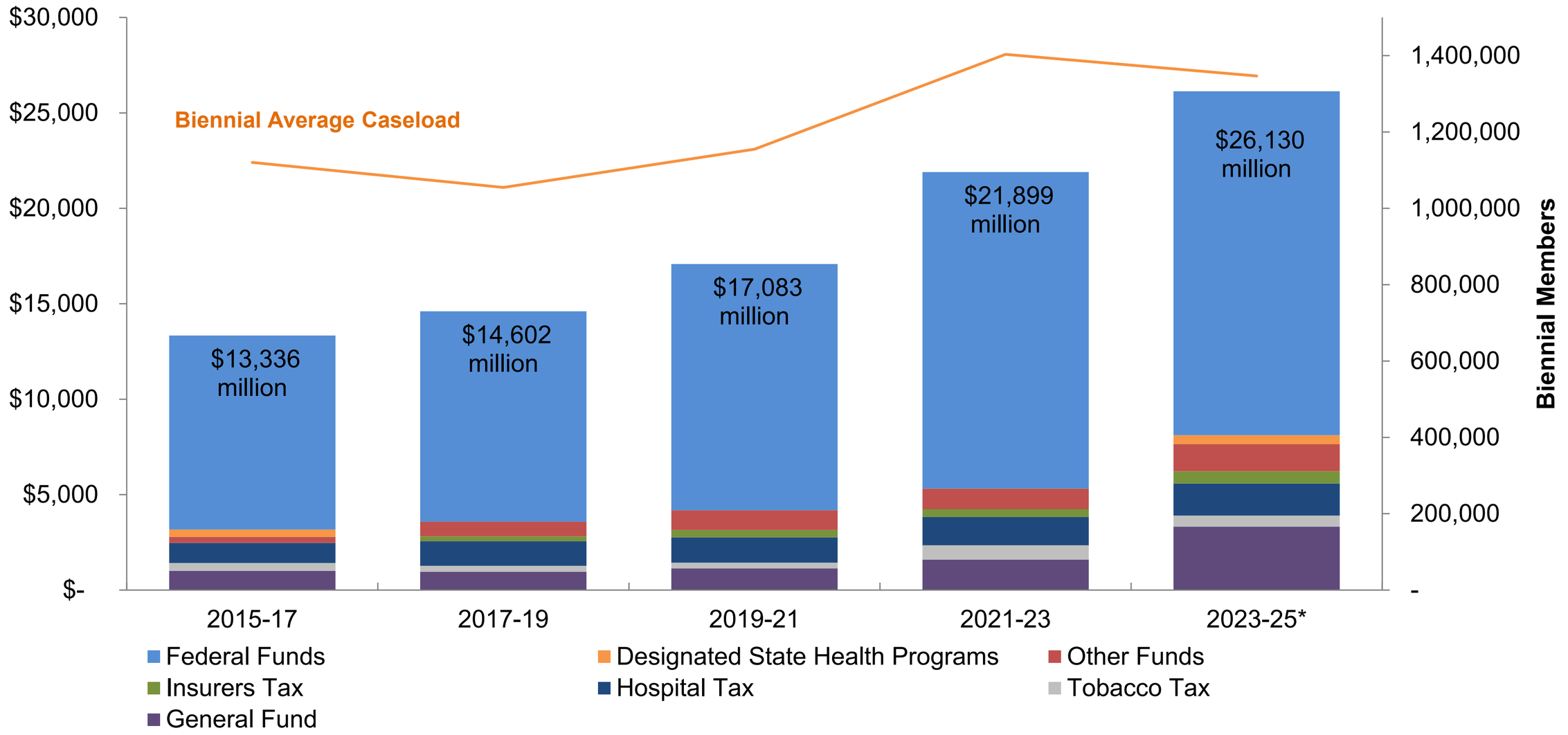
OHA Medicaid Actuals (no admin) by funding type and CCO vs FFS

	2015 - 2017	2017 - 2019	2019 - 2021	2021 - 2023	2023 - August 2025*
GF	1,007	961	1,143	1,598	3,375
OF	1,921	2,623	3,037	3,722	4,267
FF	10,408	11,018	12,903	16,579	17,805
TF	13,336	14,602	17,083	21,899	25,448
		14			
CCO	10,020	11,102	13,155	17,493	20,501
FFS	3,316	3,500	3,928	4,405	4,946
Total	**13,336**	**14,602**	**17,083**	**21,899**	**25,448**

* Data for 2023 – 2025 does not officially close until the end of 2025.

Note: GF data includes HOP. GF changes from 2021-2023 to 2023-2025 are due in part to FMAP decrease.

Medicaid Historical Funding Sources

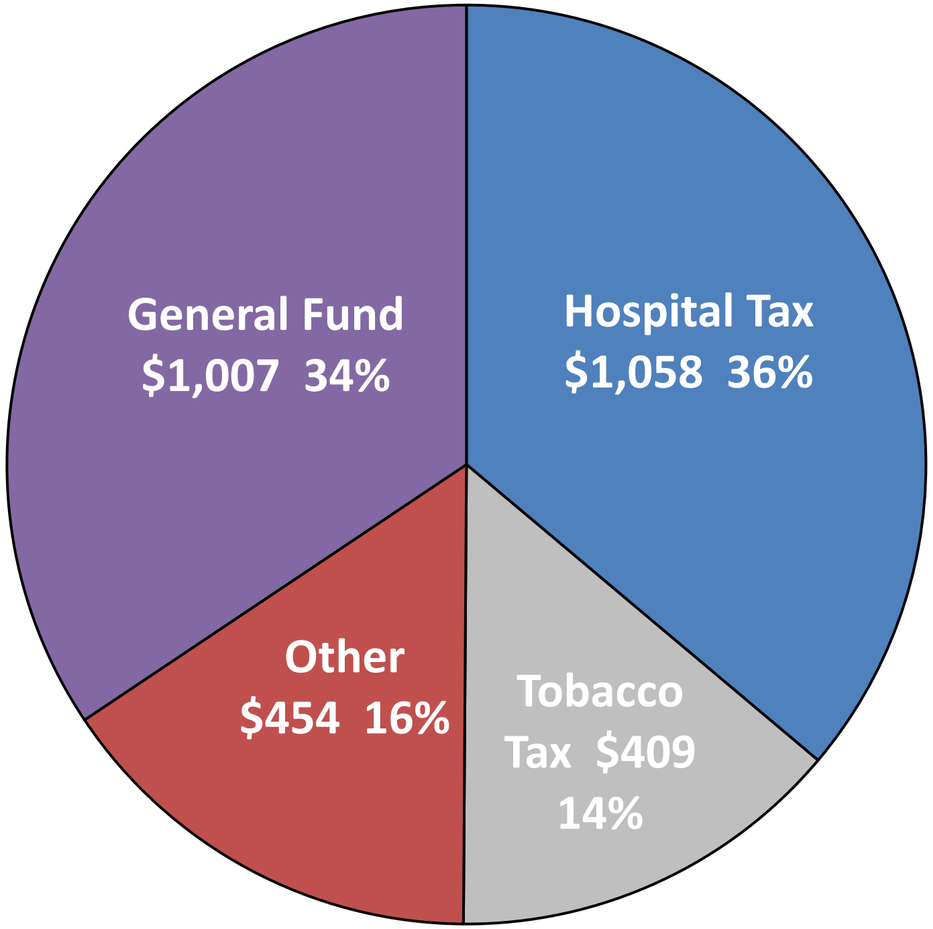


* Data for 2023 – 2025 does not officially close until the end of 2025.

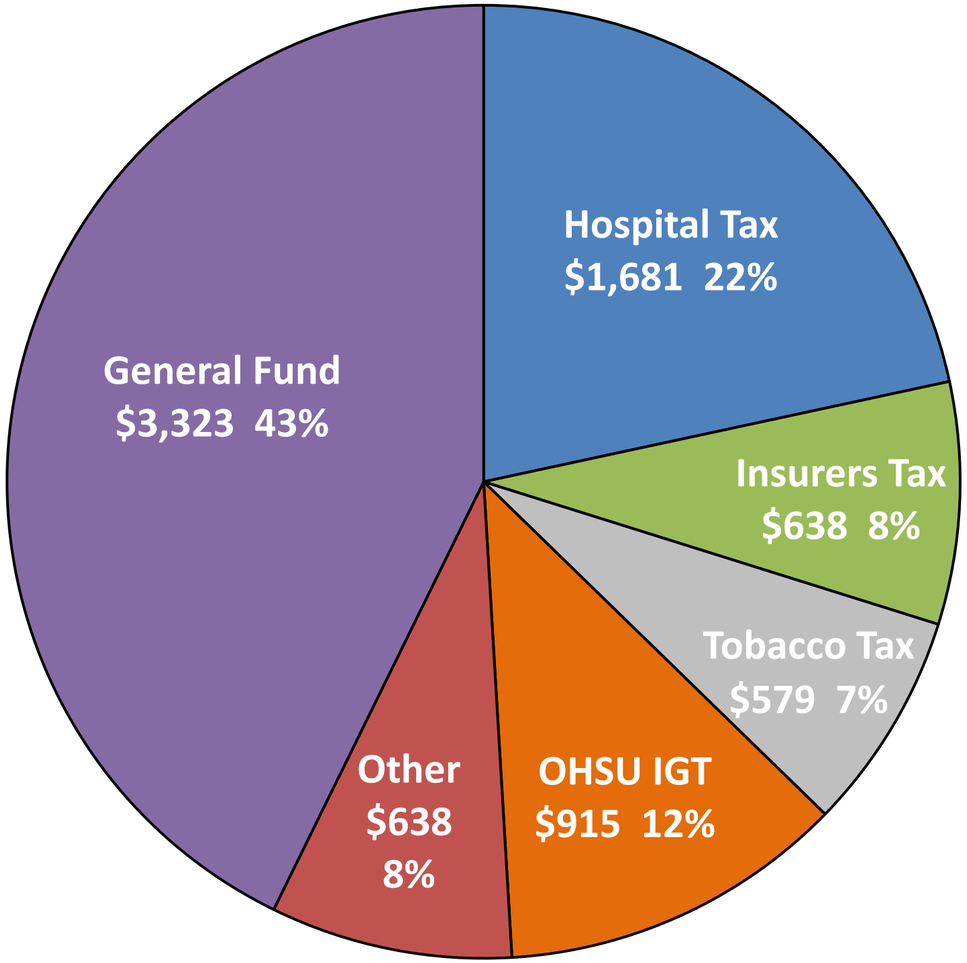
Note: GF data includes HOP. GF changes from 2021-2023 to 2023-2025 are due in part to FMAP decrease.

Medicaid State Funds by Source (in Millions)

2015 - 2017



2023 - 2025



Oregon Medicaid Capitation Rates Trends

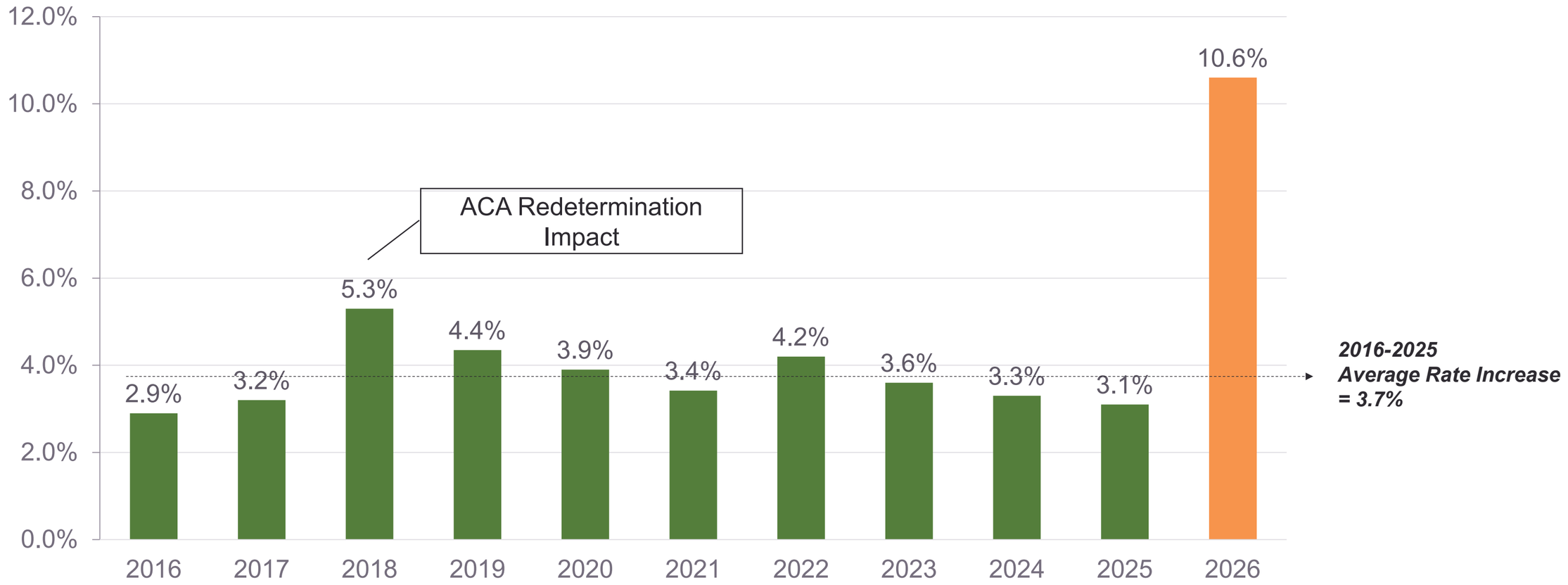
- **CCO PMPM growth stayed close to state budgetary objectives** from 2016 through 2025 even with various programmatic fluctuations.

- **System spend and complexity has grown primarily due to legislative and agency actions expanding eligibility** (e.g., HOP, BHP) and increasing levels of BH access/payment.

- **CY26 cost increases reflect underlying utilization changes that escalated rapidly,** requiring novel rate increase; OHA and MAG are working on responsive changes to assure sustainable financing.

Oregon Medicaid Capitation Rates Over The Years

Annualized growth rate has been consistent at a statewide level, except for 2018 and 2026



- The year over year rate increases for Oregon Medicaid's capitation rates has stayed consistent around the 3.4% budget target. 2018's YoY rate increase was due to the ACA redetermination; some other years were impacted by Legislatively-funded benefit improvements. 2026's projected rate increase of 10.6% is well beyond historical levels.
- Chart is in total funds; however, state fund increases targeted 3.4% in most years resulting in slightly different total fund impacts.

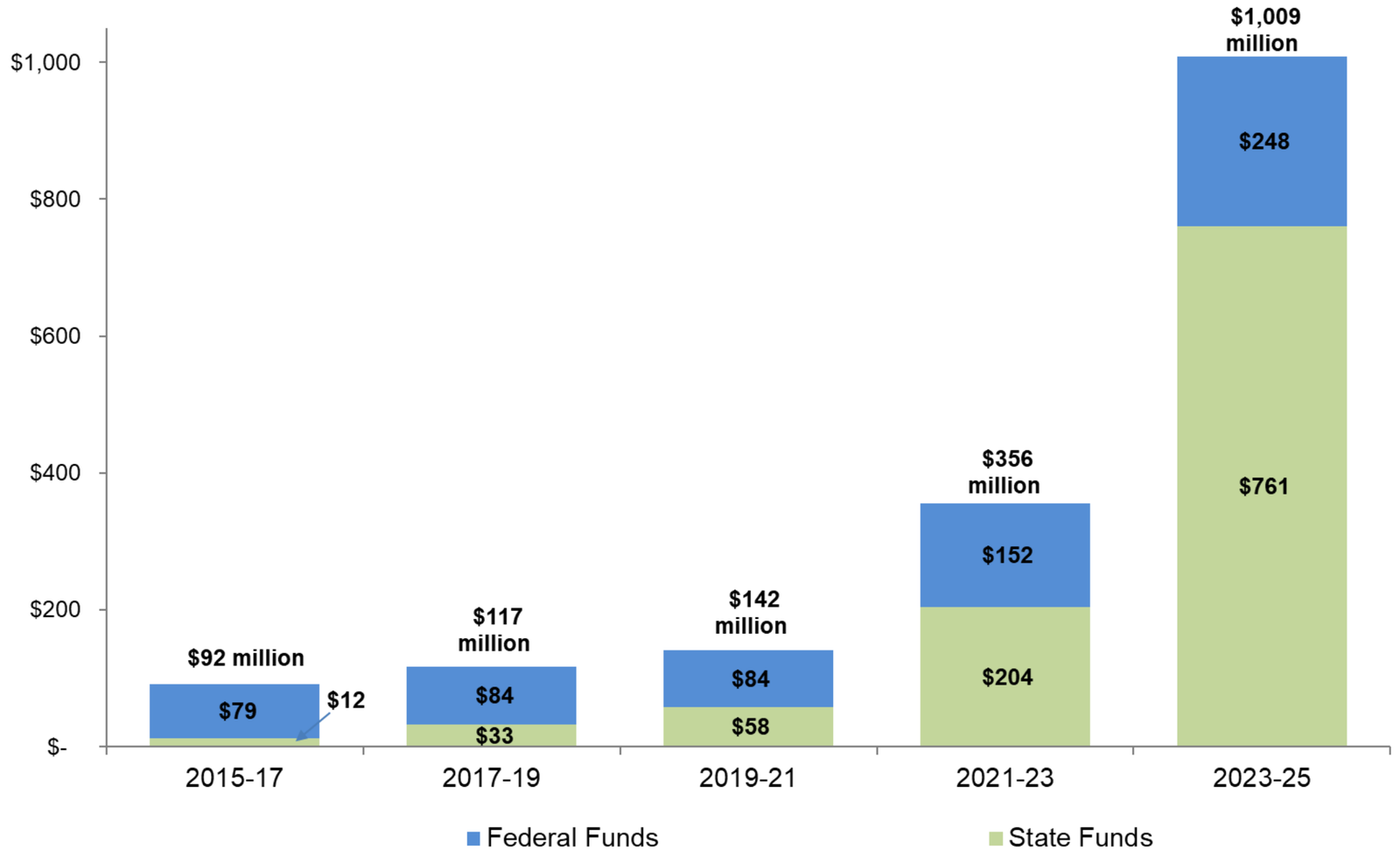
Oregon Medicaid Capitation Rates, 2016 - 2026

The Statewide Per Member Per Month (PMPM) rate has changed as the population and spending patterns have changed.

The statewide average PMPM capitation rates reflect changes to the underlying population over the years. As a result, direct comparisons of these PMPMs year over year are incomplete due to underlying population changes.

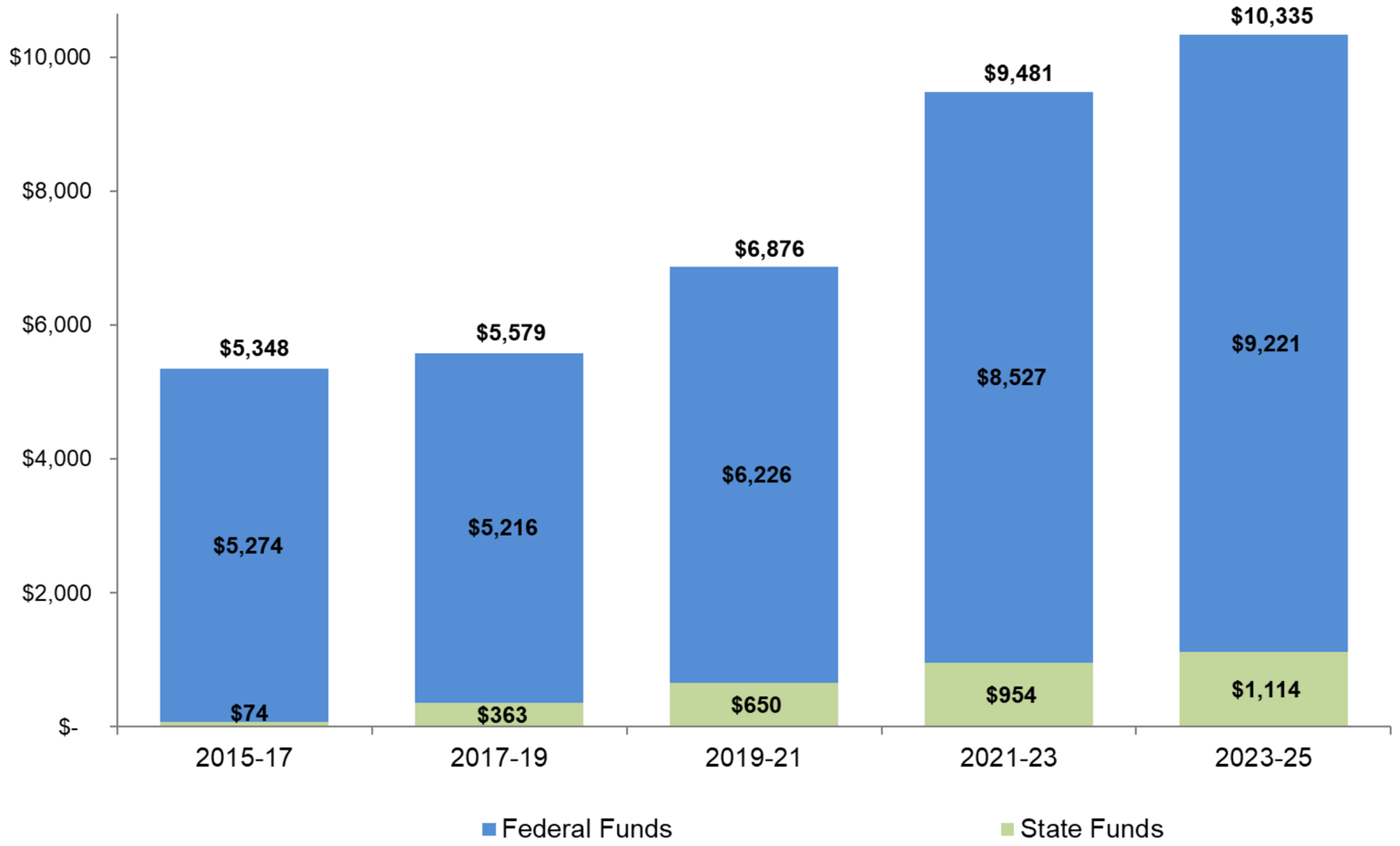
Healthier Oregon Expenditures in Millions, 2015 - 2025

Provides benefits for individuals eligible for Medicaid except for citizenship/residency requirements.



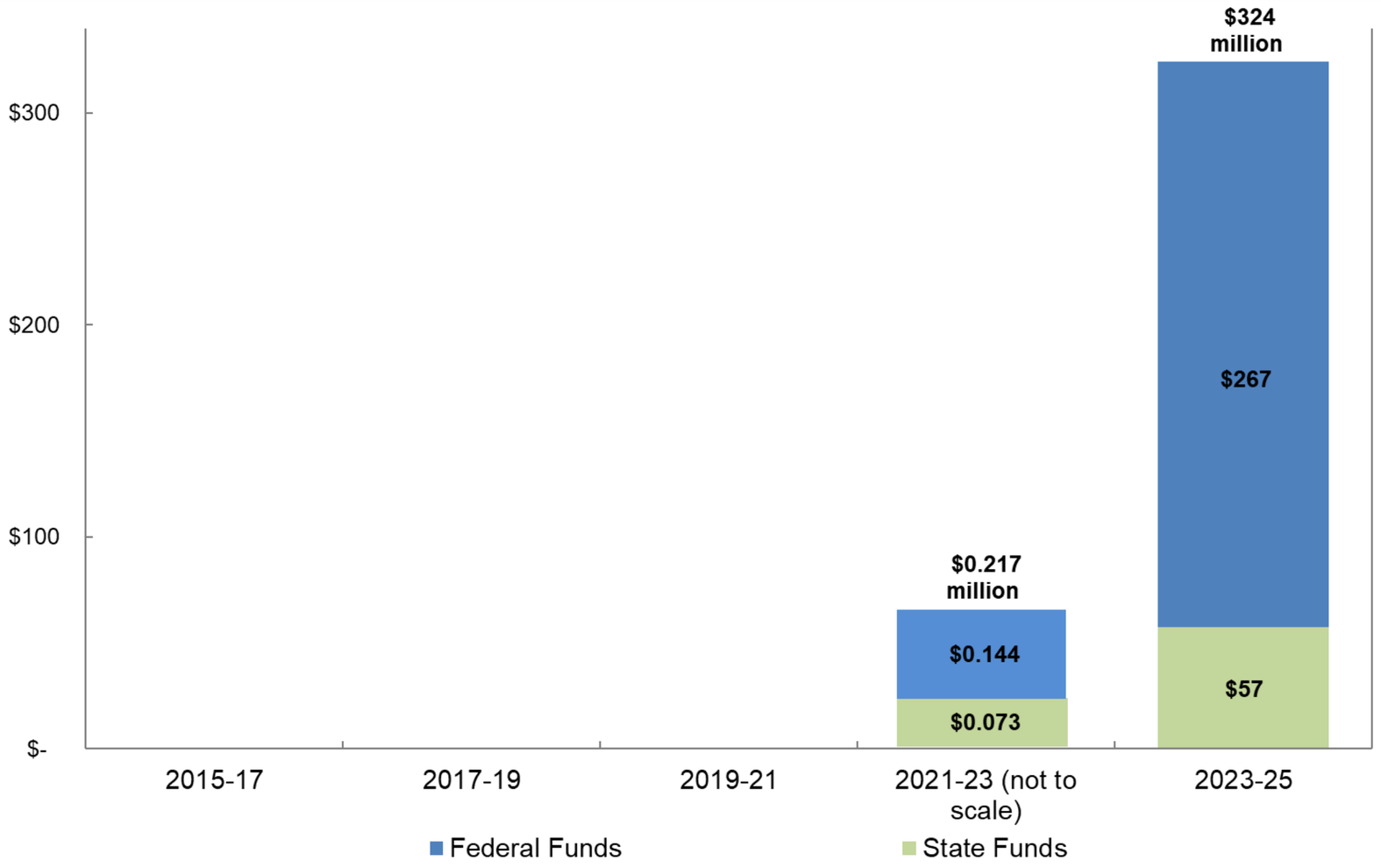
Includes Citizenship-Waived Medical (CWM) Program and CWM Plus, Cover All Kids (began Jan 2018), the expansion to ages 19-25 & 55+ in July 2022, and the expansion to include all adults in July 2023. Collectively now referred to as Healthier Oregon (HOP).

ACA Expansion Population Expenditures in Millions, 2015 - 2025



- Affordable Care Act (ACA)/Expansion population began in January 2014. Expenditures do not include Leverage, Non-OHP (such as MMA Clawback, Part A & B, etc.,) and exclude CWM & CWM+.
- All biennia exclude HOP except for 2021-23. Due to programmatic changes and the complexity of the data, HOP expenditures have not been removed at this time.

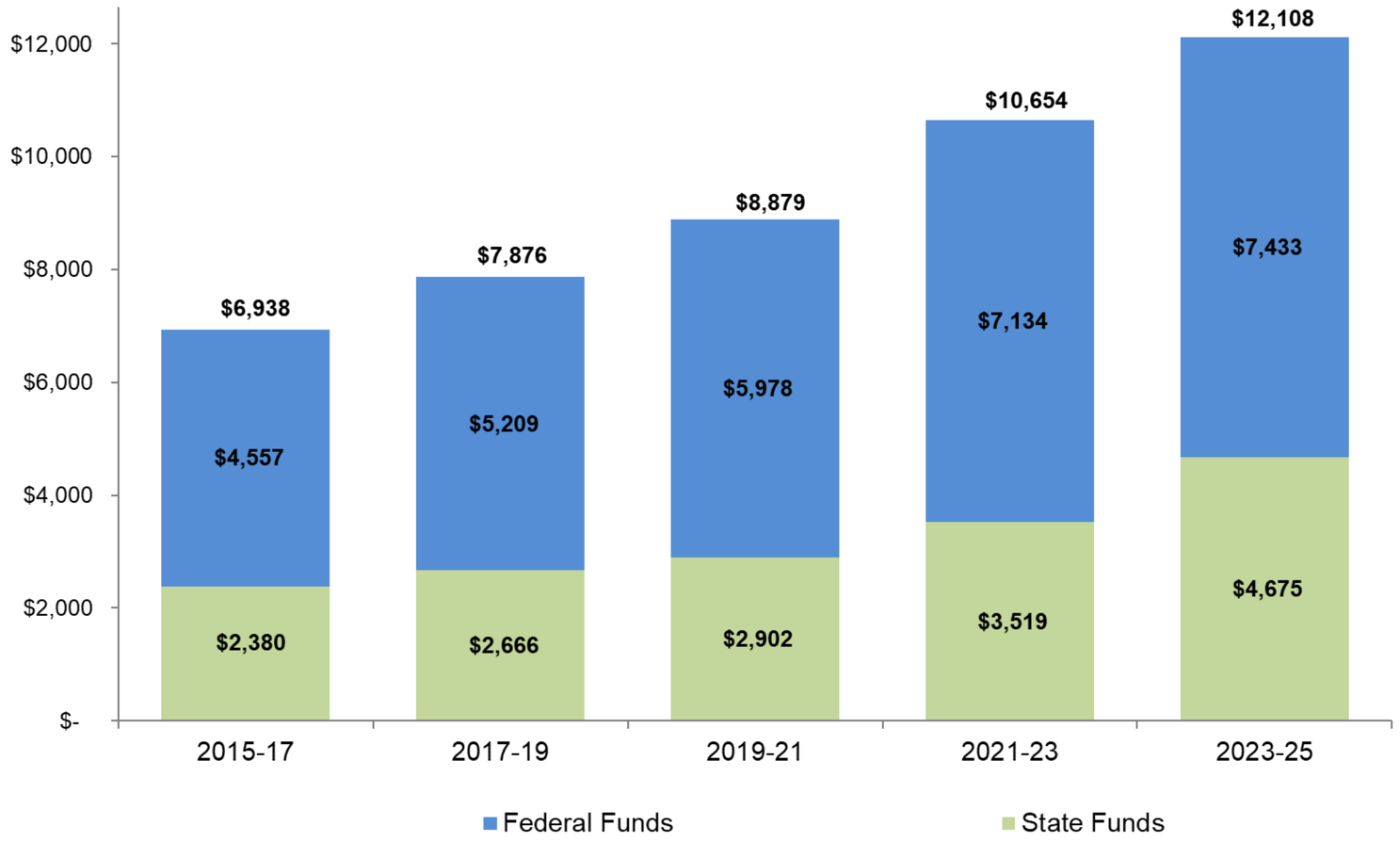
OHP Bridge in Millions, 2021 - 2025



- 2021-23 represents 3 months of the Temporary Medicaid Expansion (TME).

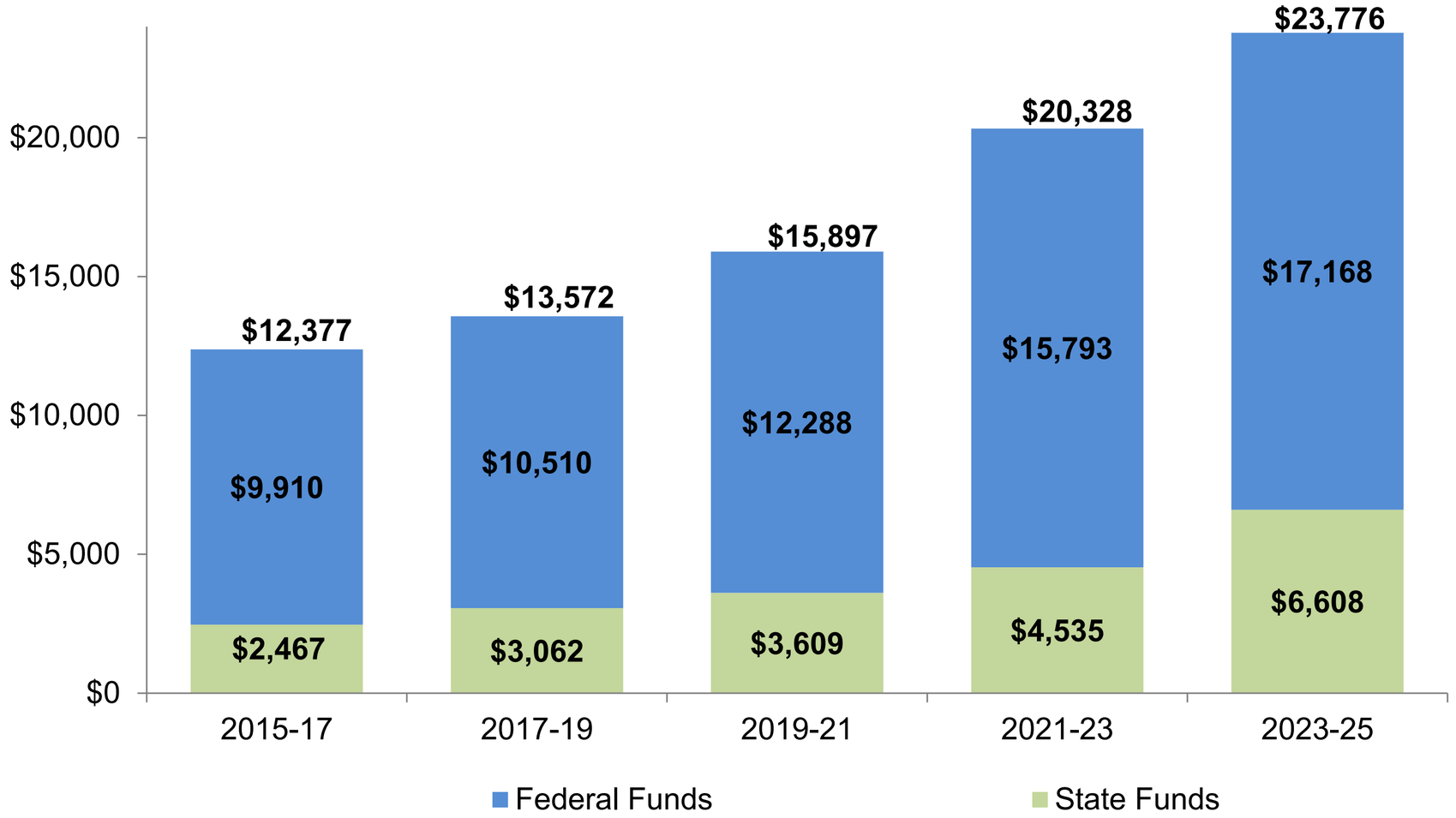
- 2023-25 amounts include spending for:
  - TME which phased-out 12/31/2024
  - OHP Bridge - Basic Medicaid
  - OHP Bridge - Basic Health Program (BHP)
  - *Note: OHP Bridge Basic Medicaid and BHP each launched July 1, 2024*

Other/Non-ACA Expenditures in Millions, 2015 - 2025



- This represents expenditures for all other Oregon Health Plan eligibility groups beside ACA, HOP (see note below) and Bridge. This includes groups such as Children's Medicaid, Children's Health Insurance Program (CHIP), Parent-Caretaker Relative, Old Age Assistance, etc.)
- Expenditures do not include Leverage, Non-OHP (such as MMA Clawback, Part A & B, etc.), and exclude CWM & CWM+.
- All biennia exclude HOP except for 2021-23. Due to programmatic changes and the complexity of the data, HOP expenditures have not been removed at this time.

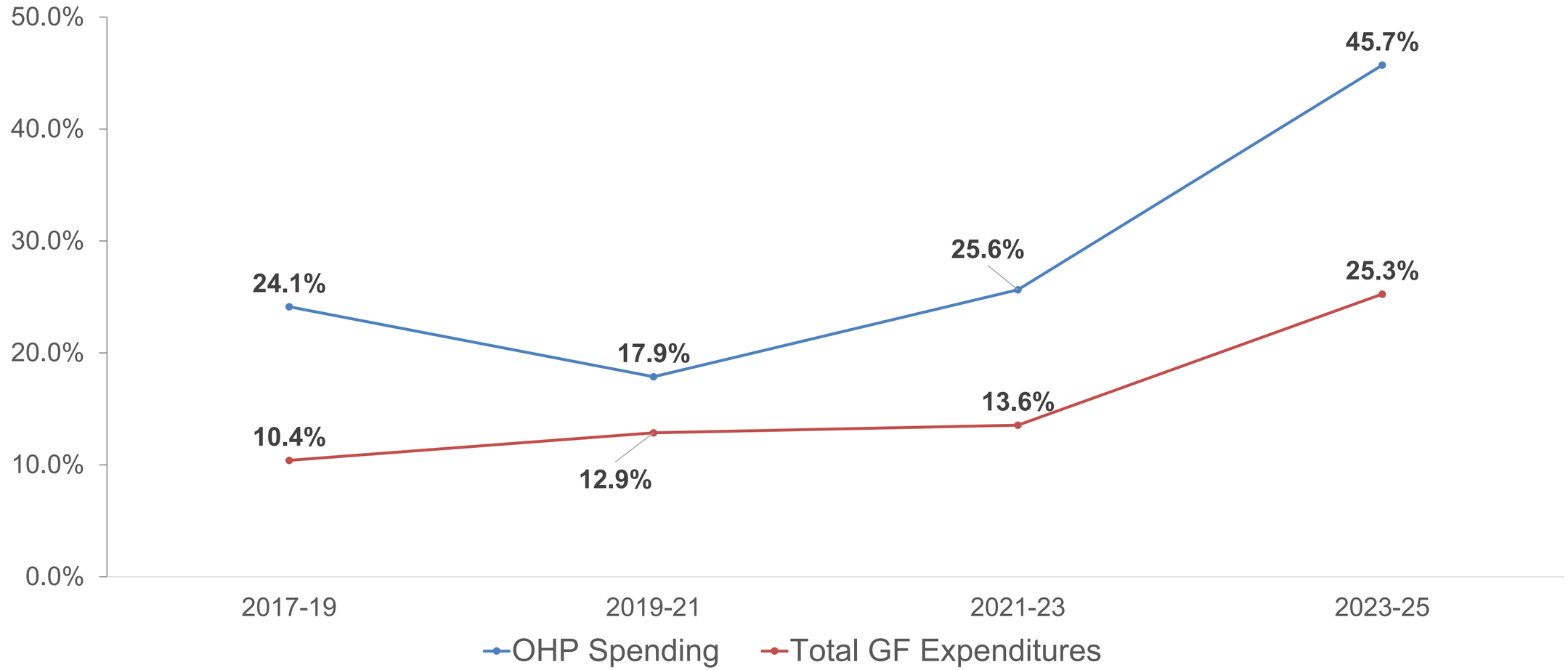
Combined Medicaid Expenditures in Millions, 2015 - 2025



Combined OHP expenditures include:

1. Healthier Oregon
2. ACA/Expansion
3. OHP Bridge
4. Other Non-ACA

Growth in OHP Spending vs Total General Fund Expenditures, 2017 - 2025



OHP Benefits

State Plans Generally Share a Similar Structure

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 a set of mandatory benefits articulated in the state plan. States may include optional benefits in their state plan. Other benefits may be state-funded only.

Changes in the OHP Benefits Package, 2020 – 2025

- Sources of benefit changes:
  - Required by state or federal law
  - Authorized via waivers
  - Included through Health Evidence Review Commission
- Fiscal impact varies
- May or may not be reflected in CCO rates

Examples of Coverage Expansion

2021

- Non-invasive prenatal screening
- Zios patch to identify heart arrhythmias

2022

- Treating hernias that interfere with activities of daily living
- Behavioral health check-ups (HB 2469, 2021)
- Telemedicine (HB 2508, 2021)

2023

- Treating handicapping malocclusions, when teeth misalignment interferes with oral function
- New test for prostate cancer (Decipher)
- Peer & community-driven programs for co-occurring disorders (HB 2086, 2021)

2024

- Increased air ambulance rates, which had not been updated in more than 10 years
- Bariatric procedures for some conditions
- Continuous glucose monitors for some conditions
- Breast cancer screening (tomosynthesis)
- Gender-affirming care (HB 2002, 2023)

2025

- Expansion of Certified Community Behavioral Health Clinics (HB 4002, 2024)
- Palliative care services (HB 2981, 2021)
- K Plan services, care for children's complex needs (SB 1557, 2024)

Cross-State Comparison of OHP Benefits Package: *Select Optional Services for Adults (21+)*

The OHP optional services benefit package is more generous compared to similar states.

Service:	Oregon	Arizona	California	New York	Washington
Physical Therapy (PT)	Up to 30 visits per year	Up to 15 visits per year to restore or maintain a skill or level of function; up to 15 visits per year to acquire a new skill or level of function	Services to prevent significant illness or disability, or to alleviate severe pain; all services require PA	No limits per year for medically necessary visits	Up to 12 visits per year; PA is required for additional visits
Chiropractic	Coverage is based on the Prioritized List	Up to 20 visits per year when ordered by the Member's primary care provider; prior authorization (PA) is required for additional visits	Up to two visits per month	Not covered	Not covered
Dental	Diagnostic, preventive, restorative, specialist, and emergency or urgent care; no limits on benefits	Emergency dental services up to $1,000 per year	Up to $1,800 per year for covered services; limit does not apply to emergency services, maxillofacial surgery or to residents of nursing facilities. Annual limit can be exceeded with PA and medical necessity	Essential services (e.g., oral exams, cleanings, root canals)	Diagnostic, preventive, treatment, prosthodontics, sedation, and teledentistry services; some services may require PA

Other State Examples of Benefit Restrictions

- As stated, common types of restrictions focus on reductions of optional services, or put restrictions on certain benefits (scope, duration, and amount). Examples include:
  - Limits on Physical Therapy, Chiropractic, and other rehab services limits: TX, FL, NC have annual visit limits
  - Behavior Health Service Limits: Several states place caps on outpatient therapy visits or require a Prior Authorization after a certain number
  - Adult vision and hearing services: Many states provide little or limited services
- **Overall—even if a state covers a service, they may have access or prior authorization limits, or low reimbursement rates that lead to little or low utilization**

Provider Reimbursement

Provider Reimbursement Summary

- OHP pays for a wide array of services through several mechanisms
  - Assessing reimbursement trends requires specificity, which often obscures big-picture conclusions
- Recent aggregate cost trends most heavily influenced by:
  - Utilization increases, particularly in behavioral health
  - Pharmacy cost increases (e.g. specialty drugs)
  - Deliberate, structural changes to reimbursement rates (discussed herein)

Overview of Provider Reimbursement

- **OHA to CCOs**
  - Monthly capitation payments per member covered
  - Separate term directed payments (“QDPs”) for hospitals and GEMT
- **OHA to Providers**
  - State plan fee for service (“FFS”) rates for “open-card” members and carve-out services
  - Wrap payments for safety net clinics and A/B hospitals
- **CCOs to Providers or Downstream Plans**
  - Negotiated FFS Rates
  - Value Based Payments (e.g. quality incentives, PCPCH payments)
  - Delegated subcapitation
  - Other financial risk-sharing arrangements
  - State Directed Payments / Uniform Rate Increases

Current Reimbursement Practices

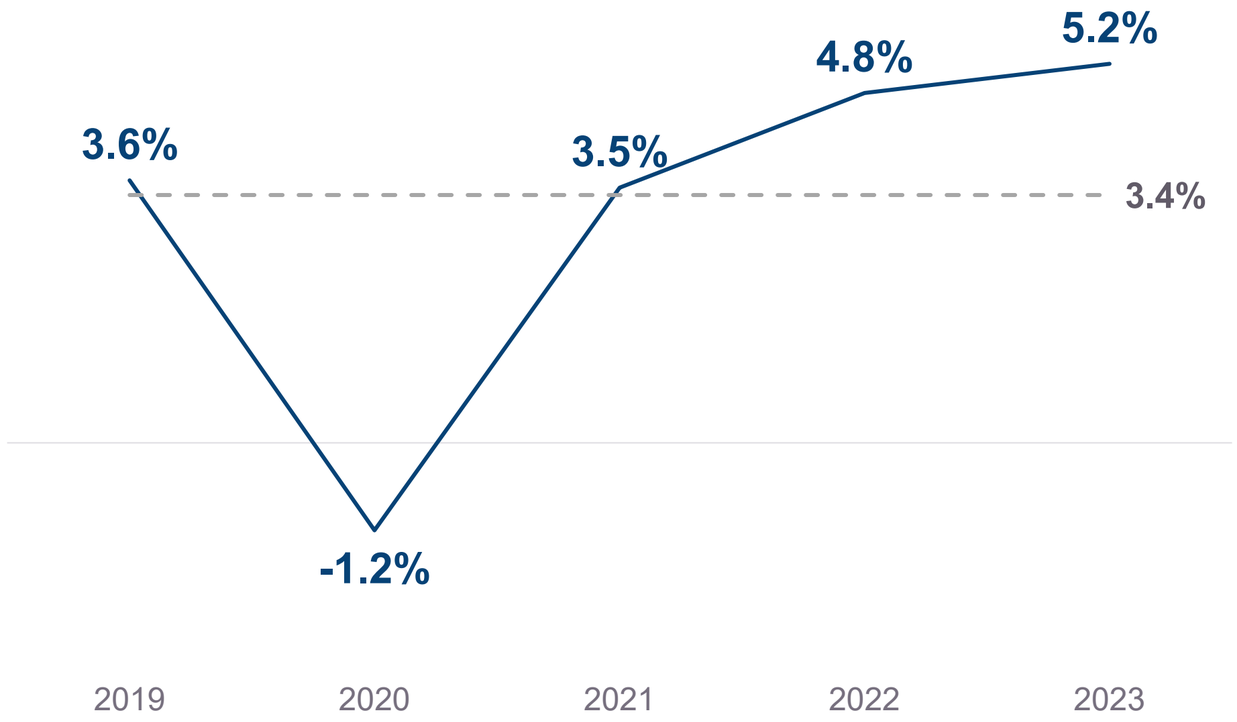
- **OHA FFS (“state plan”) schedule**
  - Professional services: 80% of Medicare target for most services
  - DRG hospitals: 100% of Medicare, partially funded by hospital tax
  - A/B hospitals: cost-based and alternative methods used which can result in payment exceeding 100% of Medicare, partially funded by hospital tax
  - Cost of pharmaceuticals is largely outside OHA control; in some cases step therapy and PA can help mitigate costs and assure value for payment
- **CCO payment practices**
  - General structure: pay FFS rates that are negotiated with providers
  - OAR 410-120-1295 provides guidance for CCO payments to non-participating providers, and becomes a reference point for CCO-provider negotiations
  - CCO contract has several provisions requiring or encouraging CCOs to pay under alternative payment methods with an emphasis on increased use of value-based payments over time
  - CCO hospital and FQHC payments are supplemented by separate financing sources

Recent Structural Changes to Reimbursement

- **Increased use of VBPs (2020):** incorporated into CCO contracts to encourage payment for value rather than for bulk – fit within existing global budgets
- **Hospital QDPs restructuring (2020):** largely cost neutral, but infused a greater portion of hospital payments into CCO capitation rates
- **BH payment rate increase (2022-2023):** ~30% in aggregate across FFS and CCOs, as funded by the Legislature
- **FFS rates standardization (starting 2023):** benchmarking most physical health professional services to 80% of Medicare, to the extent possible within existing biennial budgets
- **Increased use / prevalence of safety net clinics (ongoing):** reimbursed via daily payment rates under federal law

OHP Cost Drivers

Growth in Total Health Care Expenditures, 2019-2023

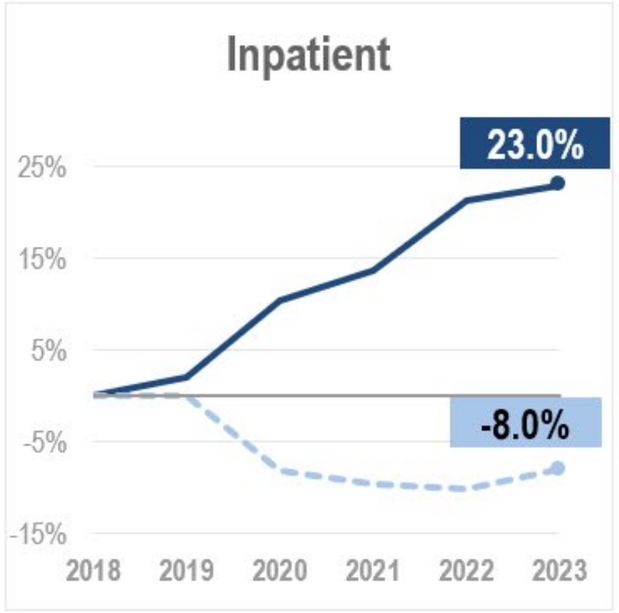


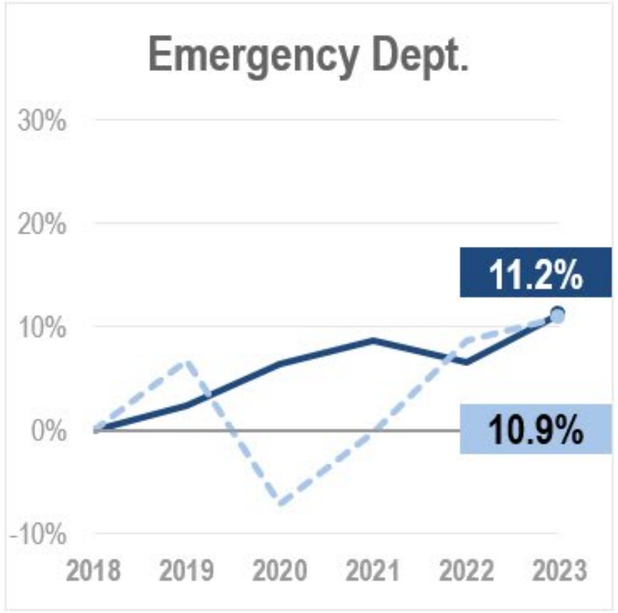
Statewide Findings

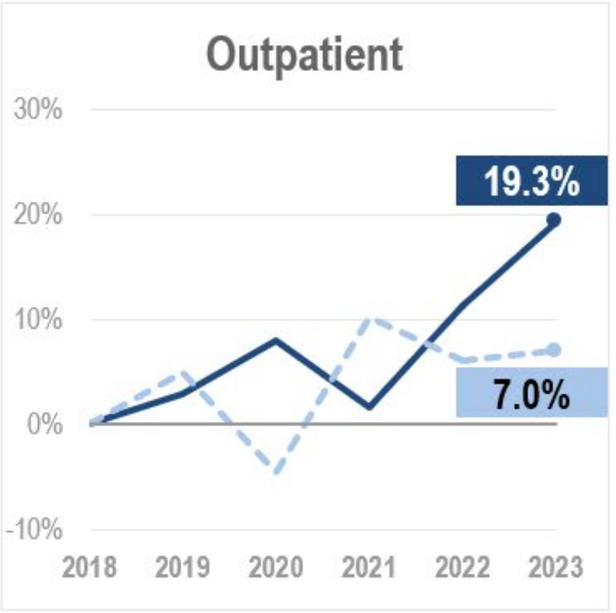
- Health care spending in Oregon in 2023 totaled almost **$39 billion**.
- Total health care expenditure spending grew **5.2%** to $10,302 per person per year in 2023.
- Health care cost growth has **exceeded the 3.4% target** in four of the five past measurement periods.

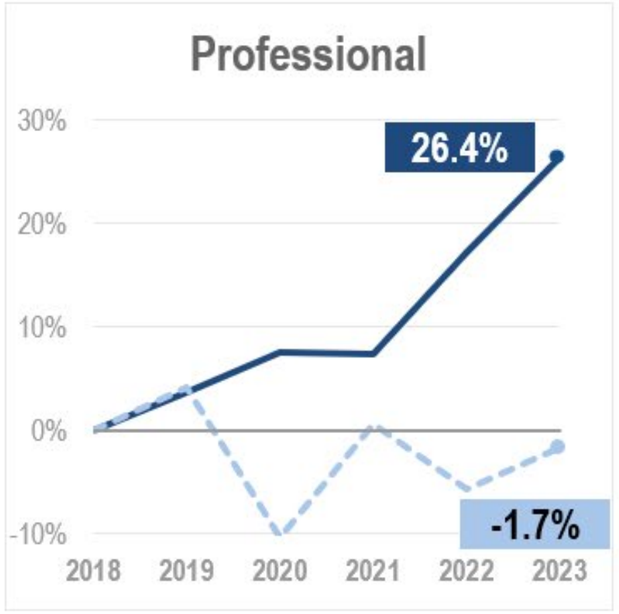
All Markets - Price Was The Major Driver of Cost Growth, 2018-2023

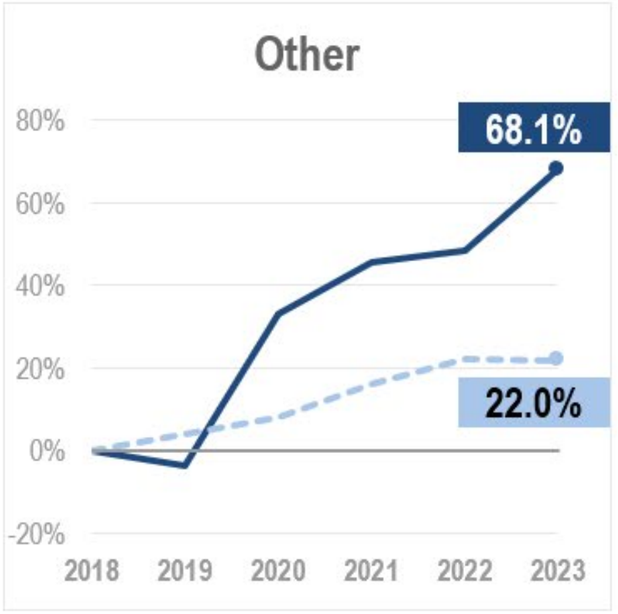
APAC claims analysis.

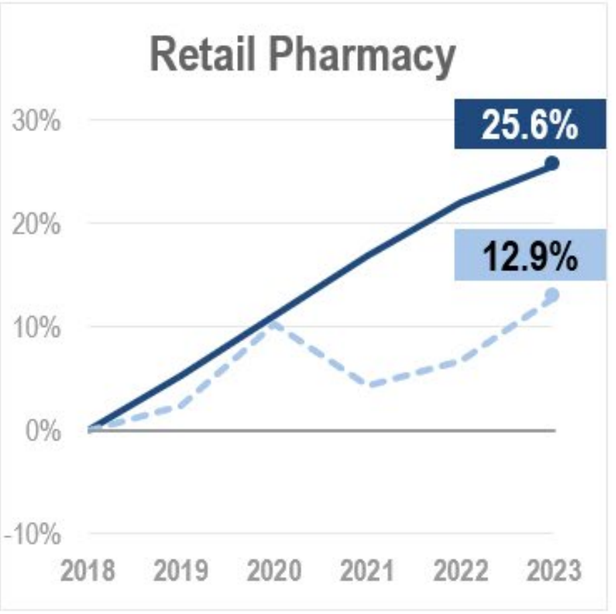






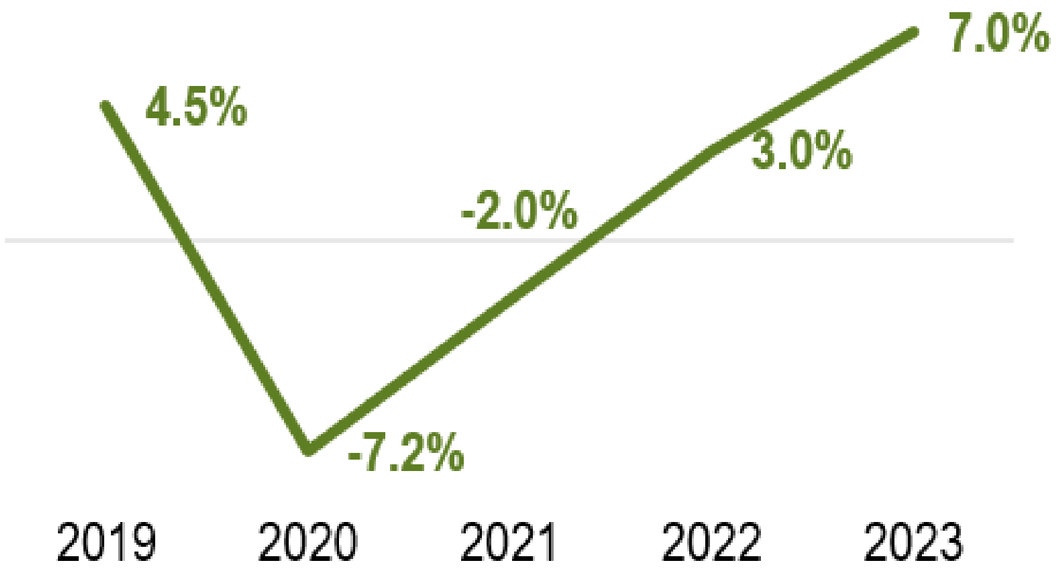






Key	
———	Overall price
- - - -	Utilization

Medicaid - Growth in Total Medical Expenses, Medicaid Market, 2019-2023

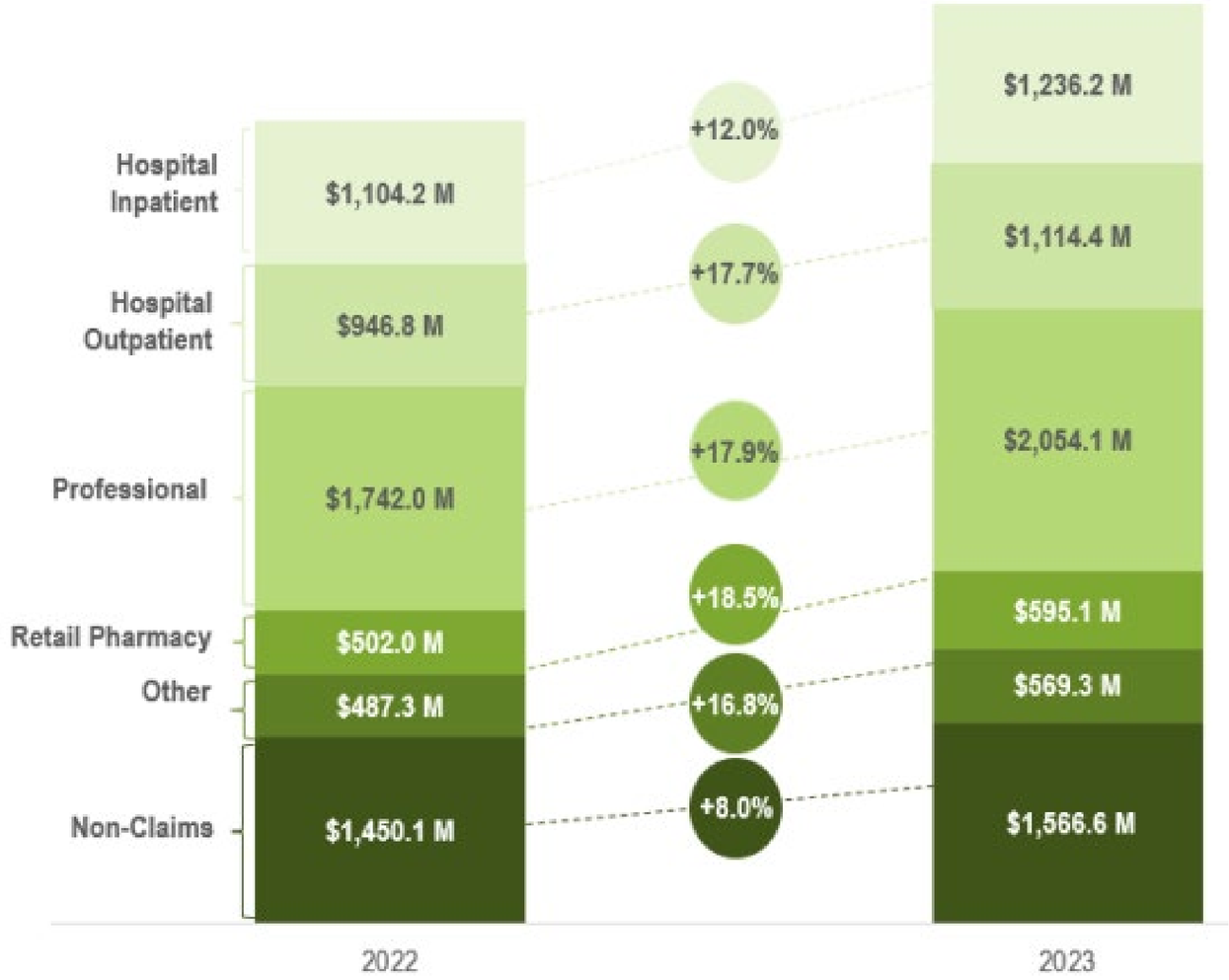


Medicaid

- Medicaid total medical expenses (TME) grew **7.0%** between 2022-2023.
- Behavioral health rate increase: Legislature appropriated funds to increase Medicaid BH rates in the '21-'23 biennium
- Hospital facility rate increase: CCOs were expected to temporarily increase payments to diagnosis-related group (DRG) hospitals to 85% of Medicare

Medicaid Spending by Service Categories, 2022-2023

Total Medical Expenses - total spending, in millions, and growth rate in Medicaid

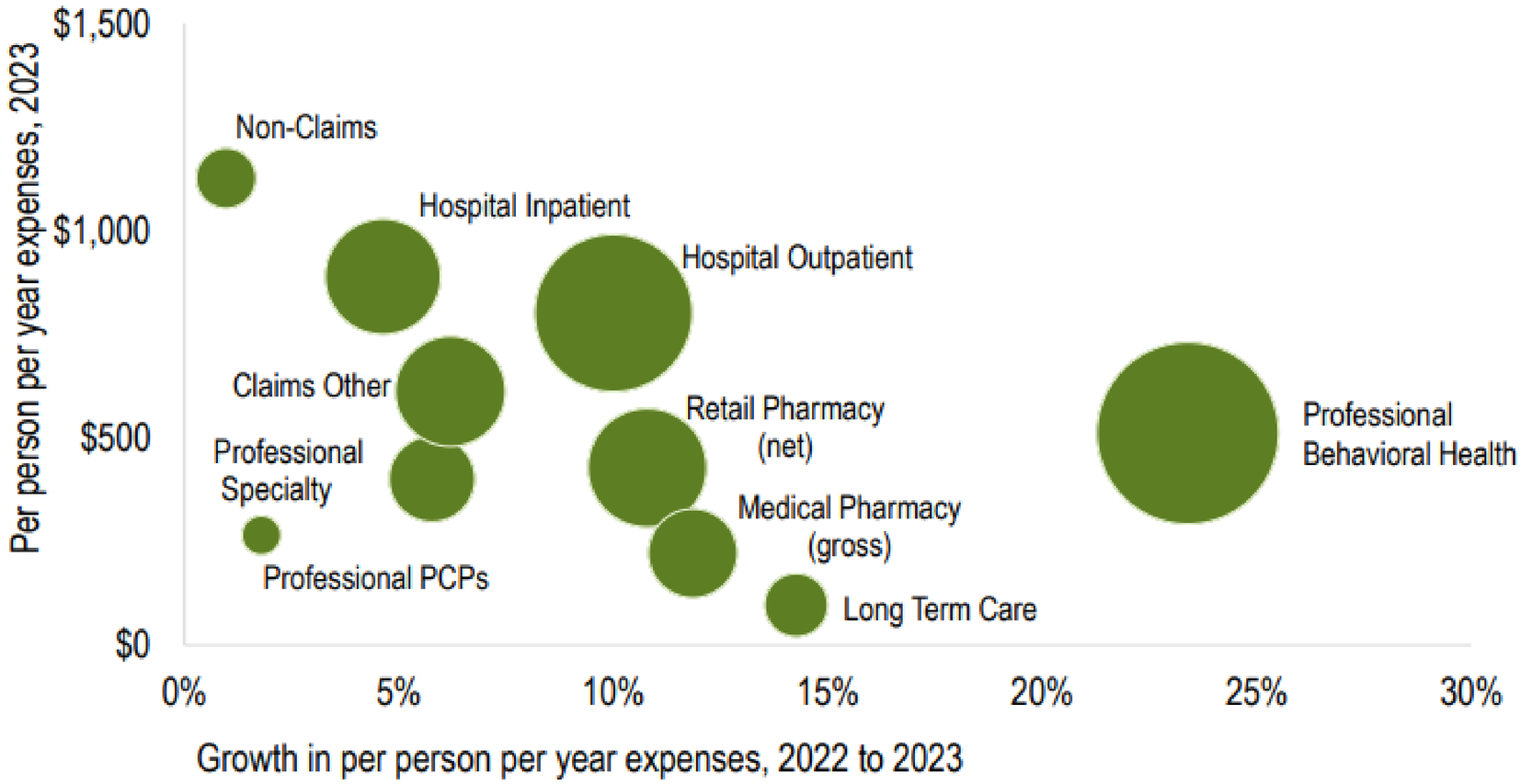


Spending is reported net of pharmacy rebates.
Note data may not align with SFY budget amounts.

https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/Oregon-Health-Care-Cost-Trends-Report-2022-2023.pdf

Medicaid Total Medical Expenditures - Per Person Per Year Spending by Service Category, 2022-2023

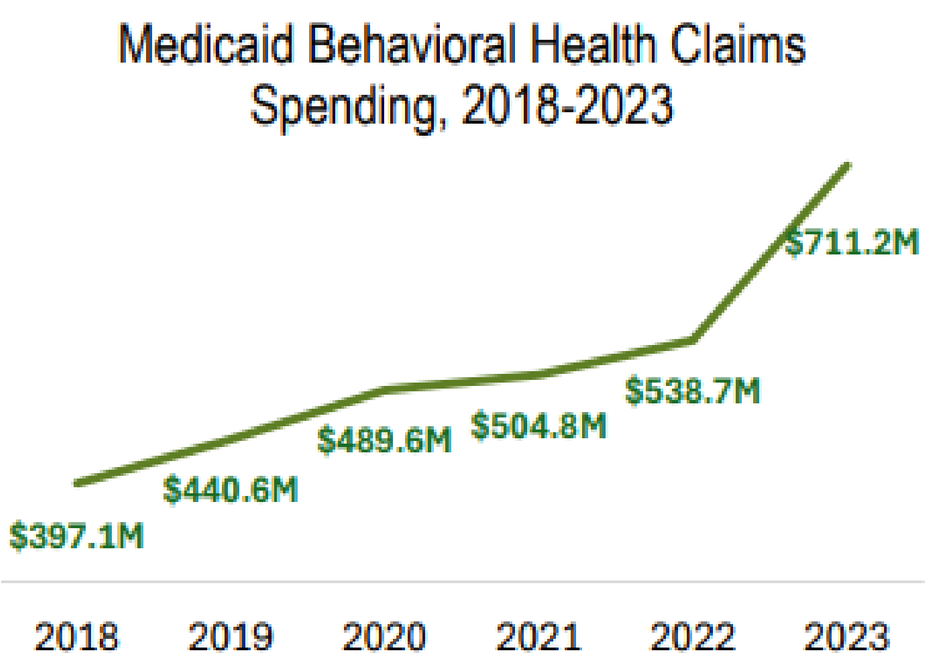
- Bubble size represents absolute dollar change in per person per year spending.
- Spending is reported gross of retail pharmacy rebates.

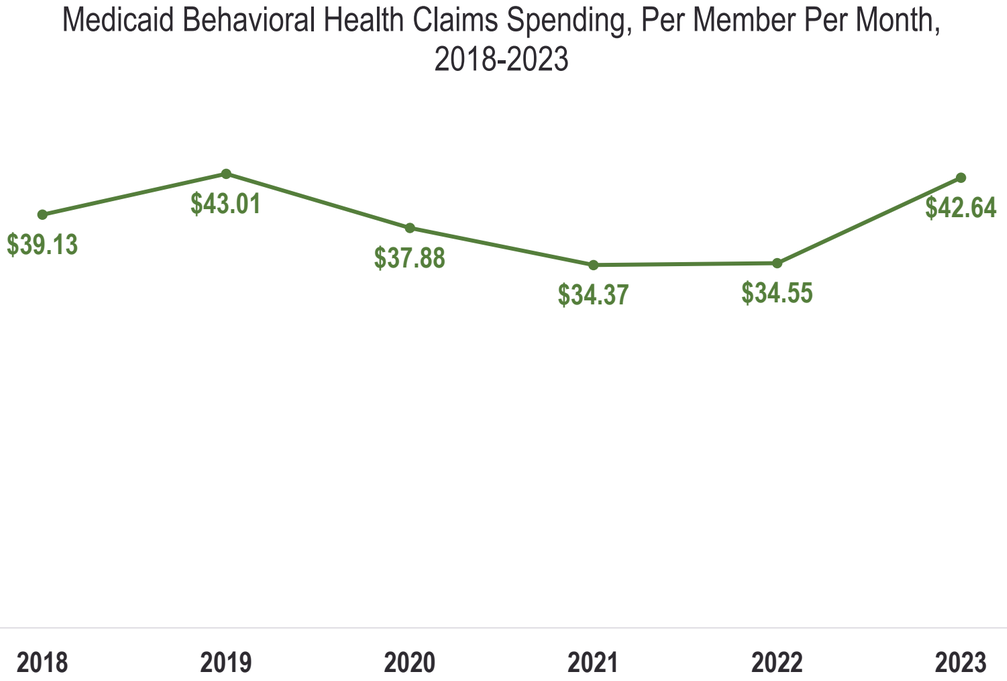


https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/Oregon-Health-Care-Cost-Trends-Report-2022-2023.pdf

Medicaid Behavioral Health Spending, 2018-2023

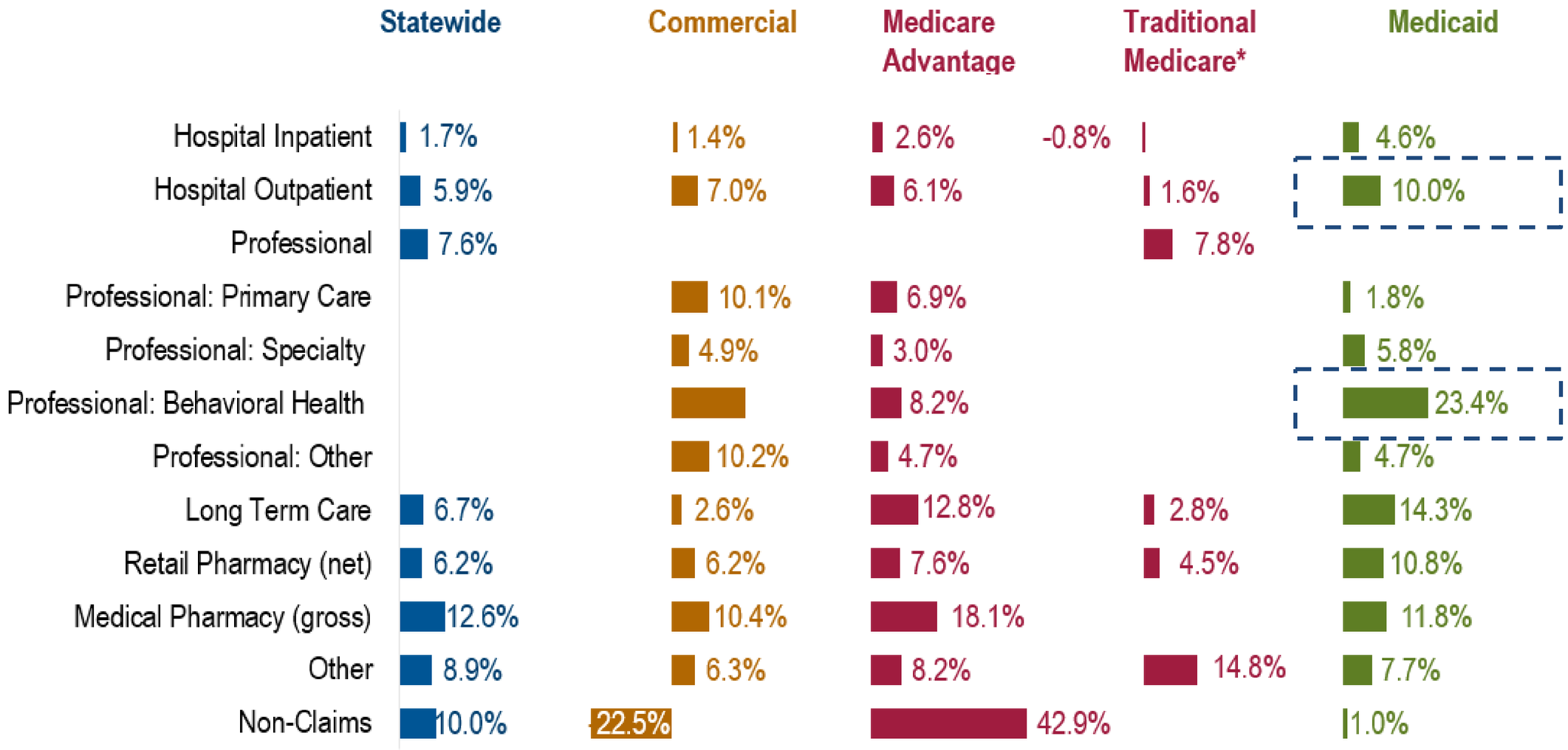
The introduction of Medicaid Behavioral Health Directed Payments (BHDPs) was responsible for almost 30% of the Medicaid cost growth between 2022-2023.





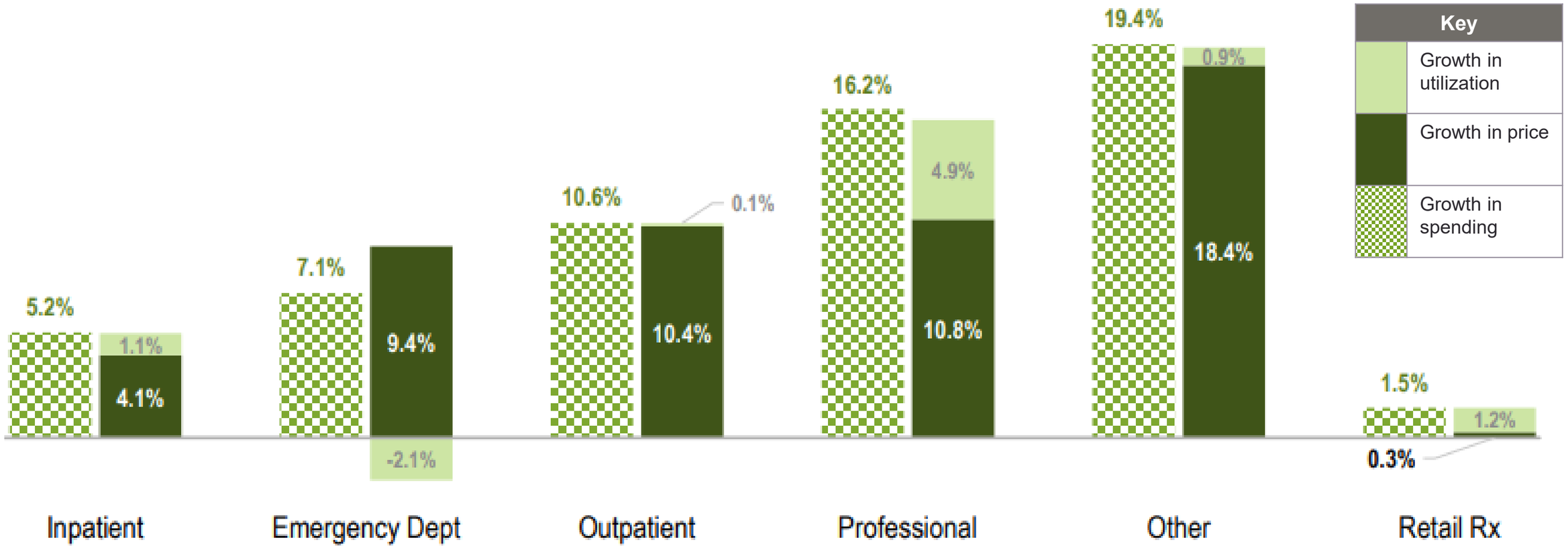
https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/Oregon-Health-Care-Cost-Trends-Report-2022-2023.pdf

All Markets - Total Medical Expenses – Percent Change in Per Person Per Year Spending by Service Category, 2022-2023



Medicaid Cost Growth Drivers – Price vs Utilization, 2022-2023

Per person cost growth.

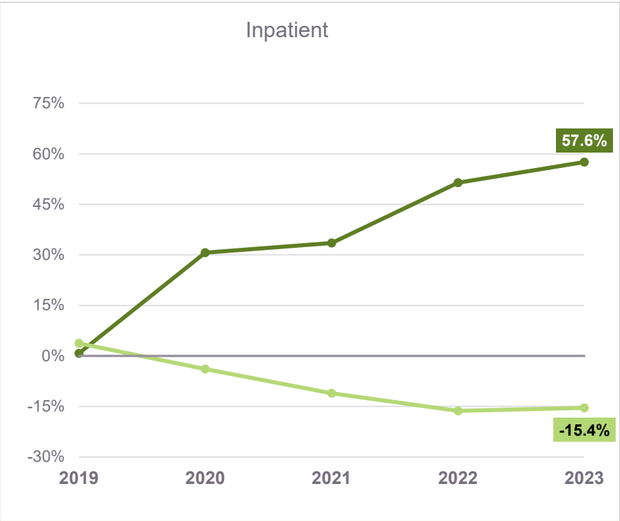


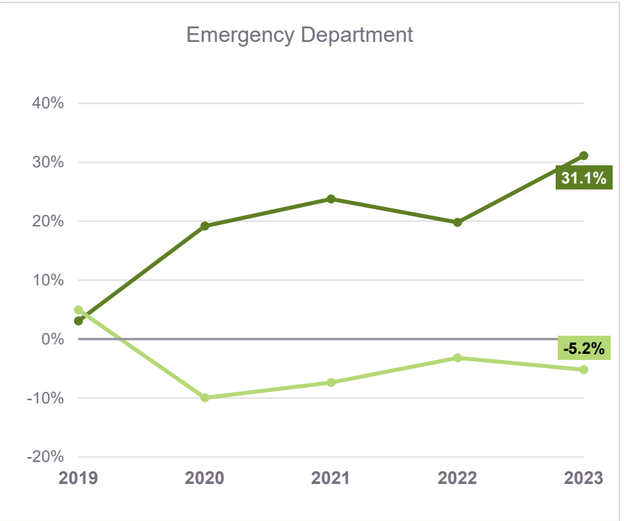
https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/Oregon-Health-Care-Cost-Trends-Report-2022-2023.pdf

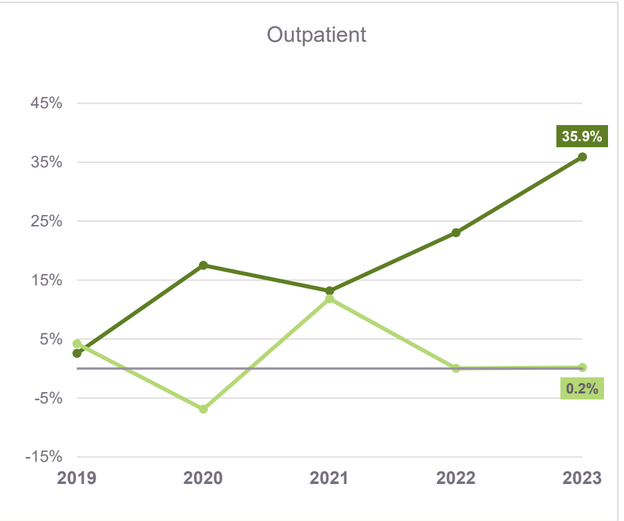
Price Was The Major Driver of Cost Growth for Medicaid, 2019-2023

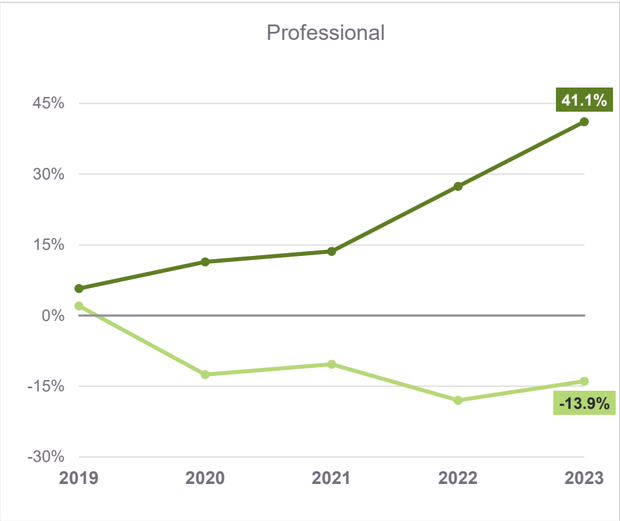
APAC claims analysis.

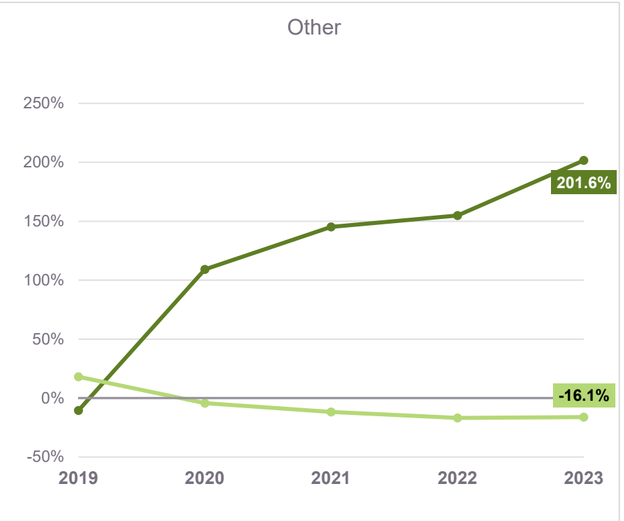
Key	
	Overall price
	Utilization

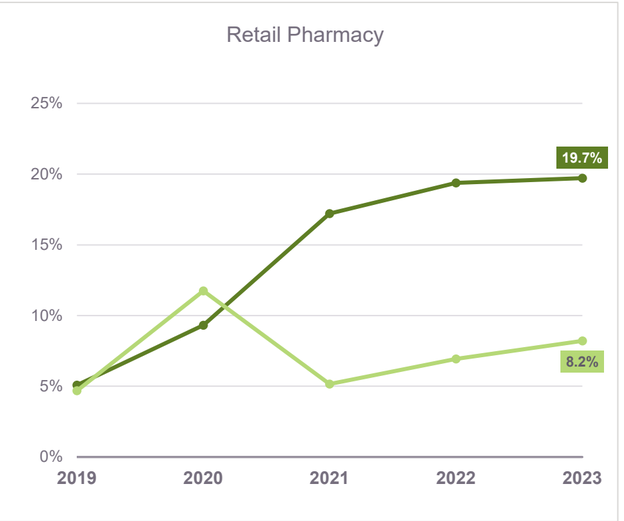








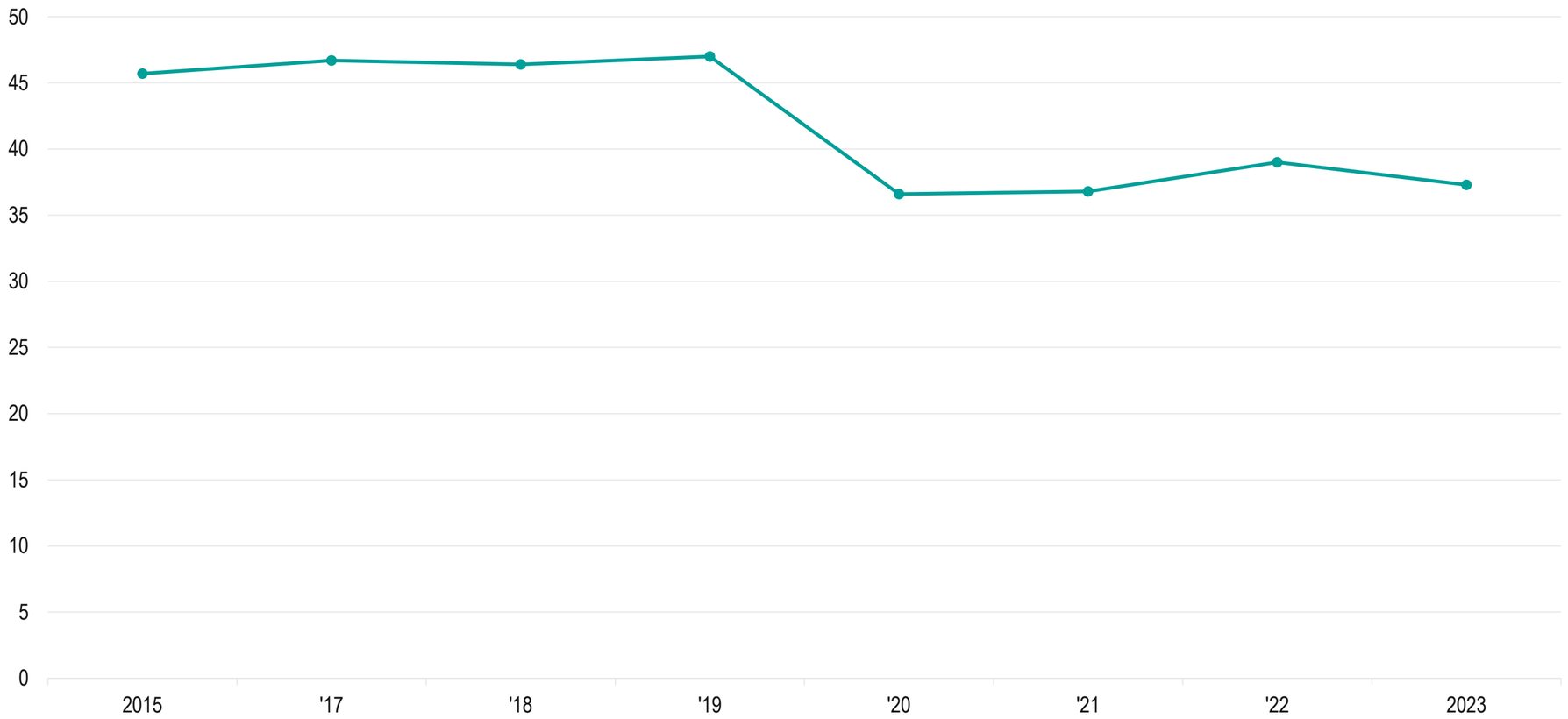




Emergency Department Utilization, 2015 - 2023

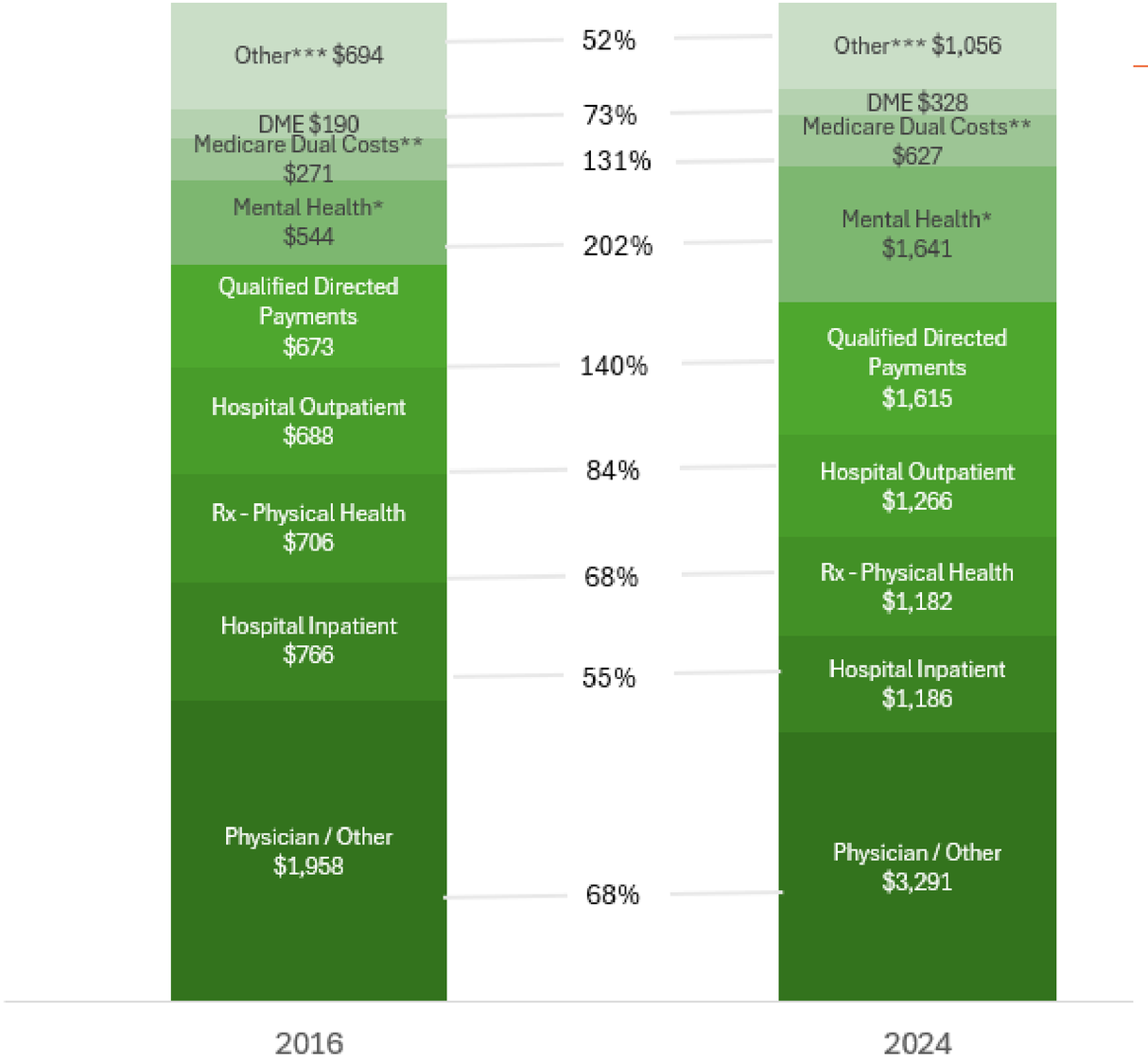
Emergency department utilization among CCO members.

Rate per 1,000 member months

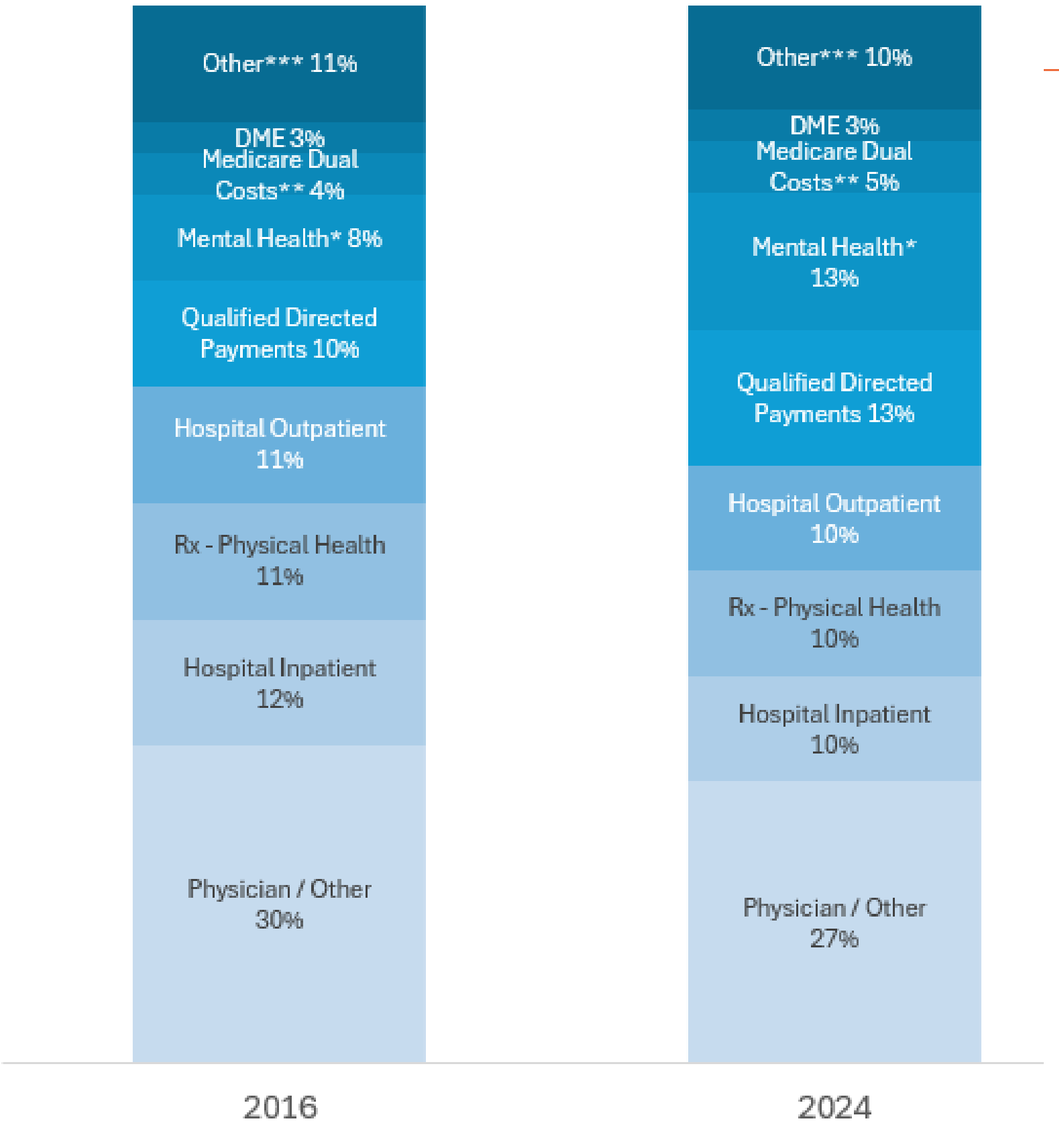


Data source: MMIS (administrative claims)

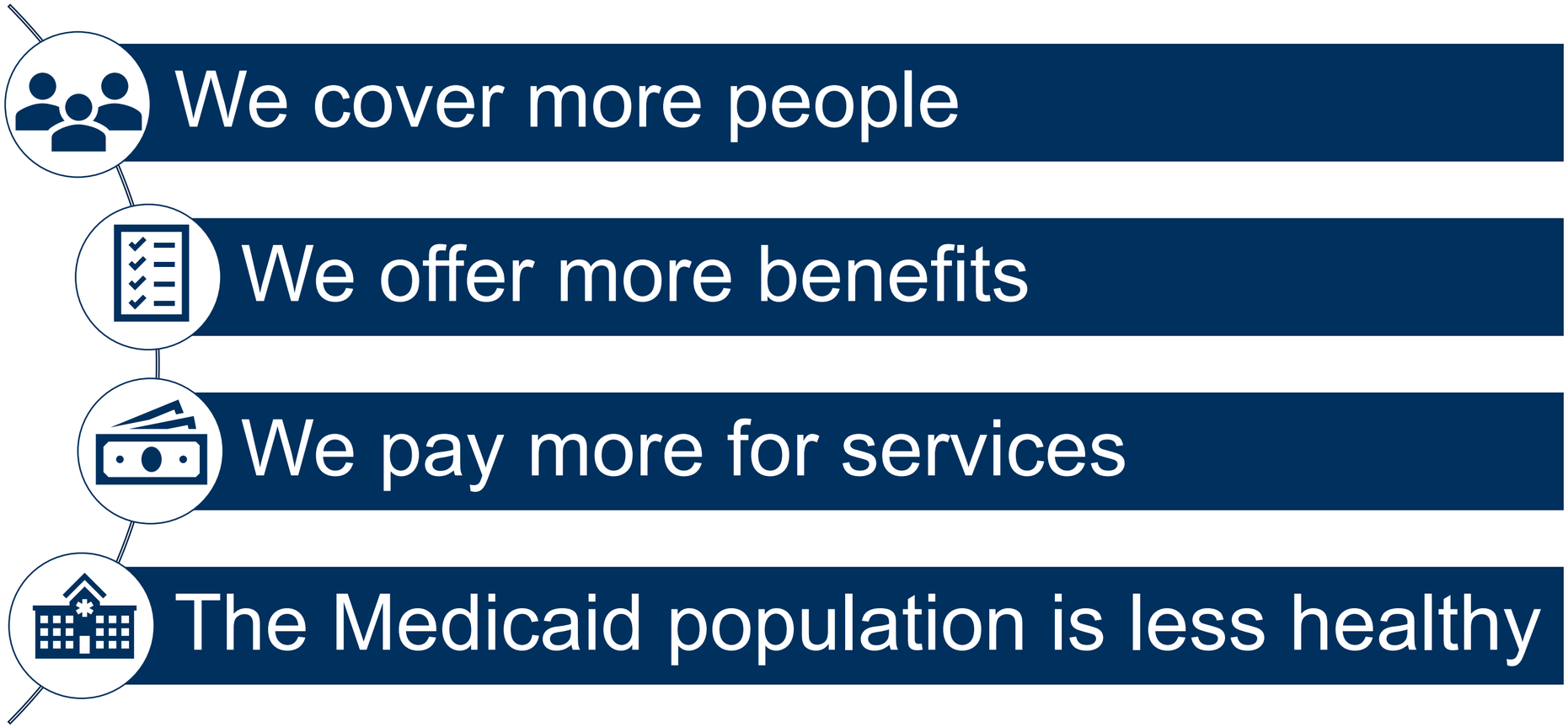
Medicaid Spending by Category, State Fiscal Years 2016 and 2024, in millions of dollars



Medicaid Spending by Category, SFY 2016 and 2024, as percent of total



In Summary


We cover more people
We offer more benefits
We pay more for services
The Medicaid population is less healthy

Office of Governor
TINA KOTEK

Appendix 2

OREGON HEALTH AUTHORITY

H.R.1 Impacts

Effective dates for Medicaid and Marketplace provisions

Marketplace

2026

January 1

- Removal of advanced premium tax credit repayment caps
- Non-citizens under 5-year bar no longer eligible to receive premium tax credits
- Failure to reconcile allowance period reduced
- Stricter pre-enrollment income verification and special enrollment period verification
- Changes to actuarial value to permit less generous plans
- Gender affirming care not allowed as an Essential Health Benefit

2027

January 1

- Refugees and asylees no longer eligible to receive premium tax credits
- Shortened open enrollme nt period; 2027 open enrollment, ends December 15, 2026

2028

January 1

- Ending automatic re-enrollment starting in the 2028 open enrollment period

Medicaid

2025

July 4

- E&E Final Rule prohibitions
- Delay NF Staffing Ratio rule implementation
- Prohibits lower provider taxes based on volume; prohibits taxes at higher rate for Medicaid units of service
- State directed payment (SDP) cap at 100% for new SDPs
- Planned Parenthood banned from Medicaid participation

December 31

- Application deadline for Rural Health Transformation funding

2026

July 4

- End Planned Parenthood ban

October 1

- Regular Federal Medicaid Assistance Percentage (FMAP) for emergency services
- End of Medicaid/Children's Health Insurance Program funds for certain non-citizens
- New provider taxes and increases before 6/4/25 prohibited

December 31

- Conduct redeterminations every 6 months

2027

January 1

- Implementation date for work requirements
- Limit retroactive coverage
- Required standard process to update address information
- Verify eligibility quarterly against Death Master file quarterly
- 1115 Waiver Budget Neutrality requirement codified

October 1

- Provider tax cap reduced by a half percentage point per year until 3.5% reached

2028

January 1

- Home equity limit allowable for long-term care seekers
- State directed payments reduce by 10 percentage points per year until no greater than 100% of Medicare levels

July 1

- New home and community-based services (HCBS) waiver option

October 1

- Copayments required (exp. Adults, >100% federal poverty level)

2029

October 1

- Eliminates option to waive disallowance of federal funds associated with "excess" improper payments

Effective dates for Medicaid and Marketplace provisions

Marketplace

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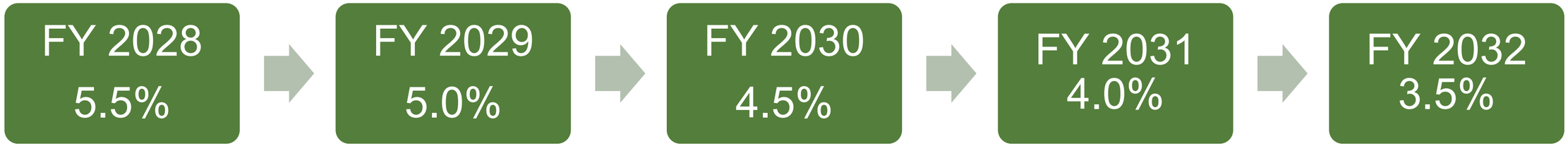
Provider Taxes

- New provider taxes and increases to existing taxes before 6/4/25 are prohibited.
- The maximum tax rate on provider taxes must phase down from 6% to 3.5% by lowering the maximum tax rate by 0.5% per year beginning October 1, 2027.



State Directed Payments

- New SDPs must limit the total payment rate to 100% of published Medicare payment rates.
- Oregon’s current SDPs are maintained but will need to reduce payment rates by 10 percentage points per year, beginning in 2028, until they are no greater than 100% of Medicare payment levels.

Work Requirements: Overview

As of December 31, 2026, states are required to establish work/community engagement requirements for individuals ages 19-64 in the adult expansion group (>=80 hours of work or related activities for the month prior to application or renewal month).

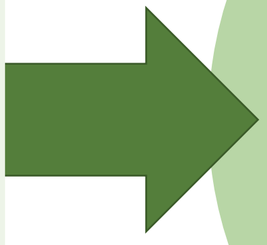
Exceptions include individuals who are:

- American Indian/Alaskan Native who are members of federally recognized tribes
- Pregnant or postpartum
- Parents and/or caretakers with children 13 years of age or younger, or caring for someone with a disability
- Veterans determined to be completely disabled
- Medically frail
- Recently incarcerated
- Participants in alcohol/SUD treatment programs
- Former foster youth
- Those meeting TANF/SNAP work requirements

SUD = Substance Use Disorder **TANF** = Temporary Assistance for Needy Families **SNAP** = Supplemental Nutrition Assistance Program

Work Requirements: Overview (continued)

- The law prohibits access to subsidized Marketplace coverage for those who lose Medicaid under this provision.
- OHA and ODHS will need to **collaborate on program design across Medicaid and SNAP.**
- States must use reliable information available (including use/implementation of electronic interfaces and/or databases) to verify compliance. Note: HR1 also requires this population be renewed **every 6 months.**
- There are **optional short-term exceptions**, including individuals in certain skilled nursing or inpatient facilities, or residing in counties where the unemployment rate exceeds a specific threshold.



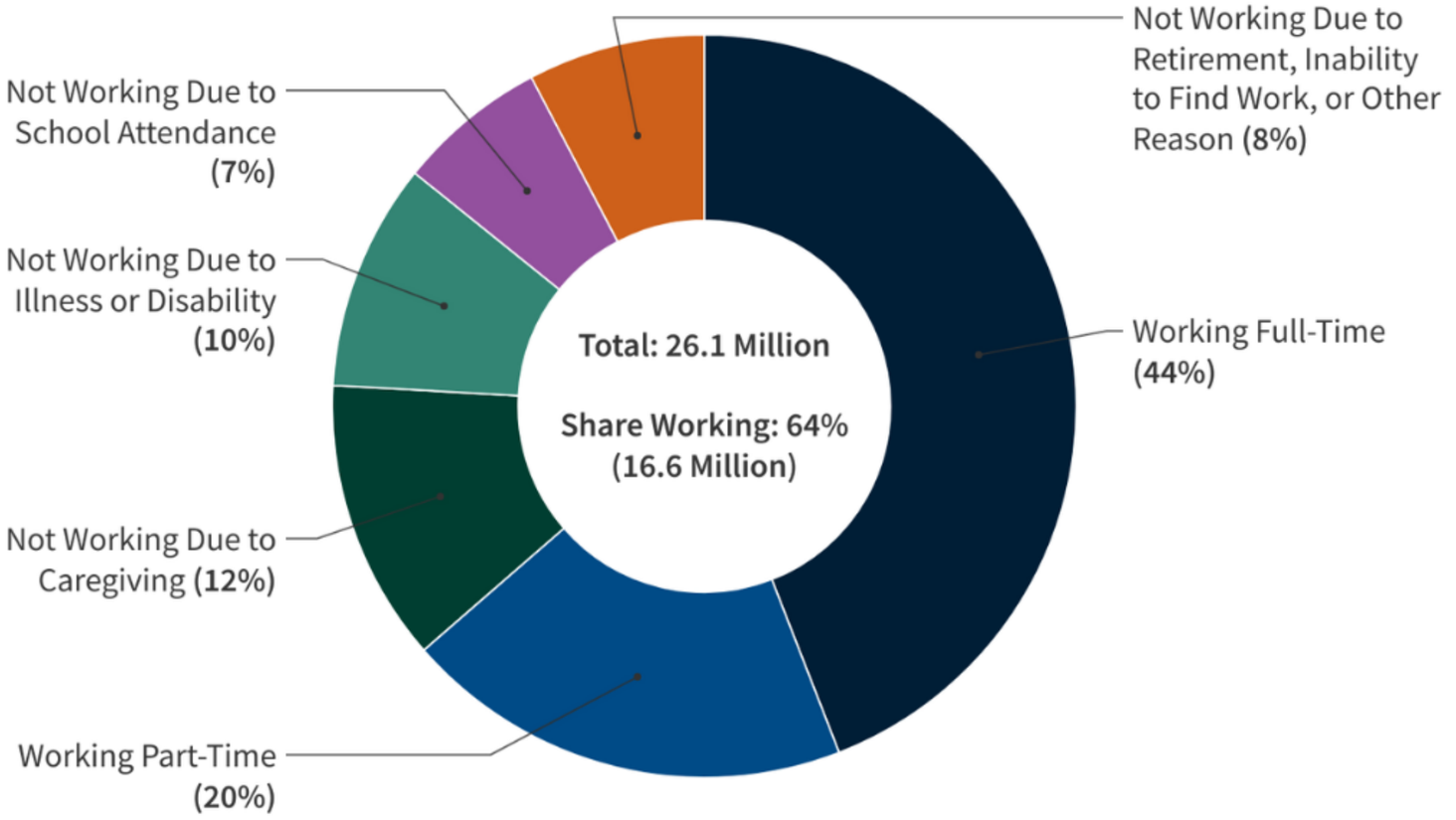
OHA (and ODHS) will need to make major IT system changes.

These IT system changes will directly impact Oregon's ability to keep people enrolled.

SNAP = Supplemental Nutrition Assistance Program **HR1** = House Resolution 1

Work Status & Barriers to Work Among Medicaid Adults, 2023

Includes Medicaid covered adults (age 19-64) who do not receive benefits from Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) and are not also covered by Medicare.



Eligibility Requirements: Overview

Eligibility policy changes include:

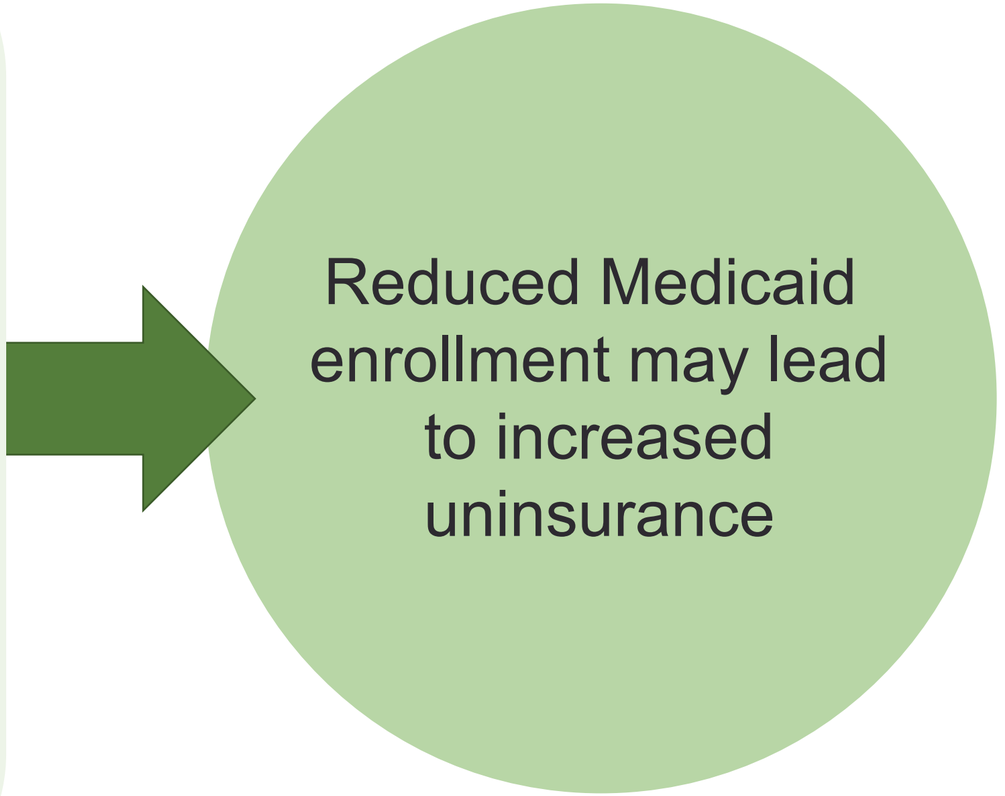
- End federal Medicaid/CHIP funds for certain non-citizens
- Monthly submissions of enrollee data
- Verify death eligibility quarterly
- Home equity limits
- Retroactive coverage reduced from 90 days to 60 or 30 days

Policies specific to the Expansion eligibility group:

- Redeterminations every 6 months
- Copayments for certain higher income individuals

Eligibility Changes: Overview (continued)

- Most adult Medicaid members will be required to **redetermine eligibility** every 6 months.
- In October 2027 **Oregon's 1115 continuous coverage** will end, requiring all members to redetermine eligibility more often.
- Cost sharing will become required in October 2028 for many adult members over 100% FPL, certain non-American Indian/Alaskan Native members, with other exceptions.
- Other eligibility changes will be required and will **reduce federal reimbursement.**



FPL = Federal Poverty Level

Impacts to OHP Bridge - BHP

- **HR 1 does not explicitly extend Medicaid or Marketplace provisions to state Basic Health Programs.**
  - Unclear whether CMS has authority or intends to extend via regulation.
  - Oregon's use of Medicaid infrastructure may also lead to BHP impact.
- HR 1 required Marketplace changes affecting BHP funding
  - Eliminating tax credit eligibility for some non-citizens will also lead to lost BHP funds in 2027.
- HR 1 did not extend enhanced Marketplace tax credits; expiration reduces BHP funding.
  - *Note: 2026 revenue still anticipated to outweigh program costs.*

The Law Does Not Address Whether New Medicaid Requirements Could be Applied to Affect OHP Bridge

New administrative barriers to Medicaid enrollment *(eff. 12/31/2026)*	• Work reporting req. and more frequent redeterminations apply specifically to Medicaid expansion population • If extended to BHPs, these would likely drive up per-member costs
Medicaid cost-sharing for members with income >100% FPL *(eff. 10/1/2028)*:	• Could affect BHP either via CMS regulation or due to reliance on Medicaid infrastructure to deliver OHP Bridge
Payment restrictions for certain Gender Affirming Care services and Planned Parenthood clinics (eff. upon enactment)	• These do not explicitly apply to BHP. It is unclear whether CMS will seek to extend restrictions to BHP.

Office of Governor
TINA KOTEK

Appendix 3

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March 30, 2026

Opportunities in Cost Savings with Clinical Practice Guidelines, NICU, and NEMT

Catherine Brett, MD, MPH, FACPM
Rachel Wright, RN, MSN

Opportunities for Cost Savings in Clinical Practice Guidelines

DME/Radiology/Laboratory

- Multi-organism Panels
- X-ray for Low Back Pain
- Recurring DME supply charges
- Monthly rental vs. purchase

Appropriate Coding

- Telehealth Level 4/5 visits and Dental Telehealth
- Appropriate Coding (36415)

Therapies

- Alternate Services
- Alternate Settings
- Alternate Personnel

Pharmacy

- MAT Therapy for Opioids in a primary care setting
- Cell Gene Therapy
- 90-day fills for high-risk conditions
- Optimize Primary Prevention Therapeutics
- Optimize Therapeutic Management

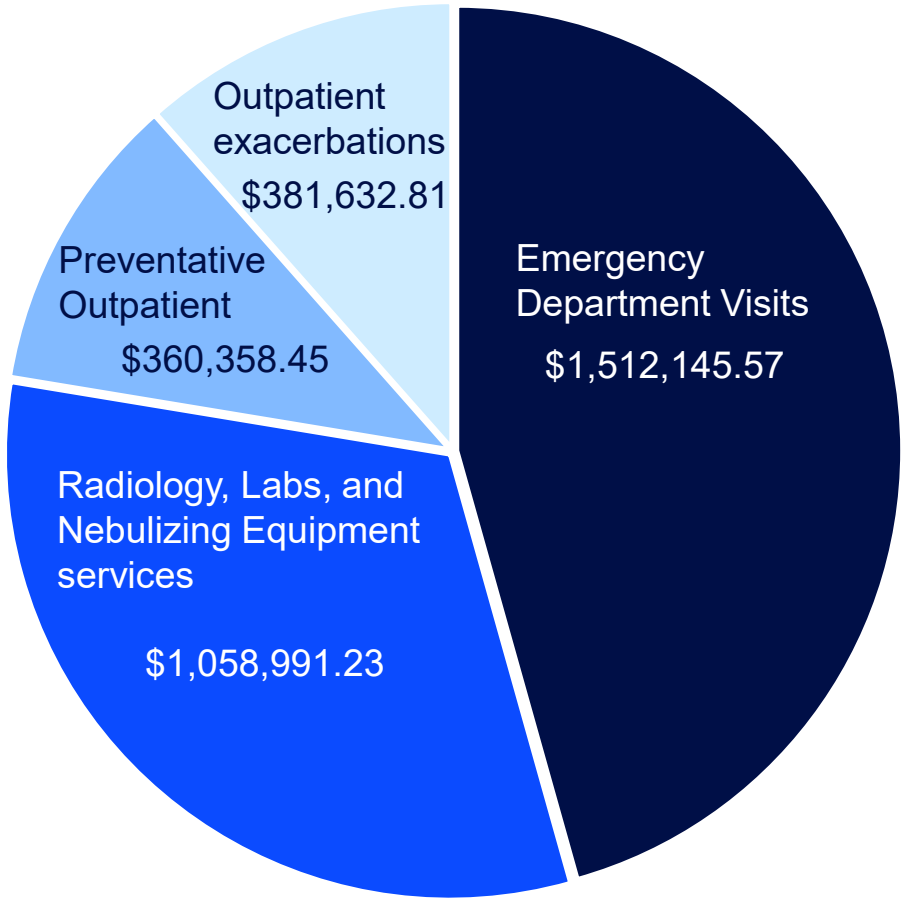
Chronic Conditions

- Targeted Case Management
- Limitation of Coverage when not Medically Necessary
- Community-based Services

Optimize Clinical Management of High-Cost Conditions

Potentially Preventable Asthma Exacerbations

CY 2024 Non-Facility Asthma Costs (excluding medications)



Diagnosis Management Program
School-based Treatment
90-day pharmacy for persistent asthma members
Short-acting beta-agonist (SABA) vs. Inhaled Corticosteroid (ICS)-formoterol
Pulmonary Rehabilitation for asthma
Home nebulization of SABA vs. metered-dose inhaler (MDI)/spacer (increased risk severe exacerbations/hospitalizations)

Opportunities for Cost Savings in Clinical Practice Guidelines

Appropriate Coding

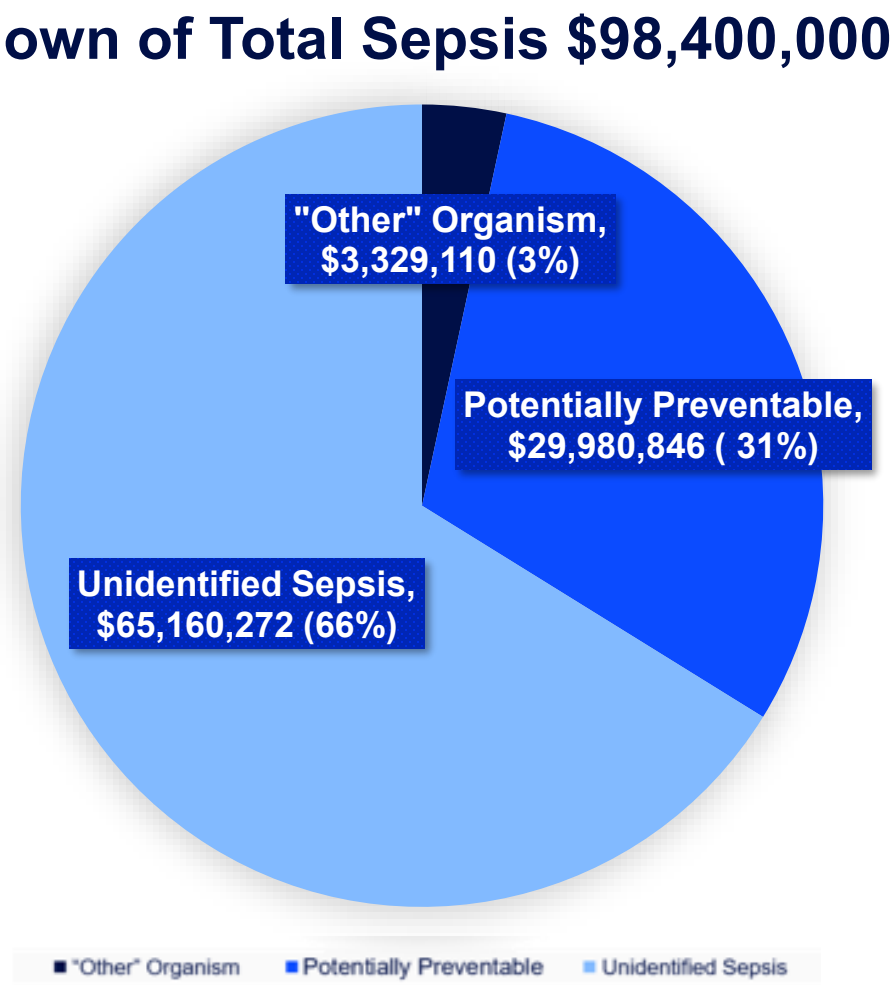
Multi-organism Panels	$1,688,742
Appropriate Coding (36415)	$ 1,312,406
Dental Telehealth	$6,843

Optimize Therapeutic Management

Asthma	$ 11,983,421
Crohn’s	$ 26,859,950
Ulcerative Colitis	$ 4,161,555
Cellulitis	$ 18,122,008
Infection	$ 18,064522
Sepsis	$ 98,368.925
Sickle Cell	$ 454,301

Optimize Clinical Management of High-Cost Conditions

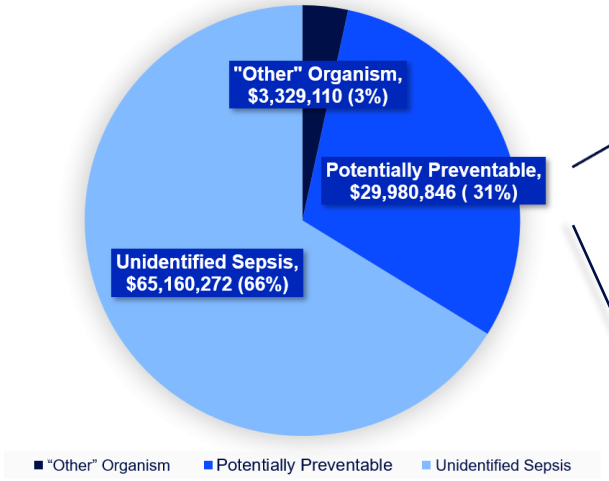
Potentially Preventable Sepsis



THIS PRESENTATION IS NOT COMPLETE WITHOUT ORAL COMMENT

Estimation of Potentially Preventable Sepsis Cost Savings

Breakdown of Total Sepsis $98,400,000 Cost



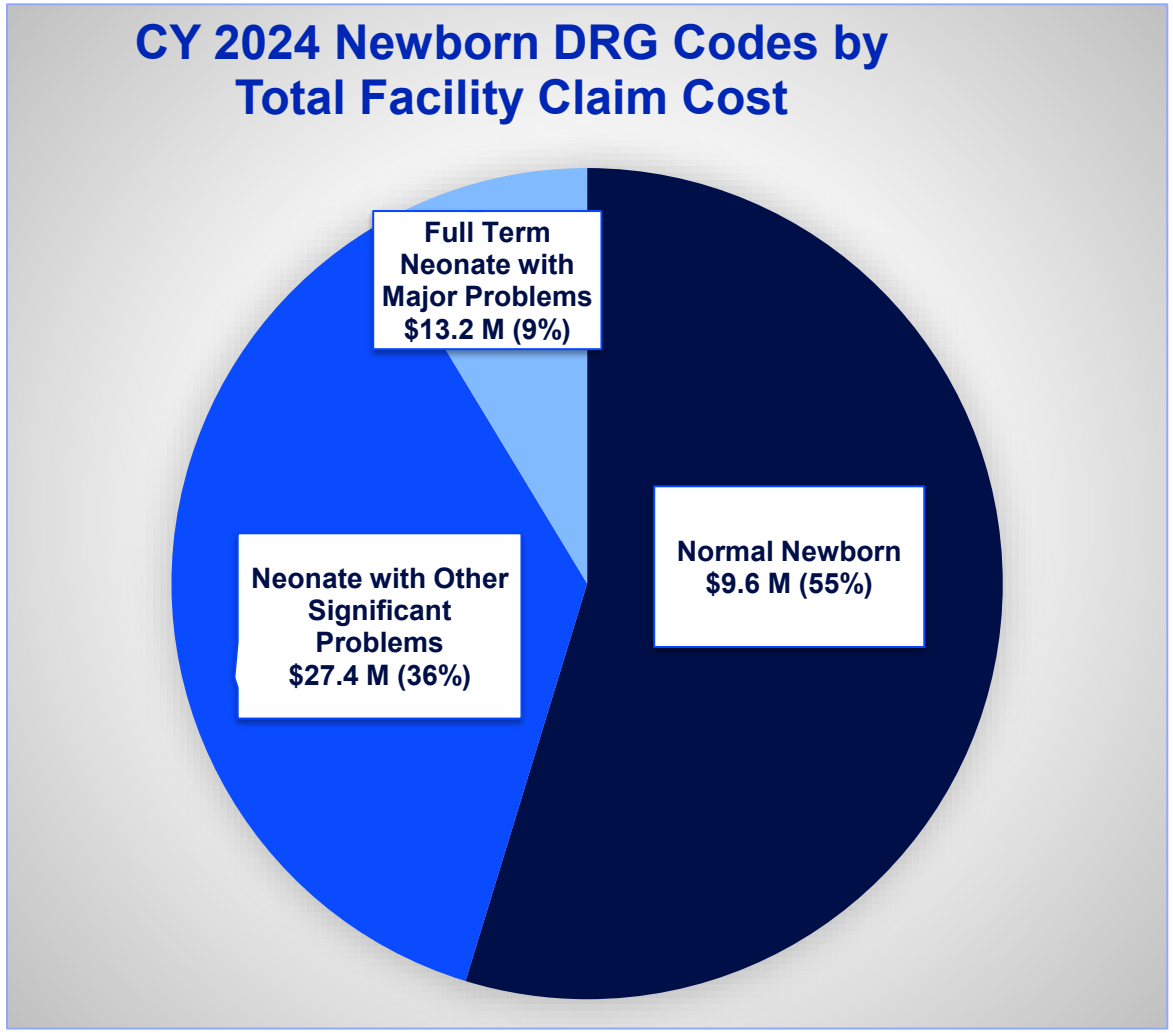
According to the World Health Organization (WHO), 23.6% of sepsis is healthcare associated.

50–70% of healthcare associated infections are preventable.

Estimate of state savings of unidentified sepsis =
$7.7 million–$10.8 million.

Diagnosis Group	Cost by Diagnosis	Sepsis Due to Organism Percent Preventable	State Savings Estimate
Strep Species	$ 9,549,157.00	Strep Pneumonia 60% Child, 90% Adults; GBS in newborn 90%	$1.4M
Staph Species	$ 11,200,000	In general, all species 80% MRSA 78%	$2.2M
E. Coli	$ 4,840,000	Optimum, 60% “Definitely preventable” 30%	$363,000
Gram Negative Species	$ 3,526,617	Hospital-acquired (majority) 30%	$264,496
Sepsis after Procedure	$ 558,657	12–40% of sepsis cases following a medical procedure or hospitalization are considered preventable; 60% of surgical site infections are preventable	$83,799
Peripartum/ OB procedure	$ 293,510	12–40% of sepsis cases following a medical procedure or hospitalization are considered preventable	$44,026
Gonococcal	$ 12,905	40–80%	$1291
Total Cost	**$29,980,846 | Lower Bound Saving Est.**		**$4.4M**

Evaluation of Newborn Cost Drivers



- High-level look at diagnosis related group (DRG) Codes 793, 794, 795
- High-Cost Utilizer data set
- Does not include costs of all births
  - Delivered outside the home
  - Transferred from an outside hospital
  - Readmissions in newborn period (0–28 days)
  - Subsequent admissions related to delivery complications that occur after delivery admission (> 28 days)

- Aggregated by diagnosis codes, not a breakdown of Neonatal Intensive Care Unit (NICU) or Critical Care Services by procedure code or length of stay (LOS)

Breakdown of Newborn Delivery Diagnoses by Costs

Conditions	Total Costs	Total Claim Count	C/S %
Newborn Affected by Maternal Conditions	$ 14,821,343	12,816	23%
Meconium	$ 5,380,287	4,043	37%
Maternal alcohol/SUD	$ 3,408,189	1,849	17%
Maternal DM/gestational DM	$ 1,623,174	1,755	47%
Isoimmunization (blood type mismatch), jaundice, alpha thalassemia	$ 1,540,191		0%
Infections	$ 1,444,290	2,367	14%
Maternal HTN d/o	$ 612,886		0%
GI	$ 8,236,401		
Respiratory	$ 7,286,736	4,788	45%
Congenital defects, Preterm, Twins	$ 5,804,363	3,082	39%
Other	$ 5,519,927	4,801	18%
“Normal” newborn (DRG 795)	$ 8,569,237	27,197	17%

Evaluation of Newborn Cost Drivers

Several key factors contribute to the financial challenges associated with NICU care:

- Hospital billing practices
- Cost variability and unpredictability
- Geographic and facility differences
- Lack of standardization

Opportunities for Reducing Cost Drivers

Understand what procedures/diagnoses are driving costs

- Primary admission vs. Readmissions
- Index intensive care stay or subsequent care

Minimize inappropriate payments

- Avoidable costs stemming from unbundled services, duplicate charges, or items that should have been included in the negotiated daily rate
- Non-Medically Indicated costs or inefficient care

Maintain cost-effective care management

- Prevention, early intervention, and proper education
  - Make informed decisions, recognize warning signs, and seek timely care
- Utilization management
- Identifying at-risk pregnancies early and ensuring consistent, personalized prenatal care
- Health-related Social Needs

Background on NEMT in Oregon

Overview

- Oregon Health Authority (OHA) provides non-emergency medical transportation (NEMT) for eligible Oregon Health Plan (OHP) clients and is included in the coordinated care organization (CCO) rates as a separate category of service (COS); no carve outs.
- Historically, NEMT was a CCO rate add-on (not a COS) to recognize the differences in utilization patterns when it was first introduced to OHP, meaning that service utilization with factored 1:1 in the rate process.
- CCOs individually contract with various brokers but are largely consolidated through a small number of brokers who have the majority of utilization.
- NEMT is also included in the dental and behavioral health CCO contracts, which are not included in this analysis.

Background on NEMT Potential Savings

- An estimated **2%–10%** of NEMT spend can be avoided through strengthened oversight and monitoring of NEMT benefit, translating to an estimated Oregon general fund (GF) savings of $0.5 million–$2.5 million based on the following audits:
  - Michigan Auditor General, Report 391-0715-20 (March 2022). 23.5% of broker claims had trip log deficiencies. https://audgen.michigan.gov/wp-content/uploads/2022/03/r391071520-2859.pdf
    - The 2022 Michigan Auditor General review found 23.5% trip log deficiency rates in a review of 150 broker and 150 plan encounter claims.
    - 3.8% of broker claims without medical needs form.
    - 18 of 150 broker claims public transportation were not verified for a Medicaid-covered service.
    - 11% of health plan non-public transportation providers had not maintained trip logs, and four claims did not verify Medicaid-covered service.
  - New Jersey HHS-OIG Report A-02-14-01001 (2016) identified $64.7 million in non-compliant New Jersey NEMT claims. https://oig.hhs.gov/oas/reports/region2/21401001.pdf
    - In 6 of the 100 sampled claims, the medical provider confirmed that the beneficiary did not receive a Medicaid-eligible medical service on the sampled service date.
    - In 7 of the 100 sampled claims, we could not determine the medical provider to whom the beneficiary was transported; therefore, we could not verify whether a Medicaid-eligible medical service was provided.

Proposed Drill Down and Translation to Oregon Dollars

Step One: Validation exercise to identify NEMT not substantiated by a medical service

- Review NEMT utilization against a medical service provided within one day
- Review cost of services by transportation type and milage for cost outliers
- Apply Target Efficiency Level (TEL)

Step Two: Potential clinical review of identified NEMT services

- Review sub-capitated data and subcontracting of NEMT (exhibit L)
- Identify missed or canceled service to account for members not showing up or refusing
- Review CCO NEMT Quarterly Reports and CCO audit reports
- Supplemental data request as necessary to gather additional data from sub-capitated venders
- Optional sample record review for federal and state NEMT requirements

Step Three: summarize findings for OHA clinical staff

- Provide summary and recommendations

Promote Clinical Efficiency: Additional Criteria

Based on CY2026 Rate Certification		
Clinical Efficiency Adjustment	**Lower Bound Saving Estimate**	**Upper Bound Saving Estimate**
Re-admission Adjustment	$27.5M	$68.8M
Cesarean Mix Adjustment	$5.5M	$9.6M
Provider Preventable Conditions	$1.4M	$2.8M
Short Stay	$1.4M	$4.1M
Cellulitis	$0.0M	$1.4M
Pharmacy Efficiency	$4.1M	$29.5M
NEMT Efficiency	$2.0M	$10.0M
Total Savings/Year	~ $41.9M	~ $126.2M
Federal contribution	~ $31.4M	~ $94.6M
Total Projected State Savings	**~ $10.5M**	**~ $31.6M**

Saving estimates are based on saving percentage ranges from existing Mercer clients as a reference point for possible outcomes

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This presentation has been prepared under the direction of Laura Bass, FSA, MAAA who is a member of the American Academy of Actuaries and meets its US Qualification Standard for issuing the statements of actuarial opinion herein. She is available at Laura.Bass@mercer.com, if this audience has questions.

To the best of Mercer's knowledge, there are no conflicts of interest in performing this work.

The suppliers of data are solely responsible for its validity and completeness. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit it. All estimates are based upon the information and data available at a point in time and are subject to unforeseen and random events, and actual experience will vary from estimates.

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MARSH

April 6, 2026

High Utilization Opportunities

Laura Bass, FSA, MAAA

Overview

Identifying Areas to Reduce Cost of Care

High Cost/High Volume Procedures

- Question: Does the frequency of a given procedure make sense given the associated diagnosis code(s)?
- Example: Chest x-rays with a primary diagnosis of chest pain suggests nothing was found on the x-ray, raising the question of why the x-ray was ordered.

Persistently High-Cost Members

- Question: Are there opportunities to improve care and reduce overall cost for these members?
  - Members defined as being in the top 10% of members by cost for two consecutive years.
- Example: Focusing interventions on consistently high-cost members with diabetes to improve disease management, enhance quality of life, and lower overall cost of care.

Notes:

- Physical health procedures and conditions were the focus of this work.
- Calendar year (CY) 2023 and CY 2024 Oregon Coordinated Care Organization (CCO) experience consistent with the CY 2026 rates was used for the analyses.

Areas of Opportunity

Areas of Opportunity

Frequent Procedures Paired with Vague Primary Diagnoses

- The vague primary diagnosis calls into question whether the procedure was clinically necessary or appropriate.
- Examples:
  - Chest x-rays for members with chest pain or shortness of breath
  - CT scans for members with abdominal pain
- Next Steps:
  - Can review additional data to aid in the identification of changes to practices
  - Inexpensive procedures may not result in significant savings opportunities despite frequency

Conditions of Persistently High-Cost Members

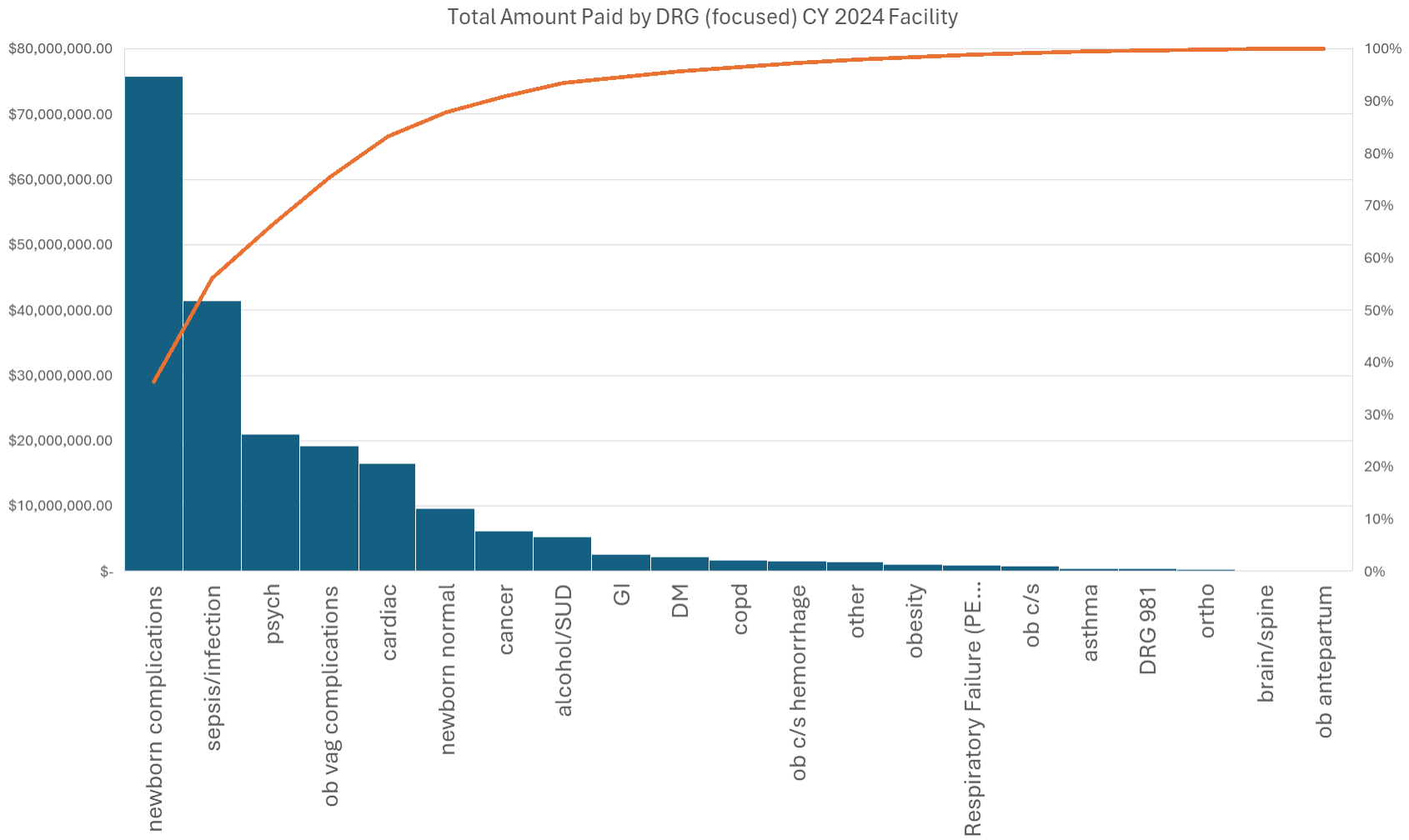
- Examples:
  - Continuous Positive Airway Pressure (CPAP) machine supplies for members with sleep apnea, respiratory failure
  - Lower back pain and neck pain
  - End-stage renal disease (ESRD)
- Next Steps:
  - Can review additional data to aid in the identification of changes to practices
  - Much of the spend may be appropriate and necessary, limiting opportunities for cost savings
- Manage hypertension and diabetes
- Visit/durable medical equipment (DME) limits

Preventive Medicine

- Examples:
  - Mammograms, general exams/encounters, sexually transmitted infection (STI) screenings
  - Blood draws
  - Dental care
- Next Steps:
  - Can review data to look for opportunities to increase use of preventive medicine
  - Can review data to confirm billing practices

Areas of Opportunity

Drivers of Facility Expenses: Newborn Complications



Statistics:

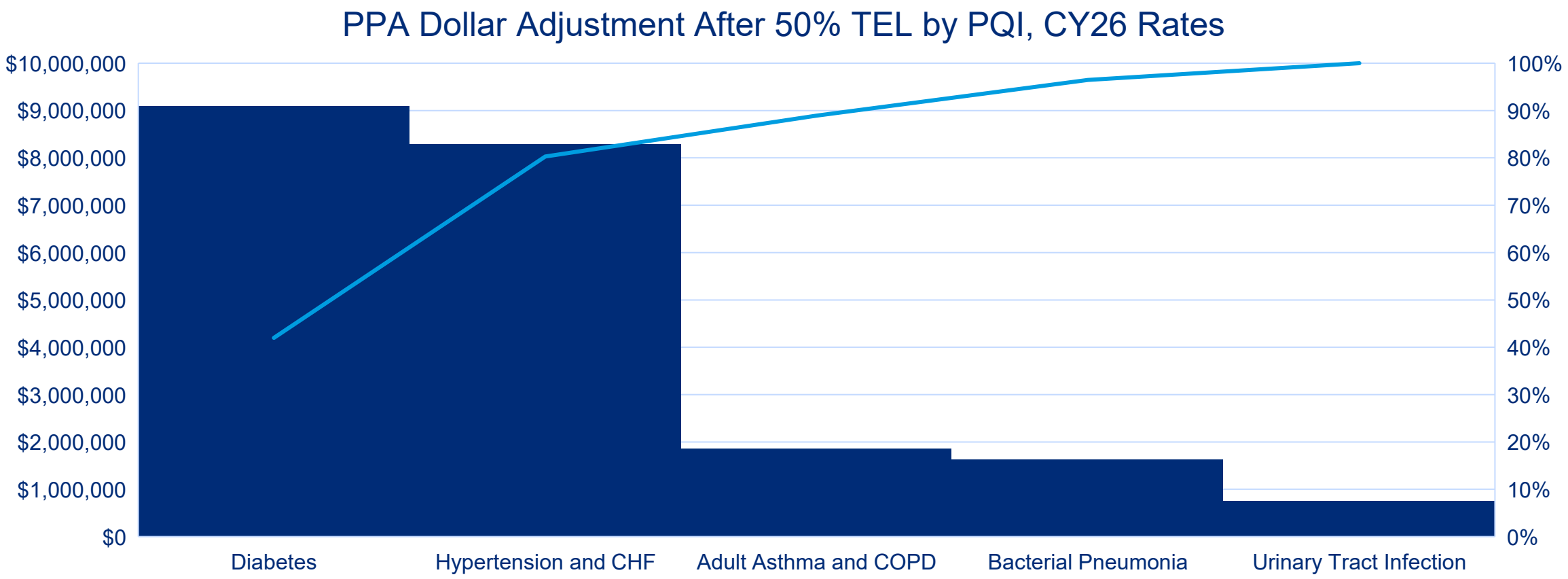
- 58% of newborn care diagnosis related groups (DRGs) are for complications
- Oregon experienced a 15% increase in Neonatal Intensive Care Unit (NICU) cases between 2016 and 2023; Idaho and Washington experienced a -1% change

Next Steps:

- C-section case mix clinical efficiency adjustment
- Readmissions clinical efficiency adjustment lends itself to reviewing all complications

Areas of Opportunity

Diabetes



Target Efficiency Level (TEL)
Prevention Quality Indicator (PQI)

Areas of Opportunity

Size and Effort Estimates

Description	Estimated Opportunity	Effort	Next Step
CPAP machine supplies and other DME	$0.6M	Additional work may not yield significant savings.	No further action
CT scans for members with abdominal pain	$0.1M	Additional work may not yield significant savings.	No further action
Chest x-rays for members with chest pain or shortness of breath	$0.9M	Additional work may not yield significant savings.	No further action
ESRD	$1.8M	Additional work may not yield significant savings.	Related to other analysis (diabetes)

Areas of Opportunity

Size and Effort Estimates

Description	Estimated Opportunity	Effort	Next Step
Cellulitis	$0M	Mercer already does this analysis for other clients	Clinical Efficiencies Adjustment
NEMT Efficiency	$0.5M	Mercer already does this analysis for other clients	Clinical Efficiencies Adjustment
Provider Preventable Conditions	$0.4M	Mercer already does this analysis for other clients	Clinical Efficiencies Adjustment
Short Stay	$0.4M	Mercer already does this analysis for other clients	Clinical Efficiencies Adjustment
Pharmacy Efficiency	$1M	Mercer already does this analysis for other clients	Clinical Efficiencies Adjustment
Cesarean Mix Adjustment	$1.4M	Mercer already does this analysis for other clients	Clinical Efficiencies Adjustment

Areas of Opportunity

Size and Effort Estimates

Description	Estimated Opportunity	Effort	Next Step
Preventative medicine	$5.8M	Increase mammographies, colonoscopies, adult wellness visits, cholesterol and diabetes screenings in adolescents with schizophrenia	Identify investment opportunities
Low back and neck pain	$1M	Clinical intervention to reduce costs	Review data to identify possibility
Newborn Complication	$5M	Identify differences between Oregon and other state's procedures that cause Oregon to have a higher rate of complications	C-section case mix clinical efficiency adjustment and/or Readmissions clinical efficiency adjustment

Areas of Opportunity

Size and Effort Estimates

Description	Estimated Opportunity	Effort	Next Step
Acute upper respiratory infection, unspecified	$0.1M	LANE analysis is already performed each year	Increase LANE TEL
Sleep apnea and respiratory failure	$0.6M	PPA analysis is already performed each year	Increase PPA TEL
Diabetes	$2.3M	PPA analysis is already performed each year	Increase PPA TEL
Re-admission Adjustment	$6.9M	Mercer already does this analysis for other clients	Readmissions clinical efficiency adjustment
Sepsis/Infection	$7.7M	Mercer already does this analysis for other clients	Readmissions clinical efficiency adjustment

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To the best of Mercer's knowledge, there are no conflicts of interest in performing this work.

The suppliers of data are solely responsible for its validity and completeness. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit it. All estimates are based upon the information and data available at a point in time and are subject to unforeseen and random events, and actual experience will vary from estimates.

Mercer expressly disclaims responsibility, liability, or both for any reliance on this communication by third parties or the consequences of any unauthorized use.

Office of Governor
TINA KOTEK

Appendix 4

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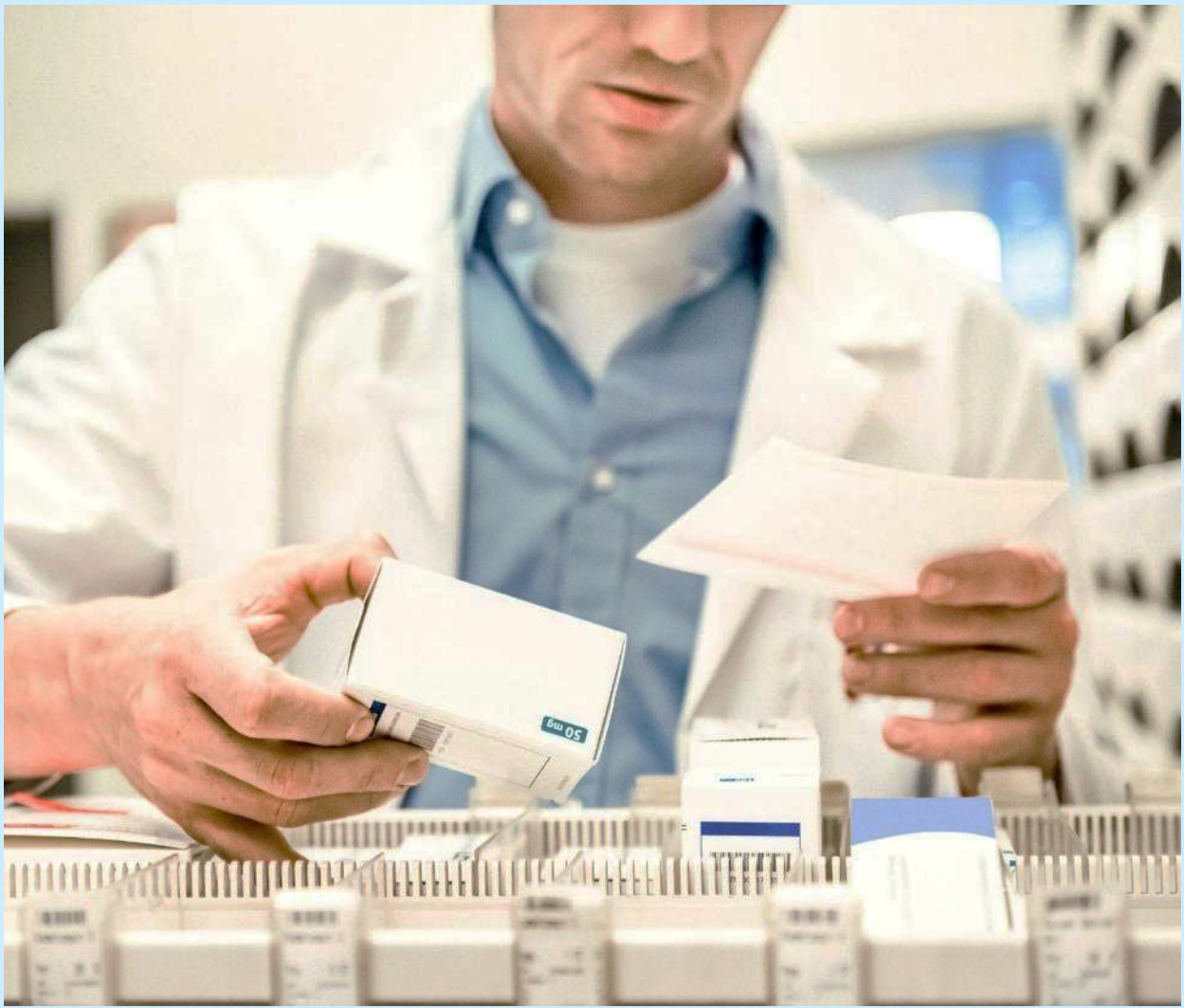
Mercer Government Human Services Consulting

April 17, 2026
Oregon Health Authority

Oregon Medicaid Pharmacy Benefit Design Report



Contents

Section 1

Executive Summary

The Governor's Advisory Group on Medicaid Sustainability requested that Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, develop fiscal projections for potential pharmacy benefit program design changes. Oregon currently carves the pharmacy benefit in to coordinated care (some behavioral health drugs are carved out to fee-for-service [FFS]), and each coordinated care organization (CCO) utilizes their own formulary and pharmacy benefit manager (PBM). States have historically used two benefit design options to capture evidence-based savings and care consistency through policy and operational levers:

1. **Primary**: A single preferred drug list (sPDL) and,
2. **Secondary**: A single pharmacy benefit manager (sPBM)

Mercer estimates OHA could save $68.3 million for the sPDL strategy. The sPBM option could save an additional $42.4 million, or may increase costs up to $5.5 million, for a combined savings range of $62.8 million to $110.7 million shown in Table 1. Savings within the range are dependent on PBM contracted rates for pricing and administrative costs.

Table 1: sPDL Cost/(Savings) Summary ($ in millions)

Fiscal Component	Total Estimated Fiscal Impact
sPDL	($68.3)
sPBM	($42.4)–$5.5
Combined	**($110.7)–($62.8)**

*sPBM results combine the effects of non-benefit load components and premium tax revenue

sPDL

Oregon's pharmacy benefit is largely managed by 16 CCOs and 13 different PDLs. Under this model, CCO PBMs solicit Market Share Rebates from manufacturers in exchange for placement on their PDL, and the state foregoes collection of manufacturer supplemental rebates on the corresponding claims. In addition, prescriber experience is complex, requiring knowledge of 13 different lists of preferred drugs and resulting in member disruption when moving between plans. Creation of a single PDL, in which all CCOs must follow the same list of preferred and non-preferred drugs, can streamline provider and member experience and allow the state to capture supplemental rebates on CCO claims. The sPDL is designed to choose the most cost-effective, clinically appropriate medications for the overall population.

For this analysis, Mercer used CCO encounter data for the first half of calendar year 2025 and estimated results in comparison to CY 2026 CCO pharmacy capitation dollars. Table 2 evaluates the potential impact to drug costs, including CCO collected rebates potential

federal and supplemental rebate offers, and non-benefit load items included in the capitation rates.

Table 2: sPDL Gross and Net Cost/(Savings) ($ in millions)

sPDL Impacts	State Share	Federal Share	Total
PDL Gross Cost Impact	($5.5)	($17.7)	($23.2)
CCO Rebates	$8.2	$26.8	$35.0
sPDL Capitation Impact	**$2.8**	**$9.0**	**$11.8**
Federal and Supplemental Rebates	($19.0)	($61.1)	($80.1)
Net sPDL Impact Cost/(Savings)	**($16.2)**	**($52.1)**	**($68.3)**

Mercer estimates that OHA could reduce total expenditure by $68.3 million (not including non-benefit load adjusted impacts).

sPBM

Secondarily, the Governor's Advisory Group requested that Mercer evaluate the two operational levers for PBM reform by implementing a sPBM. A PBM is a third-party vendor that administers key pharmacy benefit functions, such as claims processing, pharmacy network services, drug list management, and utilization management. Many states have moved to a sPDL while only a few have implemented a sPBM. Of the two design options, the sPDL model is generally more straightforward to implement with less tax implications and no reimbursement considerations. The sPBM, while requiring a sPDL, also requires careful state-specific considerations around reimbursement, provider taxes, networks, and data sharing.

The option for a sPBM could simplify and standardize the pharmacy benefit program by eliminating duplicative operations and oversight requirements. This approach may increase transparency and potentially give OHA access to additional cost-saving opportunities using the following sPBM program design options:

- PBM Full Service — In this option, the CCOs remain at risk for pharmacy costs and must use an OHA-selected PBM instead of their own. Under a full-service model, an OHA-selected PBM would assume nearly all functions of managing the pharmacy benefit with certain data sharing and care coordination tasks remaining with the CCOs.
- PBM Administrative Costs Only (ASO) — In this option, the CCOs also remain at risk for pharmacy costs and must use an OHA-selected PBM. Under an ASO model, an OHA-selected PBM would assume claims processing, provider reimbursement and pharmacy network management, while the CCOs would retain responsibility for prior authorizations.

This report outlines sPDL and sPBM benefit changes and the operational and fiscal opportunities and challenges of each model. For this analysis, Mercer used CCO encounter data for the first half of calendar year 2025 and estimated results in comparison to CY 2026 CCO pharmacy capitation dollars. In Tables 3 and 4 below Mercer estimated sPBM

administrative and non-benefit load costs included in the capitation rates in addition to the sPDL results shown in Table 2. These values represent total dollar changes under the sPBM designs relative to status quo expenditures that were projected for CY 2026.

Table 3: Full Service PBM Cost/(Savings) Summary ($ in millions)

Fiscal Component	State Share (A)	Federal Share (B)	Total Estimated Fiscal Impact (C = A + B)
Gross Pharmacy Expenditures	$0.0	$0.0	$0.0
sPDL Impacts	($16.2)	($52.1)	($68.3)
sPBM Impacts	($9.8) - $1.1	($31.9) - $3.5	($41.8) - $4.6
Non-Benefit Load Impacts	($0.3) - $0.2	($0.9) - $0.5	($1.2) - $0.7
Premium Tax Revenue	($0.3) - $0.6	$0.0 - $0.0	($0.3) - $0.6
Net Cost/(Savings) to Oregon	**($25.7) - ($15.3)**	**($85.0) - ($48.1)**	**($110.7) - ($63.4)**
Changes to Capitation %	**-2.4% to 1.3%**	**-2.4% to 1.3%**	**-2.4% to 1.3%**
Changes to Capitation $	**($7.3) - $4.0**	**($23.8) - $13.1**	**($31.2) - $17.1**
Net Change %	**-12.9% to -7.7%**	**-12.0% to -6.8%**	**-12.2% to -7.0%**
Net Change $	**($25.7) - ($15.3)**	**($85.0) - ($48.1)**	**($110.7) - ($63.4)**

Table 4: ASO PBM Cost/(Savings) Summary ($ in millions)

Fiscal Component	State Share (A)	Federal Share (B)	Total Estimated Fiscal Impact (C = A + B)
Gross Pharmacy Expenditures	$0.0	$0.0	$0.0
sPDL Impacts	($16.2)	($52.1)	($68.3)
sPBM Impacts	($9.0) - $1.2	($29.1) - $3.9	($38.1) - $5.2
Non-Benefit Load Impacts	($0.3) - $0.2	($0.8) - $0.5	($1.1) - $0.7
Premium Tax Revenue	($0.4) - $0.5	$0.0 - $0.0	($0.4) - $0.5
Net Cost/(Savings) to Oregon	**($24.9) - ($15.2)**	**($82.0) - ($47.6)**	**($106.9) - ($62.8)**
Changes to Capitation %	**-2.1% to 1.4%**	**-2.1% to 1.4%**	**-2.1% to 1.4%**
Changes to Capitation $	**($6.4) - $4.2**	**($20.9) - $13.5**	**($27.3) - $17.7**
Net Change %	**-12.5% to -7.6%**	**-11.6% to -6.7%**	**-11.8% to -6.9%**
Net Change $	**($24.9) - ($15.2)**	**($82.0) - ($47.6)**	**($106.9) - ($62.8)**

Mercer estimates that cost savings are achievable under the primary sPDL strategy, as well as under both sPBM models ranging from $63 million to $111 million in total expenditures. Please note that Non-Benefit Load and Premium Tax Revenue can interact with pharmacy

expenditures when viewed separately. Results are dependent on future contracted pricing terms for the sPBM, sPDL development and many other design elements that are critical for OHA to consider.

Section 2

Introduction

Single Preferred Drug List

A PDL is a mechanism to control drug utilization and ensure members receive appropriate medications at a cost-effective price. In addition, manufacturer rebate agreements often require preferred placement of the product(s) on the PDL and could necessitate preferring one drug over a competitor. Under the current model, each CCO and/or their PBM can create a unique PDL and enter into rebate agreements with drug manufacturers. For the purposes of this report, rebates accrued to CCOs will be known as Market Share rebates. Given the at-risk arrangement with OHA, CCOs are incentivized to structure their PDLs to minimize drug costs by preferring lower-gross-cost drugs and taking advantage of manufacturer rebate offers.

When discussing a sPDL program, it is important to understand the basis of Medicaid drug rebates. The Medicaid Net Cost of a drug is based on three components:

- The Drug Cost, which represents the ingredient cost paid to the provider.
- The federal rebate, based on the Medicaid Drug Rebate Program (MDRP).
- Supplemental rebates that states receive pursuant to agreements with drug manufacturers. Unlike supplemental rebates, CCO Market Share Rebates do not directly reduce Medicaid Net Costs but are considered in capitation rate development.

Consider the following formulas for the current CCO-driven PDL model versus an OHA-developed sPDL model:

CCO-driven PDL: [Drug Cost] – [Market Share Rebate] = [CCO Net Cost]

sPDL: [Drug Cost] – [federal rebate] – [supplemental rebate] = [Medicaid Net Cost]

When CCOs develop their PDLs, the State of Oregon (State) still collects federal rebates on the CCO drug utilization, however the CCOs only have insight into and control the Drug Cost and Market Share Rebates. Federal Rebates are proprietary and confidential to Medicaid programs. Consequently, CCO PDLs are developed without consideration of federal rebates or Medicaid Net Cost. Additionally, supplemental rebates that manufacturers offer to states may lead to a lower Medicaid Net Cost than those achieved by the CCO's PBM Market Share Rebate agreements. Consider Table 5 below, which outlines three blinded real-life drug examples of generic products with lower gross costs compared to a comparable branded product. In each drug example, the CCOs had high utilization for the cheaper generic product without having full visibility into the true next cost for OHA. OHA's PDL would prefer the more expensive brand product over the generic due to the significantly lower net cost per drug.

Table 5: Gross to Net Cost Examples

Cost Component	Generic Drug A	Brand Drug A	Generic Drug B	Brand Drug B	Generic Drug C	Brand Drug C
Average Cost of Drug	$533	$617	$194	$223	$207	$246
Average Rebate	$77	$768	$32	$163	$47	$195
Average Net Cost/Drug	**$456**	**($151)**	**$162**	**$60**	**$160**	**$50**

This report will explore the considerations of a statewide sPDL, which moves responsibility of PDL development from the CCOs to OHA. This strategy allows OHA to account for all three Medicaid Net Cost variables, potentially reducing net pharmacy spend. Implementing a sPDL model simplifies the pharmacy benefit for prescribers, members and pharmacies, reducing administrative burden. However, implementing a single PDL may also change capitation rates as CCOs will no longer be able to collect Market Share rebates and may be directed to prefer higher-gross-cost drugs. Additional considerations and fiscal modeling will be detailed later in this report

Overview of PBMs

A PBM is a third-party entity that coordinates functions essential to providing pharmacy benefits. Currently, CCOs may contract with the PBM of their choice. There are six different PBMs contracted with the 16 CCOs participating in Oregon Medicaid. In some cases, CCOs contract with a PBM that is a related party, which can lead to misaligned incentives between the CCOs and OHA.

The term sPBM is used for a scenario in which the pharmacy benefit remains carved in to coordinated care, but all CCOs contract with a single OHA-selected PBM. OHA would mandate that all CCOs work with the selected sPBM while the CCOs remain at risk for the cost of pharmacy services. The sPBM would assume nearly all functions of the current PBM such as claims processing, provider contracting and payments, and reporting. Utilization management, including prior authorizations, would also be functions of the sPBM under the Full-Service scenario.

The sPBM would take on most pharmacy benefit-related administrative expenses. Because these costs may be duplicative, this approach could lower this component of capitation payments to CCOs. The exact division of responsibilities is a key OHA decision point.

Administrative Duties

OHA will have a choice in who adjudicates prior authorizations and other administrative functions: transferring this responsibility to the sPBM or keeping it with the CCOs. Processing prior authorizations include:

- Receiving requests from providers
- Operating a call center
- Reviewing documentation

- Adjudicating appeals
- Addressing grievances
- Sending notices of decisions to providers and beneficiaries

One focus of Mercer's analysis is to determine how administrative expenses might shift under these two models. If CCOs are responsible, total administrative costs will be higher because each CCO will have its own infrastructure relative to the single infrastructure of the sPBM.

Why States Implement a sPBM

States implement sPBMs in managed care for a variety of reasons, including, but not limited to:

- Administrative Ease: Managing a single PBM can streamline administrative processes, reducing complexity and the burden on state resources.
- Flexibility in Pharmacy Network and Payment Methodology: A single PBM model allows flexibility in pharmacy network design and pharmacy reimbursement methodologies. Mercer believes that the sPBM structure under managed care could continue to pay pharmacy providers at rates sufficient to maintain access. These payment agreements with the sPBM may need to be outlined in detail through the CCO contract to align provider reimbursement expectations.
- Consistency in Benefits Administration: A single PBM offers a uniform approach to the pharmacy benefit. Provider administrative burden, both at the physician and the pharmacy level, may be reduced compared to the current design, which requires providers to operate under multiple PBM administrative processes. The prescribers and pharmacies would have one point of contact for all Medicaid members for prior authorization and technical assistance.

States have many different reasons for making a pharmacy benefit design change and there is no single model that fits all Medicaid programs. A state may prioritize consistency in benefit administration, provider payment flexibility, enhance oversight of spread pricing, enhanced care coordination, fiscal savings, or any combination of the above.

Section 3

Single Preferred Drug List

While many states implement a sPDL as a stand-alone program, a sPBM model requires the sPDL component to lessen administrative burden and create economies of scale. The sPBM and sPDL can be implemented at the same time or the sPDL can be implemented first, as timelines and resources allow. States can require CCOs to follow the FFS PDL, or they can create a partial sPDL that only includes select therapeutic classes. CCOs can continue to manage drugs that are not on the sPDL and may, in some circumstances, continue to collect manufacturer market share rebates.

sPDL Overview

Mercer evaluated the financial impact of sPDL implementation by considering the current FFS PDL and Preferred Diabetic Supplies List and identifying opportunities to maximize federal and supplemental rebates. Oregon is one of 15 states participating in the Sovereign States Drug Consortium (SSDC), a Medicaid supplemental rebate pool that leverages the collective volume of 13 million covered lives to gain purchasing power and improve supplemental rebate offers from manufacturers to lower the net Medicaid cost of drugs. The main benefits from participation in a purchasing pool include reduced drug costs due to increased negotiating power, collaboration with other states regarding best practices in administration, and streamlined procurement processes. OptumRx negotiates offers on behalf of SSDC annually and on an ad hoc basis, with rebate agreements lasting for one year. Oregon collaborates with other member states to evaluate these offers when designing the FFS PDL, accepting those that align with OHA's clinical and financial preferences. Within the Oregon base data, Mercer found that 82% of CCO drug spend falls under a therapeutic class managed by SSDC.

Rebate Considerations

Mercer compared CCO drug utilization for the first half of CY 2025 to the federal rebate and SSDC supplemental rebate offers as of January 2026 to develop an sPDL that minimizes Medicaid Net Cost by shifting a substantial portion of nonconforming CCO utilization to clinically equivalent preferred products. The estimated decrease in total (state and federal) annual net CCO drug costs using the modeled sPDL is $58.9 million. Note that in some cases, modifications to clinical criteria will be required, which may increase utilization and, consequently, gross and net drug costs.

The top 4 consolidated drug groups with opportunities for savings are shown in Table 6. Mercer's analysis included claims data from the first half of calendar year 2025 (1H2025); the dollar amounts shown below represent the annualized total change in gross and net expenditures for the drug classes currently on the FFS PDL for the Non-Healthy Oregon Project (HOP) (populations that Mercer sets capitation rates for).

Table 6: Top 4 Drug Group Cost/(Savings) ($ in millions)

	Original		sPDL Modeled		Gross Change		Net Change (State and Federal $)	
Market Basket	**Original Paid**	**Original Net Paid**	**sPDL Paid**	**sPDL Net Paid**	**Gross Change $**	**Gross Change %**	**Net Change $**	**Net Change %**
Targeted Immune Modulators	$182.8	$132.5	$156.7	$95.6	($26.1)	-14.3%	($36.9)	-27.8%
Diabetes, including GLP-1 Receptor Agonists and GIP Therapies, SGLT-2 Inhibitors, Insulins, and CGMs	$152.5	$80.4	$157.2	$53.9	$4.7	3.1%	($26.5)	-33.0%
Inhaled Respiratory Agents	$28.2	$19.9	$30.6	$14.6	$2.4	8.5%	($5.3)	-26.6%
Substance Use Disorders and Growth Hormone	$36.1	$28.7	$36.1	$27.6	$0.0	0.0%	($1.1)	-3.8%
All Other	$670.0	$461.8	$669.1	$473.9	($0.9)	-0.1%	$12.1	2.6%
Total	$1,078.3	$729.5	$1,058.3	$670.6	($20.0)	-1.9%	($58.9)	-8.1%

**Please note that totals are rounded and annualized from Mercer's analysis of 1H2025 claims data. Aggregate results presented in this report may differ due to differences in population and time periods displayed in the CY 2026 capitation rate buildup. Abbreviations: glucagon-like peptide-1 (GLP-1), glucose-dependent insulinotropic polypeptide (GIP), sodium-glucose cotransporter-2 (SGLT-2), continuous glucose monitor (CGM)*

Member Disruption

Whenever changes are made to a PDL, disruption resulting in gaps in medication possession can occur when a drug that a member is currently taking becomes non-preferred and a new prescription and/or prior authorization is required. When comparing current CCO utilization against the modeled sPDL, Mercer found that nearly 90% of current prescriptions would be preferred and not require provider intervention when shifting to the sPDL. While this suggests a high degree of compatibility, some member disruption is expected to occur and be concentrated in certain drug classes, including Targeted Immune Modulators, Insulins, and

Oral Diabetes Agents. However, this can be minimized by communicating upcoming changes to CCOs, providers, and members early and often. In some cases, it may be appropriate to allow continued use of a non-preferred agent, but this reduces realized savings.

Gross Cost and Capitation Rate Considerations

When applying the sPDL gross and net cost expenditures to the non-HOP populations that Mercer sets capitation rates for, there are two primary components. Currently, Mercer removes CCO Market Share rebates from capitation rates, assuming CCOs collected 2.8% of total pharmacy expenditures in Market Share rebates. Under the first component, sPBM and sPDL scenario, these rebates would no longer be collected by the CCOs, therefore causing an upward adjustment to rates. For the second component, Mercer estimated an overall gross cost change due to product shifting of preferred products on the PDL. When applying these two factors together, Mercer estimates a total increase to capitation rates of $11.8 million as observed in Table 7 below:

Table 7: sPDL Gross and Net Cost/(Savings) ($ in millions)

sPDL Impacts	State Share	Federal Share	Total
PDL Gross Cost Impact	($5.5)	($17.7)	($23.2)
CCO Rebates	$8.2	$26.8	$35.0
sPDL Capitation Impact	**$2.8**	**$9.0**	**$11.8**
Federal and Supplemental Rebates	($19.0)	($61.1)	($80.1)
Net sPDL Impact Cost/(Savings)	**($16.2)**	**($52.1)**	**($68.3)**

**Table isolates sPDL considerations and excludes other non-benefit load calculations*

Under the sPDL and sPBM, rebates are now accounted for outside of capitation rates. Mercer estimates enhancements to both federal and supplemental rebates with an estimated $68.3 million in potential savings. A portion of the $80.1 million in federal and supplemental rebates under the modeled sPDL is offset by the loss in CCO Market Share rebates currently being removed from capitation rates. In total, Mercer estimates a net cost savings benefit to OHA by moving to a sPDL model.

340B Overview

The 340B program is complex and expansive. Congress created the 340B program in 1992 to lower the drug costs for safety net providers. The program's stated goals are to extend 340B-covered entities' (CEs') "scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services."[1] The Office of Pharmacy Affairs within the Health Resources and Services Administration (HRSA) administers the program. The 340B program requires drug manufacturers participating in Medicaid to sell covered outpatient drugs to CEs at discounted prices determined by statutory formulas linked to the federal Medicaid drug rebate program. The financial savings are significant, estimated

[1] Health Resources & Services Administration. "340B Drug Pricing Program", available at https://www.hrsa.gov/opa/index.html.

to exceed 50% of total drug costs. The drug manufacturers are not required to provide a 340B price for a drug and pay a Medicaid rebate for the same drug, a situation referred to as a duplicate discount.

States and US territories are grappling with how to effectively work with 340B CEs to provide services to more Medicaid members while also ensuring program compliance with federal rebate invoicing, collection and reporting. With the recent growth in participation, there has been increased attention paid to the 340B program's benefits, as well as recognition of increased need for transparency, accountability, and traceability.

There are no Federally Qualified Health Center (FQHC) reporting requirements specific to 340B. However, FQHCs are required to submit progress reports and annual reports to HRSA. All non-grant funds, including margin generated by 340B dispensing, must be used for costs within the scope of the health center's services or for the benefit of the health center's patient population.

Medicaid FFS programs obtain cost savings through a 340B program by realizing drug price reductions at the point of sale rather than collecting drug manufacturer rebates after dispensation.

The duplicate discount prohibition creates an inherent tension between 340B CEs and State Medicaid programs — there is only one discount to go around. Tension exists between the need for CEs to maintain their 340B margins to fund other activities within their organization and the need for state Medicaid programs to realize the potential budget savings associated with drug rebates or 340B.

340B Interaction with sPDL Development

The Governor's Advisory Group requested that Mercer assess the impact of the sPDL and rebates for both OHA and 340B providers. Because the only one federal rebate or discounted purchase price is extended to Medicaid and 340B CEs, Mercer's sPDL assessment took into consideration the lowest net cost to the program across 340B and non-340B utilization. Table 8 below shows an example using two claims for the same drug, a non-340B eligible claim and a 340B eligible claim:

Table 8: sPDL Switch Example for 340B and non-340B

Product	Non-Preferred Drug			Switch to Preferred Drug		
Claim Type	Gross Cost to Medicaid	Rebate to Medicaid	Net Cost to Medicaid	Gross Cost to Medicaid	Rebate to Medicaid	Net Cost to Medicaid
Non-340B	$300	($80)	$220	$600	($400)	$200
340B	$300	$0	$300	$600	$0	$600
Total	**$600**	**($80)**	**$520**	**$1,200**	**($400)**	**$800**

Throughout the sPDL analysis, Mercer identified CCO drug utilization that is non-preferred on the modeled sPDL; where this occurs, Mercer shifts most of this utilization to the preferred products. Because sPDL choices are based on net costs, there are instances where the

gross cost of a drug is higher than the non-preferred drug. In the example above, the non-340B drug switch to the preferred product would generate cost savings to OHA. However, because the 340B CE has already received a discounted purchase for this drug, OHA is no longer eligible to receive any rebates, leading to a net cost increase due to the higher gross cost of the drug. When considering the mix of 340B and non-340B claims, Mercer found a net cost savings for the modeled single PDL.

Mercer's strategy throughout the sPDL analysis and optimization was to evaluate a holistic approach that resulted in low gross cost impact to 340B providers and drug switch movement that generated net cost savings to OHA.

Mercer did not receive 340B specific drug indicators, however, based on rebate data provided by OHA, Mercer estimates that 30% of the total dollars in 1H 2025 pharmacy claims are not rebate eligible. Apart from disqualifying criteria from the MDRP, such as products that are not covered outpatient drugs or other criteria, Mercer assumes that a large majority of these non-rebate eligible products are 340B-eligible claims. Despite the limitations in OHA's ability to receive rebates for these products, Mercer estimates the optimized sPDL will result in a net cost benefit to OHA with minimal disruption to 340B provider payments.

Table 9 below shows the total breakdown in projected expenditures between rebate eligible and non-rebate eligible claims. It is estimated that there would be a 2.6% reduction in gross costs due to product shifting to lower cost preferred products on the PDL. While these shifts represent lower total costs to 340B providers, this does not consider 340B provider margin which has unknown impacts. Under the sPBM model, OHA may have additional opportunities to provide pricing alternatives for 340B providers that can balance the unknown margin impacts from the sPDL.

Table 9: Rebate and Non-Rebate Eligible Spend Breakdown

Claim Type	Original Paid	sPDL Modeled	Gross Cost Change $	Gross Cost Change %
Rebate Eligible	$876.1	$862.8	-$13.3	-1.5%
Non-Rebate Eligible	$373.9	$364.0	-$9.9	-2.6%
Total	**$1,250.0**	**$1,226.8**	**-$23.2**	**-1.9%**

Although the Mercer-designed sPDL will not negatively impact CEs per claim reimbursement, the state is spending $373.9M on claims, both for 340B and state-only programs, that have no rebate, either federal or supplemental. To mitigate this, a separate PDL focusing on even lower gross cost agents could be developed, reducing the gross spend to the state on claims that do not collect rebates.

Section 4

Pharmacy Benefit Administration and Management Options

In the pharmacy benefit designs discussed in this report, Mercer assumes two different administrative arrangements that involve the use of an OHA-selected PBM: either Full Service or ASO. The sPBM model could lead to greater rebate collection through more efficient and accurate rebate invoicing and potential for enhanced sPDL compliance due to the streamlined coding process with a single PBM. Additionally, the sPBM model reduces the administrative burden for members, prescribers and providers above and beyond the benefits of a sPDL.

Administrative costs in capitation rates reflect the costs between the CCOs and their contracted PBMs; however, requiring each CCO to contract with one sPBM can create operational efficiencies. For example, in Oregon Medicaid, each CCO's PBM may staff five reporting analysts per plan, totaling 80 employees across the managed care system. The sPBM may only require five total reporting analysts since increased data volume does not necessarily require proportionally increased staff. It is important to note that states may require additional staff to provide oversight for the sPBM, and this increased headcount must be considered when calculating administrative costs. Although reporting, analytics, and processing can be streamlined through the sPBM, prior authorizations can be managed in one of two ways.

Program Design Option 1: Full Service PBM

Prior Authorization is Performed by the OHA-Selected PBM

Under this option, the sPBM will handle all claims processing, provider payment, call center(s) for utilization management (prior authorization decisions and appeals) and member services, as well as other administrative duties that the CCOs or their current PBMs currently perform.

The administrative costs projected in calendar year (CY) 2026 capitation rates related to pharmacy benefits are approximately $36.5 million[2]. To estimate possible changes in pharmacy administrative costs in capitation rates resulting from implementing a sPBM model, Mercer reviewed publicly available administrative cost information from states that have shifted to a sPBM model and estimated costs by administrative category.

[2] Capitation rates include 8.3% administrative costs across all categories of service. Mercer estimates that $36.5 million is the portion of administrative costs allocated to projected pharmacy expenditures.

Program Design Option 2: Administrative Services Only

Administrative Services Only PBM

For this option, the CCO will continue to manage their own call centers for utilization management, but all other administrative functions would be handled by the sPBM. Of the design options in this report, this represents a comparatively small change from current program design since administrative costs in this given scenario require that each plan maintains infrastructure and staffing to handle certain administrative duties.

Estimated Fiscal Impacts by sPBM Model

Table 10 breaks down projected administrative costs by CCO and sPBM administrative components.

Table 10: Pharmacy Benefit Design Administrative Summary ($ in millions)

sPBM Model	(A) Current CCO Admin	(B) Projected CCO Admin	(C) Projected sPBM Admin	(D) Projected Total Admin (D = B + C)	(E) Projected Savings (Costs) (E = D − A)
Full-Service	$36.5	$7.9–$8.1	$5.2–$14.5	$13.1–$22.7	**($23.4)–($13.8)**
ASO	$36.5	$13.1–$13.5	$3.7–$9.7	$16.8–$23.2	**($19.7)–($13.2)**

Mercer estimates that long-term administrative cost savings are achievable under either sPBM scenario with higher savings under the Full-Service Model. It is believed that there are additional upfront costs for sPBM implementation that are not accounted for in the capitation impacts. Mercer believes this one-time implementation cost would be incurred in year one to an amount equal to the annual sPBM administration costs in Table 10, column C.

Section 5

Pricing Options

The Governor's Advisory Group asked Mercer to evaluate various pharmacy payment changes. In the status quo environment, each PBM negotiates pricing contracts between their CCO and the pharmacy networks across Oregon. Drug costs consist of two main components; the ingredient cost which reimburses the pharmacy for purchase price of the drug, and the dispensing fee which compensates the pharmacist for costs of preparing and dispensing the medication. CCOs typically pay a higher rate on ingredient cost with a lower dispensing fee relative to what the state pays in FFS. Due to the unknown outcome of the selected sPBM contracted rates, Mercer utilized two methods to project possible pricing outcomes for the future sPBM:

- Exercise 1: Mercer utilized a comparator PBM pricing agreement and applied the contracted rates to 1H 2025 CCO encounter data.
- Exercise 2: Mercer independently evaluated each CCOs pricing performance from 1H 2025 CCO encounter data relative to an industry standard pricing benchmark, average wholesale price (AWP), and compared each PBMs performance against another.

Each PBM operating in Oregon Medicaid's program today may have drastically differing pricing contracts with their CCOs. This may include differences in:

- Pricing terms between brand and generic drug channels
- Drug specific pricing rates for specialty medications
- Definitions between brand, generic and specialty medications
- Drug exclusions from pricing guarantees (340B, Indian health services, dispensed as written (DAW), third-party liability, etc.)

These differences in PBM pricing contracted terms and definitions may allow each PBM to appear to have lower or higher pricing relative to each other. One primary benefit of a sPBM is that contracting with one vendor through the request for proposal (RFP) process allows OHA to introduce aggregated pricing competition to better manage drug costs and allow for more consistency in payments for pharmacies across the State. Additionally, through the sPBM procurement process, OHA may have better oversight and understanding of the total net lowest reimbursement option depending on the goal of the program.

Utilizing Exercise 1, Mercer leveraged the comparator PBM contracted rates in relation to the existing CCO data to establish a reasonable range of possible outcomes for the future sPBM.

Utilizing Exercise 2, Mercer further refined the range of outcomes for the future sPBM by comparing each CCOs PBM pricing performance in a "Best Athlete" exercise. All 16 CCOs pricing performance between brand and generic channels were evaluated relative to AWP, then subsequently used to benchmark all CCO encounter claims against those rates. Understanding that each CCO varies in expenditure volume and drug mix, Mercer

aggregated the top eight and bottom eight performing CCOs to minimize individual CCO drug mix differences. This allowed Mercer to triangulate a range of lower or higher pricing outcomes with the future selected sPBM.

Furthermore, Mercer used professional judgment and industry knowledge to smooth outlier performances of top and bottom performing CCOs with the understanding that a PBM bidding for the sPBM procurement may bid with different rates than are currently contracted with the existing CCO.

On average, Mercer estimates that gross pharmacy expenditures could decrease or increase by an estimated $18.4 million.

Table 11: PBM Re-Pricing ($ in millions)

Spend Category	Projected CY 2026 Total Pharmacy Expenditures
Pharmacy Spend	$1,250
sPBM Pricing Impact	($18.4)–$18.4
Final Projected Costs sPBM Pricing Adjusted	**$1,231.6–$1,268.4**

Non-Benefit Load Components

Within the capitation rate buildup that Mercer performs for OHA and apart from projecting gross medical expenditures, there are other non-benefit components to capitation rates that include the manage care premium tax, underwriting margin, and administrative costs. Each non-benefit cost component is described below.

Managed Care Organization Premium Tax

The State requires MCOs to pay a 2.0% MCO assessment on premium/capitation revenue. While the 2.0% premium tax is assessed on total projected expenditures, we do not anticipate meaningful changes to the component in the rate buildup under the sPBM program design change assuming pharmacy benefits are still included in the contract.

However, there are careful considerations that need to be taken for OHA to retain the premium tax revenue as currently collected. Although Oregon state laws allow for MCOs to be taxed subject to federal healthcare related tax rules, PBMs generally do not qualify as MCOs and are not, on their own, recognized under federal law as an eligible class of healthcare service which can be taxed. This may mean that if OHA were to structure the contract of a sPBM directly with the entity, those dollars may not be tax eligible. However, Mercer believes that structuring a sPBM agreement whereby the CCOs all contract directly with the sPBM, the administrative costs would continue to be a taxable service included in the managed care capitation revenue. Mercer advises careful legal counsel to assess the full impact between Oregon tax code and the PBM agreements.

Underwriting Margin

Mercer develops underwriting margin assumptions, which implicitly and broadly consider the cost of capital requirements and inherent risk of the CCO program. Underwriting margin percentages were determined as a percentage of the CCO capitation rates and remain consistent between status quo and sPBM scenarios. Mercer believes these costs would have minimal changes.

Administrative Costs

To estimate the administrative costs of a sPBM, Mercer reviewed both public and private sPBM administrative cost estimates in the industry. Additionally, through engagement of the comparator PBM rates, Mercer estimated both ASO and Full Service PBM administrative costs, which landed squarely within the estimated range of Mercer's marketplace research.

As noted in previous sections, Mercer anticipates a more considerable change to the pharmacy administrative cost component between status quo and sPBM scenarios within the capitation rate buildup.

Section 6
Combined Fiscal Impacts

This section outlines a total estimated capitation rate buildup of each fiscal consideration outlined in this report using 1H 2025 encounters and annualized for a calendar year estimate. Both ASO and Full Service fiscal estimates are shown below for the CCO populations, excluding HOP.

Table 12 below presents the Full Service fiscal impact:

Table 12: Full Service sPBM Budget Estimated Impact

Fiscal Impact Components	State Impact (A)	Federal Impact (B)	Total Estimated Fiscal Impact (C = A + B)
Coordinated Care Capitation Rate Impact			
Gross Pharmacy Expenditures	$294.5	$955.5	$1,250.0
PDL Gross Cost Impact	$0.0	$0.0	$0.0
PBM Pricing Impact	$0.0	$0.0	$0.0
CCO Rebates	($8.2)	($26.8)	($35.0)
CCO Admin	$8.6	$27.9	$36.5
Underwriting Gain	$6.0	$19.5	$25.5
Premium Tax	$6.1	$19.9	$26.1
Total CCO Pharmacy Capitation	**$307.0**	**$996.1**	**$1,303.1**
Coordinated Care Net of Rebate Cost Impacts			
Federal Rebates	($81.5)	($287.9)	($369.4)
Premium Tax Revenue	($26.1)	$0.0	($26.1)
Net Cost to Oregon	**$199.4**	**$708.2**	**$907.6**
sPBM Modeled Coordinated Care Capitation Rate Impact			
Gross Pharmacy Expenditures	$294.5	$955.5	$1,250.0
PDL Gross Cost Impact	($5.5)	($17.7)	($23.2)
PBM Pricing Impact	($4.3)–$4.3	($14.1)–$14.1	($18.4)–$18.4
CCO Rebates	$0.0	$0.0	$0.0
CCO Admin	$3.1–$5.3	$10.0–$17.3	$13.1–$22.7
Underwriting Gain	$5.9–$6.1	$19.1–$19.8	$24.9–$25.9
Premium Tax	$6.0–$6.2	$19.4–$20.2	$25.4–$26.4
Total CCO Pharmacy Capitation	**$299.7–$311.0**	**$972.2–$1,009.1**	**$1,271.9–$1,320.2**

Fiscal Impact Components	State Impact (A)	Federal Impact (B)	Total Estimated Fiscal Impact (C = A + B)
sPBM Modeled Coordinated Care Net of Rebate Cost Impacts			
Federal Rebates & Supplemental Rebates	($100.5)	($349.0)	($449.5)
Premium Tax Revenue	($25.4)–($26.4)	$0.0–$0.0	($25.4)–($26.4)
Net Cost to Oregon	**$173.7–$184.1**	**$623.2–$660.1**	**$796.9–$844.2**
Combined Fiscal Impact			
Changes to Capitation %	**-2.4% to 1.3%**	**-2.4% to 1.3%**	**-2.4% to 1.3%**
Changes to Capitation $	**($7.3)–$4.0**	**($23.8)–$13.1**	**($31.2)–$17.1**
Oregon Medicaid Net Cost Impacts			
Net Change to OHA %	**-12.9% to -7.7%**	**-12.0% to -6.8%**	**-12.2% to -7.0%**
Net Change to OHP $	**($25.7)–($15.3)**	**($85.0)–($48.1)**	**($110.7)–($63.4)**

Table 13 below presents the ASO fiscal impact.

Table 13: ASO sPBM Budget Estimated Impact

Fiscal Impact Components	State Impact (A)	Federal Impact (B)	Total Estimated Fiscal Impact (C = A + B)
Coordinated Care Capitation Rate Impact			
Gross Pharmacy Expenditures	$294.5	$955.5	$1,250.0
PDL Gross Cost Impact	$0.0	$0.0	$0.0
PBM Pricing Impact	$0.0	$0.0	$0.0
CCO Rebates	($8.2)	($26.8)	($35.0)
CCO Admin	$8.6	$27.9	$36.5
Underwriting Gain	$6.0	$19.5	$25.5
Premium Tax	$6.1	$19.9	$26.1
Total CCO Pharmacy Capitation	**$307.0**	**$996.1**	**$1,303.1**
Coordinated Care Net of Rebate Cost Impacts			
Federal Rebates	($81.5)	($287.9)	($369.4)
Premium Tax Revenue	($26.1)	$0.0	($26.1)
Net Cost to Oregon	**$199.4**	**$708.2**	**$907.6**
sPBM Modeled Coordinated Care Capitation Rate Impact			
Gross Pharmacy Expenditures	$294.5	$955.5	$1,250.0
PDL Gross Cost Impact	($5.5)	($17.7)	($23.2)

Fiscal Impact Components	State Impact (A)	Federal Impact (B)	Total Estimated Fiscal Impact (C = A + B)
PBM Pricing Impact	($4.3)–$4.3	($14.1)–$14.1	($18.4)–$18.4
CCO Rebates	$0.0	$0.0	$0.0
CCO Admin	$4.0–$5.5	$12.8–$17.7	$16.8–$23.2
Underwriting Gain	$5.9–$6.1	$19.1–$19.8	$25.0–$25.9
Premium Tax	$6.0–$6.2	$19.5–$20.2	$25.5–$26.4
Total CCO Pharmacy Capitation	**$300.6–$311.2**	**$975.2–$1,009.6**	**$1,275.7–$1,320.7**
sPBM Modeled Coordinated Care Net of Rebate Cost Impacts			
Federal Rebates & Supplemental Rebates	($100.5)	($349.0)	($449.5)
Premium Tax Revenue	($25.5)–($26.4)	$0.0–$0.0	($25.5)–($26.4)
Net Cost to Oregon	**$174.6–$184.3**	**$626.1–$660.5**	**$800.7–$844.8**
Combined Fiscal Impact			
Changes to Capitation %	**-2.1% to 1.4%**	**-2.1% to 1.4%**	**-2.1% to 1.4%**
Changes to Capitation $	**($6.4)–$4.2**	**($20.9)–$13.5**	**($27.3)–$17.7**
Oregon Medicaid Net Cost Impacts			
Net Change to OHA %	**-12.5% to -7.6%**	**-11.6% to -6.7%**	**-11.8% to -6.9%**
Net Change to OHA $	**($24.9)–($15.2)**	**($82.0)–($47.6)**	**($106.9)–($62.8)**

Key Observations

It is important to note that these fiscal impacts are provided as range estimates. The largest contribution to this variability in the range estimates is the future contracted sPBM Pricing Impacts. A reduction in overall sPBM Pricing may lead to higher administrative costs with the contracted sPBM, whereas a neutral or cost increase may lead to a reduction in administrative costs.

- A Full Service sPBM is estimated to generate total program impact ranging from ($110.7) million to ($63.4) million.
  - A majority of the Full Service sPBM cost impact is generated from the sPDL's estimated reduction in both gross cost and net cost from enhanced rebate collection.
- An ASO sPBM is estimated to generate total program impact ranging from ($106.9) million to ($62.8) million.
  - Like the Full Service sPBM model, these cost impacts are also generated from the shift from a CCO managed PDL to a sPDL.
  - There are lower administrative cost savings opportunities under this model due to a larger portion of existing administrative costs remaining with the CCOs.

Section 7
Caveats and Limitations

Methods

Data

- Medi-Span database to summarize various data fields including the AWP and WAC.
- Oregon Health & Science University (OHSU) provided Mercer with various data files received on January 30, 2026, that included:
  - Unit Rebate Amount (URA) file from Quarter 1 2025 titled “1Qtr2025URA.txt”
  - Unit Rebate Offset Amount (UROA) file from Quarter 1 2025 titled “1Qtr2025UROA.txt”
  - URA file from Quarter 2 2025 titled “2Qtr2025URA.txt”
  - UROA file from Quarter 2 2025 titled “2Qtr2025UROA.txt”
  - A data summary and field definitions file titled “DataFiles.xls”
  - January 1, 2025, through June 30, 2025, CCO-submitted encounter and FFS data with runout through December 31, 2025, limited to pharmacy point-of-sale transactions titled “Mercer_PDLPBM_MedicaidClaims.txt”
  - Drug unit conversion file titled “NDC_Unit_Conversion_Mercer.xlsx”
  - Supplemental rebate offer files titled “SR_Offers_2026.xls”
  - Invoiced supplemental rebate offers from Quarter 1 2025 titled “SRInvoiceList_Drugs_1Q2025.csv”
  - Invoiced supplemental rebate offers from Quarter 2 2025 titled “SRInvoiceList_Drugs_2Q2025.csv”
  - URA data elements and file layout titled “URA File Layout.pdf”
  - UROA data elements and file layout titled “UROA File Layout.pdf”
- OHA Provided three files relating to PDL status and SSDC rebate offers on February 6, 2026:
  - 2026 PDL status titled “PDL_byNDC.XLS”
  - SSDC slide deck including negotiated offers titled “SSDC 2026 Offers Paige’s Slides (FINAL) (1).pptx”
  - A PDF version of the supplemental rebate offers cost sheet titled “OREGON_CY2026 SSDC Offers_20250711_1Q2025_FFS_V5_WOF (1).pdf”

Assumptions

sPDL Analysis

- Mercer received encounter data for CCOs pre-populated with federal and supplemental invoiced rebates for 1H 2025 (January 1, 2025–June 30, 2025).
- The following data points and adjustments were made to the encounter data:
  - The 2026 PDL status was applied at an NDC level.
  - The UROA was applied at the NDC level.
  - The URA was applied at the NDC level.
  - The Unit Conversions were applied at the NDC level.
  - The 2026 supplemental rebate offers were applied at the NDC level using the drug quantity on the encounter unless a unit conversion existed. When a unit conversion existed, the supplemental rebate offer was applied to the converted unit quantity.
- The data outputs included the assigned PDL status, gross encounter paid amount, baseline federal rebate, and the assigned supplemental rebate offer tiers one through four.
- The data was categorized into four different population groups:
  - Federally funded and rebate eligible
  - Federally funded and non-rebate eligible
  - State funded and rebate eligible
  - State funded and non-rebate eligible
- State and federally funded groupings were provided by OHA. Whether a claim was rebate eligible was dependent on varying factors:
  - Rebate eligible claims are determined by whether:
    - A claim was previously invoiced for a federal rebate indicated on a claim
  - If a claim had no federal rebate it was assumed to fall into one of the following groups:
    - 340B eligible claim, if in the federally funded category
    - Title XXI Children's Health Insurance Program (CHIP), if designated as state funded
    - HOP, if designated as state funded
    - Other non-rebate eligible reasons
- Mercer first reviewed non-preferred encounter data and shifted utilization to preferred products on the sPDL in therapeutic classes where baseline data experienced low

preferred adherence. Because data was aggregated across all population groups, all switch assumptions were reviewed for cost efficiency accounting for both gross and net expenditures across both rebate and non-rebate eligible programs. Using an aggregated methodology allowed Mercer to evaluate instances where existing preferred product placement may not achieve lowest net cost to OHA due to the high volume of non-rebate eligible products. In instances where the current FFS PDL increased net costs, Mercer made PDL recommendations that allow OHA to be cost efficient.

- Once Mercer developed an optimized PDL, differing slightly to the current FFS PDL, the drug shift recommendations were applied separately to the federally and state funded programs to individually assess gross and net cost impacts.

Limitations of this analysis include:

- Differences in time periods between the URA listed on the claim and the supplemental rebate offers that align to the 2026 PDL. The claim data is on a 1H 2025-time basis whereas the supplemental rebates are oriented to CY 2026. In some cases, rebates may be over or understated due to changes in negotiation or changes in drug pricing.
- The analysis does not take into consideration individual CCO PDL strategy changes from CY 2025 to CY 2026. The analysis assesses the CY 2026 PDL from 1H 2025 point-in-time data only.

Mercer made alterations to the existing FFS PDL structure within the guidelines of SSDC's supplemental rebate offers. In some instances, Mercer moved non-preferred products to preferred status and accepted a rejected supplemental rebate offer. Results in this report are dependent on renegotiation and structuring of the current PDL.

Pricing Analysis

Mercer reviewed pricing results in two ways:

Pricing Exercise 1

Mercer used blinded comparator PBM pricing to estimate pricing results if Oregon Medicaid pharmacy were priced to the comparator rates. Results were priced at a claim level and resulted in a reduction in overall expenditures of 0.8%.

The blinded results excluded the following claim categories:

- LTC pharmacy claims
- 340B claims identified through the HRSA Medicaid Exclusion List
- Outlier claims including:
  - Third-Party Liability
  - Kaiser Family Foundation
  - Integrated Delivery System (IDS)
  - Brand Claims with discounts greater than 50% off AWP
  - Generic Claims with discounts greater than 98% off AWP

Results should be viewed within the context of these drug claim exclusions due to the large volume of 340B and outlier claims. These results were used for reasonability in Mercer's final estimated range of costs or savings for the future contracted PBM.

Pricing Exercise 2

Mercer further evaluated the pricing of CCO pharmacy encounters with fewer exclusions using observed discounts between brand and generic claim payments relative to AWP. Each CCO was independently evaluated for their pricing payments within those drug channels. Each CCO pricing results as a discount off AWP was then applied to total CCO encounter drug costs to estimate the range of savings or costs if that CCO's PBM contracted rates were applied to all CCOs.

To smooth out variability, Mercer aggregated the top and bottom performing CCOs and applied these rates to total encounter expenditures to estimate a lower or upper bound range. These results were as follows:

- Lower Bound Range: -2.5%
- Upper Bound Range: 4.4%

Due to regional variability and the possible drug mix variation of the CCO groupings of top and bottom performers, Mercer applied further reasonability of pricing results to estimate the future sPBM's contracted rates. Mercer assumes that during a competitive bidding process for a sPBM, there may be economies of scale in contracted rate performance. The final range variation that Mercer recommends for this exercise is as follows:

- Lower Bound Range: -1.5%
- Upper Bound Range: 1.5%

Exclusions to this analysis include:

- Third-Party Liability Claims
- Zero Paid Claims
- 340B Claims

Limitations of this analysis include:

- Results will depend heavily on the procurement process and the PBMs that bid for the sPBM. Mercer acknowledges that PBM bids may come in more aggressive, but OHA may select a PBM with higher rates due to extenuating factors such as PBM administrative capabilities and administrative costs that may offset drug pricing performance.
- Mercer was asked to maintain consistency in 340B provider payment levels did not assume any changes to 340B claims.

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Disclosures

This report is prepared on behalf of the OHA and is intended to be relied upon only by OHA. To the best of Mercer's knowledge, there are no conflicts of interest in performing this work. The suppliers of data are solely responsible for its validity and completeness. Mercer has reviewed the data and information for internal consistency and reasonableness, but we did not audit it. All estimates are based upon the information and data available at a point in time and are subject to unforeseen and random events, and actual experience will vary from estimates. Users of this report are cautioned against relying solely on the data contained herein. Mercer provides no guarantee, written or implied, that this report is 100% accurate or error-free. This report is being provided for informational purposes only. Mercer reserves the right to refine it as they see fit at any time.
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Mercer Health & Benefits LLC
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
www.mercer-government.mercer.com

SMART-D
State Interview Analysis

Single Preferred Drug List and Single Pharmacy Benefit Manager Implementations

Prepared for the
Governor's Advisory Group on Medicaid Sustainability

April 2026

Based on interviews with state Medicaid pharmacy officials in:
Idaho, Mississippi, Missouri, New York, Ohio, Oklahoma, Tennessee, Texas, and Washington

Center for Evidence-based Policy
Oregon Health & Science University
3030 S Moody Ave., Suite 250
Portland, OR 97201
Phone: 503-494-2182
Fax: 503-494-3807
http://centerforevidencebased policy.org

Executive Summary

This report synthesizes findings from structured interviews with Medicaid pharmacy officials in 9 states: Idaho, Mississippi, Missouri, New York, Ohio, Oklahoma, Tennessee, Texas, and Washington. Each interview explored how states have implemented single preferred drug lists (PDLs) or single pharmacy benefit managers (PBMs) to consolidate Medicaid pharmacy benefit administration, reduce costs, and improve program oversight.

The findings are organized around key decision themes directly relevant to Oregon, which currently operates 16 coordinated care organizations (CCOs), 13 unique PDLs, and 6 PBMs. The analysis is designed to inform the Governor's Advisory Group on Medicaid Sustainability as it evaluates options for pharmacy benefit reform within the Oregon Health Plan (OHP).

The central takeaway across the 9 states is consistent: consolidating the pharmacy benefit under a single PDL or single PBM can yield meaningful financial returns—primarily through supplemental rebate optimization and administrative cost reduction—*but requires substantial planning, dedicated staffing, robust contract design, proactive stakeholder engagement, and phased implementation timelines of 18 months or more*.

Background and Purpose

The Governor's Advisory Group on Medicaid Sustainability was convened to evaluate cost-saving measures within the OHP. One focus area is the administration of the Medicaid pharmacy benefit. Oregon currently operates a decentralized model with 16 CCOs, 13 unique PDLs, and 6 PBMs. This structure can create variability in formulary access for beneficiaries, increase administrative complexity for providers and pharmacies, fragment the state's purchasing leverage, and limit the state's ability to capture supplemental rebates.

Many states have consolidated pharmacy benefit administration using one or both of two primary approaches: implementing a single, statewide PDL that all managed care plans must follow, and/or contracting with a single PBM to process pharmacy claims statewide. Through the SMART-D initiative, Oregon conducted structured interviews with officials from 9 states that have implemented varying models of pharmacy benefit consolidation. The interviews followed a standardized set of 9 questions covering the impetus for change, financial analyses, regulatory authority, staffing, implementation timelines, 340B policy, lessons learned, and longer-term vision. See Appendix A for the list of interview questions.

This report distills those interview findings into key themes, with specific attention to the implications and considerations most relevant to Oregon's decision making. *Important note: the information gathered through the interviews reflects the direct feedback from state officials and any references to specific budget savings and/or staffing have not been validated by SMART-D staff.*

Summary of Key Interview Findings

Rationale for Consolidation of the Pharmacy Benefit

- Nearly every state cited **supplemental rebate optimization and patient/provider experiences** as the primary considerations for pharmacy benefit consolidation
- A single PDL allows states to negotiate enhanced supplemental rebates with manufacturers after consolidation.

- Consolidation also reduced the state's administrative burden by decreasing the workload of monitoring managed care organization (MCO) operations
- States also noted reduced burden on patients who changed MCOs and no longer had to navigate different formularies

Cost-Savings Evidence and Financial Analysis

- Most states did not conduct pre-implementation savings analyses, in part due to **missing data on MCO-specific rebate dollars,** which prevented direct comparison
- 1 state conducted an internal analysis that estimated a **75%–80% reduction in administrative costs**
- Post-implementation analyses:
  - **Single PDL and Single PBM results:**
    - Savings results due to single PDL or PBM implementations varied widely due to program design decisions, including:
      - Moving from a PBM network that averages costs across in-network pharmacies to a set reimbursement logic for all pharmacies; and
      - Modifications to pharmacy dispensing fees to increase access to pharmacies within the state.
    - Additionally, publicly reported savings may not be appropriate comparators to Oregon as they rely on actuarial estimates with ranges of potential costs and savings predicated on assumptions that may not apply to other states. Further, they are based on different populations with different sizes and underlying characteristics.
    - Other states reported that rebate collections substantially increased

340B Policy

- Treatment of 340B-covered entities emerged as the single most complex and politically sensitive policy area
- States varied in their approach to 340B and rebates; some states assumed all claims from a covered entity are 340B, while others required claim-level indicators of 340B stock
- Reimbursement methodologies also varied and included using 340B ceiling prices, approximating acquisition costs, or applying shared-savings methodologies
- 2 interviewed states carved out specific drugs or entity types from 340B to capture Medicaid Drug Rebate Program savings
- 340B stakeholders were active in most states, but the intensity of pushback varied

Legislative and Regulatory Authority

- Most states required some form of legislative action to implement pharmacy benefit consolidation
- Political dynamics caused some timeline delays, and even one governor-veto, in many of the interviewed states

Implementation Timeline and Phasing Strategy

- Implementation timelines ranged from 6 months to multiple years
- Interviewed staff recommended budgeting at least 12–18 months to implement a single PDL

- Interviewees recommended a phased implementation for a single PDL by identifying drug classes with the highest potential for increased rebates to capture savings sooner

Staffing and Administrative Infrastructure

- **Mid-range states** operated with teams of 8 to 12 staff, typically including 3 to 4 pharmacists and a mix of operational, rebate, and administrative support positions
- A Medicaid Chief Pharmacy Officer or Director Pharmacy (a trained pharmacist), played a large role in states by providing overall leadership support and alignment with MCOs
- Additional critical roles included clinical pharmacy support, prior authorization (PA) criteria, drug utilization review (DUR), clinical edit development, vendor oversight, data management, and MCO operations liaison

Stakeholder Engagement and Communication Strategy

- Every state identified stakeholder engagement as a critical success factor
- Interviewees suggested creating tailored messaging unique to providers, enrollees, legislators, and 340B entities
- States shared successful countermeasures to opposition, including transparent data sharing, prospective outreach, consistent and frequent communication, and executive-level communication

Vendor Contracting and Oversight

- **Interviewees emphasized the need for robust contract language and enforcement mechanisms,** including service-level agreements with liquidated damages, anti-spread pricing protections, and required vendor staffing (e.g., dedicated clinical pharmacists)

Multi-Agency Purchasing

- While the immediate focus of the interviews was on Medicaid pharmacy benefit consolidation, some states expressed ambitions to extend consolidated purchasing to public employee plans, retirement systems, or corrections pharmacy

Overview of State Models

The 9 states interviewed represent a spectrum of consolidation approaches. Understanding the range of models provides essential context for interpreting their experiences and assessing applicability to Oregon.

Implementation dates across the interviewed states ranged from the late 1990s to 2024, with 1 state still in the early stages of planning. The number of MCOs across these states ranged from 3 to 17, and Medicaid populations ranged from approximately 300,000 to over 7 million lives.

Figure 1 below summarizes each state's pharmacy model and highlights specific policy characteristics.

Figure 1. Overview of Interviewed State Pharmacy Models

MCO Risk	State Risk
Single PDL With MCOs at Financial Risk *3 States*	**Single PDL + Single PBM** *1 State Implemented* *1 State in Planning Process*
• MCOs retain their PBM relationships (financial risk for the pharmacy benefit) but must follow the state's PDL, prior authorization criteria, and reimbursement rules. • In one state, MCOs and PBMs are statutorily prohibited from collecting their own supplemental rebates, preserving that function for the state. • Implementation dates ranged from 2012 to 2024.	• Phased approach example: state launched PDL first and the PBM approximately 2 years later. This approach had the most rigorous cost-savings evidence compared to other states interviewed. • 1 state is currently designing a single PBM model as part of a broader transition from fee-for-service to comprehensive managed care, with a target go-live of 2029.
Single PBA *1 State*	**Full Pharmacy Carve-Out** *3 States*
• Single vendor processes all pharmacy claims and manages point-of-sale PA under the state's clinical rules. • MCOs retain financial responsibility for the pharmacy benefit. MCOs receive claims data for care management purposes but no longer adjudicate pharmacy claims or manage separate PA processes. • PBA reimburses pharmacies using state-driven logic (AAC and NADAC), rather than a traditional pharmacy network that relies on AWP minus % averages by drug channel (e.g., generic drug products at community pharmacies). • Procurement process: amended existing fiscal agent contract rather than issuing a new procurement.	• Fee-for-service administration with state-contracted PBM. • Interviewed states carved out the benefit across several decades: late 1990s, 2009, 2023. • State functions as, or closely oversees, the PBM, manages the PDL, negotiates supplemental rebates, and reimburses pharmacies directly. • MCOs in these states have no financial responsibility for outpatient pharmacy.

Abbreviations. AAC: average acquisition cost; AWP: average wholesale price; MCO: managed care organization; NADAC: national average drug acquisition cost; PA: prior authorization; PBA: pharmacy benefit administrator; PBM: pharmacy benefit manager; PDL: preferred drug list.

Full Pharmacy Carve-Outs

Three states fully carved the outpatient pharmacy benefit out of managed care, returning it to FFS administration with a state-contracted PBM. These carve-outs occurred at different times—one in the late 1990s, another in 2009, and a third in 2023. In these models, the state either functions as or closely oversees the PBM, manages the PDL, negotiates supplemental rebates, and reimburses pharmacies directly. MCOs in these states have no financial responsibility for the outpatient pharmacy benefit.

Single PDL With MCOs at Financial Risk

Three states implemented a single, statewide PDL while keeping the pharmacy benefit within managed care. MCOs retain their PBM relationships and bear financial risk for the pharmacy benefit, but they are contractually required to follow the state's PDL, PA criteria, and reimbursement rules. In one of these states, MCOs and PBMs are statutorily prohibited from collecting their own supplemental rebates, preserving that authority for the state. Implementation dates ranged from 2012 to 2024.

Single Pharmacy Benefit Administrator

One state implemented a centralized pharmacy benefit administrator (PBA) model, in which a single vendor processes all pharmacy claims and manages point-of-sale PA under the state's clinical rules, while MCOs retain financial responsibility for the pharmacy benefit. Under this model, MCOs receive claims data for care management purposes but no longer adjudicate pharmacy claims or manage separate PA processes. The PBA reimburses pharmacies using state-driven logic, including actual acquisition cost and National Average Drug Acquisition Cost, as opposed to using a traditional pharmacy network that relies on AWP *minus* % averages by drug channel (e.g., generic drug products at community pharmacies). The state accomplished this by amending its existing fiscal agent contract rather than issuing a new procurement.

Single PDL and Single PBM

One state implemented both a single PDL and a single PBM in a phased approach, launching the PDL first and the PBM approximately 2 years later. This state's formal post-implementation analysis represents the most rigorous cost-savings evidence among the interviewed states.

Managed Care With Single PBM Planning Phase

One state is currently in the planning and procurement phase, designing a single PBM model as part of a broader transition from FFS to comprehensive managed care, with a target go-live of 2029.

Key Findings

1. Rationale for Consolidation

Nearly every state interviewed cited *supplemental rebate optimization* as a primary or leading driver for pharmacy benefit consolidation. Additional motivations varied but clustered around several consistent themes.

Supplemental Rebate Capture

When MCOs independently manage formularies, they negotiate their own rebates, which are typically reflected in reduced capitation rates rather than generating direct state revenue. By consolidating covered lives under a single PDL, states can negotiate supplemental rebates directly with manufacturers at significantly higher volumes. Five states cited this as the primary financial rationale for consolidation. One state specifically noted that decentralization could have resulted in the loss of an estimated 60% of historical rebate collections.

Addressing PBM Transparency and Spread Pricing

One state's experience was particularly instructive. In the 2010s, it became a national example of problematic PBM behavior, with analyses revealing that significant portions of Medicaid administrative spending were flowing to PBM profit margins through spread pricing. This accelerated pharmacy closures, particularly in high-Medicaid areas. That state's subsequent single PBM implementation directly addressed these practices by setting a statewide standard reimbursement logic and increasing dispensing fees to $10 per claim, resulting in pharmacy satisfaction rates quadrupling from approximately 10%–15% to 50%. Another state's early carve-out design eliminated spread pricing from the outset, thereby avoiding the need for later corrective action. A third state found that oversight of multiple PBMs was difficult due to complex corporate structures—particularly when an MCO and its PBM shared the same parent company—and concluded that the multiple PBM model did not align with the goals of its Medicaid managed care system.

Provider and Beneficiary Experience

Multiple states emphasized that provider frustration with managing multiple formularies was a significant motivator for reform. When providers must navigate different PDLs across multiple plans, administrative burden increases and prescription adjudication becomes more complex. A single PDL also ensures continuity of drug access, even when members change plans—a particularly relevant consideration in Medicaid, where enrollment churn is common. One state specifically noted that pharmacists were navigating multiple routing combinations, clinical and PA protocols, and administrative approaches across its 3 MCOs. After consolidating to a single claims processor, PDL compliance increased to 97%–99%, and there was a substantial decrease in provider calls, appeals, and complaints. The increase in PDL compliance also led to increases in supplemental rebates for the state.

Reducing the Need to "Police" MCO Behavior

Two states noted that, prior to consolidation, MCOs would sometimes send provider communications that conflicted with the statewide PDL; for example, recommending an alternative drug despite the preferred status of another. Full consolidation addressed this issue by centralizing formulary communications and removing MCOs from the adjudication process. One state reported that the administrative burden of enforcing MCO compliance with the universal PDL and PA criteria decreased significantly after moving to a single PBA.

Oregon Implication:

With 16 CCOs operating 13 different PDLs, Oregon is likely experiencing fragmentation challenges similar to those that motivated other states to act. The state may also be leaving

substantial supplemental rebate revenue uncaptured; providers may be navigating significant formulary complexity, and beneficiaries may experience disruptions when changing CCOs.

2. Cost-Savings Evidence and Financial Analysis

The rigor of pre- and post-implementation financial analysis varied considerably across states.

Pre-Implementation Analysis

Most states did not conduct comprehensive, drug-by-drug cost-savings analyses before implementation. A significant barrier was the proprietary nature of MCO-specific rebate data, which prevented direct comparisons. Individual state approaches relied on consulting reports that showed MCOs were consistently paying higher rates to Pharmacy Benefit Managers for pharmacy claims than FFS. States also engaged actuaries for informal analyses projecting tens of millions in savings, conducted repricing analyses by reprocessing managed care claims under FFS mechanisms and modeling supplemental rebate opportunities, and relied on aggregate rebate projections and historical trend growth. One state conducted an internal feasibility analysis comparing its multiple PBM administrative costs against a single-vendor model, estimating a 75%–80% reduction in administrative costs and at least $3.2 million in annual savings. Several states noted that the inability to access MCO rebate data inherently limited the precision of pre-implementation projections.

Post-Implementation Evidence

The most rigorous post-implementation analysis came from a state that implemented both a single PDL and single PBM. That state engaged actuaries to compare actual pharmacy costs against a counterfactual estimate of costs under the prior MCO-managed system. The analysis identified $140 million in net savings over the first 2 years, including $333 million in administrative cost savings. The same state documented a $400 million increase flowing to retail pharmacies through higher dispensing fees (from $0.73 per claim under MCOs to $10.00 per claim under the state program), funded in part by recapturing excess specialty drug margins on the ingredient drug cost. That state also reported a fourfold increase in pharmacy satisfaction and a net gain in independent community pharmacies, particularly in high-Medicaid areas where higher dispensing fees improved financial viability.

Other states reported that supplemental rebate collections increased substantially over time, though savings sometimes lagged the initial implementation period due to expansion of the PDL over time, and the lag between when utilization is incurred under a new rebate agreement and when rebate revenue is received. The state with the longest-running carve-out reported stable drug spend growth of approximately 2.2%–2.5% annually. The state that implemented a single PBA via fiscal agent amendment reported that the 75%–80% administrative cost-savings estimate had not been independently verified post-implementation, but that the operational improvements (e.g., fewer provider calls, higher PDL compliance, reduced enforcement burden) were consistent with the projected gains. No state reported negative financial outcomes from consolidation for the Medicaid program.

Oregon Implication: The Oregon Health Authority has recently commissioned an actuarial analysis that will model rebate capture opportunities under consolidation scenarios, recognizing that precision will be limited by proprietary CCO/PBM rebate data. If Oregon pursues a single PDL or PBM, the state should consider building in an evaluation framework at the outset, including

establishing a baseline counterfactual to enable future comparisons. The state may also want to engage with local community pharmacies regarding traditional pharmacy network pricing, creating a set reimbursement logic, and pharmacy dispensing fees to address pharmacy deserts in the state.

3. 340B Policy: Approaches, Challenges, and Revenue Implications

The treatment of 340B-covered entities emerged as *the single most complex and politically sensitive policy area* across all interviews. Every state has grappled with how to balance 340B entity interests against Medicaid's need to maximize rebate capture, and their approaches vary significantly.

Core 340B Policy Tensions

A key policy decision states face is determining how the benefit of 340B discounting is distributed between 340B-covered entities and the state. When a 340B-covered entity dispenses 340B-designated stock (e.g., a prescription) to a Medicaid beneficiary, the state generally cannot claim a rebate on that claim (42 CFR §447.509). The Medicaid Drug Rebate Program and the 340B program are two separate federal programs, but the discounts are considered the same by manufacturers, therefore only one program can capture the discounted savings net pricing (if both the Medicaid program and the 340B entity capture the savings, this is commonly considered 'double dipping'). States have two primary policy levers to influence the distribution of 340B savings between covered entities and the State—reimbursement methodologies and 340B use prohibitions (select carveouts). Reimbursing above a covered entity's actual acquisition cost transfers some to all of the benefit of 340B discounting to the covered entity. 340B entities often rely on the margin between their acquisition cost and reimbursement to fund safety-net services across all payer types, while the Medicaid Drug Rebate Program only impacts Medicaid beneficiaries. Since Medicaid is generally viewed as a state safety-net program, many states focus on capturing the full benefit of 340B discounting, which can cause significant tension with 340B-covered entities.

Operational constraints and impacts on 340B covered entities and the communities they serve are key considerations when evaluating 340B discounting benefit capture.

Reimbursement Methodologies

States' reimbursement methodologies directly determine who accrues the benefit of 340B discounting, but policies may differ between FFS and managed care. In FFS, states are required to cap 340B drug reimbursement at the 340B ceiling price. This effectively ensures that the states capture at least a portion of the benefit of 340B discounting because there is less or no spread between the acquisition cost and Medicaid reimbursement for a 340B covered entity to capture; however, when covered entities negotiate prices lower than 340B ceiling prices, they may still retain a significant spread unless states additionally implement policies to ensure providers are paid at their invoiced price.

In managed care, states have greater flexibility with 340B reimbursement policy as 340B stock does not necessarily need to be capped at the 340B ceiling price. States have adopted various reimbursement methodologies beyond traditional PBM network rates, including 340B ceiling price; actual acquisition cost plus dispensing fee (based on state-specific pharmacy surveys); and approximations of acquisition cost derived from the state's own analysis of ceiling prices

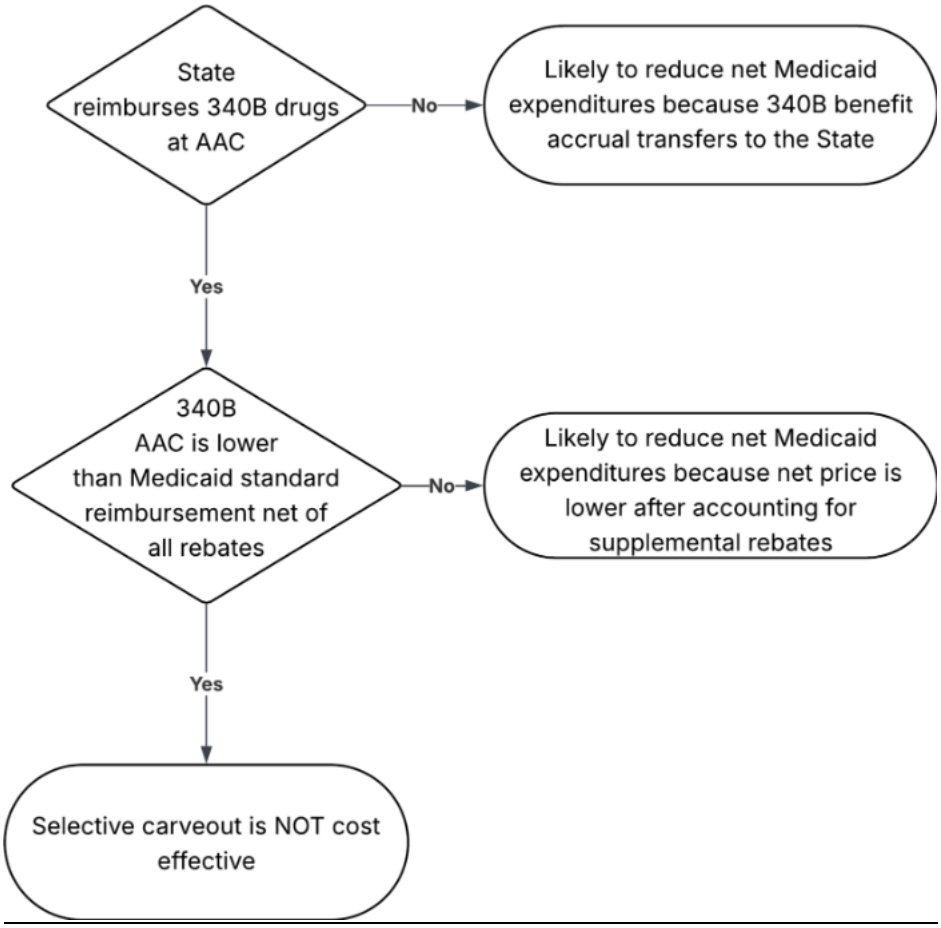
(approved via State Plan Amendments). In states where MCOs bear pharmacy risk, some have required MCOs to adopt the same adjudication logic used in FFS (340B ceiling price). One state currently reimburses 340B entities using a self-reported actual acquisition cost (AAC) methodology, but is considering implementing system edits to enforce 340B ceiling price reimbursement caps after a preliminary analysis identified potential overpayments of approximately $3 million annually (suggesting covered entities were not billing their actual acquisition cost and capping reimbursement at the 340B ceiling price would mitigate losses from inappropriate billing); the state also plans to conduct audits to validate prior payments.

Selective Carve-Outs

States have the option to prohibit specific drugs or entity types from using 340B stock. This allows the state to collect standard federal rebates and state supplemental rebates on the utilization. Two states have pursued selective carve-outs of specific drugs or entity types from 340B. One is developing regulations to carve preferred PDL drugs out of 340B to capture supplemental rebates, with gene and cell therapies already carved out. Another passed budget provisions differentiating by entity type: hospitals may use 340B drugs but are reimbursed at the ceiling price (or may elect not to use 340B and have the state claim rebates); contract pharmacies are banned for hospital-covered entities; and grantees (FQHCs, disease clinics) were not affected. The latter state's negotiations on this provision took approximately 8 months and involved extensive consultation with peer states.

Whether the total net Medicaid expenditure is higher or lower when using this strategy depends on the state's reimbursement methodology and if the covered entity has acquisition costs below the state's net reimbursement after accounting for supplemental rebates. There is ample evidence that covered entities can negotiate prices below the 340B ceiling price, but whether these prices are lower than what the state would otherwise pay depends on the size of state supplemental rebates for a drug. The logic map below illustrates the financial outcome for the state and providers under different scenarios.

Diagram 1: Impact of Select Carveouts on Net Medicaid Expenditures



Provider Revenue Return

One large state took a distinctive approach by returning a significant portion of 340B savings to eligible providers by distributing the 340B value as spending grants to Federally Qualified Health Centers (FQHCs), hospitals, and Ryan White facilities. This approach reduced perceived risk for smaller safety-net entities and provided predictable disbursements. The state used this strategy both to soften opposition and to ensure that savings flowed to safety-net care, rather than being absorbed entirely by the Medicaid program or diverted through third-party administrator fees.

Claim-Level Identification

Because 340B covered entities may use a combination of 340B and non-340B stock, not all drug claims from a 340B-covered entity are ineligible for rebates. To ensure their Medicaid programs are invoicing for all applicable rebates, most states interviewed require 340B entities to identify drug claims submitted using 340B stock at the point-of-sale using claim-level indicators (e.g., note 20 on pharmacy claims and UD modifiers on medical claims). This allows for differentiation between 340B and non-340B claims for appropriate reimbursement and rebate adjudication.

One state transitioned from an all-or-nothing approach, where all claims from carved-in providers were treated as 340B, to a claims-level approach, gaining precision in rebate collection but also

increasing disputes as manufacturers scrutinized individual claims. Another state mandated claim-level identification after discovering that many pharmacies were not recording 340B modifiers under a voluntary system. A third state has required claim-level indicators since 2012 and uses the modifier to pay at the ceiling price (capturing the 340B value at point-of-sale); this requires 340B entities to ensure they are appropriately logging 340B claims and working with manufacturers on disputes as opposed to the state working through the post-adjudication rebate process to capture the savings. A fourth state implemented system-level flagging of covered entities during claims adjudication, allowing 340B entities to either pass on the value at point-of-sale or decide to not use 340B stock on Medicaid patients.

Stakeholder Dynamics

340B policies that reduce provider-capture of 340B pricing spread consistently provoke the strongest stakeholder opposition. One state experienced aggressive tactics, including picketing at Medicaid board meetings, disruption of legislative hearings, and organized mobilization. Another state faces recurring legislative attention, with annual bills. Multiple states noted that larger hospital systems are the primary source of organized opposition, while smaller safety-net providers (e.g., FQHCs and Ryan White clinics) tend to be less adversarial and, in some cases, pass discounts through to Medicaid beneficiaries. States that engaged 340B stakeholders early—using clear financial data and differentiated approaches by entity type—reported more manageable opposition. One state reported initial pushback from hospital pharmacies when reimbursement methodology changed, but no sustained opposition after the transition was complete.

Oregon Implication: 340B policy will be among the most consequential and politically sensitive decisions the state considers. If Oregon pursues a single PDL or PBM, the state should develop a clear 340B strategy early, informed by the range of approaches described above. Key decisions include whether to require claim-level identification, which reimbursement methodology to apply to 340B claims, whether to implement selective carve-outs for high-rebate drugs, and how to address different entity types (hospitals vs. FQHCs). Currently, OHA captures 340B claims from contract pharmacies (e.g., community pharmacies that have been granted 340B access from 340B entities) through a process standardized by their FFS vendor, Gainwell. This process relies on the current post-adjudication rebate process, where 340B claims are removed by Gainwell at the claim level. For 340B covered entities, the entire entity's claims are removed from the rebate process; therefore, removing claims that were not 340B stock and could be eligible for a rebate. OHA is working on aligning the 340B entity process to the contract pharmacy process, therefore only removing 340B claims from rebates and not the entire entity's claims – thus increasing state rebate values. However, an overall 340B shared savings model that returns at least a portion of savings (e.g., the higher upfront ingredient costs that is currently being paid on 340B claims that cannot be submitted for rebates) to providers may offer a politically viable path. Early, transparent engagement with 340B stakeholders, with clear data on financial impacts, is essential to successful policy development and managing opposition.

4. Legislative and Regulatory Authority

The legislative and regulatory pathways varied across states, reflecting different political dynamics and statutory frameworks. However, several consistent patterns emerged.

Most states required some form of legislative action to implement pharmacy benefit consolidation, though the scope ranged widely. In some states, broad statutory mandates directed the move to consolidated pharmacy management as part of larger Medicaid restructuring efforts. In others, targeted legislation specifically required a single PDL or a single PBM. One state was able to implement a single PDL through a contract amendment with its existing vendor, requiring no new statutory authority for that initial step; however, the subsequent move to a single PBM required legislation. Another state implemented its carve-out via a Medicaid waiver rather than statute. One state received a legislative directive to assess the feasibility of a single PBM vendor and, upon finding it favorable, implemented the change by amending its existing fiscal agent contract without requiring additional legislation.

Implementation timelines imposed by legislatures also varied substantially. One state was given only 6 months between legislation and required go-live, creating a compressed and challenging implementation period. Others had years between legislative directive and implementation, in some cases because waiver approvals or other administrative prerequisites extended the timeline.

Political dynamics shaped outcomes in important ways. In one state, the governor vetoed the single PBM component of a legislative directive while allowing the single PDL to proceed. In another, MCOs and pharmacy stakeholders contested the design through the legislative process, with MCOs pushing to manage pharmacy themselves and pharmacies advocating for FFS. The final program design reflected compromises reached through that process.

Oregon Implication: If Oregon pursues a single PDL or PBM, the state will need to assess what authority exists under current statutes and CCO contract language, and identify any gaps requiring legislative action. Other states' experiences suggest that early legislative engagement is critical, that political dynamics can shape which elements of consolidation proceed, and that the legislative process itself may become a forum for stakeholder opposition. Building legislative support proactively, before formal proposals are introduced, was a consistent recommendation. One state's experience implementing changes via a fiscal agent contract amendment demonstrates that some consolidation approaches may be achievable within existing contractual authority.

5. Implementation Timeline and Phasing Strategy

Implementation timelines ranged from 6 months to multiple years. States that allowed more time consistently reported better outcomes and fewer operational disruptions.

Timeline Ranges

The state with the most rigorous post-implementation data took 18 months from vendor selection to single PBM go-live and considered this the minimum viable timeline. Another state in the planning phase is budgeting at least 12–18 months from acquisition to implementation, citing a peer state's difficulties with a timeline under 12 months. The state with the most compressed timeline (6 months from legislation to go-live) managed the transition through intensive coordination but described it as a significant challenge. One state used a 2-year delay between operational readiness and go-live productively for stakeholder engagement, which proved valuable in reducing opposition. The state that pursued a fiscal agent contract amendment reported approximately 1 year from planning initiation to implementation, though earlier legislative direction to assess feasibility had preceded that planning by roughly 2 years.

Phased Rollout

One state's experience provides a detailed model for phased implementation. It initially planned to implement many drug classes simultaneously, but scaled back and spread implementation across multiple quarterly rollouts over approximately 2.5 years, ultimately building a comprehensive PDL covering nearly 800 drug classes. That state recommends prioritizing drug classes with the largest rebate or savings opportunities in early phases to demonstrate impact and build institutional momentum. Planning windows of 120–180 days per phase were recommended for coordinating clinical decisions, operational configuration, PBM implementation, and communications.

Sequencing Considerations

Multiple states recommended implementing a single PDL before moving to a single PBM, reasoning that this approach aligns prescribers and MCO expectations and reduces subsequent pushback when the PBM transition occurs. The state with the most rigorous financial data followed this sequence, implementing the single PDL approximately 2 years before the single PBM, with the PDL serving as a foundation for later operational consolidation. However, 1 state offered a contrasting perspective: its officials noted that phasing PDL implementation across multiple MCOs and PBMs can produce heavy coordination burdens and provider confusion, and that a simultaneous "big switch" approach—consolidating the PDL and claims processing at the same time—may be preferable in some circumstances. The data elements (e.g., claims encounters and utilization management, including PAs) of sharing files nightly and weekly, across all entities, were a significant lift for many state agencies.

Oregon Implication: If Oregon pursues a single PDL or PBM, the state should plan for a minimum 18-month implementation timeline from procurement (or directive) to go-live, with quarterly phase-ins of drug classes prioritized by rebate opportunity. Oregon may be uniquely positioned to support such an approach, as it has already led a statewide PBM procurement that is authorized under statute to serve managed Medicaid entities, creating a unique pathway for broader alignment.

6. Staffing and Administrative Infrastructure

Every state emphasized that *adequate internal staffing is essential*, even when vendors provide substantial operational support. States that underestimated staffing needs experienced operational strain, delayed reviews, and reduced oversight capacity.

Staffing Levels Across States

The range of pharmacy team sizes across the 9 states was significant, reflecting differences in program size, model type, and vendor reliance. At the lower end, one state operated with just 2 staff (1 pharmacist and 1 operations person), in addition to their Chief Pharmacy Officer, and acknowledged this was insufficient—recommending 3–5 dedicated staff for sustainable PDL management. Another state began its single PBM implementation with 3 pharmacists and found this inadequate, ultimately tripling to 9 pharmacists.

Mid-range states operated with teams of 8–12 staff, typically including 3–4 pharmacists and a mix of operational, rebate, and administrative support positions. One state specifically created a dedicated liaison role to triage the high volume of daily operational questions between the state and MCOs during implementation—a role multiple states identified as essential. The state that implemented a single PBA through a fiscal agent contract amendment reported that internal

staffing did not increase significantly, as the vendor absorbed the PA adjudication workload by hiring pharmacists for the PA unit; however, the state retained responsibility for formulary and DUR oversight with its existing small team and noted a current vacancy to be filled.

A Medicaid-specific Chief Pharmacy Officer or Director of Pharmacy, who is a trained pharmacist, was highlighted by states as a key ingredient in the implementation of a single PDL or single PBM. This individual usually led the implementation of the program's vision and provided key leadership across the Medicaid agency.

Critical Roles and Functions

Clinical pharmacy staff were consistently identified as the most critical resource needed for PDL development, PA criteria, DUR, clinical edit creation, and vendor oversight. Operational staff for claims reconciliation, data management, and systems configuration were also highlighted. Beyond state staff, vendor-provided resources played an important supplementary role. Two states specified required vendor account team structures in their contracts, including dedicated clinical pharmacists, ensuring continuity regardless of vendor personnel changes.

PA Migration

Multiple states identified PA conversion as one of the most technically complex aspects of implementation and the most critical to beneficiaries' continuity of care. One state reported that converting existing PAs from multiple MCO systems to a single processor was critical to a smooth transition and recommended investing in a robust migration strategy with dedicated subject-matter expertise. Another state found that MCO-transferred PA data was incomplete, requiring a temporary suspension of PAs and contributing to a utilization increase during the transition period. The temporary suspension of PAs can lead to 'grandfathering' (e.g., allowing patients to use non-preferred products without switching if they are already established); this can lower PDL compliance and, in turn, lower supplemental rebates.

Oregon Implication: If Oregon pursues a single PDL or PBM, the Oregon Health Authority should assess its current pharmacy operations capacity and realistically plan for building a dedicated pharmacy oversight team; this should include increasing capacity with clinical pharmacists and pharmacy administrative professionals, supplemented by vendor-provided clinical and operational resources. The experience of one state tripling its pharmacy team from 3 to 9 pharmacists is particularly instructive. A dedicated liaison role for CCO coordination should also be considered early in the implementation process. Staffing investments should be front-loaded rather than reactive.

7. Stakeholder Engagement and Communication Strategy

Every state identified stakeholder engagement as a *critical success factor*. The depth and sophistication of engagement strategies varied, with states that invested more heavily in communication reporting smoother implementations and less disruptive opposition.

Communication Volume and Frequency

The most intensive engagement model among states involved monthly stakeholder calls with Q&A sessions for real-time questions, transparent coverage comparisons published as public materials, and a centralized repository of all communications and analyses. That state also rebranded its Medicaid pharmacy program with a consumer-facing name to emphasize continuity of care for

beneficiaries rather than administrative restructuring. Another state held daily meetings with national pharmacy association partners during implementation; these partners served as real-time operational monitors, reporting issues from the ground and enabling problem resolution within hours. That same state met with independent pharmacy partners weekly for bidirectional communication.

Tailored Messaging

Multiple states emphasized the importance of tailoring communications to different audiences:

- Providers responded to messaging about reduced administrative burden from a single formulary
- Enrollees responded to messages about continuity of drug access
- Legislators required data on cost savings and program integrity
- MCOs and PBMs needed technical specifications and real-time operational clarity
- 340B entities needed financial impact data

Dedicated Engagement Resources

One state built a dedicated education and outreach team of pharmacists, pharmacy technicians, and administrative staff that focused on transition assistance for special populations. These relationships shifted the dynamic with many stakeholders from adversarial to collaborative and created long-term collaboration between Medicaid and its partners. Several other states created dedicated liaison or coordinator positions to manage the volume of daily operational questions during and after implementation. These roles were consistently identified as high-value investments.

Provider Transparency During Clinical Deliberations

One state emphasized the value of maintaining transparency to providers during PDL and DUR deliberations—specifically, showing clinical and fiscal analyses during Pharmacy and Therapeutics (P&T) committee meetings to build provider trust and support. That state found that when providers understood the clinical and financial rationale behind formulary decisions, they were more likely to support the consolidated approach.

Managing Opposition

Opposition is expected and should be planned for. Effective countermeasures included transparent data-sharing showing where value was flowing under the current system, proactive outreach before formal proposals, consistent and frequent communication that maintained the state's framing of the change, and executive-level engagement when operational disputes escalated. The state with the longest-running carve-out emphasized that legislative engagement was critical, as lawmakers became a primary forum for challenge and scrutiny. One state reported that after consolidation, "no news was good news"—the significant decrease in provider calls and complaints signaled that the transition had resulted in smoother operations.

Oregon Implication: If Oregon pursues a single PDL or PBM, the state should consider developing a comprehensive stakeholder engagement plan, supported by adequate staffing and dedicated engagement professionals, well before implementation.

Oregon should build on the state's existing efforts to support critical access pharmacies. Engaging local community pharmacies early, particularly around traditional pharmacy network pricing, standardized reimbursement logic, and pharmacy dispensing fees, would help the state continue addressing pharmacy deserts and strengthen access in underserved areas.

Stakeholder work should also include regular forums (monthly or more frequently during implementation), audience-tailored messaging for CCOs, pharmacies, providers, 340B entities, and enrollees, a centralized repository of public-facing materials and analyses, dedicated liaison or outreach roles, transparent data-sharing on formulary impacts and financial rationale, and early and sustained engagement with the legislature.

8. Vendor Contracting and Oversight

Robust vendor contract design emerged as one of the most emphasized themes across all interviews. States consistently reported that weak or ambiguous contract language created costly problems, while strong contracts provided the leverage needed for effective program management.

Key Contract Provisions

- **Service-Level Agreements (SLAs) With Liquidated Damages:** Multiple states emphasized including specific timelines, service-level expectations, and financial penalties for untimely or incorrect vendor actions. One state noted that vendor delays or errors carry significant cost consequences, and without contractual penalties, states have limited recourse. Another state in the planning phase is building SLAs and liquidated damages into its single PBM contract, enforced through state contracts rather than relying on inter-contractor penalties.
- **Anti-Spread Pricing Protections:** States addressed spread pricing through different mechanisms. One state's original contract design eliminated it from the outset. Another implemented a single PBM specifically to end documented spread pricing abuses. A third prohibited MCOs from collecting supplemental rebates by statute, removing the financial incentive for spread pricing.
- **Cross-Contract Alignment:** States with both PBM and MCO contracts emphasized the importance of ensuring alignment between the two. Without explicit coordination requirements in both contract sets, operational conflicts arise that the state has limited ability to resolve. Two states required explicit contract language enforcing cooperation between PBMs and MCOs.
- **Required Vendor Staffing:** Two states specify required vendor account team structures and dedicated clinical pharmacist counts in their PBM contracts, ensuring the state's operational capacity was extended, regardless of internal vendor staffing decisions.
- **Reporting and Data Exchange:** States that require MCOs to mirror a state PDL emphasized the importance of regular data exchange. Approaches included weekly formulary files, daily NDC-level files, and encounter data editing to verify PDL adherence. One state help weekly meetings with its PDL vendor for ongoing monitoring. The state that implemented a single PBA provided MCOs with read-only access to claims data and daily/weekly PDL and claims extracts, enabling MCOs to continue care management and participate in DUR/P&T meetings while the state retained control over adjudication and cost data.

- **Leveraging Existing Contracts:** One state chose to amend its existing fiscal agent contract rather than issue a new RFP, reasoning that the vendor already had in-depth knowledge of the state's expectations and the experience of winning a similar procurement in another state. This approach reduced administrative complexity and procurement timelines. The implementation cost was approximately $3.5 million with ongoing operations of approximately $2 million per year.

Enforcement Lessons

One state's experience illustrates the risks of relying on broad contract leverage alone. When MCOs tested the boundaries of the state's service level requirements, the state found it lacked targeted enforcement tools. Executive-level escalation (CEO-to-CEO discussions) eventually resolved issues, but the state recommended building specific contractual remedies for priority items from the outset, rather than relying solely on general contract leverage.

Oregon Implication: If Oregon pursues a single PDL or PBM, the state should invest heavily in contract design before implementation. Contracts should include SLAs with financial penalties for untimely or incorrect actions, anti-spread pricing provisions, specified vendor staffing requirements, mandatory data exchange protocols and reporting, and explicit coordination requirements between vendors and CCOs. The PBM contracts developed by states with the longest-running and most successful programs may serve as useful templates. Oregon should also evaluate whether existing contractual relationships could be leveraged to reduce procurement complexity.

9. Multi-Agency Purchasing and Longer-Term Strategic Vision

Several states discussed the potential for expanding consolidated purchasing beyond Medicaid to other state agency drug purchasing, as well as participation in multi-state purchasing pools.

Two states expressed ambitions to extend consolidated purchasing to public employee plans, retirement systems, or corrections pharmacy. One has an active initiative exploring a single PBM encompassing multiple state purchasers, though it remains in the research phase. Another state with the longest-running single PBM program noted that its Medicaid PBM contract has been used as a model by other state agencies when procuring pharmacy benefits for other populations. Two states have explored broader consolidation multiple times but consider it currently too complex to pursue.

Oregon Implication: While the immediate focus would most likely be on Medicaid pharmacy consolidation, Oregon could consider designing the infrastructure to accommodate future expansion. If the state builds a single PDL and/or PBM for OHP, the same platform could potentially be extended to other state agencies.

Critical Considerations for Oregon

If Oregon pursues a single PDL or PBM, based on the synthesis of all 9 state Medicaid interviews, the state should thoroughly examine the 8 critical considerations below.

1. Commission a financial analysis with a built-in evaluation framework [In process]. Conduct a financial analysis that models rebate capture opportunities, including a reasonable lag period

before any new rebates would be actualized, along with the costs of enhanced staffing. Simultaneously, establish a baseline and methodology for any post-implementation evaluation.

2. Develop a 340B strategy early and transparently. Identify Oregon's current 340B landscape, model the rebate revenue implications of different policy approaches, and engage stakeholders early with clear data. Consider differentiated treatment for hospitals versus safety-net covered entities and evaluate whether returning a portion of savings to providers would be politically and programmatically appropriate.

3. Consider a phased approach, starting with a single PDL. Implement a statewide PDL requirement for all CCOs as the first step, followed by evaluation of further PBM consolidation. Prioritize drug classes with the largest rebate or savings opportunities. This sequencing can reduce initial disruption, align stakeholder expectations, and build the operational foundation for deeper reform. Multiple states followed this sequence successfully.

4. Plan for an 18–24-month implementation timeline. Based on multi-state experience, Oregon should allow a minimum of 18 months from policy directive to go-live, with longer timelines preferred. A phased rollout, prioritizing drug classes with the highest rebate capture opportunities may be effective.

5. Assess and build out current pharmacy staffing capacity before implementation, and not after. Oregon should assess its current pharmacy capacity and realistically plan for building a dedicated pharmacy oversight team (led by a Chief Pharmacy Officer with clinical experience), with additional clinical pharmacists, and state pharmacy program staff supplemented by vendor-provided clinical and operational resources. States that started with minimal staffing consistently found it insufficient. A dedicated CCO liaison role should be established early. PA migration should be treated as a critical workstream requiring dedicated subject matter expertise.

6. Design robust contracts with specific enforcement mechanisms. Develop detailed contract requirements including SLAs with liquidated damages, anti-spread pricing provisions, mandatory data-exchange protocols, vendor staffing requirements, and explicit CCO/PBM coordination obligations. Evaluate whether existing contractual relationships can be leveraged to reduce procurement timelines and administrative complexity.

7. Launch a comprehensive stakeholder engagement campaign. Develop a multi-audience communication plan well in advance of implementation. Include regular forums, transparent data sharing, consumer-facing messaging, dedicated outreach staff, and early legislative engagement. Maintain transparency during clinical deliberations to build provider trust.

8. Engage the legislature early and strategically. Identify the statutory or regulatory authority needed and begin legislative conversations before formal proposals. Frame the initiative around beneficiary access, cost savings, and program integrity. Be prepared for organized opposition and develop responsive materials in advance.

Appendix A: Interview Questions

SMART-D – State PDL/PBM Interview Questions

1. How would you describe the impetus behind your state's efforts to move to a single PDL/PBM?

2. What cost savings analysis, if any, was done prior to the state's implementation?

3. What cost savings analysis, if any, has been done post implementation?

4. What, if any, state regulatory and/or statutory authority was needed to make the move?

5. Can you describe the necessary administrative infrastructure (i.e., number and type of staff) that was needed to support this new work?

6. Approximately how long did it take the state to implement a single PDL/PBM?

7. How did your state address 340B covered entities with this move? Has your state addressed 340B passthrough pricing with 340B covered entities?

8. What would you consider to be the top 2-3 key implementation lessons learned or considerations for other states?

9. Does your state have a longer-term vision that includes other state agencies related to pharmacy alignment/purchasing