COALITION FOR A HEALTHY OREGON

Oregon's Voice for Community Based Health

Oregon State Legislature
House Committee on Health Care
900 Court St NE
Salem, OR 97301

Submitted Electronically

February 3, 2026

Testimony in Opposition to HB 4003

Chair Representative Rob Nosse, Vice-Chair Representative Ed Diehl, Vice-Chair Representative Travis Nelson, and Members of the Committee:

For the record, my name is **Henry T. O'Keeffe**, and I am the vice-president of Health Care Policy at the **Pac/West Lobby Group**. I represent the **Coalition for a Healthy Oregon (COHO)**, which includes seven coordinated care organizations (CCOs) serving more than **450,000 Medicaid members** through the **Oregon Health Plan**: **Advanced Health**, **AllCare CCO**, **Cascade Health Alliance**, **InterCommunity Health Network Coordinated Care Organization**, **Trillium Community Health Plans**, **Umpqua Health Alliance**, and **Yamhill Community Care**. I urge you to vote no on **HB 4003** and any amendments we have seen to date.

Whether we pass **HB 4003** or not, **ORS 414.694**—which requires the **Oregon Health Authority (OHA)** to use a funding line on the **Prioritized List of Health Services** to determine Medicaid coverage—will no longer apply to Oregon's Medicaid program after our **1115 waiver** expires on **December 31, 2026**. In this testimony, I will first review the communications between OHA and the **Centers for Medicare & Medicaid Services (CMS)** showing that CMS supports Oregon making minimal administrative changes to comply with federal rules, without needing new legislation. Next, I will explain why **HB 4003** is unnecessary because OHA can handle this transition through existing rules and processes. Then, I will discuss key federalism principles from U.S. Supreme Court rulings that prevent the federal government from forcing states to pass or repeal specific laws, including how preemption works to override conflicting state laws without requiring legislative action. Finally, if lawmakers choose to take legislative action, I will describe COHO's proposed amendment to **HB 4003**, which aligns with CMS guidance by preserving evidence-based coverage without a funding line. In the end, **ORS 414.694** will be outside Oregon's Medicaid framework either by statute if **HB 4003** passes or through federal preemption if we maintain the status quo.

CMS Guidance Supports Minimal Administrative Changes, Not Legislation

The communications between OHA and CMS make clear that Oregon can transition away from the funding line with minimal changes, using the **Prioritized List** to guide medical necessity decisions under state plan authority. (**See COHO-CMS-OHA Corespondance.pdf**)

In an email dated **December 23, 2025**, **Emma K. Sandoe** from OHA asked CMS for clarification on whether Oregon could port the **Prioritized List** to a state plan amendment (SPA) or, if not, continue using it as a clinical guidance list without a funding line to comply with **Special Term and Condition (STC) 13.9** of the **1115 waiver** (Sandoe/12-23-25).

CMS responded on **January 20, 2026**, affirming that while direct porting with a ranking and funding line isn't allowed, the state can use the list to inform medical necessity criteria, deferring to Oregon on its processes like those of the **Health Evidence Review Commission (HERC)** (CMS/1-20-26).

A follow-up from CMS on **January 21, 2026**, confirmed that the **Prioritized List** can still guide medical necessity, with coverage and denials authorized through the state plan (CMS/1-21-26). Technically, this means denials based on limited evidence of efficacy—similar to services below the current funding line—can continue if tied to Oregon's definition of medical necessity in **ORS 414.065** and **OAR 410-141-3830**, without referencing a funding line. CMS emphasized deference to the state, aligning with OHA's goal of minimal changes to avoid disrupting members, providers, and CCOs.

HB 4003 is Unnecessary: Preserve Evidence-Based System Administratively

There is simply no need for **HB 4003** because Oregon can preserve its evidence-based Medicaid system through administrative actions alone. For decades, the **Prioritized List**, developed by HERC under **ORS 414.690**, has guided cost-effective, evidence-based coverage. OHA has cited CMS correspondence to justify **HB 4003**, which repeals **ORS 414.694** and amends other statutes to remove the list entirely. But CMS's responses actually support small changes, not a full legislative overhaul. (**See COHO-Admin-Solutions.pdf**)

CMS says the state can keep using the **Prioritized List** to guide medical necessity criteria, respecting Oregon's evidence reviews. Denials for services with limited efficacy can continue if linked to state-defined necessity rules. OHA's fallback plan—relying on HERC for clinical policies, outlining benefits in the state plan, and basing decisions on necessity without a funding line—got a clear "yes" from CMS. This can happen through existing rules and manuals, keeping HERC's transparent process intact. The waiver's **STC 13.9** requires phasing out the funding line by **December 31, 2026**, but CMS confirms this approach meets federal rules without risking funding or SPA denials. Rushing **HB 4003** could expand coverage without budget controls, straining resources and disrupting care—contrary to OHA's own aim for minimal changes.

Federal Law Prohibits CMS from Forcing State Legislation

Federal law and Supreme Court rulings make clear that the federal government, including agencies like CMS, cannot force Oregon to pass or repeal specific laws like **HB 4003**. The U.S. Constitution sets up a system called **federalism**, which splits power between the national government and states to protect freedom and keep governments accountable. The **Tenth Amendment** says any powers not given to the federal government belong to the states or the people. (**See COHO Federalism Memo.pdf**)

A key rule, called the **anti-commandeering doctrine**, stops the federal government from taking over state legislatures or officials to do its work. In **New York v. United States (1992)**, the Court said Congress can't force states to pass laws for federal programs, like handling radioactive waste. **Printz v. United States (1997)** extended this to state officials, striking down a law-making local sheriffs do federal gun checks. **Murphy v. National Collegiate Athletic Association (2018)** ruled that even

banning states from allowing sports betting is a command, because Congress can't order states around—it has to regulate people directly. Agencies like CMS can't do this either, as **Youngstown Sheet & Tube Co. v. Sawyer (1952)** says the president (and agencies) can only act based on laws or the Constitution, not make up rules to force states.

Preemption ties into this: federal law can override conflicting state laws under the **Supremacy Clause**, but only if it regulates private people or businesses directly, not by telling states what laws to pass. In **Murphy**, the Court said preemption doesn't let the federal government disguise commands to states. Here in Oregon, we see this in action with laws that stay on the books but can't be enforced due to federal preemption, like **Article XV, Section 5a** of the Oregon Constitution defining marriage as only between a man and a woman, which became unenforceable after **Obergefell v. Hodges (2015)** required states to recognize same-sex marriages—it's still there but ignored. Similarly, **Article I, Section 11** allowing non-unanimous jury verdicts in felonies was preempted by **Ramos v. Louisiana (2020)**, requiring unanimous juries, so it's in the Constitution but not used. Statutes like **ORS 743A.040** on health insurance benefits are partially unenforceable against certain employer plans due to **ERISA (1974)**, and administrative rules on railroad safety (**OAR 741-305-0000**) yield to federal railroad laws. These examples show state laws can become inoperative without repeal, just as **ORS 414.694** can be preempted post-waiver without **HB 4003**. CMS can't compel legislation; it must respect state choices. (**See COHO-Preemption Examples.pdf**)

If Legislative Action Is Chosen, Adopt COHO's Evidence-Based Amendment

If lawmakers choose to take legislative action rather than rely on administrative compliance and federal preemption, we should adopt COHO's stand-alone amendment to **HB 4003**, which aligns perfectly with CMS guidance by shifting to an "**Evidence line**" on the **Prioritized List** instead of a funding line. This amendment updates **ORS 414.025** to define the **Evidence line**, where services above it have strong evidence and are presumed covered (with reasonable limits), while those below lack enough evidence for broad coverage but can be approved individually based on a patient's needs. It amends **ORS 414.690** to require HERC to set this **Evidence line** based only on clinical evidence, not budget cuts, and keeps the list's ranking for guidance without tying it to funding. Changes to **ORS 414.065** ensure medical necessity criteria align with this line, with appeals for denials.

It repeals **ORS 414.694** to remove the funding line reference, as HB 4003 does, but preserves the evidence-based system. New sections mandate studies on implementation and data needs, plus technical assistance for a smooth transition starting **January 1, 2027**. This matches CMS's **January 20 and 21, 2026**, responses allowing the list for medical necessity without a funding line, ensuring minimal changes while complying with **STC 13.9**. It's a smart, evidence-focused fix that avoids unnecessary overhauls. (**See COHO-Evidence-Line-Amendment**)

Thank you for your time and consideration. I am happy to answer any questions.

Respectfully submitted,

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