COALITION FOR A HEALTHY OREGON

Oregon's Voice for Community Based Health

There is No Need for HB 4003: We Can Preserve Oregon's Evidence-Based Medicaid System Through Administrative Action

Oregon's Prioritized List of Health Services, developed by the Health Evidence Review Commission (HERC) under ORS 414.690, has ensured cost-effective, evidence-based coverage for decades. The Oregon Health Authority (OHA) cites CMS correspondence as justification for HB 4003 (formerly LC 91), which repeals ORS 414.694 and amends statutes like ORS 414.025 and 414.065 to eliminate the list. However, a close review shows CMS guidance supports minimal, administrative changes—not legislative overhaul. Here's why no bill is needed in 2026.

1. CMS Emphasizes State Deference and Allows Use of Prioritized List for Medical Necessity

CMS's January 20, 2026, response to OHA states: "The state can continue to use the prioritized list to guide medical necessity criteria," deferring to Oregon on processes like HERC's evidence reviews (ORS 414.690). Denials based on limited efficacy (aligning with below-line services) are permitted if tied to state-defined necessity (ORS 414.065; OAR 410-141-3830). While direct porting with a ranking/funding line is not allowed, clinical criteria can inform necessity under state plan authority (42 CFR § 440.230 on amount, duration, scope). This aligns with OHA's December 23, 2025, stated goal of "minimal changes" without mandating HB 4003's repeals.

2. OHA's Compliance is Accomplished Without Legislation

OHA's fallback—relying on HERC for clinical policies, outlining benefits with ADS in the state plan, and basing decisions on necessity (not funding line)—receives CMS affirmation: "Yes" to all four points (Jan. 20, 2026). This can be implemented via rules (OAR 410-141-3830) and manuals, preserving HERC's transparent process (ORS 414.690). STC 13.9 requires phase-out by December 31, 2026 (Oregon 1115 Waiver STCs, 2022-2027), but CMS confirms the approach complies with federal rules (42 U.S.C. § 1396a state plan requirements). HB 4003 exceeds this, risking a hasty disruption to members and providers.

3. Waiver Expiration Does Not Demand Immediate Legislation

CMS's January 21, 2026, confirmation: "Yes, your understanding is correct, the prioritized list can still be used for medical necessity criteria but the authority for coverage and denials would be the state plan." With time until the existing waiver ends, OHA can submit a Phase-Out Plan and SPA amendments without altering statutes. No funding threats or SPA denial risks are mentioned—rushing HB 4003 could expand coverage without fiscal controls, straining budgets. Existing laws

(ORS 414.065 on necessity; 42 CFR § 440.230) already provide the framework for a smooth transition.

Key Quotes from CMS-OHA Correspondence:

- Dec. 23, 2025 (OHA): "We aim to make the minimal changes necessary."
- Jan. 20, 2026 (CMS): "CMS defers to the state to determine their medical necessity process."
- Jan. 21, 2026 (CMS): Prioritized List "can still be used for medical necessity criteria."

COHO urges lawmakers: Delay HB 4003 until after CMS approves the Phase-Out Plan. Preserve our evidence-based system!

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