Governor's Sustainable Medicaid Funding Advisory Group
Workgroup Meeting Notes 2026-04-27

Note Taker: Numi Lee Griffith, Senior Policy Advisor, DCBS-DFR

Meeting Overview

- **Types of Rebates** (context for analysis)
    - MDRP – Federally mandated automatic rebates (inflation adjusted)
    - Supplemental rebates (negotiated by the state in excess of MDRP in return for inclusion on the state PDL).
    - CCO Rebates – Additional rebates negotiated by individual CCOs
- **Single PDL Concept** - single formulary across all CCOs and FFS enrollees
    - Assumed as a prerequisite for single PBM implementation
    - In other states, Mercer has seen net spending reductions of 2%-5% of pharmacy costs when moving into a single PDL model
    - Expected to increase brand utilization relative to interchangeable generics, but still generates net total savings due to increased rebates.
        - Individuals CCOs do not have visibility into rebates and may favor generics that would generate net savings through rebates under a single PDL model.
    - **Results of analysis**
        - Oregon participates in the Sovereign States Drug Consortium (SSDC), a rebate pool across 15 states for FFS pharmacy claims.
            - Mercer reviewed rebates offered to SSDC to model expected cost impacts from moving to a single PDL.
        - **Total potential savings:** $68m gross, $16.2m state
        - **Therapeutic Classes with greatest opportunity for savings:**
            - Targeted Immune Modulators
            - Diabetes drugs (including insulins and GLP-1s)
            - Inhaled Respiratory Agents
            - SUD and growth hormones
        - Did not find increased gross spend in findings due to the prevalence of biologic products. Still showed net savings due to rebates.
        - **340B Interactions**
            - Mercer assumed that around 30% of pharmacy claims are associated with 340B entities due to those claims being ineligible for rebates.

        - Model showed a 2.6% reduction in gross expenditures for non-rebate eligible claims due to product shifting to lower cost preferred products.
        - Projects a reduction in gross spend of $9.9m
- **Single PBM Concept –** single PBM processes all pharmacy claims in Medicaid program across both managed care and FFS members
    - Single PBM could reduce administrative costs, potentially enhancing rebate opportunities.
    - Less burden on pharmacy providers and CCO members.
    - Higher opportunity for state oversight.
    - Could be either a full service PBM model or only administrative considerations
        - Generally, a "full-service" PBM model will generate more savings than a partial implementation of this concept.
    - *Question:* are provider administrated drugs considered in this?
        - *Response:* No, this was limited to retail pharmacy claims
    - **Model Results:** total savings between $62m-$101m / $15-$25m state savings with combined single PDL / single PBM. Variance due to differences between different PBM pricing models and contracted administrative rates.
    - *Question:* is it better to implement both ideas at the same time?
        - Would be difficult to do both at once. Other states generally lead with a move to single PDL before implementing a single PBM.
    - *Comment:* fully integrated multi-state systems can currently generate additional savings through generic drugs. Moving to higher use of brand names could actually increase costs downstream, would force systems to maintain multiple formularies for different markets.
        - *Response:* acknowledges that higher gross costs may be expected, but points out that this model showed both gross savings and net savings.
    - *Question:* presentation noted "success" of a single PDL model in Indiana. How was success measured for these purposes?
        - *Response:* the state realized net savings on prescription drugs.
    - *Question:* how does this consider pharmacy reimbursement?
        - *Response:* assumes status quo at the pharmacy level. Would effectively lead to a single contract for pharmacies serving Medicaid instead of separate contracts on a CCO-by-CCO basis.
    - *Question:* how does FFS spend historically compare to CCO spend on Rx?

        - *Response:* difficult to analyze due to population / demographic differences and differences in drug mix. In general, FFS costs have been higher.
    - *Question:* how would this interact with multi-line carriers? Is there a single PDL across markets, or is Medicaid separate?
        - *Response:* some systems on the call indicated that they maintain separate formularies for commercial and Medicaid, while one noted that they use unified drug purchasing for all served markets.
    - *Comment:* notes that WA & CA have implemented an aligned PDL, and is a state where the same integrated health systems operate. How has that experience worked out in those states?
    - *Question:* should we be looking at a full carve-out of pharmacy to realize even greater savings, given that behavioral health and certain high cost drugs are already carved out?
        - *Response*: this would have additional fiscal implications. Full carve-out would reduce CCO capitation rates and therefor also decrease revenue collected through provider rates. In a previous analysis these costs were found to outweigh potential savings.
- **Smart-D presentation**
    - SMART-D conducted interviews with pharmacy officials in 9 states that have consolidated pharmacy benefit administration for their Medicaid population
    - Models for implementation in states interviewed:
        - Single PDL with MCOs retaining financial risk
        - Full carve-out of pharmacy
        - Single PBM
        - Single PDL / Single PBM
    - Takeaways from interviews
        - Commission financial analysis of impacts (in progress)
        - 340B strategy early and transparently
        - Use a phased approach
        - Plan for 18-24 month implementation process
        - Assess needs for additional pharmacy staffing at the agency level before starting implementation
        - Design robust contracts with specific enforcement mechanisms
        - Comprehensive stakeholder engagement
        - Engage the legislature early and strategically

    - *Comment*: hospitals generally would resist a rebate approach to 340B or a move to a full carve-out of pharmacy. Currently hospitals are very reliant on 340B revenue to shore up their financials.
    - *Comment:* state can achieve more leverage through combining Medicaid with other Medicaid programs as opposed to aligning Medicaid and commercial. MDRP rebates make it difficult to combine Medicaid and other markets.
    - *Comment:* presentation did not contain many cons of making this switch. What is the alternative perspective on this?
- **Next Steps for the MAG**
    - Three more meetings
    - Asking MAG members to prepare their own list of how to achieve a $420m reduction in Medicaid spend. Prompt will be coming to members.
        - Looking to identify areas of potential alignment
        - Looking to identify current areas of disagreement
    - Alternative is flat rate cut, and will be offered as comparison.
        - *Comment:* we haven't had the same sort of discussion about the pros and cons of doing a flat rate cut.
            - *Response:* next meeting will try and address this.

Sustainable Medicaid Funding Advisory Group
Meeting Notes May 11, 2026
Note Taker: Numi Lee Griffith, Senior Policy Advisor DCBS-DFR

Meeting Summary

Survey Responses

- Asked group members to identify areas for continuing work.
- Around 2/3 of group members provided responses.
- **Most frequent response from members: define a core Medicaid benefit.**
    - *Comment:* without the prioritized list, it becomes much more difficult to define / control medical necessity – will come down to decisions by ALJ in assessing provider recommendations.
    - *Comment:* OHA is already facing a significant lift in developing our next state plan amendment due to the mandatory phase out of the prioritized list.
    - Several members noted a need to **better define the role of CCOs in delivering Health Related Services and Needs (HRSN)**
- **Many members also called for simplification of administration program wide.**
- **Third was a call for behavioral health system reform**
    - Decreased complexity and better defined responsibilities between counties and CCOs
- **Program Outcomes and Quality Incentive Programs**
    - Better definition of outcomes / make program an incentive and not an expectation for funding.
        - *Comment:* incentive payments become an expectation / necessity because the base capitation rate has been held artificially low.
- **Coordination with Long Term Services and Supports (LTSS)**
    - Improve timely hospital discharge
    - Better manage the benefit / opportunity to increase managed care tax revenue
    - *Comment:* LTSS and acute care need to be better aligned.
        - *Question* – what are we talking about as part of LTSS for alignment? We've already been doing lots of work on hospital discharge and haven't cracked the nut yet.
            - *Response* – hospitals don't currently have a financial incentive to move people out of hospital beds, leading to patients remaining in the highest cost mode of care. Should be trying to align incentives across Medical and LTSS systems to direct people towards the lowest cost appropriate care available.
            - *Response* – this should be re-worded to focus more on coordination?
        - *Comment* – the bottleneck isn't just system capacity, it's also been difficulties with processing guardianships to allow for transfer.

        - *Comment* – in our past work on LTSS we have seen a real challenge in capacity, and this is centered in the home & community services setting, not in the skilled nursing system which does have capacity. We need to be more specific in what we are talking about so reforms are directed appropriately.
- **Define the core Medicaid Population and Protect it**
    - Paraphrase: is the intent of our state program to serve a core group of the most vulnerable or is it a program advancing universal health coverage?
    - *Comment:* we've been grappling with this question as a state – everyone wants universal coverage but no one wants to pay with it. The Medicaid population has kind of become caught in the middle of this debate.
    - *Comment:* Medicaid has often been viewed as a the best vehicle to move towards universal care, but we can't have a single payer that pays current Medicaid rates and maintain an operational health system.
    - *Comment:* there's only been a few policies implemented in the past few decades that have effectively reduced mortality, and Medicaid expansion has been one of those. Simply stepping away from coverage doesn't necessarily save societal costs – much of what is uncovered will shift into uncompensated care.
    - *Comment:* we've already chosen to use Medicaid as a vehicle for coverage expansion. Not just as a state, but through the passage of the federal ACA. The ACA was a compromise with private providers and carriers to not move to a national single payer model. Having made that choice, we should stick with it until there is a real opportunity to make a national leap in health policy again ("every 50 years").
    - *Comment:* even in a universal system like Canada, the program is still a defined benefit with specified limits. There are certain services that are in and out.
    - *Comment:* if we're looking to go to a system where CCOs are fully responsible for outcomes under a global budget, we should fully commit to that sort of model.
        - *Response:* there has been a lot of legislation requiring coverage of specific benefits and.
    - *Comment:* on a big picture level, this is an issue of hydraulics – pressure between coverage and reimbursement rates and outcomes. This item could be redrafted to better reflect those dynamics.
    - *Comment:* this is really only the first of a series of "terrible conversations" and the upcoming financial squeeze is likely to be even worse. We should not leave this conversation without defining our principles, since those principles are going to be vital in guiding those future conversations.
- **Rephrasing the question: what advice would you give the Governor?**
    - *Response:* we really need to work on identifying the outcomes we want and where the care with the best outcomes for particular individuals lies – as an

example, pediatricians tend to have better results for children than Family Medicine providers.
    - *Comment:* we need to explore how technology can supplement pathways to primary care – using "AI" models or AI enhanced delivery of care
        - *Response:* OHA is currently working on pilot projects to explore this as a way to address the shortage of primary care. How can AI be leveraged to address primary care – e.g. by triaging simple issues such that we can reduce avoidable Emergency Department use?
    - *Comment:* we need to fully redesign the benefit program, using HERC to direct benefits to be better aligned with a commercial benefit. This should include overall simplification across the entire system. Rather than having AI or other pilots driven by the state agency, move more towards a purely global budget model and let each CCO try strategies like AI.
        - *Comment:* agree that we no longer have a true global budget, and we should really commit to either a global budget model or a more rigid defined benefit. We can't do both.
        - *Comment:* trying new things is good to talk about, but it needs a lot of state support to really pull off.
    - *Comment:* change really needs to be narrowly focused on specific goals and metrics. In the past we've tried to do too many different things at once, and ended up not really accomplishing any of them.

Summary of Options Discussed for budgeting exercise

- This is in preparation for the prioritization exercise that should be completed by all group members ahead of the next meeting of the group.
- The exercise directs all members of the group to put together their own list of reductions to reach the $420m budget target.
- List of policy options includes a flat cut in CCO budgets between 0.5% and 4% across the board as an alternative to more targeted policy options.
- Certain options listed are mutually exclusive.
- **Option:** statewide expansion of Health Share's targeted High Acuity Behavioral Health population strategy.
    - *Comment:* in favor of these ideas, but really should put these reforms in action before cutting CCO rates in order to reflect those savings.
- **Option:** utilization management and service adjustments for Applied Behavior Analysis (ABA) therapy.
    - *Question:* what has driven issues around ABA? Is it the bad press that the treatment has received, or something else. How did this get so out of alignment with actual need, and how can we avoid this for other treatments in the future.
        - *Response:* there's a variety of factors that have lead to increased / over-utilization of ABA therapy. This includes investment in ABA

treatment delivery by private equity, changes to diagnostic criteria, increased use of telehealth, etc.

- **Option:** elimination or reduction of 'optional' benefits
    - *Comment:* some of these benefits are also mandated by state statute and would require legislative action to actually cut (naturopaths).
    - *Comment:* changes to optional benefits still require federal approvals. The proposal is basically presented as the choice to start the process of reduction.
- **Option** – flat rate reductions
    - *Question:* does this include percentage cuts to OHA's budget?
        - *Response:* no. This represents percentage cuts to CCO and FFS reimbursement rates.
    - *Comment:* we've had past analysis of how to do a true global budget and whether that can be implemented in a way that the federal government accepts as actuarially viable. Generally, the conclusion has been it's not possible. Instead, our conversations about additional flexibility are more directed towards loosening some of the administrative requirements rather than trying to get to a 'true' global budget implementation.

"Homework"

- Purpose of budgeting exercise: understand areas of alignment and divergence; inform final report to the governor.
- Intended to provide an opportunity for feedback, and for group members to offer recommendations without wearing their 'stakeholder' hat. Responses to Manatt team.
- Each member to identify $210 in reductions to prioritize and a second group of $210 to total approximately $420 in total spending reductions. Options within these tranches is not 'ranked'.
- *Question* – given the announcement that Healthier Oregon will be transferred into FFS, does that impact the savings we're looking for here and do we have a projection of the savings expected through that transition?
    - *Response* – we do have estimates, but we are not viewing this as impacting the savings target within this exercise.

Governor's Advisory Group on Medicaid Sustainability

Meeting Notes – June 8, 2026

Note Taker: Numi Lee Griffith, Senior Policy Advisor DCBS-DFR

Meeting Summary

MAG Feedback Survey

- *Comment:* concern about 'inefficient' pharmacy spend – suggests wasteful spending under the current CCO model. Possibly double-dipping in potential savings with the sunset of "Provider Prevails."
    - *Comment:* transparency about what spending is removed will be important – communication with providers and the public.
    - *Comment:* CCOs will only see this as a rate reduction, but the CCO doesn't necessarily have sufficient control to actually eliminate this inefficient spend.
    - *Comment:* difficult issue to manage – once the patient shows up, we have to take care of them. This makes this a difficult area to 'bend the curve'
- *Question:* expressed confusion about how the top 10 items were ranked.
    - *Response:* the ranking of items in the second tranche of options is a little squishier, and combines multiple inputs.
    - *Comment:* there's probably a lot of things that are had lots of votes but were split between first choice and second choice – so this way of slicing the data underrepresents the support for certain options.
        - *Response* – this is true, but we'll see more in the "heat map" analysis
    - *Comment:* problem with anonymity of survey. Would prefer to see the flat reduction in spend, but personally agnostic about the 'how' that savings is achieved.
- *Comment:* I don't think we have a realistic path to create savings on prenatal and NICU admissions. To actually create savings here we need to address the substance use problem in the maternal population. Maybe this should come off of the list.
    - *Response:* this was something of a 'finger in the wind' projection of possible savings through prevention. We will be discussing whether certain options should be removed later in the meeting.
- *Comment:* cannot reach the target without addressing medication somehow.
- *Comment:* the options that are really focused on being "more efficient" are more theoretical and less likely to actually create the desired savings.
- *Comment:* on cuts to outpatient psychotherapy, recommend just implementing 4% cut, without reductions in FFS with CCO market assumed to follow.

    - *Comment:* Implementing as a market-wide mandate avoids political heat on the CCOs for implementing psychotherapy rate cuts.
- *Comment: (re: "do not recommend" list)* not averse to cuts to admin costs in principle (this is admirable), but hesitant to support without a clearer path to how those savings are achieved.
- *Comment:* I think we should do both across the board cuts and more targeted cuts.
    - *Comment:* problem with across the board cuts is that there is no protection for provider rates. Hospitals are already struggling, notes that hospital rates were cut for some hospitals in a year that CCOs had a 10% rate increase.
        - Nothing in current law protects hospital rates.
        - *Response:* I read these changes as a hair-cut across the board, including hospitals and other provider types.
- **NOTE:** across the board cut assumed equal cuts made to the OHA administrative budget for Medicaid as well as FFS / CCO cuts.
- *Comment:* proposals that are projected efficiency are effectively rate cuts, and that really covers the bulk of what we've discussed.
    - *Response:* so you're arguing in favor of a rate cut?
        - *Response:* yes. So much of this doesn't have an actual plan for savings, we might as well just move forward with a flat cut.
        - *Question:* Could we split the difference? i.e. by setting a targeted cut with a list of preferred ways to achieve that savings.
- *Comment:* we need more information that states the potential impacts of the various options. Decision makers may not have the necessary expertise to understand all of the downstream unintended impacts.
    - *Response:* so what approach would you recommend?
        - *Response:* pharmacy and behavioral health spend are definitely problems we need to address, but those decisions should be made with the right experts in the room to understand the impacts.
- *Question:* will there be an opportunity to meet with the Governor's team to follow up and explain some of the reasoning and implications behind the final report's comment?
    - *Response:* there is an opportunity over the next few months for the Governor to ask OHA to do additional work to provide more insight into how these options could work out.
- *Comment:* we should get more real about defined cuts to specific benefits. Just choosing a target number with flexibility to achieve the cut falls short of the mandate for this group.

Heat Map of Policy Option Rankings

- *Comment:* need to more aggressively target things that are not providing value to the system. Uncertain about potential savings from single PDL, but it is an area that really needs to be addressed – and is likely an area where cost will continue to

control and we currently have little ability to address as a state. Cutting spend in pharmacy preserves funding for hospitals etc.
- *Comment:* thought about members subject to work requirement – coverage of prosthetics and PT may be what allows a member to work at all, so limiting or removing this benefit doesn't make sense.
- *Comment:* understand the anxiety about reducing the number of CCOs, but maybe this is a thing we should be considering more seriously.
    - *Response:* the idea is out there, and there was significant divergence within the group about the desirability. It is something the Governor can choose to consider.
- *Comment:* isn't there a risk in flat cuts of not having CCOs renew?

Areas of Alignment / Consensus

- Suggested summary statements:
    - **High Alignment on the first grouping of options**
    - **Alignment not eliminating benefits, but limiting them**
    - **Alignment around not targeting dental**
    - **Alignment around additional work to verify potential savings**
    - **Alignment around 1-2% flat cuts, but little support for larger flat cuts (noting concern for certain provider groups.**
- *Comment:* there has been a real tension in this discussion between flexibility / local control & statewide oversight. I started out this work favoring identified cuts, but over the course of this discussion I've moved towards favoring flat cuts due to the variance from CCO to CCO. Notes continued support of the single PDL.
- *Comment:* maximum flexibility is really hard if we're also trying to protect certain things. Hard to ensure desired outcomes at the statewide level.
- *Comment:* not necessarily advocating for maximum flexibility, but rather transparency as to how cuts are being achieved. Need shared decision making.
- *Comment:* seems to be a lot of alignment around the need to address behavioral health spend.
- *Comment:* possible to do technology investments that will genuinely identify what care is truly low value. Infrastructure to support the work of the HERC.

Outline of the Report to the Governor

- Process will be iterative. Further analysis will come on timing, feasibility of savings, etc. Plan for further engagement is still being developed, but the governor is interested in deep engagement on issues and will probably be follow-up with stakeholders as we narrow in on approach.

Sustainability Discussion

- Prior consensus on top five areas for sustainability work.

- Looking to develop narrative around these items.
- **Define a Core Medicaid Benefit**
    - *Comment:* 3rd bullet – review should not be tied to budget. HERC should do regular review of the value provided by the Medicaid benefit regardless of the current budget forecast.
    - *Comment:* looking for more explicit language regarding pharmacy spend
    - *Comment:* Medicaid is more than just health care, want language that reflects the full scope of the benefit.
- **Simplify Medicaid Administration**
    - *Comment:* should be a recognition that DHS has a role in administration of Medicaid, also noting the needs of the frontline workers for enrollment etc.
    - *Comment:* more focus on "what" we want to achieve rather than "how" we want to achieve it. The 'how' creates additional mandates on the program.
    - *Comment:* is there a provider simplification element to this?
        - *Response:* yes, it's embedded in this point, but it could be stated more clearly.
        - *Response:* OHA has already stood up a number of tables on provider engagement that are working on administrative burden facing the provider community.
        - *Response:* ***we will add some language to the last bullet point on this item.***
- **Reduce Behavioral Health Complexity**
    - *Comment:* need to think about how we are maximizing our federal match for behavioral health services.
    - *Comment:* there's a need for greater accountability and right now the delivery mechanism is spread out across too many different entities.
    - *Comment:* should be a statewide needs analysis with clearly defined responsibilities for where capacity building gets done and by whom.
        - *Response:* we already have this analysis, so what are we actually looking for with this recommendation?
            - *Response:* we need to actually implement those reductions and define who is responsible for implementation
        - *Response:* there's a lot of capacity currently in the pipeline, but it will take time for a lot of those beds to come online.
            - We're working on creating the capacity that the legislature funded. There is ongoing work to determine needs moving forward, including local engagement on the study's recommendation.
        - *Suggestion:* we should explicitly refer back to the PCG study. Concern about how behavioral health advocates will react to this report in highlighting administrative simplification.
        - *Revision:* ***Follow the PCG study and continue to investigate.***
            - *Comment:* expressing concern about specific reference to PCG when other work is ongoing.

        - *Response:* ***will word more broadly.***
- **Better define desired outcomes for CCOs**
    - *Comment:* should add some recommendation for analysis of CCO performance. Note disparity across how providers perceive different CCOs
        - Identify "what works" and move towards that
        - *Response:* the current procurement could have been an opportunity to do this type of analysis and set priorities (noting legislative direction to delay the next procurement cycle).
        - ***ADD: language re – opportunity to address this in next procurement***
        - *Comment:* this is a more urgent problem and we should be working towards this now.
            - ***ADD: begin discussion on CCO goals for next procurement ASAP, rather than waiting until next year.***
- **Coordinate with LTSS System for Timely Hospital Discharges**
    - *Comment:* this work isn't limited to the Governor's office. The legislature has been kept in the loop on these discussions, and some legislators are very engaged on issues like Behavioral health and hospital discharge challenges.
        - *Comment:* yes, but these issues are closely tied together and not all legislators may recognize how intertwined they are.
    - *Comment:* suggest framing this issue as a systemic problem in effectively moving people to the most appropriate care setting efficiently.

Office of Governor
TINA KOTEK

Governor's Advisory Group on Medicaid Sustainability

June 8, 2026

For discussion purposes only.

Agenda

Office of Governor
TINA KOTEK

Summary of MAG Survey Responses	60 min
Approach to Governor Report	60 min

Office of Governor
TINA KOTEK

Reminder

- We are developing a list of potential options
- Not everyone will endorse each option – not looking for consensus
- Need to understand the impact of options
- Initial meetings focused on many of the "customary" ideas
- These later meetings are an opportunity to develop "transformational" ideas to improve and sustain our Medicaid system – be thinking of those!

The options shown in this presentation are for discussion only and do not constitute recommendations by OHA or the Governor's Office.

Potential impacts to OHP Members remain an essential consideration for each option. Preliminary savings estimates are based on data from recent years and subject to change.

While savings were originally estimated annually, they are presented as estimated biennium savings here and in the accompanying Excel worksheet.

MAG Feedback Survey

Link to feedback summary Excel

Summary of MAG Survey Responses

Reminder: **MAG members were asked to develop their preferred and secondary packages of options each totaling $210M. Members could also indicate if they opposed an action and provide qualitative feedback.**

- Responses were received from **16** MAG members.
- Key findings:
  - Changes to behavioral health program were most likely to feature in priority option selections
  - Greater support for more measured pharmacy options (e.g., sunset provider prevails) than more robust restructuring of the pharmacy infrastructure (e.g., single PDL, combined sPDL/sPBM)
  - Greater support for limiting optional benefits than for cutting benefits
  - Generally Limited support for across-the-board budget cuts
- While responses were generally aligned, there are some areas of misalignment (e.g., changes to dental benefit, implementation of a single PDL).

Top 10 Preferred Options for the First $210M Package

Top 10 Options	Est. Range of State Savings	Votes
No longer cover labs with no clinical value	$3.00M	15
Under current CCO Model: Facilitate **statewide expansion of the HSO High Acuity Behavioral Health (HABH) strategy** to generate an estimated 1% - 5% of savings	$3.20M - $18.20M	14
Modify psychotherapy guidance to reduce visits that do not satisfy medical necessity or provide meaningful clinical outcomes	$10.60M - $11.80M	14
Reduce outpatient psychotherapy FFS rates by 4% and direct CCO psychotherapy payment rates to use the new FFS rates as a maximum.	$23.20M	12
Under current CCO Model: Implement a **package of administrative simplification actions to reduce overall admin costs by 1% - 3%.**	$5.00M - $14.80M	12
Limit physical therapy/occupational therapy visits	$8.00M	11
Sunset "Provider Prevails" and require justification for non-preferred drugs.	$0.06M - $0.26M	11
Applied Behavior Analysis (ABA) services adjustments and utilization management	$8.60M	10
Review pharmacy claims for inefficient spend and reduce capitation payments to CCOs	$8.20M - $59.0M	9
Additional clinical efficiency criteria: Mercer identified a series of potential efficiencies for further evaluation by the HERC	$20.00M - $48.60M	9
Illustrative Total of Top 10 Selections	**$89.86M - $195.46M**	

Top 10 Preferred Options for the Second $210M Package

Top 10 Options	Est. Range of State Savings	Votes
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%.	$9.80M	6
Cut to OHA Medicaid budget across the board (includes all FFS and CCO expenses): 2%	$168.0M	6
Reduce unnecessary NICU days, through clinical efficiencies/implementation of Perinatal Care Overlay	$4.60M - $12.40M	6
Applied Behavior Analysis (ABA) services adjustments and utilization management	$8.60M	5
Under FFS Model: **Carve out of Dental services**	$21.0M	5
Carve out NEMT to FFS and centralize services	$13.00M	5
Under Current CCO Model: **Implement NEMT efficiencies**	$1.00M - $5.00M	5
Increase clinical efficiency under existing criteria **(raising Targeted Efficiency Level [TEL] above 50%)**	$9.60M - $19.20M	4
OHA to contract with multiple or single DCOs to provide dental coverage to all OHP members	$2.60M - $5.20M	4
Remove massage therapy	$5.60M	4
Illustrative Total of Top 10 Selections	**$243.80M - $267.80M** *Note, there are overlapping options here*	

Top 10 Options Listed as "Do Not Recommend"

Options	Est. Range of State Savings	Votes
Remove adult dental benefit	$87.80M	7
Adjusted CCO Model: **Reduce CCO Admin cost to 25th percentile nationwide**	$60.60M	6
Increase clinical efficiency under existing criteria **(raising TEL above 50%)**	$9.60M - $19.20M	5
Under FFS Model: **Carve out of Dental services**	$21.00M	5
Cut to OHA Medicaid budget across the board (includes all FFS and CCO expenses): 4%	$336.00M	5
Cut to OHA Medicaid budget across the board (includes all FFS and CCO expenses): 3%	$252.00M	5
Remove physical therapy/occupational therapy benefit	$16.00M	5
Adjusted CCO Model: **Reduce the number of CCOs to reduce administrative costs**	$4.80M - $27.00M	4
Cut to OHA Medicaid budget across the board (includes all FFS and CCO expenses): 2%	$168.0M	4
Implement a single PDL	$24.30M	4

Note: *The removal of the case management, prosthetics, and vision benefits also each received 4 votes.*

Trends in Qualitative Responses

- Across dental, clinical efficiency/UM, pharmacy, and across-the-board cuts, commenters repeatedly come back to: **any approach that adds administrative layers (for OHA and/or CCOs) is risky and may erase savings.**
- **Skepticism is high that "clinical efficiency" is a proxy for rate cuts**, with many viewing these as shifting risk to CCOs for largely uncontrollable costs. Respondents emphasize that true policy or benefit strategies require upfront investment, statewide alignment, and policy changes, not just rate reductions.
- A **recurring value is local accountability and adaptability** — respondents resist options perceived as "centralization by default."
- There are **disagreement amongst commenters about dental**: Respondents disagree on structure (carve-out vs subcontracting), but agree on the underlying problem: dental access and admin duplication are both serious constraints. They diverge on which risk is worse (access collapse vs duplicative admin).
  - Where people are open to carve-outs (dental, NEMT), it is almost always conditional on strong and timely data-sharing + care coordination integration to avoid fragmentation in care delivery
- **Pharmacy options raise capacity concerns.** Benefits of a single PDL/PBM are uncertain, while implementation risk—especially OHA administrative capacity amid competing priorities and limits to CCO flexibility —is high; respondents suggest learning from states that have protected covered entities.
- **Benefit limits were preferred over benefits cuts** due to concerns over increased downstream costs (e.g., greater ED utilization) that would offset savings.
- **Across the board cuts were controversial**. Some view across-the-board cuts as administratively efficient and compatible with local flexibility. Others see them as dangerous (provider instability) or as deferring the problem to OHA (i.e., "MAG handing off exercise").

Heatmapping by Priority Ranking

Top Preferred Options, Ranked by First $210M Package Selection

Option	Preferred Option for First $210M Package	Preferred Option for Second $210M Package	Option Not Selected	Indicate If You Strongly Recommend NOT Pursuing This Option (response is not required)
No longer cover labs with no clinical value	15	-	1	-
Under current CCO Model: Facilitate statewide expansion of the HSO High Acuity Behavioral Health (HABH) strategy to generate an estimated 1% - 5% of savings	14	1	1	-
Modify psychotherapy guidance to reduce high-frequency, long-duration visits that do not satisfy medical necessity or provide meaningful clinical outcomes	14	1	1	-
Reduce the same outpatient psychotherapy FFS rates by 4% and direct CCO psychotherapy payment rates to use the new FFS rates as a maximum.	12	2	2	-
Under current CCO Model: Implement a package of administrative simplification actions to reduce overall admin costs by 1% - 3%.	12	1	2	1
Limit PT and OT visits	11	2	3	-
Sunset “Provider Prevails” and require justification for non-preferred drugs.	11	4	1	-
Applied Behavior Analysis (ABA) services adjustments and utilization management	10	5	1	-
Review pharmacy claims for inefficient spend and reduce capitation payments to CCOs	9	2	3	2
Additional clinical efficiency criteria: Mercer identified a series of potential efficiencies for further evaluation by the HERC	9	3	2	2

Top Preferred Options, Ranked by First $210M Package Selection Continued

Options	Preferred Option for First $210M Package	Preferred Option for Second $210M Package	Option Not Selected	Indicate If You Strongly Recommend NOT Pursuing This Option
Limit Prosthetics	7	3	4	2
Limit massage therapy	7	2	6	1
Limit adult dental	7	1	6	2
Limit case management	7	-	7	2
Limit naturopath services	7	3	5	1
Limit acupuncture, chiropractic visits	7	2	6	1
Under FFS Model: Carve out of Dental services	6	5	-	5
Remove massage therapy	6	4	5	1
Remove naturopath services	6	4	5	1
Implement a single PDL	6	2	4	4

Top 10 Options with Strongest Opposition

Option	Preferred Option for First $210M Package	Preferred Option for Second $210M Package	Option Not Selected	Indicate If You Strongly Recommend NOT Pursuing This Option
Remove adult dental benefit	1	3	5	7
Adjusted CCO Model: Reduce CCO Admin cost to 25th percentile nationwide	5	2	3	6
Increase clinical efficiency under existing criteria (raising TEL above 50%)	4	4	3	5
Under FFS Model: Carve out of Dental services	6	5	-	5
Cut to OHA Medicaid budget across the board (includes all FFS and CCO expenses): 4%	1	1	9	5
Cut to OHA Medicaid budget across the board (includes all FFS and CCO expenses): 3%	-	2	9	5
Remove physical therapy/occupational therapy benefit	-	2	9	5
Adjusted CCO Model: Reduce the number of CCOs to reduce administrative costs	5	2	5	4
Cut to OHA Medicaid budget across the board (includes all FFS and CCO expenses): 2%	1	6	5	4
Implement a single PDL	6	2	4	4

Heatmapping by Options Category

Summary of Responses by Options Category

Option	Preferred Option for First $210M Package	Preferred Option for Second $210M Package	Option Not Selected	Indicate If You Strongly Recommend NOT Pursuing This Option
Adjust CCO Structure				
Under current CCO Model: Implement a package of administrative simplification actions to reduce overall admin costs by 1% - 3%.	12	1	2	1
OPTION 1: Adjusted CCO Model: Reduce the number of CCOs to reduce administrative costs (OR)	5	2	5	4
OPTION 2: Adjusted CCO Model: Reduce CCO Admin cost to 25th percentile nationwide	5	2	3	6
OPTION 1: Under current CCO Model: Contract with multiple or single DCOs to provide dental coverage to all OHP members. (OR)	5	4	7	-
OPTION 2: Under FFS Model: Carve out of Dental services	6	5	-	5

Summary of Responses by Options Category, *cont.*

Option	Preferred Option for First $210M Package	Preferred Option for Second $210M Package	Option Not Selected	Indicate If You Strongly Recommend NOT Pursuing This Option
Clinical Efficiency/ Utilization Management				
Increase clinical efficiency under existing criteria (raising TEL above 50%)	4	4	3	5
Additional clinical efficiency criteria: Mercer identified a series of potential efficiencies for further evaluation by the HERC	9	3	2	2
Applied Behavior Analysis (ABA) services adjustments and utilization management	10	5	1	-
Reduce unnecessary NICU days, through clinical efficiencies/implementation of Perinatal Care Overlay	3	6	4	3
Under current CCO Model: Facilitate statewide expansion of the HSO High Acuity Behavioral Health (HABH) strategy to generate an estimated 1% - 5% of savings	14	1	1	-
Modify psychotherapy guidance to reduce high-frequency, long-duration visits that do not satisfy medical necessity or provide meaningful clinical outcomes	14	1	1	-
OPTION 1: Under Current CCO Model: Implement NEMT efficiencies (OR)	6	5	5	-
OPTION 2: Carve out NEMT to FFS and centralize services	6	5	4	1

Summary of Responses by Options Category, *cont.*

Options	Preferred Option for First $210M Package	Preferred Option for Second $210M Package	Option Not Selected	Indicate If You Strongly Recommend NOT Pursuing This Option
Provider Rate Reductions				
OPTION 1: 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%. (OR)	5	6	5	-
OPTION 2: Reduce the same outpatient psychotherapy FFS rates by 4% and direct CCO psychotherapy payment rates to use the new FFS rates as a maximum.	12	2	2	-
Pharmacy				
Review pharmacy claims for inefficient spend and reduce capitation payments to CCOs	9	2	3	2
Sunset "Provider Prevails" and require justification for non-preferred drugs.	11	4	1	-
OPTION 1: Enforce a Mental Health PDL and require PA for non-preferred mental health drugs. (OR)	5	2	6	3
OPTION 2: Implement a single PDL (OR)	6	2	4	4
OPTION 3: Implement a combined single PDL/single PBM	5	3	5	3

Summary of Responses by Options Category, *cont.*

Option	Preferred Option for First $210M Package	Preferred Option for Second $210M Package	Option Not Selected	Indicate If You Strongly Recommend NOT Pursuing This Option
Benefit Scope Limits				
Limit case management	7	-	7	2
Limit naturopath services	7	3	5	1
Limit PT and OT visits	11	2	3	-
Limit speech therapy	5	2	9	-
Limit speech therapy	4	2	10	-
Limit acupuncture, chiropractic visits	7	2	6	1
Limit massage therapy	7	2	6	1
Limit vision benefit	5	3	6	2
Limit Prosthetics	7	3	4	2
Limit adult dental	7	1	6	2

Summary of Responses by Options Category, *cont.*

Option	Preferred Option for First $210M Package	Preferred Option for Second $210M Package	Option Not Selected	Indicate If You Strongly Recommend NOT Pursuing This Option
Benefit Removal				
No longer cover labs with no clinical value	15	-	1	-
Remove case management	3	3	6	4
Remove naturopath services	6	4	5	1
Remove massage therapy	6	4	5	1
Removal acupuncture/ chiropractic benefit	6	2	7	1
Remove vision benefit	-	3	9	4
Remove prosthetics benefit	-	3	9	4
Remove physical therapy/occupational therapy benefit	-	2	9	5
Remove speech therapy benefit	-	3	9	4
Remove adult dental benefit	1	3	5	7

Summary of Responses by Options Category, *cont.*

Option	Preferred Option for First $210M Package	Preferred Option for Second $210M Package	Option Not Selected	Indicate If You Strongly Recommend NOT Pursuing This Option
Across-the-Board Budget Cuts				
OPTION 1: Cut to OHA Medicaid budget across the board (includes all FFS and CCO expenses): 0.5% (OR)	4	3	6	3
OPTION 2: Cut to OHA Medicaid budget across the board (includes all FFS and CCO expenses): 1% (OR)	4	3	7	2
OPTION 3: Cut to OHA Medicaid budget across the board (includes all FFS and CCO expenses): 2% (OR)	1	6	5	4
OPTION 4: Cut to OHA Medicaid budget across the board (includes all FFS and CCO expenses): 3% (OR)	-	2	9	5
OPTION 5: Cut to OHA Medicaid budget across the board (includes all FFS and CCO expenses): 4%	1	1	9	5

Office of Governor
TINA KOTEK

Approach to Governor Report

Placeholder

For discussion purposes only.

Office of Governor
TINA KOTEK

Reminder: MAG 2026 Schedule

Date	Topic
1/5	[Complete] Pharmaceutical spending
2/2	[Complete] Benefits
3/2	[Complete] Behavioral Health
3/16	[Complete] CCO construct and administrative simplification
3/30	[Complete] Hospital costs, carve out of high-cost procedures
4/13	[Complete] FFS population costs and management
4/27	[Complete] Follow up from pharmacy & benefits discussions
5/11	[Complete] Review options and discuss MAG feedback exercise
6/8	[Complete] MAG feedback on options
6/22	Review and finalize report to the Governor

For discussion purposes only.

Select Qualitative Responses

Select Qualitative Feedback

Options Category	Select Feedback

Adjust CCO Structure	• **CCO structure:**
	  • All of these [options] should be considered but need to be paired with a more concerted evaluation of what outcomes we want out of the CCO model and aligning contract and deliverable expectations with those outcomes.
	  • CCO's need adequate admin to perform all the functions required by OHA. Also support moving back to a DCO contract structure.
	  • This is directionally positive but carries moderate implementation risk because OHA has historically expanded administrative scope . This may require material changes within OHA for successful execution.
	  • Reducing the number of CCOs runs counter to the CCO model of local/community driven health care delivery and financial accountability.
	  • Much of Medicaid spending is driven by medical utilization — not administrative overhead — and local CCOs are often better positioned to manage provider relationships, community partnerships, behavioral health coordination, and high-cost member interventions that prevent expensive downstream care given closer proximity and relationships. There is also little evidence supporting the theory that larger CCOs are more cost effective based on historical data…In rural regions especially, losing locally governed organizations could weaken provider engagement and accelerate hospital and provider instability, ultimately driving higher utilization and higher medical costs rather than meaningful long-term savings.
	• **Changes to dental benefit:**
	  • Moving to a single or limited DCO structure risks creating monopoly dynamics that historically reduce competitive pressure, weaken local accountability, and increase long-term costs rather than lowering them. There is a significant likelihood of decreasing access to providers.
	  • If Dental is carved out we must have access to timely dental utilization data and care gap information
	  • I am strongly against carving out dental services. This would be reliant on OHA contracts with dentists which would result in very little access for members.
	  • Oregon's FFS model is generally more expensive and creates greater fragmentation, re-siloing of care, and reduced care coordination between physical, behavioral, and oral health systems. Not only would OHA be taking on direct responsibility for managing this benefit, but it would also be assuming responsibility for the downstream impacts of poor or fragmented management. This could include increased emergency room utilization tied to unmet dental needs, increased primary care visits resulting from untreated oral health conditions, and increased pharmacy costs associated with delayed or inadequate care. Is the state going to be financially responsible for all dental-related ER visits under this model? Additionally, how would OHA operationally coordinate regional primary care providers with dental delivery systems in a way that meaningfully integrates physical and oral health care? Building and maintaining that infrastructure would likely require substantial new staffing, contracting, oversight, and administrative "roll-up" costs at the state level.

Select Qualitative Feedback, *cont.*

Options Category	Select Feedback

Clinical Efficiency/ Utilization Management	• I don't believe that you can reduce NICU days, this should be a metric for the QIP program.
	• Clinical Efficiency Adjustments are just cuts to CCO rates and often for utilization/spend that is not very controllable.
	• In general, the "clinical Efficiency/UM Options" category represents reasonable strategies for CCOs to cut costs. Conversely, they can still be pursued by CCOs under a more general across the board rate cut. The challenge of pursuing these initiatives independently, or as carve outs, is that each item will create additional administrative costs for both the OHA and CCOs. It is more efficient to pursue across the board cuts and allow CCOs the ability to find community based efficiencies based on local market dynamics.
	• CCO rates are already close to not being actuarially sound, this increases the risk of CMS not certifying the rates (which will negate savings). Many of the current LANE adjustments seem to lack controllability (e.g., head wounds presenting to the ED) so this does not seem realistic.
	• The HERC part of the clinical efficiency criteria is absolutely critical - this needs to be in benefit/policy adjustment, not just taken out of CCO rates prospectively. I think its very important to develop a statewide strategy for the HABH population but I'm very concerned because its listed as a clinical efficiency strategy and we need to make the upfront investments in both capacity and policy to make it actually happen. Its can not just be built in as a rate cutting methodology.
	• Further transparency is required to understand how adjustments are made and there should be opportunities for CCOs and partners to react and provide input related to adjustments to rates. We are concerned about potential actions that would create one-sided risk transfer where rates are reduced immediately without savings, as they can have downstream impacts on providers.
	• Changes to NEMT Benefit:
	  ◦ Some local CCOs have tightly integrated NEMT into the total care experience for members where drivers play a key role in flagging member needs and utilization management has been effectively managed. A centralized service loses the care coordination value and likely exposes risks in FWA that are more difficult to detect. The state also takes on greater risk (e.g., will OHA pay providers when their NEMT services fail to get members to appoints on time?)
	  ◦ If you carve out NEMT the CCOs must get a commitment to appointment validation and access to care coordination related information
	  ◦ NEMT the discussion was mixed the rural areas have limited options and have implemented something that is working.

Select Qualitative Feedback, *cont.*

Options Category	Select Feedback
Provider Rate Reductions	• Current Behavioral Health rates for Oregon Medicaid exceed commercial reimbursement rates. • Seems like a very straightforward change that should be made. • As a general matter, we oppose provider rate caps or reducing these reimbursements as this will threaten patient access to care, strain margins, and shift care to higher cost settings such emergency departments.
Pharmacy	• CCO pharmacy cost trends have generally remained below national benchmarks, making it difficult to assume that additional top-down reductions by OHA would produce meaningful savings without impacting access or shifting costs elsewhere. It is also unclear how much of the remaining pharmacy spend is already constrained by legislative mandates, statewide policy decisions, or OHA requirements that limit the utilization management tools available to CCOs. • I'm very concerned about our collective ability to implement something like a single PDL given that we're updating the prioritized list, transitioning the entire HOP population, and will be needing to sunset key waiver provisions at the same time as supporting members to maintain coverage through work requirements, etc. • A statewide PDL may simplify administration, but it can also increase total costs by limiting CCO flexibility to use targeted utilization management, step therapy, and local cost-control strategies. Maximizing supplemental rebates does not always equal the lowest net cost of care, especially if it drives increased use of high-cost brand medications because the supplemental contracts limit or ban medical management of the drugs as contract terms in order to receive the rebate. These numbers do not factor these realities into the assumption of savings. • The benefits of a single PDL and/or single PBM are inconclusive. The most significant risk is the prospect of building the required administrative capacity and competency at the OHA to successfully implement at the agency level. A project of this scope would also compete with OHA resources and capacity at a time when 1) the OHA is fundamentally changing the parameters of the prioritized List and 2) taking on the provision of all health benefits delivered to the Healthy Oregon Program population affecting 100k Oregonians. • We do not believe it is in the best interest of Oregon or Medicaid members for the pharmacy purchasing model to shift to a single PDL or a standalone mental health PDL. We do not support disease specific carve outs for prescription drugs, though we believe of the three options presented, a mental health PDL would have the lower likelihood of disruption to members and providers. Areas of concern include how mental health parity will be considered to ensure equitable access to mental health drugs and mental health medications have high individual variability in response and tolerability. Problems may arise if prior authorization for non-preferred psychiatric medications are required, which could lead to higher hospitalization rates and higher overall medical costs. If the state pursues a single PDL option for Medicaid, we want to ensure policy makers understand the substantial risks both in terms of fragmented care for patients and increased pharmaceutical costs. Careful attention should be given to how a single PDL is implemented; how drug costs are negotiated; how formularies are determined; and how the state can support integrated systems to ensure the policy choice does not overly burden members with complex processes while simultaneously increasing costs to an already overburdened system.

Select Qualitative Feedback, *cont.*

Options Category	Select Feedback
Benefit Changes/ Scope Limits	• I don't think you can reduce the BH Spend and limit case management in BH. I think case management has to be part of reducing the spend. • The Dental benefit needs to be thoroughly examined. Current workforce (Dental provider Network) constraints are acute and deteriorating rapidly. • Lack of access to dental care will increase ED utilization. If there is a backstop in place (some coverage), we may be able to keep average ED dental visits relatively low and avoid significant long-term cost growth. • We believe that OHP members should have meaningful access to affordable healthcare services and support the maintenance of comprehensive benefits that meet the needs of the target population and are clinically informed. The essential health benefit design under the Affordable Care Act (ACA) establishes a framework to prioritize coverage of high-value, clinically necessary services that should be leveraged to align benefits against. We believe it is important to maintain access to core health benefits, and that if changes to optional benefits are required to achieve target savings, that benefits be strategically limited as opposed to removing entire categories. Benefits such as adult dental preserve coverage and access to essential oral health services, support preventative care, and promote overall health and well-being for Medicaid members. As limits or potential benefit eliminations are considered, we encourage the state to also consider the downstream impacts that may arise from cost shifts to other high-cost or acute services…In addition, as the state proceeds with transition from the prioritized list to state plan amendments, we encourage partnership with health plans to maintain flexibility for implementing clinically driven medical necessity criteria that serves the unique needs of their enrollees.
Across-the-Board Budget Changes	• Consider focusing these cuts on improving efficiencies within long-term care. • These cuts will directly impact provider rates (may need to focus the cut to not impact access) • Across the board cuts are the most administratively efficient, can be supported by OHA policy development, and allow for the most flexibility at the local level for CCOs to seek efficiencies and leverage local market dynamics. • I fear that any kind of cut to OHA's budget will simply translate into rate cuts or otherwise cuts to providers and CCOs directly; meaning, internal efficiencies will not be the first priority for the agency, if this ends up being a formal recommendation. A strategy like this would equate to the MAG simply handing off this exercise to OHA alone, which I strongly oppose. • This is important to also include OHA administrative expenses - this should not just be CCO and FFS. • We should avoid across the board rate cuts which, at this moment of provider instability, will collapse the health care system.