OREGON OFFICE of RURAL HEALTH

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Rural Health Transformation Program (RHTP) Webinar Series

H.R. 1 Impacts on Medicaid and Rural Health

The mission of the Oregon Office of Rural Health is to improve the quality, availability and accessibility of health care for rural Oregonians.

The Oregon Office of Rural Health's vision statement is to serve as a state leader in providing resources, developing innovative strategies and cultivating collaborative partnerships to support Oregon rural communities in achieving optimal health and well-being.

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Webinar Logistics

- Audio is muted for all attendees.
- Select to populate the chat feature on the bottom right of your screen. Please use either the chat function or raise your hand on the bottom of your screen to ask your question live.
- Presentation slides and recordings will be posted shortly after the session at: https://www.ohsu.edu/oregon-office-of-rural-health/rural-health-transformation-program

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Goals for webinar

01

Provide an overview of selected sections of H.R. 1

02

Gather feedback to learn what will be useful information for potential future webinars

Agenda

01 H.R. 1 overview and impact in Oregon
Oregon

02 Deeper dive on changes

03 Q&A and discussion

BUDGET RECONCILIATION ACT OF 2025

What is H.R.1?

H.R.1 (also referred to as the “One Big Beautiful Bill Act”) is a federal tax and spending statute passed by Congress and then signed into law by Donald Trump on **July 4, 2025**.

H.R.1 makes significant changes to **health care, SNAP, student loans, and energy programs** .

State and federal regulations and guidance on H.R.1 are in flux. Today's presentation is aimed to provide an overview, but final OHA and ODHS rules and guidance should be consulted for the latest changes, especially if you're helping members/patients navigate eligibility changes.

Health care changes in H.R.1 (mostly Medicaid)

ELIGIBILITY

Who qualifies

- New 80-hour/month work & community-engagement rule (expansion adults 19–64)
- Coverage ended for certain non-citizens (refugees, asylees, trafficking survivors)
- Retroactive coverage shortened

ADMINISTRATIVE

How you stay enrolled

- Eligibility redeterminations every 6 months
- Quarterly eligibility & Death Master File checks
- New address-update process; copays for some adults >100% FPL

FINANCING

How Oregon pays for it

- Provider tax cap steps down 6% → 3.5% (FY2028–2032)
- State-directed payments capped at 100% of Medicare
- IGT (Intergovernmental Transfer)-funded payments reduced; Healthier Oregon FMAP shift

OVERVIEW

Timeline

Medicaid impacts, 2026–2027

		OREGON IMPACT
Jul 4, 2025	**Planned Parenthood funding ban.** Prohibition of payments using federal funds for 1 year. Lawsuit pending, but ban was in place through July.	OR allocated $10m from emergency fund for FFS carve out for OHP members.
Oct 1, 2026	**Non-citizen eligibility ends.** Refugees, asylees and other lawfully residing non-citizens with temporary protective status no longer eligible for Medicare/Medicaid/CHIP.	OHA projects immediate loss of **$22 million** in federal funds. Additionally, all Healthier Oregon Program members must be moved to FFS.
Jan 1, 2027	**Work requirements + Retroactive coverage cut.** Work requirements for the ACA expansion population, with categorical exemptions. Retroactive coverage from 90 days to 30 days for the ACA expansion population; 60 days for all other Medicaid/CHIP members. Plus a required CMS-approved address verification process.	Manatt estimates initial loss of **17–22% of enrollees**. Higher uninsured/uncompensated care, higher administrative cost for the state, more administrative burden on members. More medical debt.
2027 (TBD)	**6-month redeterminations.** Redetermination every 6 months for expansion adults; 12 months for all others.	Higher uninsured rates of eligible individuals who lose coverage due to paperwork issues. OHA awaiting guidance on exact start date. Current 2-year continuous eligibility waiver expires 9/30/27.
Oct 1, 2027 FFY 2028	**Provider tax ceiling falls 6% → 3.5%.** States above the cap must reduce 0.5 points per year from FY2028 until 3.5% in FY2032.	Loss of **$12 billion** in federal matching funds over 10 years.

Medicaid impacts: 2028 and beyond

		OREGON IMPACT
Oct 1, 2028 FFY 2029	**Reduction in limits for state directed payments** to 100% of Medicare rates for expansion states and 110% for non-expansion states. States above limit need to reduce payments by 10 percentage points per year beginning in 2028.	Reduced supplemental payments to hospitals and nursing facilities, potentially impacting provider revenues and care delivery.
Oct 1, 2028 FFY 2029	**Cost sharing requirements.** Requires states to implement cost-sharing of up to $35 for adults for many services, excluding primary care, behavioral health, emergency services and services in exempt rural settings.	Administrative challenges with implementation. Cost sharing has been demonstrated to prevent access to needed care for Medicaid members, even at lowest amounts.
Oct 1, 2029 FFY 2030	**Removes good-faith waivers for erroneous payments.** Removes ability to waive federal penalties for a state's good-faith efforts to correct erroneous excess Medicaid payments under the Payment Error Rate Measurement (PERM) program and other state and federal audits.	No option for waived penalties even when there are good faith efforts.

Timeline of Changes to Oregon Health Plan (OHP)

October 2026

Some immigrants will move to Healthier Oregon

Some members will receive notices about meeting work or activity rules

January 2027

Work or activity rules begin for some adults

Shorter time period for help with recent medical bills (retroactive coverage)

Healthier Oregon members will move to OHP Open Card (Fee for Service)

Late 2027

More frequent renewals

Continuous eligibility rules end for adults and change to one year for children

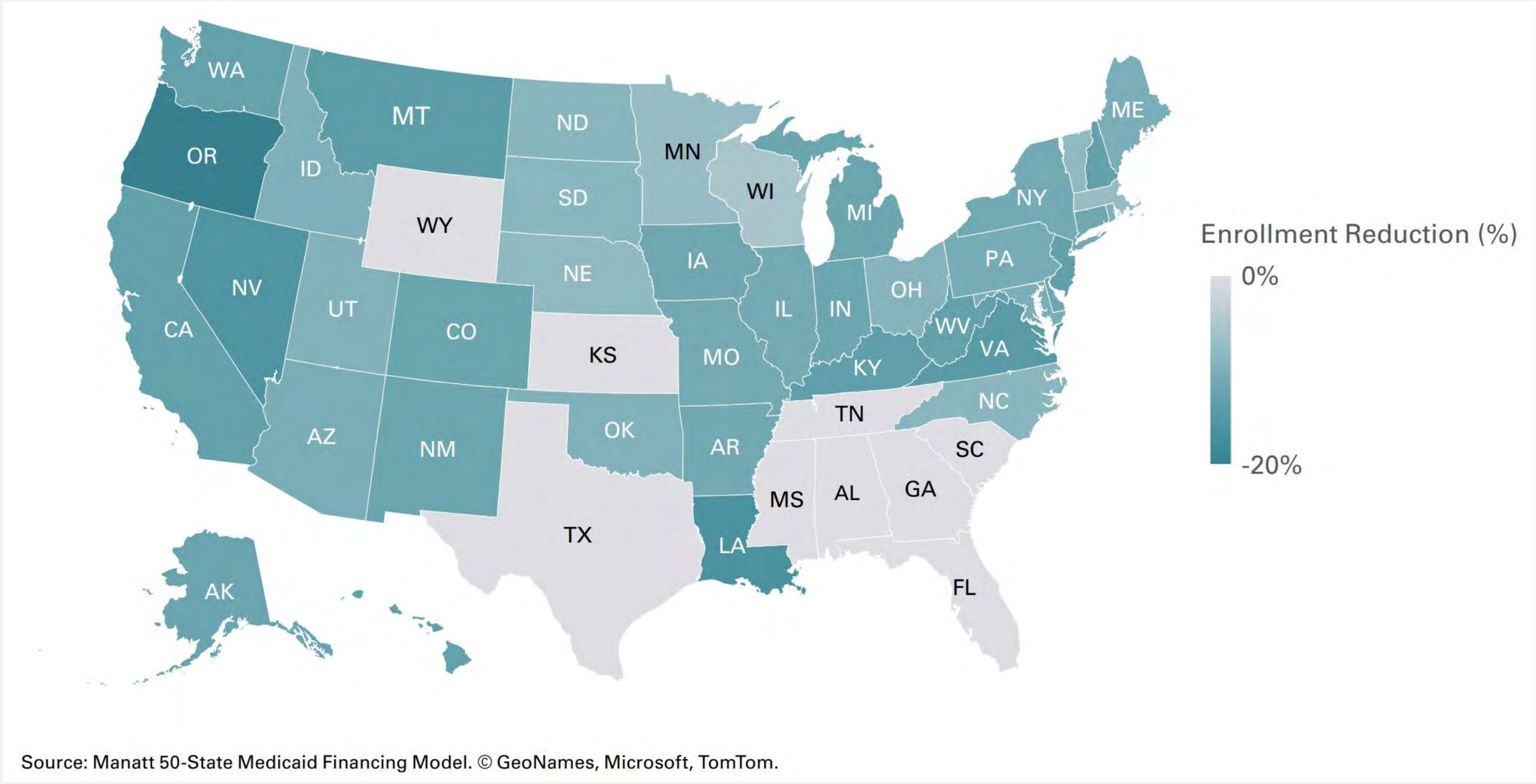
October 2028

Some adults will begin paying a small fee (copay) for some services

OVERVIEW

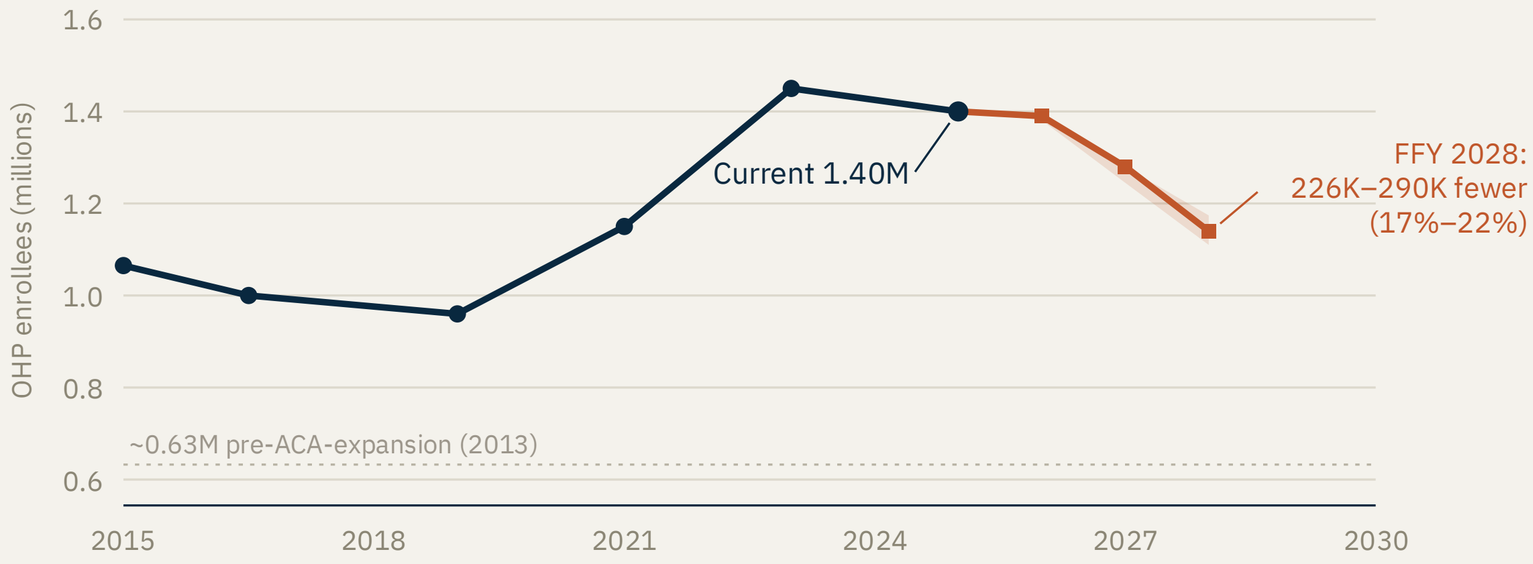
Coverage and Financial Impacts for Oregon

Oregon projected to be the hardest hit from work requirements



Source: Manatt 50-State Medicaid Financing Model. © GeoNames, Microsoft, TomTom.

With new work requirement rule, enrollment drop could hit 290,000 in 2028



Historical OHP enrollment

H.R.1 projection (mid)

H.R.1 loss range (Manatt, FFY 2028)

WHAT DRIVES THE DROP

80-hour/month work & reporting rules (Jan 2027)

Eligibility redeterminations every 6 months

Loss stems mostly from paperwork churn — not people becoming ineligible

Those who lose OHP are barred from subsidized Marketplace coverage

OHA's initial estimate was ~200,000, but new CMS rules (June 2026 interim final rule) are pushing that number higher. Manatt FFY 2028 estimates: 226,000 (17%) under HR1 to 290,000 (22%) with new CMS rule. *Sources: Manatt Health, CMS Work Requirements Rule 50-State Analysis (Jul 2026); OHA / Governor's Advisory Group (2026).*

Financial impacts on the state through 2031

The state faces a total estimated impact of **$9.4 billion** between lost federal funds and a newly created state fund budget gap.

STATE GENERAL FUND GAP

~$1.4B

H.R.1 creates a new state budget hole that grows to 10% of the state's Medicaid budget. Total, 2025–31.

FEDERAL FUNDS LOST

~$8.3B

Reduction in federal funds from various H.R.1 changes. Total, 2025–31.

Source: Governor's Advisory Group on Medicaid Sustainability, Final Report (Jul 2026), Figure 1. The report's combined figure is $9.41B (2027–31); shown separately here because a state budget gap and lost federal funds are different in kind.

What coverage loss will cost the Oregon Oregon health care system

Covering fewer people amounts to “savings” in the state & federal budgets, but these dollars are no longer paying for care.

Source: Governor's Advisory Group on Medicaid Sustainability, Final Report (Jul 2026), Figure 1 (caseload / ‘Savings’ rows).

$6.87B

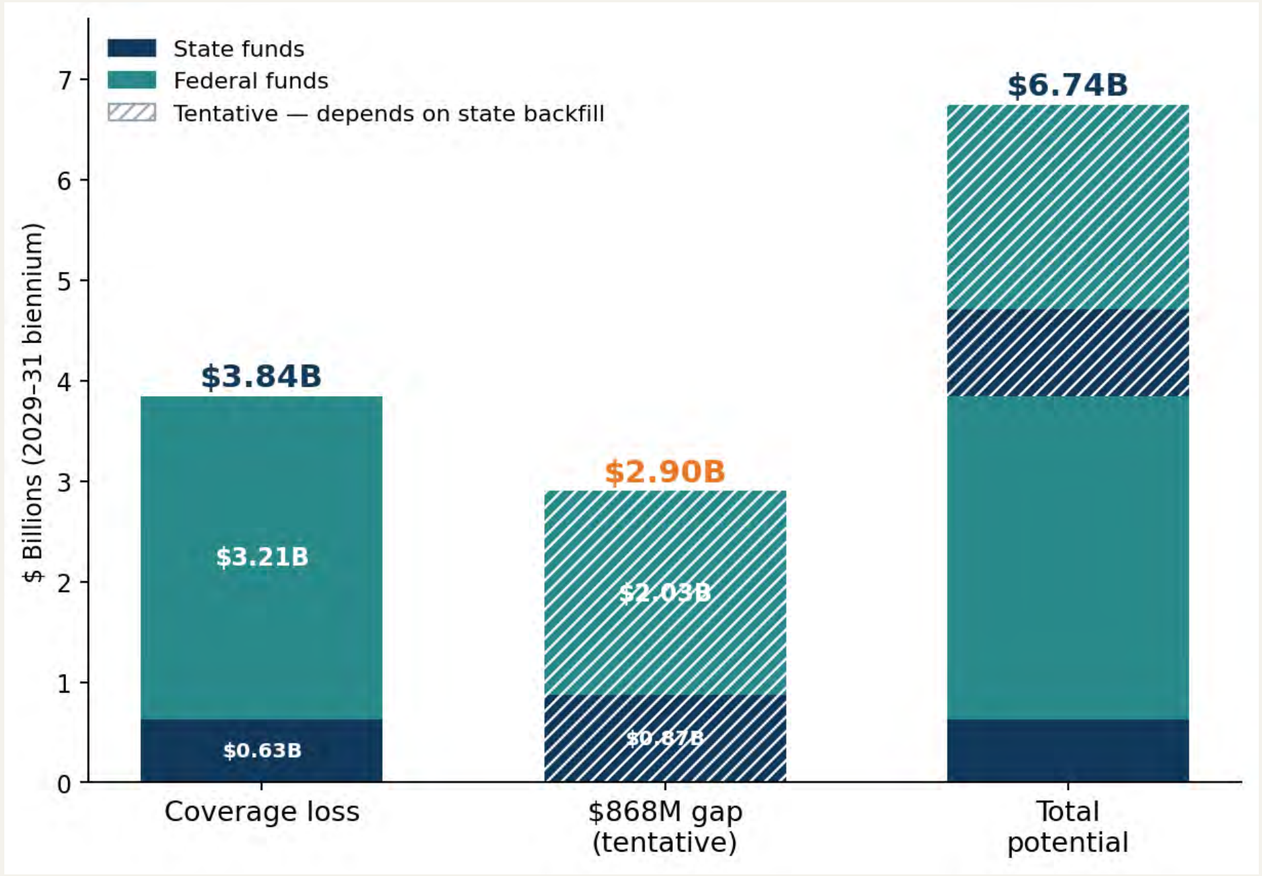
Cumulative loss of funding to the health care system as people lose OHP coverage, by 2031.

~85%

federal — most of the funding lost is federal match.

The impact grows if the general fund gap in 29–31 biennium is not filled

In addition to the loss of coverage from H.R.1, the Legislature may have to further cut eligibility, benefits or rates.



$3.84B

coverage loss — reimbursements providers lose as individuals lose OHP coverage (state + federal funds).

+$2.9B

potential additional impact. If the Legislature can't fill the $868M gap, total impact grows more than 3x when you account for lost federal match.

Sources: Governor's Advisory Group on Medicaid Sustainability, Final Report (Jul 2026), Figure 1 (coverage/caseload rows); Oregon Health Authority (gap and federal-match estimate). The $868M gap and its ~$2.03B federal match are tentative — the impact depends on how much of the gap the Legislature can fill. Budget share is illustrative (~$36B projected 2029–31 total funds).

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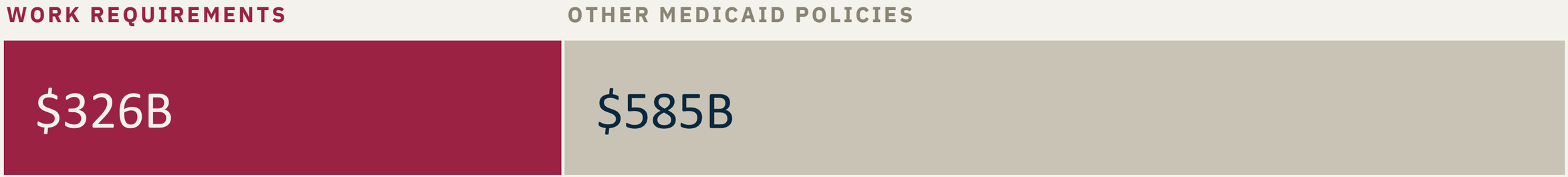
Eligibility Changes

Work requirements provide a significant portion of the H.R.1 budget cuts budget cuts

Work requirements make up about **36%** of the $911 billion in total federal Medicaid spending cuts over ten years.



Note: The total Medicaid cuts of $911B include $79B in estimated Medicaid spending interactions. Source: KFF analysis of CBO estimates of the enacted reconciliation package.

Work requirements will be the biggest cause for the coming drop in health coverage

Work requirements alone account for **5.3 million** of the 10 million increase in uninsured people, CBO estimates for 2034.

Note: CBO estimated a total increase of 10 million uninsured individuals in 2034. This total and “other policies” includes 300,000 in estimated coverage loss due to interaction between policies; “other policies” also includes Medicare and Marketplace changes. Source: KFF analysis of CBO estimates of the enacted reconciliation package.

Most Medicaid enrollees who can work, already do work

Medicaid work requirements will mostly affect people who are working, ill or disabled, caregivers, or students. Non-elderly adult enrollees not receiving SSI, 2016.

- Working: 60%
- Ill or disabled:* 15%
- Taking care of home or family: 12%
- Going to school: 6%
- Retired: 4%
- Could not find work: 2%
- Other: 1%

*People receiving Supplemental Security Income (SSI) are exempt from Medicaid work requirements. Figure shown here includes people who are ill or disabled but not receiving SSI. Source: Kaiser Family Foundation analysis of March 2017 Current Population Survey, via Center on Budget and Policy Priorities.

Work requirements

MUST BE IMPLEMENTED BY JAN. 1, 2027

Individuals ages 19–64 applying for or renewing coverage through the ACA Expansion Group must meet work requirements to qualify for Medicaid.

QUALIFYING ACTIVITIES

- 80 hours per month of work or a SNAP defined work program, community service
- Enrolled in education at least half time
- Or any combination of the above
- Alternatively, individuals can qualify by earning at least **$580/month** — or averaging that over six months for seasonal workers

HOW IT IS VERIFIED

01 At application and each redetermination, states must "look back" one or more consecutive months (up to three) to confirm compliance.

02 If a person is denied or disenrolled due to work requirements, they need to file a new application to re-apply — triggering the compliance check for at least the month prior to application.

Ways to meet OHP work and activity rules

80 hours per month of paid or unpaid work

Starting January 2027, some adults ages 19–64 who do not qualify for an exemption will need to meet OHP work *and* activity rules by showing one of the following:

Gross household income of more than **$580 per month**

80 hours per month of work, education, training programs, or unpaid work like volunteering (community service)

Enrollment in high school, a GED program, at least half time in higher education

Federal minimum wage is $7.25/hour; Oregon's is $14.55–$16.30 (Portland Metro). This means fewer hours than other states — 37.3 hours/month at $15.55.

GED = General Equivalency Degree.

Not subject to work requirements

New federal work requirements don't apply to certain individuals
Not an exhaustive list – some exceptions are very specific

- Under the age of 19
- American Indian or Alaskan Native
- Dually eligible (entitled to Medicare Part A / enrolled in Part B)
- Incarcerated or recently released from incarceration
- Spent at least a week away to receive care or to help others get care
- Foster youth and former foster youth under the age of 26
- Blind or have a serious or disabling health condition
- Already meeting work requirements for TANF or SNAP
- In treatment for alcohol or drug use
- Live in a federally declared disaster or high unemployment rate area
- Pregnant or receiving postpartum coverage
- Disabled veterans
- Care for a child under the age of 14 or individual with a serious health condition or disability
- Recently admitted to the hospital or other care facility

The CMS Interim Final Rule on work requirements

1 **Stricter than the law.** Beyond H.R. 1's five medical-frailty categories, CMS added a functional test — individuals must also prove their condition "significantly impairs" their ability to perform the 80 hours, narrowing the exemption.

2 **Self-attestation is temporary and limited.** Permitted (under penalty of perjury) when reliable data is unavailable through Dec. 31, 2027; from Jan. 1, 2028, medical frailty may be self-attested only once per enrollment period, then documentation is required.

3 **Data-first verification.** States must check data sources and use ex parte processes first; only where data are unavailable may they require documentation or accept self-attestation.

4 **Hard for states, risky for enrollees.** The rule departed from prior CMS guidance and added requirements not in H.R. 1, on a tight timeline (effective Jan. 1, 2027). Analysts warn it will push more eligible people out of coverage; CMS projects ~2.3 million fewer enrolled in FY 2027.

1 Foley Hoag — CMS Issues Interim Final Rule Imposing Medicaid Work Requirements (June 2026). 2 Holland & Knight — CMS Issues Interim Final Rule (June 2026); McDermott+ (June 2026). 3 State Health & Value Strategies — CMS Releases Interim Final Rule on Medicaid Work Reporting Requirements (June 2026). 4 KFF — Key Takeaways (July 2026); Georgetown CCF — IFR Explainer (July 2026).

Reducing retroactive coverage makes a bad situation worse

90-days retroactive coverage has been an essential feature of Medicaid since **1972**.

H.R. 1 changes this. Starting in January 2027, it shrinks the period of retroactive coverage to:

30 days

for adults aged 19 to 64 enrolled in the ACA Medicaid expansion

60 days

for all other Medicaid enrollees, including children

WHAT IT MEANS ON THE GROUND

- Without retroactive coverage, health care providers and the state absorb the cost of uncompensated care
- Serious financial loss for hospitals, who must provide emergency care regardless of coverage — especially rural hospitals
- Also negatively impacts nursing homes and exacerbates access problems
- A double whammy combined with changes to redetermination and work requirements, which will result in more people losing coverage or “churning” on and off Medicaid

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Other Program Eligibility Changes

SNAP: New ABAWD work requirements & early impacts

New SNAP work requirements apply to “Able-Bodied Adults Without Dependents” (ABAWDs). H.R.1 expanded these to more than **300,000 Oregonians**.

NEWLY REQUIRED GROUPS

- **Ages 18–64** — previously exempt after 54
- **Adults with children over 14** in the household — previously under 18
- **Veterans, former foster youth, and people experiencing homelessness**

Those covered must complete **at least 80 hours/month** of approved activities — paid or unpaid work (self-employment, volunteering/Workfare, or trading work for shelter), a SNAP Employment & Training program, or a combination with education while still working. Miss the 80 hours, and SNAP is limited to three months in any three-year period.

AS A RESULT OF THESE CHANGES

6,948

people lost SNAP at the end of April 2026

5,258

people lost SNAP at the end of May 2026

4,589

people lost SNAP at the end of June 2026

Changes to Oregon Health Insurance Marketplace

CHANGES ALREADY IN PLACE

- Lawful permanent residents who have had their status less than five years no longer eligible to receive premium tax credits on Marketplace plans — still potentially eligible for Healthier Oregon
- Advance premium tax credit repayment caps removed — individuals responsible for full amount of overpayment

FEDERAL CHANGES COMING 2027

Some non-citizens no longer eligible to receive premium tax credits on Marketplace plans

Shortened Open Enrollment: Nov. 1 to Dec. 31, 2026 for coverage starting Jan. 1, 2027

Applicants must provide proof of income if reported income doesn't match IRS records

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Administrative Changes

More frequent redeterminations (renewals)

Currently, most OHP members renew **every two years**.

The federal government will require more frequent Oregon Health Plan (OHP) renewals.

STARTING IN 2027

Every 6 months

Some adults will renew every six months

Every 12 months

All other OHP members will renew once per year

More frequent redeterminations - details

6-month redeterminations for many adults

Beginning December 31, 2026, low-income adults ages 19 through 64 without disabilities (the ACA expansion population) must have their Medicaid eligibility redetermined every 6 months

The only exemption is for AI/AN members (American Indian and Alaska Native)

12-month redeterminations for everyone else

All other members will need to renew every 12 months, including children and programs based on disability.

People always lose coverage at renewal — more frequent renewals will mean more coverage loss and churn: losing coverage and then gaining it back a few months later. More people will become uninsured.

72%

In 2023, 72% of people who lost access to Medicaid lost it not because of ineligibility … but because they had difficulty navigating complex applications and paperwork.

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Changes to Healthier Oregon

About Healthier Oregon and Open Card

Healthier Oregon

A mostly state-funded program that allows Oregon to offer full Oregon Health Plan (OHP) coverage, regardless of immigration status. Federal match for emergency and pregnancy related services.

OHP Open Card

Also known as Fee-for-Service or FFS, one of the ways members can be covered. Some members have OHP Open Card, some members are covered by a coordinated care organization (CCO), and some members are covered through a mix of both.

2 Healthier Oregon members will transition from CCOs to OHP Open Card Card

The Centers for Medicare & Medicaid Services (CMS) released a new federal rule that state programs like Healthier Oregon cannot be administered through Coordinated Care Organizations (CCOs).

Starting in January 2027, Healthier Oregon will use the OHP Open Card provider network instead of Coordinated Care Organizations.

Healthier Oregon members covered through Open Card will **continue to have the same covered benefits**, but the network of health care providers that members can seek health care from **may be different**.

Provider info page: oregon.gov/oha/HSD/OHP/Pages/Provider-Enroll.aspx

3 New work and activity rules will apply to some Healthier Oregon members

Because of H.R. 1, many adult Healthier Oregon members must meet the new federally required work and activity rules.

Some members ages 19 to 64 years old will need to complete work or other qualifying activities — such as work, go to school, be in job training, or volunteer, or a combination of these.

Some members will qualify for exemptions that mean they do not need to meet the rules.

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Finance Changes

Financing changes in H.R.1

Provider tax step-down

Provider taxes are a way for states to pay for their share of the Medicaid program and receive federal match. Today, **roughly a quarter** of Oregon's Medicaid budget is funded by provider taxes. The allowed provider tax rate of **6% falls to 3.5% by 2032** . New or increased provider taxes after are prohibited.

State-Directed Payments (SDP)

SDPs are how states enhance provider rates to account for provider taxes they pay. SDPs will be capped at **100% of Medicare** instead of commercial rates. Oregon's existing SDPs will be reduced 10 points per year starting 2028. Functionally this adds another limit to how much states can use provider taxes to fund Medicaid, requiring them to cut programs or invest new general fund revenue.

Intergovernmental Transfers (IGT)

An IGT is like a provider tax but paid by a public entity. While IGTs were not reduced, they fall under the same directed-payment limits, functionally significantly reducing how much the state can use IGTs to cover the state share of Medicaid.

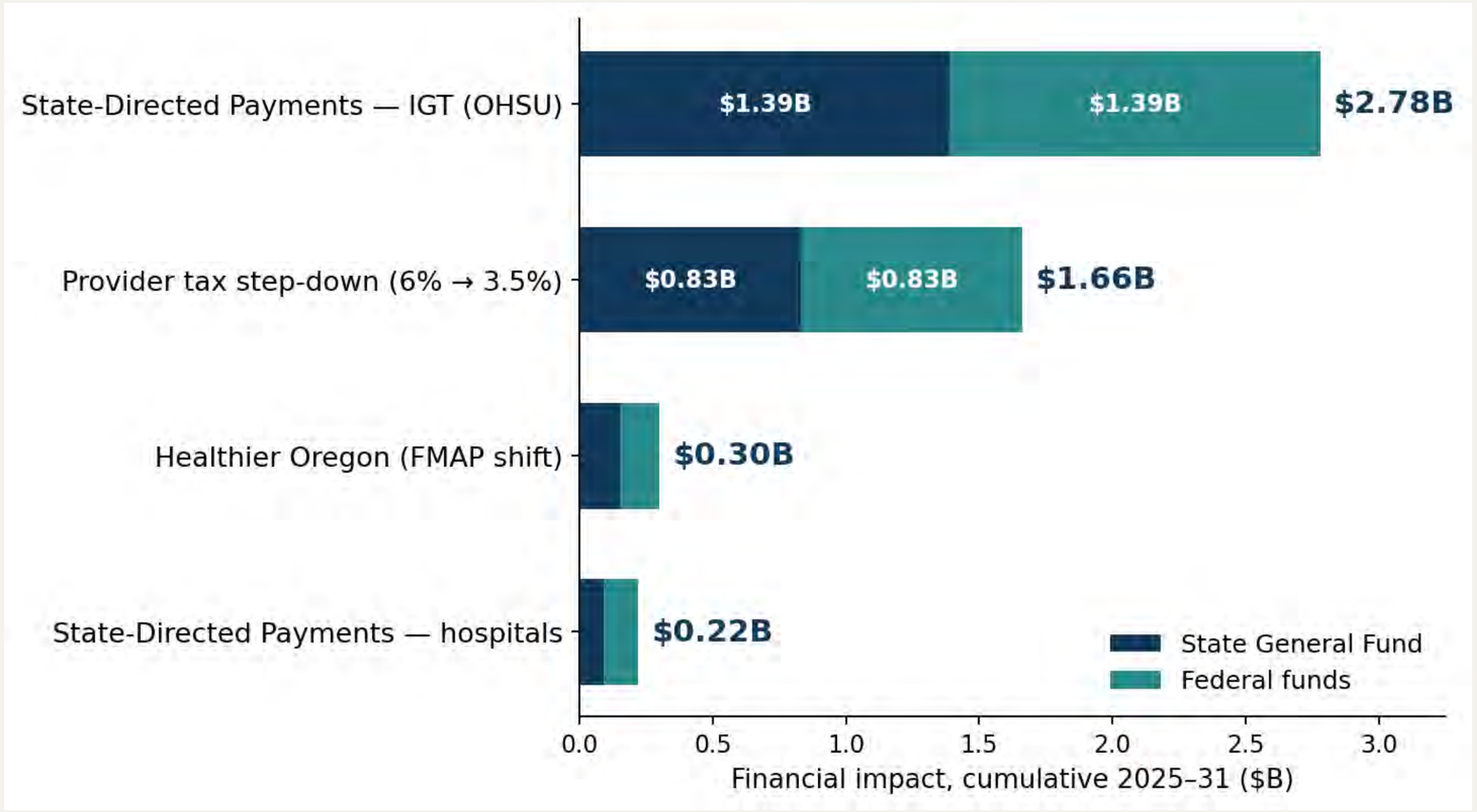
Healthier Oregon / FMAP

Reduced federal match for emergency services provided to certain non-citizens.

Sources: Governor's Advisory Group on Medicaid Sustainability, Final Report (Jul 2026); OHA. Provider-tax cap per H.R. 1 / 42 CFR §433.68.

What those financing changes cost

STATE AND FEDERAL FUNDS, CUMULATIVE 2025–31



$4.95B

State + federal funds lost to financing cuts by 2031 — $2.49B federal plus a $2.46B state General Fund gap.

Provider funded transfers take the biggest biggest hit

New limits on the OHSU IGT ($2.79B) and hospital provider tax ($1.66B) have the largest state budget impact.

Source: Governor's Advisory Group on Medicaid Sustainability, Final Report (Jul 2026), Figure 1 ('Challenges' rows: H.R. 1 §71115, §71116, §71110).

DISCUSSION

Oregon Rural Health Collaborative

RHTP funds cannot supplant Medicaid funding

RHTP dollars can help rural systems adapt to federal Medicaid cuts, but they cannot be used to directly offset or replace those cuts or to pay for services that should be covered by Medicaid or other insurance.

RHTP funds may not be used to finance the non-federal share of Medicaid — no use as state match, Intergovernmental Transfer equivalents, or to plug Medicaid budget holes.

RHTP cannot be used to directly replace federal Medicaid cuts in H.R. 1 or to restore coverage or benefits that H.R. 1 removes. CMS has stated the program is not intended to “replace the funding cut in H.R. 1.”

There are other non-allowable uses of RHTP funding (in addition to above).
For more information, see OHA's website.

How could your community and the Oregon Rural Health Collaborative prepare for H.R.1 (and how could RHTP funds help)?

Some examples:

Communication and coordinated messaging support	Education and training	Outreach to Medicaid enrollees	Application support to Medicaid enrollees
Coordinating access to volunteer/job opportunities	Leveraging CHW navigators	Convening regional stakeholders to coordinate and leverage community resources	Scaling programs for the uninsured

Your ideas here!

Discussion and feedback

What do you want to learn more about?
What ideas are you considering in your community?

Questions?

Stay informed by checking OHA's website. www.oregon.gov/oha/hsd/ohp/pages/federal-changes.aspx

ORH Announcements

- **Next ORH Community Conversations** (*Register here*):
  - **July 23** at 12 p.m. | Revitalizing Oregon's Rural EMS Workforce

- **Oct. 7-9, Bend, OR | 43rd Annual Oregon Rural Health Conference**
  (*More information here*)

- Do you have an idea for another webinar you'd like to see? A question that came up that you didn't have answered? Would you like to request technical assistance? (*Submit a request/ comment here*)

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