OREGON OFFICE of RURAL HEALTH

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Rural Health Transformation Program (RHTP) Webinar Series

H.R. 1 Deeper Dive: Administrative and Financing Changes

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.
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- 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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Diana Bianco



Mike Bonetto



Cathy Kaufmann



Jeremy Vandehey

OHSU

NEXUS
HEALTH STRATEGIES

Goals for webinar

1. Go deeper on H.R. 1 administrative and financing changes
2. Share resources and ideas for what your community can do to navigate the changes
3. Q&A and Discussion



Agenda

01 Big Picture: H.R. 1 Changes and Timeline

02 Deep Dive: Administrative Changes

03 Deep Dive: Financing Changes

04 Resources and Ideas: What Your Community Can Do

05 Q&A and Discussion

H.R. 1 impacts on the Oregon Health Plan (OHP)

ELIGIBILITY

Who qualifies

- New work or activity rules: 80 hours/month (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 for some adults, at least every 12 months for everyone else (even kids) (In Oregon, t*his change doesn't go into effect until October 1, 2027)*
- 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

Timeline of 2027 Changes to Oregon Health Plan (OHP) and Healthier Oregon

October 2027

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.

Some immigrants will move to Healthier Oregon

January 2027

Work or activity rules begin for some adults

More frequent renewals (every 6-months) 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)

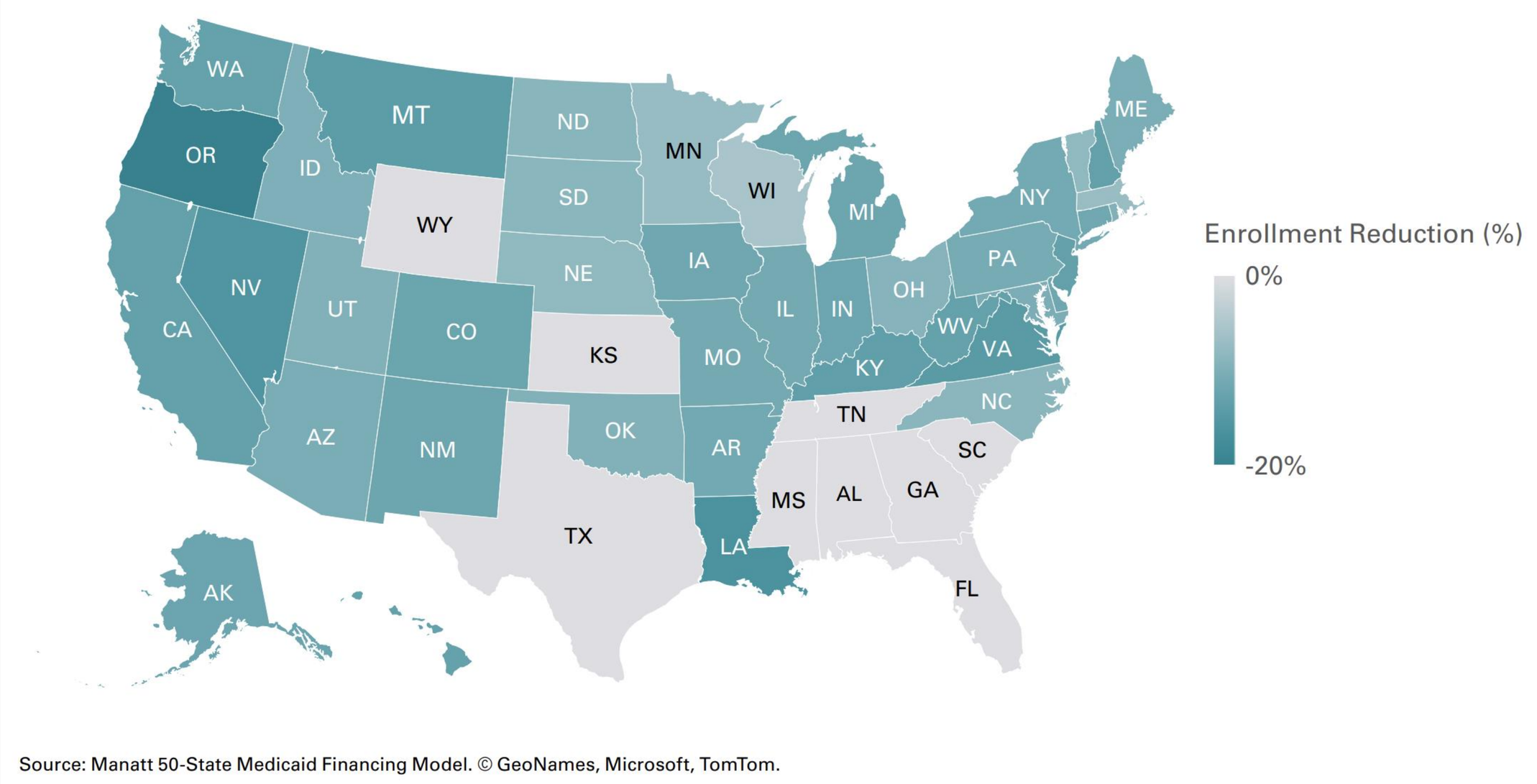
Late 2027

More frequent renewals for everyone:

- Every 6-months for some adults
- Every 12-months for all other adults
- Every 12-months for all children

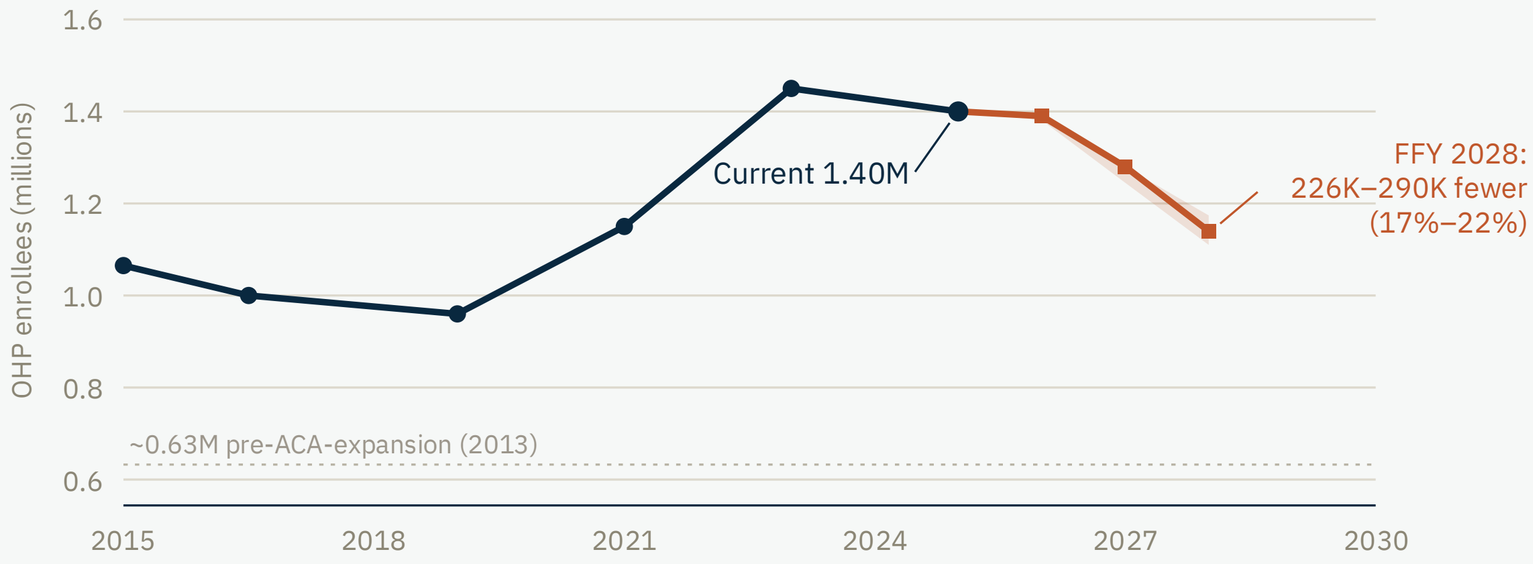
Note: Medicaid in Oregon is part of OHP. References to Medicaid in this presentation mean federal changes that will impact OHP. Healthier Oregon is the part of OHP that covers individuals not eligible for federal Medicaid due to immigration status.

Oregon projected to be the hardest hit from work or activity rules



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

With new work or activity rules, enrollment drop could hit 290,000 in 2028



WHAT DRIVES THE DROP

80-hour/month work or activity 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

Historical OHP enrollment

H.R. 1 projection (mid)

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

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 H.R. 1 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).*

PART 2

Deep Dive on the Administrative Changes

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Work or Activity Rules and 6-Month Renewals Only Apply to the "MAGI Adult" Population

MAGI MEANS:	Eligibility is based on Modified Adjusted Gross Income, a tax-based income test, with no asset test
WHO:	Adults ages 19–64 who aren't pregnant, don't qualify for Medicare, and don't fit another OHP category (Aged, Blind and Disabled, Parents/Caretakers below 40% FPL, etc.)
INCOME RANGE:	**Adults without dependent children:** 0% up to 138% of the federal poverty level. Before the ACA, there was no ongoing Medicaid category for this group. **Parents/caretakers:** above about 40% FPL (Oregon's pre-ACA parent limit) up to 138% FPL. Parents below that floor stay in the traditional parent/caretaker category.
COVERAGE:	Full OHP Plus benefits
FUNDING:	The federal government pays 90% of costs (compared to Oregon's regular federal match rate of 60%)

> Before the ACA, Oregon could cover only a limited number of low-income adults through its waiver program, OHP Standard. In 2008, about 90,000 people entered a lottery for roughly 10,000 openings.

There are 564,177 MAGI Adults enrolled in Oregon Health Plan as of Oct. 2026*

40% of OHP members

**Represents a slight undercount as some of the ~85,000 people in the MAGI Parents/Caretakers eligibility group (those with children 14 and over) will also need to be subject to these requirements.*

County	MAGI Adults	Total OHP	% MAGI Adults
Baker	2,269	5,656	40.1%
Benton	10,482	21,542	48.7%
Clackamas	41,606	104,874	39.7%
Clatsop	5,958	14,006	42.5%
Columbia	6,228	15,635	39.8%
Coos	10,207	24,704	41.3%
Crook	3,532	9,231	38.3%
Curry	3,791	8,141	46.6%
Deschutes	26,004	59,927	43.4%
Douglas	17,950	43,926	40.9%
Gilliam	253	632	40.0%
Grant	929	2,221	41.8%
Harney	1,088	2,785	39.1%
Hood River	3,086	8,509	36.3%
Jackson	35,506	87,269	40.7%
Jefferson	4,136	11,459	36.1%
Josephine	17,233	40,109	43.0%
Klamath	11,824	29,780	39.7%
Lake	1,290	3,199	40.3%
Lane	55,857	127,348	43.9%
Lincoln	7,939	18,469	43.0%
Linn	18,123	47,535	38.1%
Malheur	4,822	16,238	29.7%
Marion	44,229	136,283	32.5%
Morrow	1,310	5,229	25.1%
Multnomah	129,139	281,478	45.9%
Polk	9,706	26,485	36.6%
Sherman	243	668	36.4%
Tillamook	3,739	9,318	40.1%
Umatilla	9,454	31,955	29.6%
Union	3,628	9,230	39.3%
Wallowa	1,027	2,407	42.7%
Wasco	3,673	10,458	35.1%
Washington	56,091	159,218	35.2%
Wheeler	153	402	38.1%
Yamhill	11,393	31,982	35.6%
Unknown	279	927	30.1%
Total	**564,177**	**1,409,235**	**40.0%**

Oregon’s move to more frequent Medicaid renewals

Oregon’s continuous eligibility waiver runs through Sept. 30, 2027, which delays the H.R. 1 requirement for more frequent renewals for most people.

Population	Today (Waiver, through Sept. 30, 2027)	After the waiver ends (Starting Oct. 1, 2027)
Expansion adults Ages 19–64, income up to 138% FPL	**2-year continuous eligibility** **Renewal every 6 months*** for members whose 2-year continuous eligibility period ends between Jan – Sept 2027.	**Renewal every 6 months***
Other adults Parents/caregivers, older adults, people with disabilities, duals	**2-year continuous eligibility**	**Renewal every 12 months**
Children ages 6–18	**2-year continuous eligibility**	**12 months continuous eligibility** (federal minimum)
Children under 6	**Covered continuously until age 6**	**12 months continuous eligibility** (federal minimum)

***American Indians/Alaska Natives are the only exemption for 6-Month Renewals**

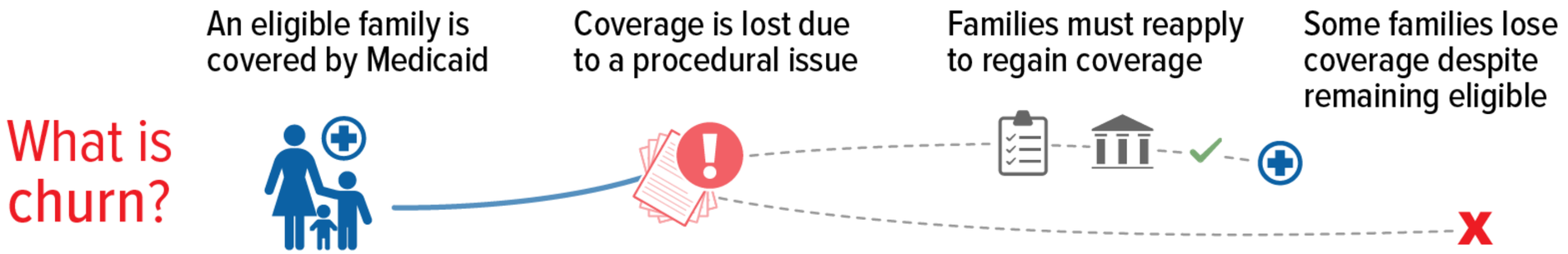
12-Months Renewal: You keep coverage for 12 months as long as your income/eligibility circumstances don’t change. (You are supposed to report changes.)
12-Months Continuous Eligibility: You keep coverage for 12 months, even if your family income/eligibility circumstances changes.

Sources: H.R. 1, Sec. 71107; Oregon Health Plan 1115 waiver (2022–2027); Consolidated Appropriations Act, 2023

More Frequent Renewals Leads to Churn

Reducing Churn Keeps Eligible Families Connected

Churn increases administrative burdens for families and state Medicaid agencies



Factors decreasing churn:

- ✓ *Ex parte* renewals
- ✓ Text reminders
- ✓ Using data sources to verify eligibility
- ✓ Accessible online platforms and call centers

Factors increasing churn:

- X More frequent renewals
- X Insufficient staffing
- X Excess verification requests
- X Confusing notices

Source: CBPP, "Medicaid *Ex Parte* Renewals Are an Efficient Strategy to Ensure Eligible Enrollees Have Healthcare, Increase Accuracy, and Reduce Administrative Costs"

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.

Source: KFF, *Medicaid Enrollment and Unwinding Tracker* (data as of Sept. 2023)

Effects of Churn on Health Access

- Research shows that disruptions in Medicaid coverage are common and often lead to periods of uninsurance, delayed care, and less preventive care for beneficiaries.

- Adults who experience churning or coverage disruptions are more likely to delay care, receive less preventive care, refill prescriptions less often, and have more emergency department visits.

    - Children with interruptions in coverage also are more likely to have missed well-child visits, screenings and vaccines, delayed care or unmet medical needs, as well as unfilled prescriptions.

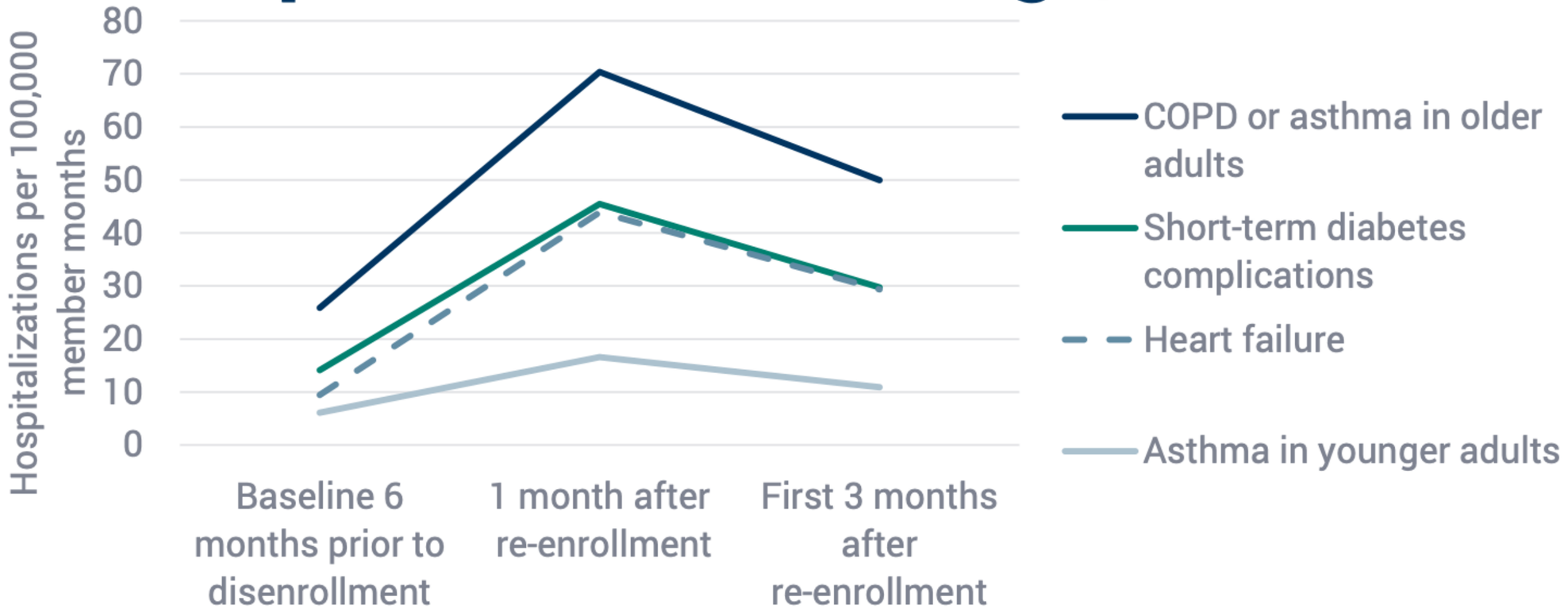
- MACPAC found that people who lost coverage and later re-enrolled became more likely to be hospitalized for preventable conditions.

    - After an episode of churn, beneficiaries were more than twice as likely to be hospitalized compared to baseline rates six months prior to disenrollment

    - Beneficiaries with longer gaps in coverage experienced larger percentage increases in rates of ED visits and hospitalizations

- A prior study in California that measured hospitalizations over five years found that Black and Hispanic beneficiaries had a much higher risk of hospitalization after an episode of churn than white beneficiaries

Rates of Hospitalizations for ACSCs Before and After a Gap in Medicaid Coverage, 2017-2019



Notes: ACSCs are ambulatory care sensitive conditions. COPD is chronic obstructive pulmonary disease. Analyses limited to adults age 18 to 64 and excludes beneficiaries dually eligible for Medicare and Medicaid. Older adults defined as age 40 to 64. Younger adults defined as age 18 to 39. The analysis excludes nine states (Alabama, Florida, Kentucky, Minnesota, New Jersey, Oklahoma, Pennsylvania, Rhode Island, and Tennessee) due to concerns with data quality in 2017-2019. In three states (Arkansas, Maryland, and Wisconsin) 2017 data are excluded due to data quality concerns.
Source: Mathematica, 2022, analysis for MACPAC of T-MSIS data.

The High Cost of Churn

- Churn results in higher administrative costs, less predictable state expenditures, and higher monthly health care costs due to pent-up demand for health care services.

- **Higher Administrative Costs:** A 2015 analysis estimated the administrative cost of one person's churning, including disenrolling and reenrolling, to cost between $400 and $600. (~$600 – $850 in today's dollars)

- **Higher Per Member Costs:** While churning lowers Medicaid medical expenditures by creating smaller monthly patient caseloads, it can lead to higher monthly per member costs.
  - Studies show people who churn in and out of coverage have higher Medicaid monthly health care costs due to pent-up demand for health care services after a period of ineligibility.
  - Cost impacts may be especially pronounced for beneficiaries with chronic conditions.
    - For example, Medicaid beneficiaries with diabetes with a lapse in coverage had per member per month costs that were $239 greater during the three months after reenrollment than in the three months prior to the coverage lapse.

- Longer coverage periods or continuous coverage leads to more predictability in monthly caseload expenditures, lower average monthly spending, lower enrollee spending on administrative costs, and better overall continuity of care for beneficiaries.

Administrative Changes: **Address Verification (Jan 2027)**

- H.R.1 address verification requirements start January 1, 2027

- States must regularly obtain address information from “reliable data sources” and take actions the Secretary specifies when addresses change.

- Each state’s process must be approved by CMS.

- Data sources the law names:
  - Mail returned by the U.S. Postal Service with a forwarding address
  - The USPS National Change of Address Database
  - Certain managed care entities (MCOs, PIHPs, PAHPs, and PCCMs)
  - Other sources the state identifies and the Secretary approves
  - Each managed care contract must require the plan to promptly send the state any address information it receives directly from enrollees or verifies with them directly.

- There are concerns that people with unstable addresses, with unstable addresses, such as people experiencing homelessness or recently released from incarceration.
  - Health Affairs article called for states to think carefully about how best to implement these requirements to avoid coverage losses
  - The National Health Care for the Homeless Council is urging states to request approval to use alternative data sources—specifically homelessness service provider addresses—for address verification.

Administrative Changes: **Eligibility and Death Checks (Jan 2027) 2027)**

- Beginning **January 1, 2027**, states are required to screen their Medicaid rolls against the Social Security Administration's **Death Master File** (or equivalent electronic data sources) at least quarterly.
  - Designed to quickly identify and disenroll deceased individuals to prevent fraudulent or improper Medicaid payments
  - States may also use other electronic sources, such as state health department vital statistics on deaths.

- States must treat DMF information as accurate
  - After providing notice and fair hearing rights, they disenroll the person without asking for more information.
  - If a state finds the DMF wrongly listed someone as deceased, it must re-enroll that person immediately, backdated to the disenrollment date.

- Also starting in 2028, states must implement monthly eligibility and death screenings for Medicaid healthcare providers

- The main risk is data quality. Bill analyses flag that false positives or data errors in the Death Master File could cause wrongful disenrollment.
  - Significant concerns with the integrity of data in the Death Master File have been raised

Administrative Changes: **Federal Duplicate Enrollment System (Oct 2029)**

- H.R.1 requires the creation and use of a new federal duplicate-enrollment system (starts Oct. 1, 2029)
- CMS must build a system that CMS and states use to prevent one person from being enrolled in Medicaid or CHIP in more than one state at the same time.
- States must submit data to the system at least monthly and during each eligibility determination or redetermination (monthly enrollee SSNs and other information)
- What happens when someone is flagged: States must confirm whether flagged individuals live in the state.
  - If they do not, the state must disenroll them, unless the Secretary specifies an exception.

PART 3

Financing Changes

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Medicaid impacts: 2028 and beyond

		OREGON IMPACT
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.
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.

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.

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

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.

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.

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

Financing changes in H.R.1: **State Directed Payments (SDPs)**

- 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.
  - Medicare rates are significantly lower than 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.

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

Financing changes in H.R.1: **Intergovernmental Transfers (IGTs)**

- 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

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

Financing changes in H.R.1: **Heathier Oregon Federal Match**

- 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.

So, What Does This All Mean? **2027-2029 Biennium**

For the 2027–29 biennium, H.R. 1 creates a combined impact of about **$3.8 billion** between lost federal funds and a new state general fund gap.

STATE GENERAL FUND GAP

$421M

The new general fund gap H.R. 1 creates for 2027–29 — about 5% of Oregon's OHA Medicaid state-funds budget.

FEDERAL FUNDS LOST

$3.37B

Federal Medicaid funding Oregon loses for the 2027–29 biennium under H.R. 1's provisions.

Source: Oregon Health Authority, Figure 1. Estimated Biennial Budget Impacts of H.R. 1 (draft for discussion, 11/24/2025). Caseload estimates are not based on the official forecast and are subject to change.

So, What Does This All Mean? 2027-2029 County Breakdown (1 of 2)

Estimated coverage loss and federal dollars withdrawn by county for the 2027–29 biennium, ranked by size of impact (1 of 2).

COUNTY	ESTIMATED COVERAGE LOSS	ESTIMATED FEDERAL $ WITHDRAWN
Multnomah	28,000	–$505M
Washington	13,800	–$386M
Lane	11,800	–$241M
Marion	10,800	–$220M
Clackamas	9,050	–$268M
Jackson	7,725	–$139M
Deschutes	5,550	–$132M
Linn	3,950	–$83M
Douglas	3,640	–$70M
Josephine	3,570	–$55M
Yamhill	2,500	–$69M
Klamath	2,470	–$43M
Umatilla	2,350	–$51M
Benton	2,175	–$60M
Coos	2,140	–$41M
Polk	2,100	–$55M
Lincoln	1,725	–$32M
Clatsop	1,300	–$28M
Columbia	1,270	–$34M
Malheur	1,250	–$20M

Source: OHA Fall 2026 Medicaid caseload forecast (Oregon Health Authority, August 2026), with the split between §71107 and §71119 derived from Oregon DAS, Estimated Impacts of H.R. 1 (Aug 11, 2025).

So, What Does This All Mean? 2027-2029 County Breakdown (2 of 2)

Estimated coverage loss and federal dollars withdrawn by county for the 2027–29 biennium, continued (2 of 2), with the statewide total across all 36 counties.

COUNTY	ESTIMATED COVERAGE LOSS	ESTIMATED FEDERAL $ WITHDRAWN
Jefferson	945	–$16M
Wasco	885	–$16M
Tillamook	845	–$16M
Curry	760	–$14M
Hood River	750	–$14M
Union	735	–$15M
Crook	720	–$15M
Baker	485	–$11M
Morrow	410	–$9M
Lake	285	–$4M
Harney	225	–$4M
Wallowa	225	–$4M
Grant	195	–$4M
Sherman	70	–$1M
Gilliam	60	–$1M
Wheeler	30	–$1M

Source: OHA Fall 2026 Medicaid caseload forecast (Oregon Health Authority, August 2026), with the split between §71107 and §71119 derived from Oregon DAS, Estimated Impacts of H.R. 1 (Aug 11, 2025).

So, What Does This All Mean? **County Impact Rankings**

The ten Oregon counties with the largest estimated 2027–29 impact, by two different measures.

BY ABSOLUTE COVERAGE LOSS

1. **Multnomah**
2. **Washington**
3. **Lane**
4. **Marion**
5. **Clackamas**
6. **Jackson**
7. **Deschutes**
8. **Linn**
9. **Douglas**
10. **Josephine**

BY LOSS PER 1,000 RESIDENTS

1. **Josephine**
2. **Malheur**
3. **Jefferson**
4. **Sherman**
5. **Klamath**
6. **Multnomah**
7. **Jackson**
8. **Lake**
9. **Lincoln**
10. **Wasco**

Source: OHA Fall 2026 Medicaid caseload forecast (Oregon Health Authority, August 2026), with the split between §71107 and §71119 derived from Oregon DAS, Estimated Impacts of H.R. 1 (Aug 11, 2025).

The Governor’s Advisory Group on Medicaid Sustainability: **Six Focus Areas**

To close the 2027–29 funding gap, the Advisory Group organized its recommendations into **six focus areas** for closing the state’s 2027–29 Medicaid budget gap.

CCO STRUCTURE

Back-end administrative and financing changes to the CCO / fee-for-service delivery model.

CLINICAL EFFICIENCY / UTILIZATION MANAGEMENT

Improve service delivery efficiency and reduce unnecessary utilization.

PROVIDER RATES

Adjust the rate of payment to providers.

PHARMACY

Restructure the pharmacy benefit to capture maximum savings.

BENEFIT CHANGES

Reduce scope of optional/mandatory benefits; remove coverage for optional benefits.

ACROSS-THE-BOARD BUDGET CHANGES

Reduce overall OHA Medicaid spending by a target percentage.

Source: Governor's Advisory Group on Medicaid Sustainability, Final Report to Governor Kotek (Jul 2026), Figure 2 — Organizing Framework for Advisory Group Options, p. 11.

So, What Does This All Mean? **2029-2031 Biennium**

For the 2029–31 biennium, the combined impact grows to about **$5.6 billion** between lost federal funds and a new state general fund gap.

STATE GENERAL FUND GAP

$868M

The general fund gap nearly doubles for 2029–31 — about 10% of Oregon's OHA Medicaid state-funds budget.

FEDERAL FUNDS LOST

$4.75B

Federal Medicaid funding Oregon loses for the 2029–31 biennium as more provisions reach full effect.

Source: Oregon Health Authority, Figure 1. Estimated Biennial Budget Impacts of H.R. 1 (draft for discussion, 11/24/2025). Caseload estimates are not based on the official forecast and are subject to change.

PART 4

Now what?
What action can you take with this information?

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Resources from OHA

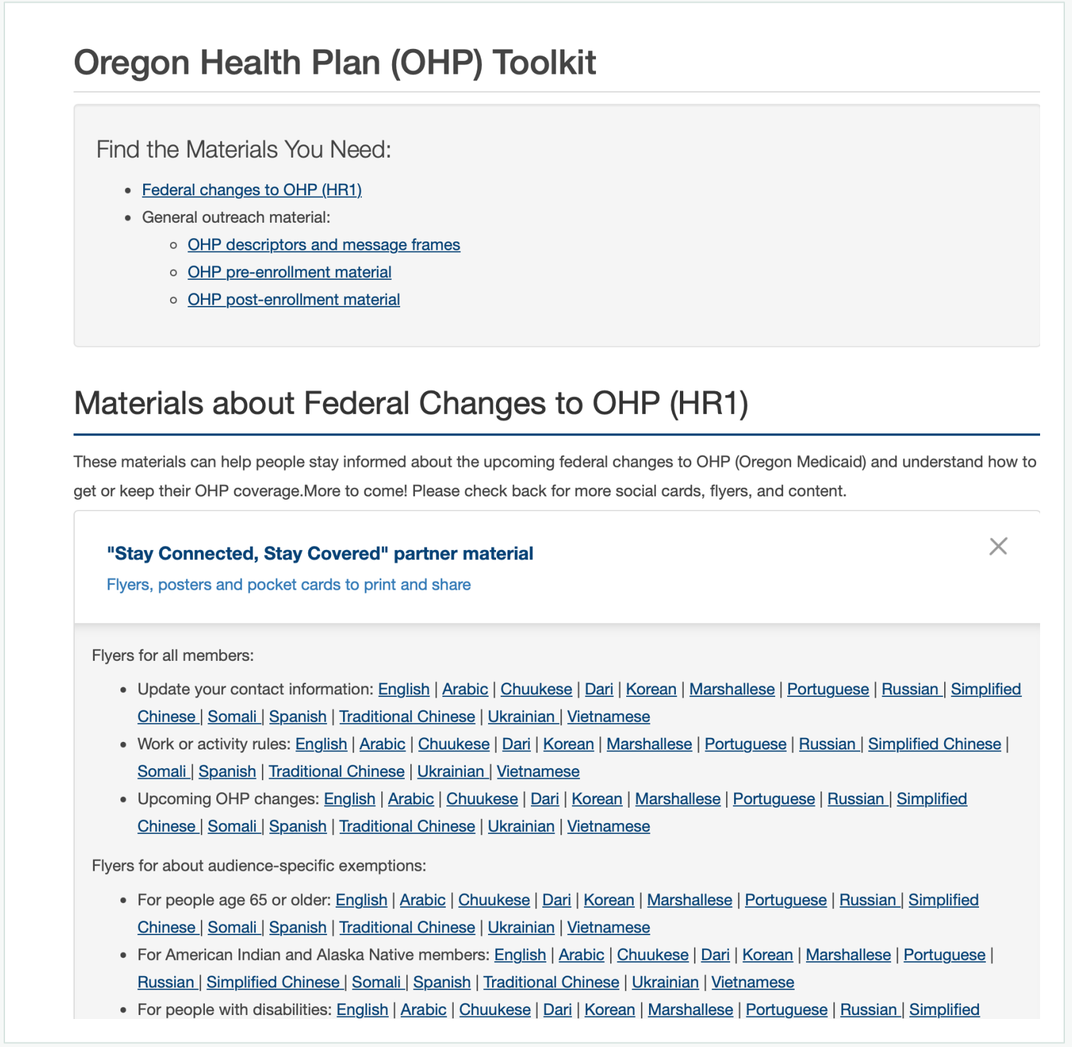
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OHA Resources

OHA has created a toolkit with printable resources

https://www.oregon.gov/oha/hsd/ohp/pages/toolkit.aspx

- General information flyers and posters in multiple languages
- Flyers about specific exemptions in multiple languages
- Fact sheets to share with OHP and HOP members in multiple languages
- Social media kit
- Videos
- Examples of the notices going to members
- Guidance for partners and providers



Oregon Health Plan (OHP) Toolkit

Find the Materials You Need:

- Federal changes to OHP (HR1)
- General outreach material:
  - OHP descriptors and message frames
  - OHP pre-enrollment material
  - OHP post-enrollment material

Materials about Federal Changes to OHP (HR1)

These materials can help people stay informed about the upcoming federal changes to OHP (Oregon Medicaid) and understand how to get or keep their OHP coverage.More to come! Please check back for more social cards, flyers, and content.

"Stay Connected, Stay Covered" partner material

Flyers, posters and pocket cards to print and share

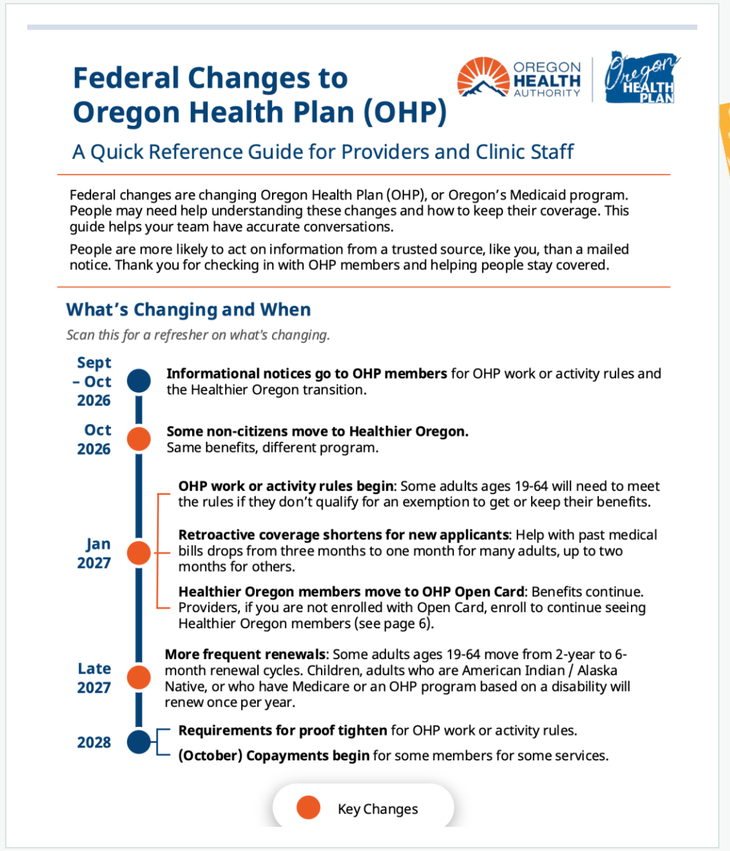
Flyers for all members:

- Update your contact information: English | Arabic | Chuukese | Dari | Korean | Marshallese | Portuguese | Russian | Simplified Chinese | Somali | Spanish | Traditional Chinese | Ukrainian | Vietnamese
- Work or activity rules: English | Arabic | Chuukese | Dari | Korean | Marshallese | Portuguese | Russian | Simplified Chinese | Somali | Spanish | Traditional Chinese | Ukrainian | Vietnamese
- Upcoming OHP changes: English | Arabic | Chuukese | Dari | Korean | Marshallese | Portuguese | Russian | Simplified Chinese | Somali | Spanish | Traditional Chinese | Ukrainian | Vietnamese

Flyers for about audience-specific exemptions:

- For people age 65 or older: English | Arabic | Chuukese | Dari | Korean | Marshallese | Portuguese | Russian | Simplified Chinese | Somali | Spanish | Traditional Chinese | Ukrainian | Vietnamese
- For American Indian and Alaska Native members: English | Arabic | Chuukese | Dari | Korean | Marshallese | Portuguese | Russian | Simplified Chinese | Somali | Spanish | Traditional Chinese | Ukrainian | Vietnamese
- For people with disabilities: English | Arabic | Chuukese | Dari | Korean | Marshallese | Portuguese | Russian | Simplified

OHA Resources



Federal Changes to Oregon Health Plan (OHP)

OREGON HEALTH AUTHORITY | Oregon Health Plan

A Quick Reference Guide for Providers and Clinic Staff

Federal changes are changing Oregon Health Plan (OHP), or Oregon's Medicaid program. People may need help understanding these changes and how to keep their coverage. This guide helps your team have accurate conversations.

People are more likely to act on information from a trusted source, like you, than a mailed notice. Thank you for checking in with OHP members and helping people stay covered.

What's Changing and When

Scan this for a refresher on what's changing.

Sept – Oct 2026
- **Informational notices go to OHP members** for OHP work or activity rules and the Healthier Oregon transition.

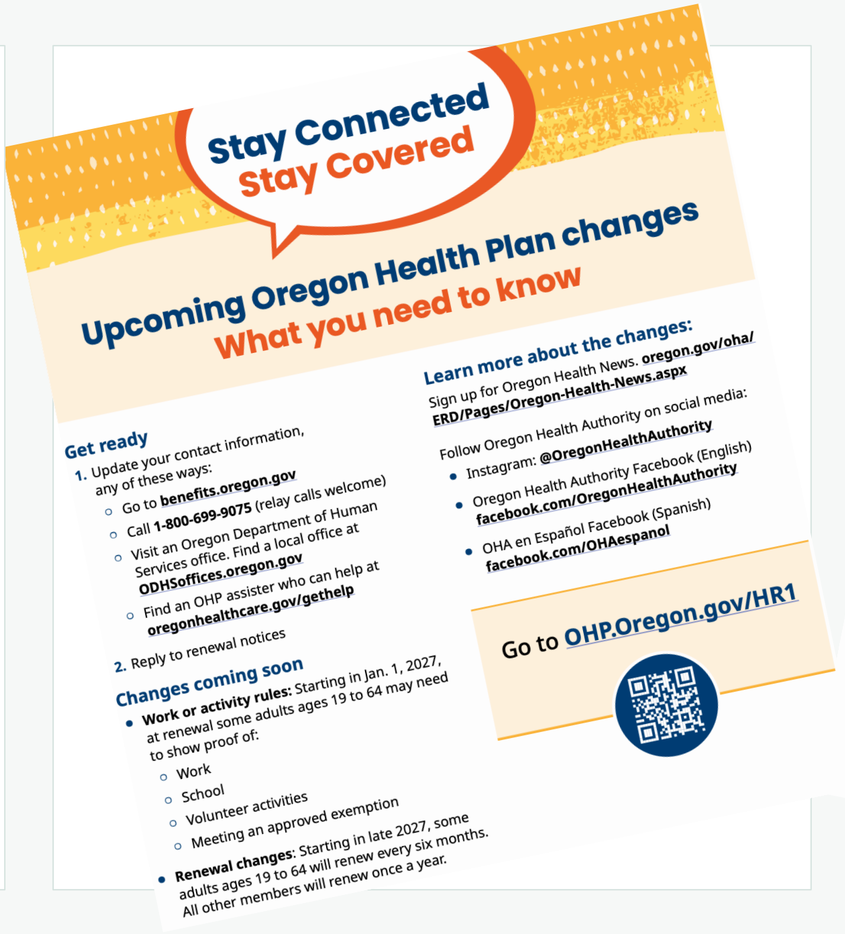
Oct 2026
- **Some non-citizens move to Healthier Oregon.** Same benefits, different program.

Jan 2027
- **OHP work or activity rules begin**: Some adults ages 19-64 will need to meet the rules if they don't qualify for an exemption to get or keep their benefits.
- **Retroactive coverage shortens for new applicants**: Help with past medical bills drops from three months to one month for many adults, up to two months for others.
- **Healthier Oregon members move to OHP Open Card**: Benefits continue. Providers, if you are not enrolled with Open Card, enroll to continue seeing Healthier Oregon members (see page 6).

Late 2027
- **More frequent renewals**: Some adults ages 19-64 move from 2-year to 6-month renewal cycles. Children, adults who are American Indian / Alaska Native, or who have Medicare or an OHP program based on a disability will renew once per year.

2028
- **Requirements for proof tighten** for OHP work or activity rules.
- **(October) Copayments begin** for some members for some services.

Key Changes



Stay Connected
Stay Covered

Upcoming Oregon Health Plan changes
What you need to know

Get ready

1. Update your contact information, any of these ways:
   - Go to **benefits.oregon.gov**
   - Call **1-800-699-9075** (relay calls welcome)
   - Visit an Oregon Department of Human Services office. Find a local office at **ODHSoffices.oregon.gov**
   - Find an OHP assister who can help at **oregonhealthcare.gov/gethelp**
2. Reply to renewal notices

Changes coming soon

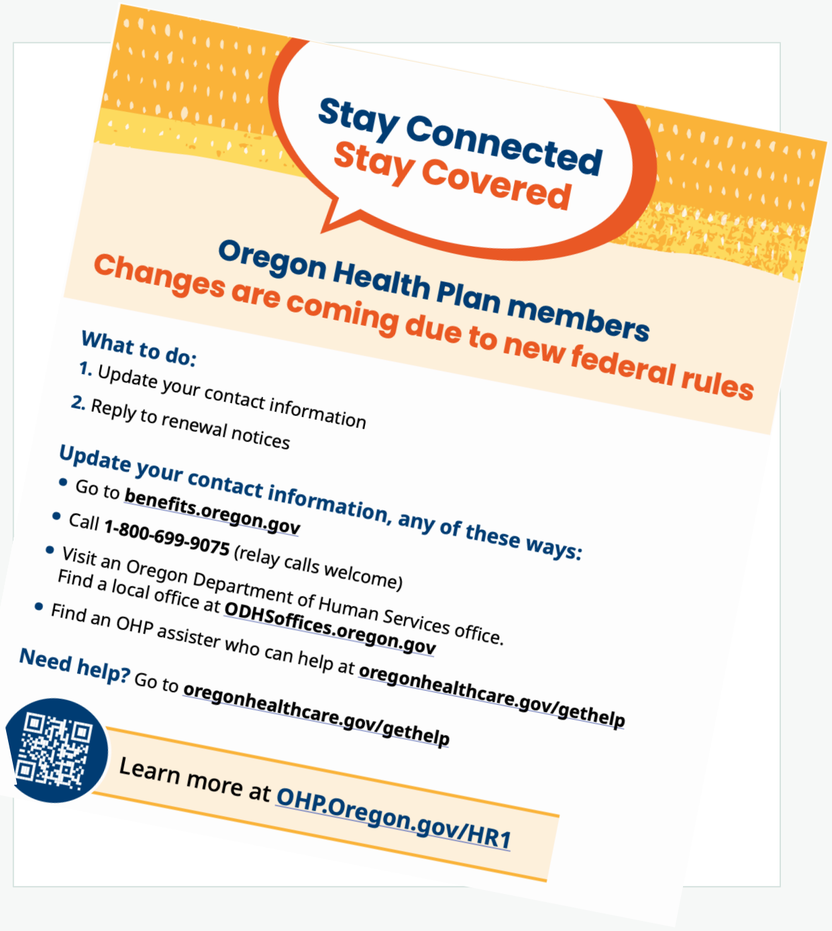
- **Work or activity rules:** Starting in Jan. 1, 2027, at renewal some adults ages 19 to 64 may need to show proof of:
  - Work
  - School
  - Volunteer activities
  - Meeting an approved exemption
- **Renewal changes:** Starting in late 2027, some adults ages 19 to 64 will renew every six months. All other members will renew once a year.

Learn more about the changes:

Sign up for Oregon Health News. **oregon.gov/oha/ERD/Pages/Oregon-Health-News.aspx**

Follow Oregon Health Authority on social media:
- Instagram: **@OregonHealthAuthority**
- Oregon Health Authority Facebook (English) **facebook.com/OregonHealthAuthority**
- OHA en Español Facebook (Spanish) **facebook.com/OHAespanol**

Go to OHP.Oregon.gov/HR1



Stay Connected
Stay Covered

Oregon Health Plan members
Changes are coming due to new federal rules

What to do:

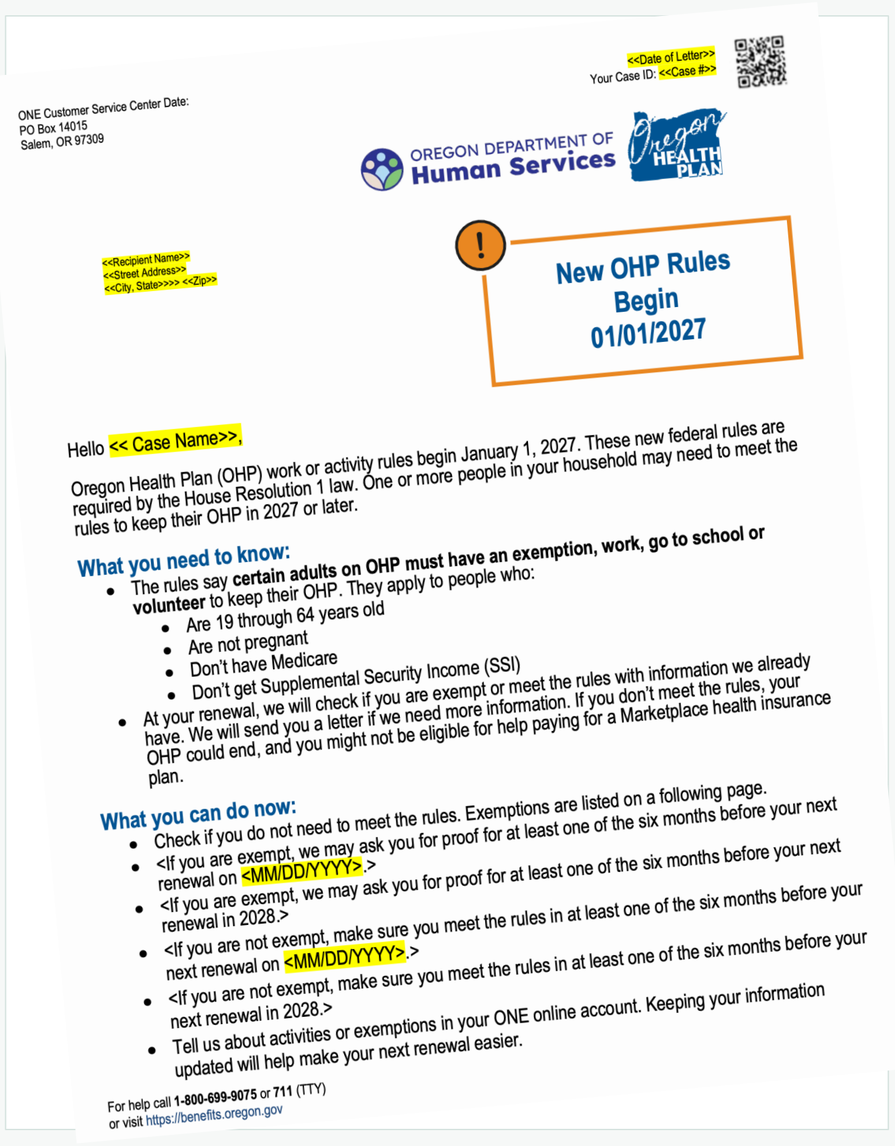
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Need help? Go to **oregonhealthcare.gov/gethelp**

Learn more at OHP.Oregon.gov/HR1

Example Notices



<<Date of Letter>>
Your Case ID: <<Case #>>

ONE Customer Service Center Date:
PO Box 14015
Salem, OR 97309

OREGON DEPARTMENT OF Human Services
Oregon HEALTH PLAN

<<Recipient Name>>
<<Street Address>>
<<City, State>>>> <<Zip>>

New OHP Rules Begin 01/01/2027

Hello << Case Name>>,

Oregon Health Plan (OHP) work or activity rules begin January 1, 2027. These new federal rules are required by the House Resolution 1 law. One or more people in your household may need to meet the rules to keep their OHP in 2027 or later.

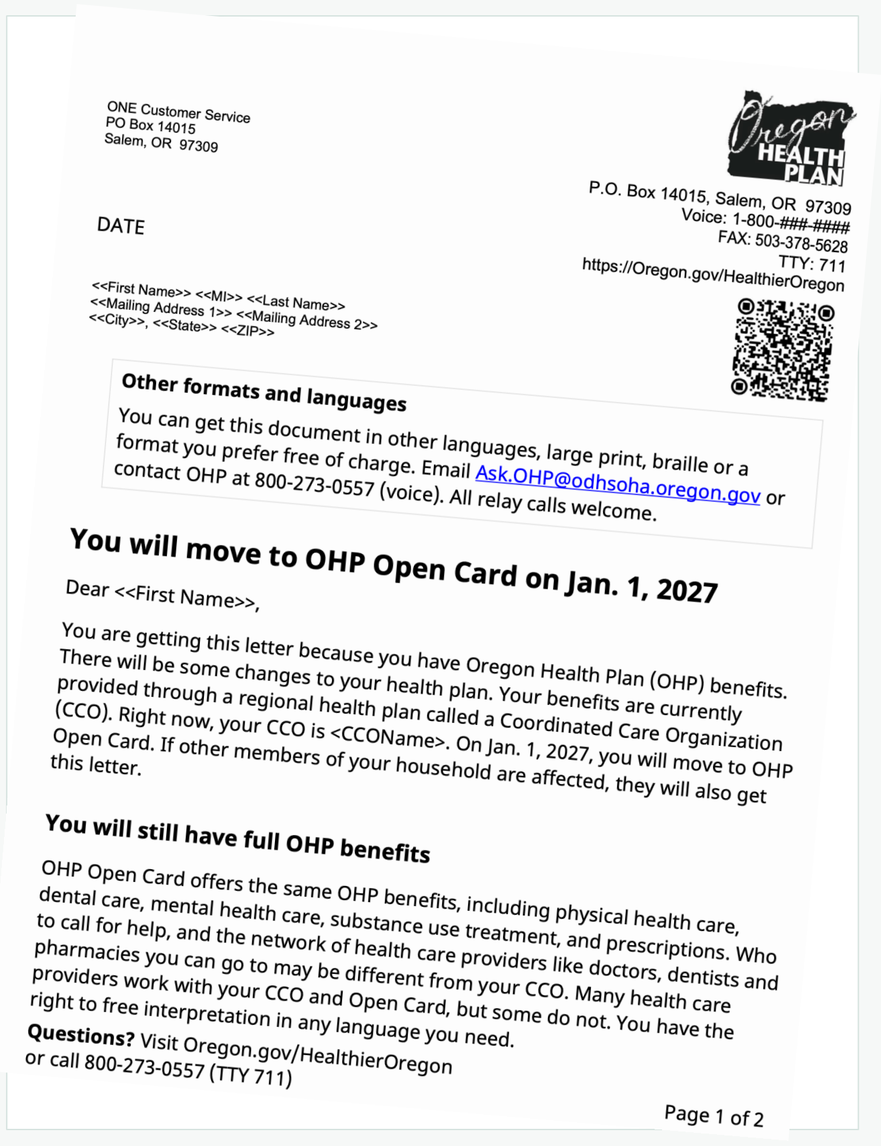
What you need to know:

- The rules say **certain adults on OHP must have an exemption, work, go to school or volunteer** to keep their OHP. They apply to people who:
  - Are 19 through 64 years old
  - Are not pregnant
  - Don't have Medicare
  - Don't get Supplemental Security Income (SSI)
- At your renewal, we will check if you are exempt or meet the rules with information we already have. We will send you a letter if we need more information. If you don't meet the rules, your OHP could end, and you might not be eligible for help paying for a Marketplace health insurance plan.

What you can do now:

- Check if you do not need to meet the rules. Exemptions are listed on a following page.
- <If you are exempt, we may ask you for proof for at least one of the six months before your next renewal on <MM/DD/YYYY>.>
- <If you are exempt, we may ask you for proof for at least one of the six months before your renewal in 2028.>
- <If you are not exempt, make sure you meet the rules in at least one of the six months before your next renewal on <MM/DD/YYYY>.>
- <If you are not exempt, make sure you meet the rules in at least one of the six months before your next renewal in 2028.>
- Tell us about activities or exemptions in your ONE online account. Keeping your information updated will help make your next renewal easier.

For help call **1-800-699-9075** or **711** (TTY)
or visit https://benefits.oregon.gov



ONE Customer Service
PO Box 14015
Salem, OR 97309

Oregon HEALTH PLAN
P.O. Box 14015, Salem, OR 97309
Voice: 1-800-###-####
FAX: 503-378-5628
TTY: 711
https://Oregon.gov/HealthierOregon

DATE

<<First Name>> <<MI>> <<Last Name>>
<<Mailing Address 1>> <<Mailing Address 2>>
<<City>>, <<State>> <<ZIP>>

Other formats and languages

You can get this document in other languages, large print, braille or a format you prefer free of charge. Email Ask.OHP@odhsoha.oregon.gov or contact OHP at 800-273-0557 (voice). All relay calls welcome.

You will move to OHP Open Card on Jan. 1, 2027

Dear <<First Name>>,

You are getting this letter because you have Oregon Health Plan (OHP) benefits. There will be some changes to your health plan. Your benefits are currently provided through a regional health plan called a Coordinated Care Organization (CCO). Right now, your CCO is <CCOName>. On Jan. 1, 2027, you will move to OHP Open Card. If other members of your household are affected, they will also get this letter.

You will still have full OHP benefits

OHP Open Card offers the same OHP benefits, including physical health care, dental care, mental health care, substance use treatment, and prescriptions. Who to call for help, and the network of health care providers like doctors, dentists and pharmacies you can go to may be different from your CCO. Many health care providers work with your CCO and Open Card, but some do not. You have the right to free interpretation in any language you need.

Questions? Visit Oregon.gov/HealthierOregon
or call 800-273-0557 (TTY 711)

Page 1 of 2

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.

HR 1 · REGIONAL ACTION

What communities can do (and are doing!)

Regions across Oregon are convening multi-stakeholder groups to discuss the impacts of H.R. 1.
The groups include CBOs, FQHCs, providers, hospitals, CCOs, assisters, and more.

How it's happening

- An existing rural health coalition
- Convened by an elected official, like a county commissioner
- Convened by the local CCO
- Convened by an OHA Innovator Agent

What they're focusing on

- ✓ Communication efforts
- ✓ Assisters
- ✓ Starting to think about coordinating and supporting volunteer opportunities

EFFORTS UNDERWAY

- Using the local public library as a dedicated space for assisters
- Drafting regionally focused informational flyers and distributing
- A locally hosted website with confirmed and available assisters

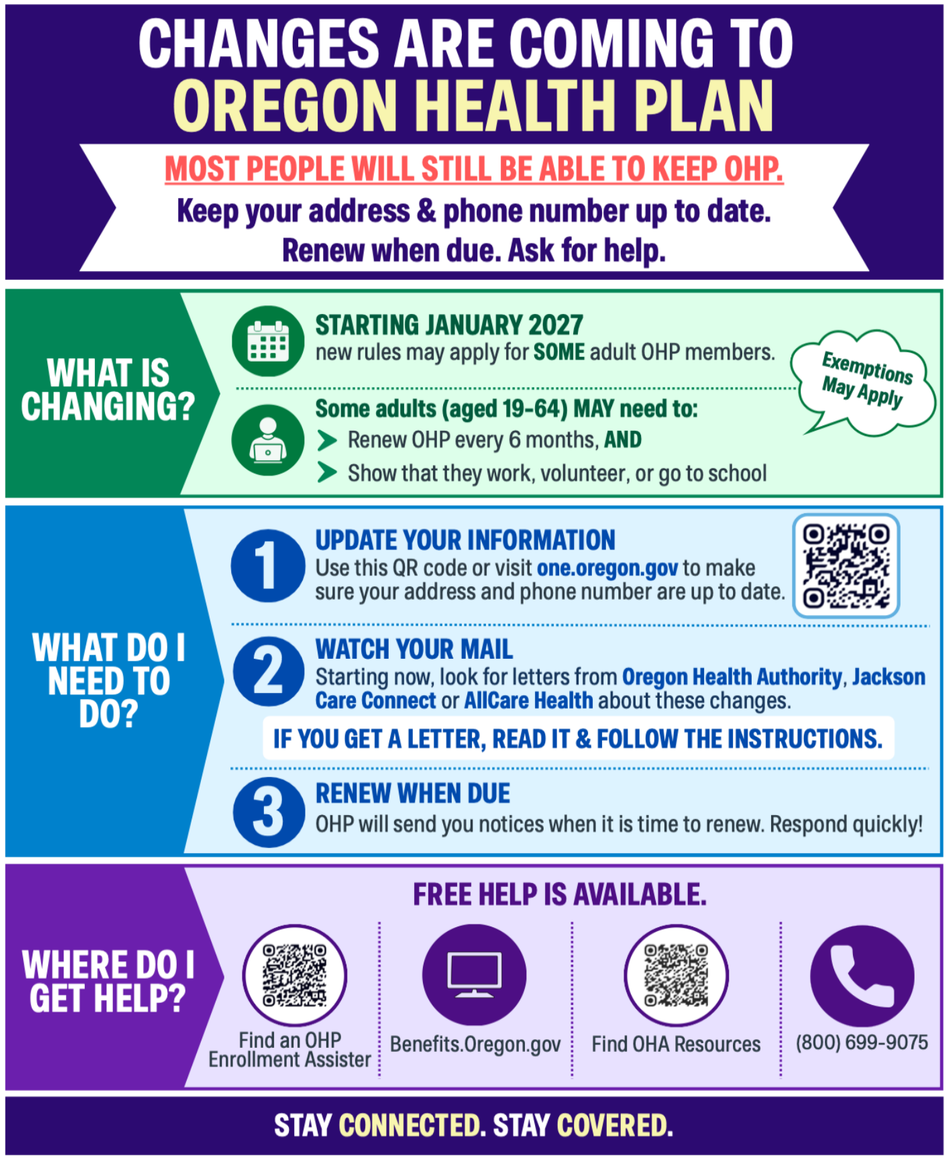
EXAMPLES

Jackson & Josephine | **Linn / Benton / Lincoln** | **Clatsop, Tillamook & Columbia**

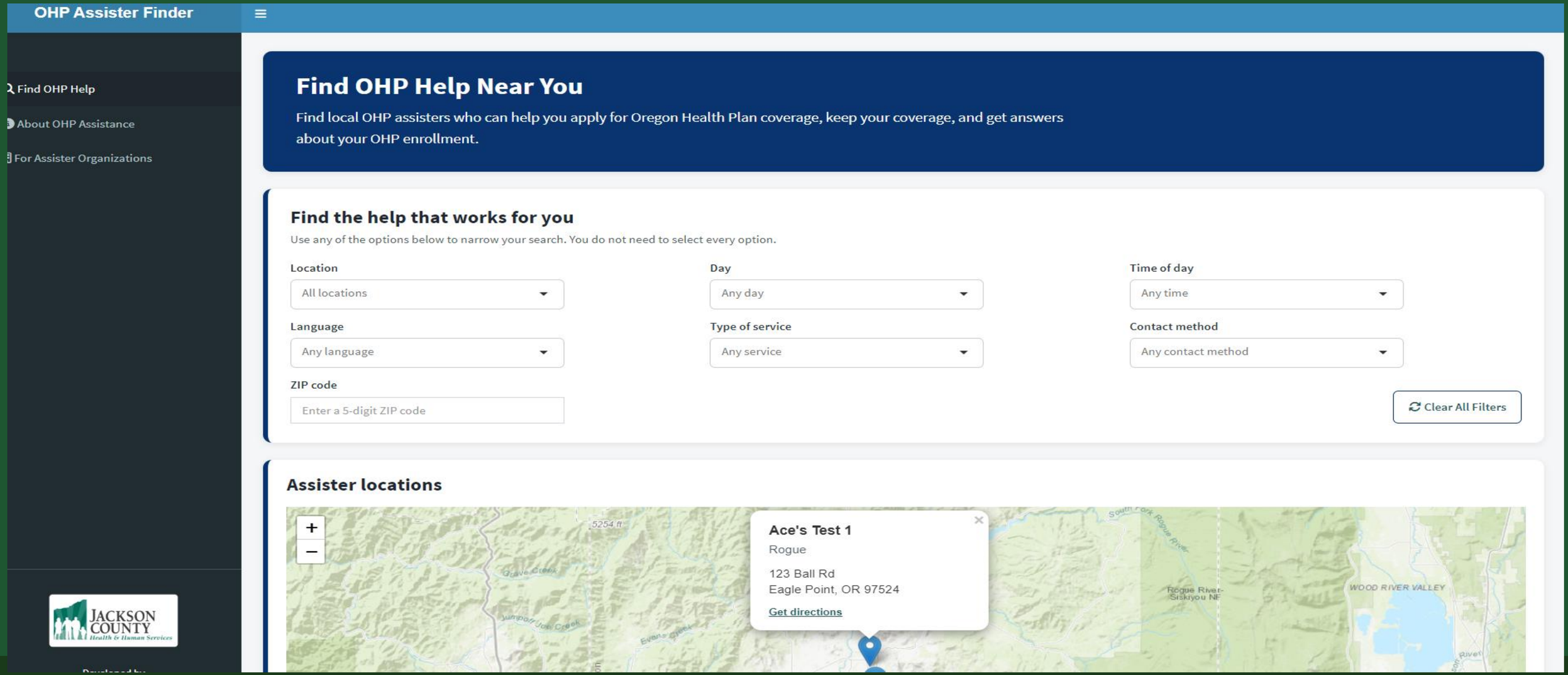
- **Jefferson Regional Health Alliance** convened providers, CBOs, CCOs, county government and others to discuss how they could work together regionally to prepare for the impacts of H.R. 1 in Jackson and Josephine counties.

- A Communications Committee drafted and is disseminating a one pager.
  - They are happy to share this template freely with other organizations and regions!
  - Spanish and Samoan language versions also available

- An Assisters Committee is getting an accurate count of available assisters and setting up a databank, hosted by Jackson County.



Strategy 2: Assister Directory



From Directory to Regional Needs Assessment

Quarterly updates create a repeatable picture of assistance supply and need

JACKSON COUNTY
Health & Human Services

1 **UPDATE** Verify assister organizations, locations, services, languages, hours, and capacity quarterly.

2 **MAP** Analyze the geographic distribution of assister organizations and individual assisters by ZIP code.

3 **COMPARE** Compare assistance supply with OHP enrollment, application/renewal demand, and other available indicators.

4 **IDENTIFY** Identify communities where additional assister capacity or targeted outreach may be needed.

Goal: a current public resource + an evidence base for regional assister capacity planning.

Planning support around H.R. 1 is available

Much of the work to get ready for 2027 goes better when local partners plan it together.

We could help your community:

- Bring local partners together: clinics, hospitals, CCOs, public health, and community organizations
- Shared learning on H.R. 1 changes
- Build a shared plan for outreach, renewals, and application support
- Identify activities RHTP funds could support

LET US KNOW IN THE CHAT

Would your community like planning support?

Put your name, organization, and community in the chat, and we'll follow up after the webinar.

Discussion

- On a scale of 1–5, how prepared does your community feel for H.R. 1 changes?
- What would help you feel more prepared?
- What do you want to learn more about regarding H.R. 1?



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



ORH Announcements

- 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*)

OREGON OFFICE of RURAL HEALTH

OREGON OFFICE of RURAL HEALTH

OPPORTUNITY Just knock.

Thank you!

Kenna Dickard
Technical Assistance Specialist
Dickard@ohsu.edu

OHSU